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Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs

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SUMMARY

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Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency primarily responsible for supporting community-based mental health and substance abuse treatment and prevention services. Located within the Department of Health and Human Services (HHS), SAMHSA provides federal funding to states, local communities, and private entities by administering block grants and other formula and discretionary grants. Through such grants, SAMHSA supports activities that include education and training, prevention programs, early intervention activities, treatment services, and technical assistance. SAMHSA does not provide mental health or substance abuse treatment. Rather, the agency supports states' efforts in providing community-based behavioral health services. SAMHSA also conducts surveillance and data collection of national behavioral health issues, provides statistical and analytic support to grantees, and administers other agency-wide initiatives. SAMHSA derives most of its statutory authority from the Public Health Service Act (PHSA). More specifically, Title V and Title XIX of the PHSA contain most authorities for SAMHSA programs and activities.

SAMHSA's two largest programs are the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG). Both block grant programs distribute funds to states (including the District of Columbia and territories) according to a formula specified in statute. The states, in turn, may distribute funds to local government entities and nonprofit organizations in accordance with a plan the state submits to SAMHSA.

SAMHSA also operates several discretionary programs, known as Programs of Regional and National Significance (PRNS). The PRNS encompass numerous grants and activities in the areas of substance abuse treatment, substance abuse prevention, and mental health. Typically, PRNS consist of programs for specific populations or areas of concern (e.g., children, suicide, opioid abuse). Some PRNS are explicitly authorized in statute while others are carried out under SAMHSA's general authorities. In addition, SAMHSA conducts surveillance and data collection, statistical and analytic support, and other agency-wide initiatives. SAMHSA provides resources for providers on treatment, prevention, and recovery for mental and substance use disorders and administers technical assistance to grantees.

SAMHSA's main source of funding is the discretionary budget authority it receives through the annual appropriations process. SAMHSA is funded through the annual Departments of Labor, Health and Human Services, and Education, and Related Agencies (Labor-HHS-ED) appropriations bill. SAMHSA's budget and appropriations fall under four categories: (1) substance abuse treatment, (2) substance abuse prevention, (3) mental health, and (4) health surveillance and program support. These categories roughly correspond with SAMHSA's four centers: (1) the Center for Substance Abuse Treatment; (2) the Center for Substance Abuse Prevention; (3) the Center for Mental Health Services; and (4) the Center for Behavioral Health Statistics and Quality.

Since its inception in 1992, SAMHSA and many of its programs have been reauthorized through legislation. While programs have been added or removed over the years, SAMHSA's primary responsibilities—including administering block grants to the states supporting mental health and substance abuse treatment services—have remained relatively consistent.

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Background and Role

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency primarily responsible for supporting community-based mental health and substance abuse treatment and prevention services. Located within the Department of Health and Human Services (HHS), SAMHSA provides federal funding for these services by administering two large formula-based block grant programs (one for substance abuse prevention and treatment services, the other for mental health services) and other formula and discretionary grants to local communities, states, and private entities.[1]

SAMHSA does not directly deliver treatment services. Rather, it supports state and local efforts in providing mental health and substance abuse (collectively known as *behavioral health*) services, primarily through funding and technical assistance. Behavioral health prevention and treatment activities have historically been the responsibilities of states. The federal government contributes supplementary support by providing funding and some direction for activities.[2] SAMHSA is the primary agency responsible for supporting state efforts in providing behavioral health treatment services. SAMHSA funds a wide range of activities including education and training for the behavioral health workforce, prevention and early intervention programs, and treatment services. SAMHSA administers its larger grant programs directly to states, and some smaller grants to localities or directly to services providers. SAMHSA also conducts surveillance and data collection, provides statistical and analytic support, maintains performance and quality information systems, and administers other agency-wide initiatives. SAMHSA derives most of its statutory authority from the Public Health Service Act (PHSA). More specifically, Title V and Title XIX of the PHSA contain most authorities for SAMHSA programs and activities.

Strategic Plan

SAMHSA's mission is to reduce the impact of substance misuse and mental illness on America's communities.[3] SAMHSA is required to develop a strategic plan every four years.[4] In its *Strategic Plan FY2019-FY2023*, SAMHSA articulates its mission, vision, and five core principles which include (1) supporting the adoption of evidence-based practices; (2) increasing access to the full continuum of services for mental and substance use disorders; (3) engaging in outreach to clinicians, grantees, patients, and the American public; (4) collecting, analyzing, and disseminating data to inform policies, programs, and practices; and (5) recognizing that the availability of mental and substance use disorder services is integral to everyone's health.[5]

SAMHSA also outlines five priority areas for FY2019-FY2023:

[1] SAMHSA awards discretionary funds to substance abuse and mental health programs through its authorities in Title V of the Public Health Service Act (PHSA) and provides the formula-based Substance Abuse Prevention and Treatment Block Grant and Community Mental Health Services Block Grant through its authorities in Title XIX of the PHSA.

[2] Medicaid—a joint federal-state program—also plays a significant role in funding behavioral health treatment. For more information, see CRS Report R43357, *Medicaid: An Overview* and CRS In Focus IF10222, *Medicaid's Institutions for Mental Disease (IMD) Exclusion*.

[3] HHS, SAMHSA, *SAMHSA Strategic Plan FY2019-FY2023*, Rockville, MD, 2018, https://www.samhsa.gov/about-us/strategic-plan.

[4] PHSA §501(l) (42 U.S.C. §290aa(l)).

[5] SAMHSA, *Strategic Plan FY2019-FY2023*.

1. Combating the opioid crisis through the expansion of prevention, treatment, and recovery support services.
2. Addressing serious mental illness and serious emotional disturbance.
3. Advancing prevention, treatment, and recovery support services for substance use.
4. Improving data collection, analysis, dissemination, and program and policy evaluation.
5. Strengthening health practitioners training and education.

For each area, SAMHSA sets an overarching goal and identifies a series of measurable objectives. Additionally, SAMHSA describes examples of key performance and outcome measures to track progress in each area.

History of SAMHSA

SAMHSA was formed in 1992 following reorganization of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Prior to 1992, ADAMHA supported treatment service delivery and scientific research related to mental health and addiction. The ADAMHA Reorganization Act of 1992 (P.L. 102-321) moved the three existing research institutes within ADAMHA—the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA)—to the National Institutes of Health. ADAMHA was then renamed SAMHSA to reflect its primary focus on funding community-based treatment services.

Community-Based Treatment Services

The early U.S. health care system offered little treatment for mental illness. By the mid-19th century, state psychiatric hospitals had begun to grow in number and size; this institutional mental health care was seen as a state responsibility and was not funded by the federal government. Due to poor conditions and largely ineffective treatment practices in institutional facilities, a movement to shift mental health treatment into community-based settings began in the 1960s. This community mental health movement advocated for treatment to take place where individuals could also receive support from their community, without the disruption of being removed from the community to receive care. The community mental health movement corresponded with the evolution of more effective, evidence-based treatments for mental health conditions: treatments that could be delivered in outpatient settings. Over time, outpatient community mental health centers replaced inpatient and residential treatment facilities. In some instances, this change was directly supported by the federal government, through grant programs and laws such as The Community Mental Health Act of 1963 (P.L. 88-164). Today, most individuals receiving mental health care receive it in community-based outpatient settings. Some short-term inpatient and residential facilities also provide care to individuals in crises or those requiring treatment for serious mental illnesses.

For more information, see CRS In Focus IF10870, *Psychiatric Institutionalization and Deinstitutionalization*.

Behavioral health services in the United States—which include substance abuse treatment and mental health care—have historically been the responsibility of states. The federal role has typically involved supporting state efforts through grant funding. This financial support has often consisted of block grants, with minimal direction to states regarding how to use these funds. Federal support for behavioral health activities was not designed for the federal government to be the primary payer, nor did the federal government intend to be the primary architect of these programs. While the federal government had nearly always played a more robust role in biomedical and health research—through the National Institutes of Health (NIH)—it did not make substantial investments in behavioral health services until the latter half of the 20th century. During the 1960s, congressional interest in mental health shifted toward a greater emphasis on

service development and provision.[6] At that time, Congress enacted grant programs to establish community-based psychiatric services, improve state hospitals, and develop centers for substance abuse treatment.[7]

The Alcohol, Drug Abuse and Mental Health Administration was created in 1973 to support states in administering substance abuse and mental health treatment services. ADAMHA provided federal funding to bolster state efforts in behavioral health care services. ADAMHA also served as the parent agency for the three research agencies covering substance use and mental health: NIMH, NIDA, and NIAAA.[8] NIDA and NIAAA were also created in the early 1970s following increased awareness of substance abuse and alcoholism as public health problems. NIMH had been established in 1946, in recognition of the burden that brain and behavioral disorders place on national health resources. Congress, determining that a strong program of research and research training would contribute to improving mental health and to treating mental illness, alcoholism, and drug abuse, established NIMH as one of the original components of the National Institutes of Health (NIH).

In addition to research, the original NIMH's mission included educating and training clinical personnel and providing grants to states to establish clinical treatment centers. This role changed with the creation of SAMHSA. As part of a reorganization of the Public Health Service agencies[9] in 1992, SAMHSA took on responsibility for education and training of providers, and for administering treatment services—activities it continues today.[10] NIMH, NIDA, and NIAAA—all now within NIH—remain the agencies primarily responsible for advancing mental health and addiction research.

Since its inception in 1992, SAMHSA and many of its programs have undergone multiple reauthorizations through legislation. Two laws—the Children's' Health Act of 2000 (P.L. 106-310) and the Helping Families in Mental Health Crisis Reform Act (Division B of P.L. 114-255, The 21st Century Cures Act)—provided comprehensive reauthorization of multiple SAMHSA programs. Most of the other reauthorizing laws established or reauthorized specific SAMHSA activities, such as individual grant programs. While many programs have been added or repealed over the years, SAMHSA's primary responsibilities—including administering block grants to the states supporting mental health and substance abuse treatment services—have remained consistent with few significant changes.

[6] Institute of Medicine (IOM), *Research and Service Programs in the PHS: Challenges in Organization*, Washington, DC, 1991, pp. 27-42, https://doi.org/10.17226/1871.

[7] Ibid.

[8] Ibid.

[9] The Public Health Service agencies represent eight of the eleven operating divisions of the Department of Health and Human Services focused on public health. For more information, see CRS Report R44916, *Public Health Service Agencies: Overview and Funding (FY2016-FY2018)*.

[10] SAMHSA shares responsibility for training behavioral health providers with the Health Services and Research Administration (HRSA) within HHS.

Figure 1. Timeline of Major Legislation Authorizing Programs and Activities Administered by SAMHSA

- **1992** ADAMHA Reorganization Act (P.L. 102-321)
- **2000** Children's Health Act (P.L. 106-310)[a]
- **2002** No Child Left Behind Act (P.L. 107-110)[b]
- **2004** Garrett Lee Smith Memorial Act (P.L. 108-355)[c]
- **2005** Sober Truth on Preventing Underage Drinking Act (P.L. 109-422)[d]
- **2010** Affordable Care Act (P.L. 111-148)[e]
- **2016** Comprehensive Addiction and Recovery Act (P.L. 114-198)[f]
- **2016** 21st Century Cures Act/Helping Families in Mental Health Crisis Reform Act (P.L. 114-255)[g]
- **2018** SUPPORT for Patients and Communities Act (P.L. 115-271)[h]

Source: Figure prepared by the Congressional Research Service (CRS) based on analysis of relevant legislation. Acts were included here if they established multiple new authorizations or made amendments to multiple existing SAMHSA authorities.

Notes: Most of these laws authorized or reauthorized several select SAMHSA activities rather than the entirety of programs or the agency as a whole. Of note, the Omnibus Budget Reconciliation Act 1981 (P.L. 97-35) provided the initial authorization for the block grant that would eventually become the mental health and substance abuse block grants administered by SAMHSA. *ADAMHA* stands for the Alcohol, Drug Abuse and Mental Health Administration. *SAMHSA* stands for the Substance Abuse and Mental Health Services Administration.

a. The Children's Health Act amended SAMHSA's existing authorities under Title V, added several new authorities, and authorized appropriations through FY2003. The 2000 reauthorization legislation also incorporated the Drug Addiction Treatment Act (DATA) of 2000 (P.L. 106-310, Title XXXV) which expanded opioid use disorder treatment using buprenorphine.[11]

b. The No Child Left Behind Act of 2001 (P.L. 107-110, Sec. 4129; enacted January 8, 2002) required SAMHSA to provide consultation to the Secretary of Education in awarding grants to local educational agencies for reducing alcohol abuse in secondary schools.

c. The Garrett Lee Smith Memorial Act of 2004 (P.L. 108-355) authorized three suicide prevention programs at SAMHSA—two grant programs and a resource center.

d. The 2005 Sober Truth on Preventing Underage Drinking (STOP) Act (P.L. 109-422) authorized SAMHSA to award grants for reducing underage drinking.

e. The Patient Protection and Affordable Care Act of 2010 (ACA; P.L. 111-148) contained several provisions relating to mental health and substance abuse services, including new SAMHSA authorities.

f. The Comprehensive Addiction and Recovery Act (P.L. 114-198) of 2016 established new—or reauthorized existing—substance abuse treatment-related activities.

g. The Helping Families in Mental Health Crisis Reform Act (Division B of the 21st Century Cures Act; P.L. 114-255) made changes to the organization of the agency and amended a number of programs.

h. The SUPPORT for Patients and Communities Act (P.L. 115-271) of 2018 primarily established new—or reauthorized existing—substance abuse treatment-related activities.

[11] For more information, see CRS Report R45279, *Buprenorphine and the Opioid Crisis: A Primer for Congress*.

Authority and Organization

SAMHSA and most of its programs and activities are authorized under Title V of the Public Health Service Act (PHSA). The substance abuse block grant (SABG) and community mental health block grant (MHBG) are separately authorized under PHSA Title XIX Part B. PHSA Title V provides the authorities for an Assistant Secretary of Mental Health and Substance Use (Assistant Secretary)[12] and four centers: the Center for Substance Abuse Treatment, the Center for Substance Abuse Prevention, the Center for Mental Health Services, and the Center for Behavioral Health Statistics and Quality. SAMHSA's four centers and main offices are depicted in **Figure 2**. Each of the four centers has a director who reports to the Assistant Secretary.

In addition to administering SAMHSA's major block grant programs, each center has general authority to fund states and communities to address priority substance abuse and mental health needs. This authority, called Programs of Regional and National Significance (PRNS), authorizes SAMHSA to fund projects that (1) translate promising new research findings to community-based prevention and treatment services; (2) provide training and technical assistance; and (3) target resources to increase service capacity where it is most needed.[13] SAMHSA conducts several programs under PRNS authorities, some of which are explicitly authorized in statute while others exist at the discretion of SAMHSA, the Secretary of HHS, or elsewhere within HHS or the Administration. SAMHSA determines its funding priorities in consultation with states and other stakeholders.

The PHSA also directs SAMHSA to conduct data collection and analysis activities related to mental health and substance abuse. These activities are centrally coordinated in the Center for Behavioral Health Statistics and Quality.

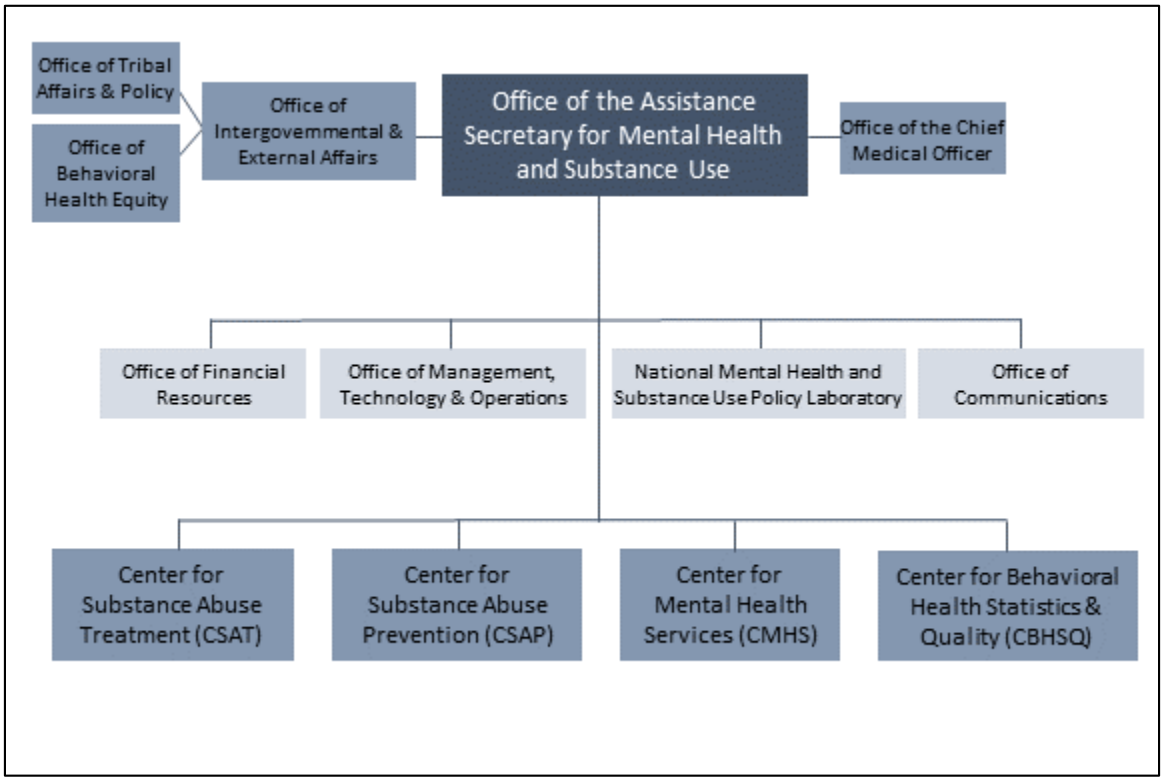
For a list of specific program authorities within each of SAMHSA's centers, see **Table 1** describing the "Substance Abuse Treatment PRNS" **Table 2** describing "Substance Abuse Prevention PRNS", and **Table 3** describing "Mental Health PRNS" later in this report.

[12] Subtitle A (§6001 and §6002) of the 21st Century Cures Act (P.L. 114-255) replaced the position of SAMHSA Administrator with a newly established Assistant Secretary for Mental Health and Substance Use (Assistant Secretary), to be appointed by the President and subject to Senate confirmation (as was the case with the Administrator). It also expanded and revised the list of responsibilities to be carried out by the HHS Secretary, acting through the newly established Assistant Secretary.

[13] See, for instance, PHSA §509, §516, and §520A.

Figure 2. SAMHSA Organizational Chart

Major Offices and Centers at the Substance Abuse and Mental Health Services Administration



Source: CRS figure based on U.S. Department of Health and Human Services, SAMHSA, *Justification of Estimates for Appropriations Committees for FY2020* and SAMHSA, *About Us; Who We Are*; *SAMHSA Headquarters Offices and Centers*, available at https://www.samhsa.gov/about-us/who-we-are/offices-centers/.

Centers

SAMHSA carries out most of its programs and activities through four statutorily established centers focusing on substance abuse treatment, substance abuse prevention, mental health services, and health surveillance and program support.

Center for Substance Abuse Treatment (CSAT)

The Center for Substance Abuse Treatment (CSAT) has primary responsibility for promoting community-based treatment and recovery services for individuals with substance use disorders.[14] CSAT does not directly deliver treatment services. Rather, the center supports state efforts through funding and technical assistance. CSAT is responsible for leading efforts to increase access to effective treatment; closing the gap between demand and capacity for treatment; promoting evidence-based practices; and strengthening treatment systems (among other responsibilities). CSAT primarily does this by administering the Substance Abuse Prevention and Treatment Block Grant (in coordination with the Center for Substance Abuse Prevention). CSAT is also authorized to develop, evaluate, and implement effective treatment programs; and enable

[14] HHS, SAMHSA, *Center for Substance Abuse Treatment*, http://www.samhsa.gov/about-us/who-we-are/offices-centers/csat.

improvement of service quality and access. For an example of the center's activities, see "Substance Abuse Treatment PRNS" later in this report.

PHSA Title V, Part B, Subpart 1 establishes CSAT, lists the Director's duties, and authorizes various programs.[15] The CSAT Director's duties include administering the Substance Abuse Prevention and Treatment Block Grant (SABG).[16] Except for the SABG, all of CSAT's programs and activities fall under the category of substance abuse treatment PRNS (for more details, see **Table 1** in the "Substance Abuse Treatment PRNS" section later in this report).[17]

Center for Substance Abuse Prevention (CSAP)

The Center for Substance Abuse Prevention (CSAP) has primary responsibility for preventing misuse (and underage use) of alcohol, tobacco, prescription drugs, and illegal drugs.[18] CSAP is responsible for leading the development of effective prevention policies, programs, and services, and enabling states, local communities, and organizations to adopt such policies, programs, and services (among other responsibilities). CSAP is authorized to prevent substance abuse through public education, training, technical assistance, and dissemination of research findings. The center primarily executes this through workforce training programs and technical assistance to grantees. The center also provides states with grants to support their strategic planning activities and for demonstration programs. For an example of the center's activities, see "Substance Abuse Prevention PRNS" later in this report.

PHSA Title V, Part B, Subpart 2 establishes CSAP, lists the Director's duties, and authorizes various programs.[19] Currently all of CSAP's programs and activities fall under the category of substance abuse prevention PRNS (for more details, see **Table 2** later in this report). CSAP works with CSAT to administer the Substance Abuse Prevention and Treatment Block Grant. The block grant includes a 20% set-aside for prevention.[20]

Center for Mental Health Services (CMHS)

The Center for Mental Health Services (CMHS) leads federal efforts supporting the prevention and treatment of mental disorders.[21] The goals of CMHS include preventing mental illness and promoting mental health.[22] CMHS is responsible for leading efforts to increase access to mental health services and improve their quality. CMHS is authorized to help prevent mental illness and promote mental health by providing funds to evaluate, improve and implement effective treatment practices; provide technical assistance to state and local mental health agencies; and collect data. CMHS supports mental health services provided by states and local governments

[15] PHSA Title V, Part B, Subpart 1 (42 U.S.C. §290bb et seq.).

[16] PHSA §507(b)(1) (42 U.S.C. §290bb(b)(1)).

[17] The CSAT also plays a role in administering two opioid-specific grant programs authorized to HHS generally, but operated by SAMHSA. See "Additional Opioid Grant Programs" later in this report.

[18] SAMHSA, *Center for Substance Abuse Prevention*, http://www.samhsa.gov/about-us/who-we-are/offices-centers/csap.

[19] PHSA Title V, Part B, Subpart 2 (42 U.S.C. §290bb-21 et seq.).

[20] HHS, SAMHSA, *FY2019 Justification of Estimates for Appropriations Committees*. The 20% prevention set-aside is specified at PHSA §1922(a)(1) (42 U.S.C. §300x-22(a)(1)).

[21] SAMHSA, *Center for Mental Health Services*, http://www.samhsa.gov/about-us/who-we-are/offices-centers/cmhs.

[22] PHSA §520(b)(1) (42 U.S.C. §290bb-31(b)(1)).

through its mental health block grant and discretionary grant programs. For an example of the center's activities, see "Mental Health PRNS" later in this report.

PHSA Title V, Part B, Subpart 3 establishes CMHS, lists the Director's duties, and authorizes various programs.[23] The CMHS Director's duties include administering the Community Mental Health Services Block Grant (MHBG)[24] and other funding programs that target specific populations or activities such as the Projects for Assistance in Transition from Homelessness (PATH) program[25] and the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program.[26] PHSA Section 561 requires the HHS Secretary, acting through the CMHS Director, to award grants under the Children's Mental Health Services program.[27] CMHS is also responsible for administering the Certified Community Behavioral Health Clinics grant program.[28] All other CMHS programs fall under the category of mental health PRNS (for more details, see **Table 3** later in this report).

Center for Behavioral Health Statistics and Quality (CBHSQ)

The Center for Behavioral Health Statistics and Quality (CBHSQ) has primary responsibility for collecting and analyzing behavioral health statistics. As the federal government's lead agency for behavioral health statistics, CBHSQ designs and implements data collection and analysis projects, advises the HHS Secretary and SAMHSA Assistant Secretary on behavioral health epidemiology, and partners with other agencies to develop federal health statistics policy (among other responsibilities).[29] CBHSQ was explicitly established in statute in 2016, though the center conducted many of its activities under other authorizations prior to its formal codification.[30]

CBHSQ's data collection programs include the National Survey on Drug Use and Health (NSDUH) and the Behavioral Health Services Information System (BHSIS), which includes the National Mental Health Services Survey (N-MHSS), the Treatment Episode Data Set (TEDS), and the National Survey of Substance Abuse Treatment Services (N-SSATS), among others.[31] One element of the BHSIS is the Inventory of Behavioral Health Services, which provides a listing of all known mental health and substance use treatment facilities used to inform SAMHSA's Behavioral Health Treatment Services Locator webpage.[32] CBHSQ also maintains the Evidence-Based Practices Resource Center.[33]

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[23] PHSA Title V, Part B, Subpart 3 (42 U.S.C. §290bb-31 et seq.).

[24] PHSA §520(b)(7) (42 U.S.C. §290bb-31(b)(7)).

[25] PHSA §520(b)(9) (42 U.S.C. §290bb-31(b)(9)).

[26] PHSA §520(b)(8) (42 U.S.C. §290bb-31(b)(8)).

[27] PHSA §561(a)(1) (42 U.S.C. §290ff(a)(1)).

[28] Established by §223 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93; 42 U.S.C. §1936(a) footnote entitled "Demonstration Programs To Improve Community Mental Health Services").

[29] HHS, SAMHSA, *Center for Behavioral Health Statistics and Quality*, http://www.samhsa.gov/about-us/who-we-are/offices-centers/cbhsq. Of note, other federal agencies also collect data related to behavioral health, such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Agency for Healthcare Research and Quality (AHRQ), and the National Institute of Mental Health (NIMH) and National Institute for Drug Abuse (NIDA) within the National Institutes of Health (NIH).

[30] PHSA §505 (42 U.S.C. §290aa-4).

[31] HHS, SAMHSA, *FY2019 Justification of Estimates for Appropriations Committees*, http://www.hhs.gov/budget.

[32] SAMHSA, *Behavioral Health Treatment Services Locator*, https://findtreatment.samhsa.gov/.

[33] SAMHSA, *Evidence-Based Practices Resource Center*, https://www.samhsa.gov/ebp-resource-center. The Evidence-Based Practice Resource Center replaced the National Registry of Evidence-based Programs and Practices (NREPP) in

CBHSQ maintains a data archive and conducts research on behavioral health access, cost, quality, outcomes, policy, and practices.[34] The center disseminates information through articles, short reports, and data spotlights. Through the Substance Abuse and Mental Health Data Archive (SAMHDA), CBHSQ provides public access to much of the data they collect for research analysis.[35] CBHSQ is also responsible for agency-wide initiatives such as efforts to develop the behavioral health workforce. Most CBHSQ activities are integrated with the other centers and cross over multiple funding lines.[36]

PHSA Title V, Section 505 establishes CBHSQ, lists the Director's duties, and authorizes various programs.[37] The CBHSQ Director's duties include coordinating SAMHSA's integrated data strategy, which includes collecting data on the incidence and prevalence of mental illness and substance abuse (the NSDUH survey), the number of individuals seeking treatment for mental illness and substance abuse issues, and the number of individuals admitted to emergency rooms as a result of substances (the Drug Abuse Warning Network [DAWN] surveillance system). Duties of the Director also include collecting data on mental health and substance abuse treatment programs (the N-SSATS survey) and making recommendations for performance metrics to evaluate SAMHSA activities. PHSA Section 505 specifies that summaries and analyses of data collected shall be made available to the public.

Headquarters Offices

Key offices within SAMHSA's headquarters are described briefly below.[38]

The *Office of the Assistant Secretary for Mental Health and Substance Use* is responsible for managing and directing the agency, leading policy and program development, and working with the Office of the Secretary in HHS (among other responsibilities). Within the Office of the Assistant Secretary is the *Office of Intergovernmental and External Affairs* and several other offices:

- The *Office of Behavioral Health Equity* is responsible for coordinating SAMHSA's efforts to ensure equitable access to high-quality behavioral health care and reduce disparities in health outcomes (among other responsibilities).[39]
- The *Office of Tribal Affairs and Policy* is responsible for supporting agency efforts to implement the Tribal Law and Order Act of 2010 (Title II of P.L. 111-211) and address behavioral health issues affecting tribal communities in collaboration with tribal governments and tribal organizations (among other responsibilities).[40]

2018.

[34] HHS, SAMHSA, *Center for Behavioral Health Statistics and Quality*.

[35] SAMHSA, Substance Abuse & Mental Health Data Archive, *What is SAMHDA?*, https://www.datafiles.samhsa.gov/faq/what-samhda-nid23. SAMHDA data are available at https://www.datafiles.samhsa.gov/.

[36] HHS, SAMHSA, *Justification of Estimates for Appropriations Committees for FY2020*, http://www.hhs.gov/budget.

[37] PHSA Title V, Section 505 (42 U.S.C. §290aa-4).

[38] Unless otherwise noted, information in this section is drawn from HHS, SAMHSA, *Offices and Centers: SAMHSA Headquarters Offices*, http://www.samhsa.gov/about-us/who-we-are/offices-centers.

[39] SAMHSA, *Justification of Estimates for Appropriations Committees for FY2020* and SAMHSA, *Organizational Structure: Substance Abuse and mental Health Services Administration (SAMHSA)*, available at https://www.samhsa.gov/sites/default/files/508_samhsa-org-chart04032019.pdf.

[40] SAMHSA, "New SAMHSA Office of Tribal Affairs and Policy," *SAMHSA News*, vol. 22, no. 4 (Fall 2014).

- The *Office of the Chief Medical Officer* (OCMO) is responsible for ensuring that medically researched and clinically approved practices are incorporated in SAMHSA programs and activities. The Chief Medical Officer also advises the Assistant Secretary on appropriate performance metrics and evaluation designs.[41]

The *Office of Communications* is responsible for guiding the agency's strategic communications plan, managing its online presence, disseminating products through the SAMHSA store (among other responsibilities).

The *Office of Financial Resources* is responsible for all functions of the Chief Financial Officer, including advising the Assistant Secretary on the agency's budget, assisting with financial management, and reducing waste, fraud, and abuse (among other responsibilities).

The *Office of Management, Technology, and Operations* is responsible for administrative services, human resources management, and information technology (among other responsibilities).

The *National Mental Health and Substance Use Policy Laboratory* is responsible for promoting evidence-based practices, evaluating service delivery models of treatment and facilitating adoption of data-driven policies (among other responsibilities).[42]

Regional Administrators

HHS has 10 regional offices to ensure that "the Department maintains close contact with state, local, and tribal partners and addresses the needs of communities and individuals served through HHS programs and policies."[43] SAMHSA's regional administrators represent SAMHSA within these areas; promote behavioral health initiatives; collaborate with other federal agencies; provide support (e.g., technical assistance) to stakeholders; and periodically report on relevant trends, issues, and policies.[44]

Advisory Councils and Committees

To help draw advice from mental health and substance abuse professionals and members of the public, SAMHSA has several advisory councils and committees:[45]

- SAMHSA National Advisory Council,
- CSAT National Advisory Council,
- CSAP National Advisory Council,

[41] SAMHSA, *About Us; Who We Are; Leadership*, https://www.samhsa.gov/about-us/who-we-are/leadership PHSA §501(g). This office was established by §6003 of The 21st Century Cures Act of 2016 (P.L. 114-255).

[42] Prior to enactment of the 21st Century Cures Act (P.L. 114-255) in 2016, SAMHSA's Office of Policy, Planning, and Innovation, which was not explicitly authorized in statute, facilitated the adoption of evidence-based policies and practices to improve behavioral health services outcomes. Title VII of the Cures Act added a new PHSA §501A which established within SAMHSA a "National Mental Health and Substance Use Policy Laboratory" (the "Laboratory"). The law requires the Laboratory to carry out "the authorities and activities that were in effect for the Office of Policy, Planning, and Innovation" before enactment of the Cures Act. The Laboratory was established by §7001 of the Cures Act.

[43] HHS, *Regional Offices*, http://www.hhs.gov/about/agencies/regional-offices/.

[44] HHS, SAMHSA, *SAMHSA Regional Administrators*, http://www.samhsa.gov/about-us/who-we-are/regional-administrators.

[45] SAMHSA, *Advisory Councils*, http://www.samhsa.gov/about-us/advisory-councils.

- CMHS National Advisory Council,
- Advisory Committee for Women's Services,
- Drug Testing Advisory Board (DTAB),
- Tribal Technical Advisory Committee,
- Interdepartmental Serious Mental Illness Coordinating Committee, and
- Interdepartmental Substance Use Disorders Coordinating Committee.

PHSA Sections 501 and 222 (respectively) require the Assistant Secretary to "establish such peer review groups and program advisory committees as are needed."[46] Some advisory councils and committees are established under SAMHSA's general authorities, while others are explicitly required in statute. For example, PHSA Section 502 requires the HHS Secretary to appoint an advisory council for SAMHSA and three of its statutorily established centers (CMHS, CSAT, and CSAP).[47] PHSA Section 501 requires the Assistant Secretary to appoint an Associate Administrator for Women's Services, who must establish an Advisory Committee for Women's Services.[48] SAMHSA also has a Tribal Technical Advisory Committee consistent HHS's Tribal Consultation Policy.[49]

Interagency Activities

SAMHSA is not the sole federal agency responsible for behavioral health-related activities. SAMHSA participates in interagency efforts to coordinate programs, share knowledge, and advance behavioral health.[50] While SAMHSA primarily supports direct behavioral health prevention and treatment services, other agencies conduct behavioral health research, provide workforce development resources, and operate other behavioral health-related programs. Other federal agencies may support other behavioral health activities—including direct services in some instances—as well.

SAMHSA is statutorily required to collaborate with other agencies—such as the Department of Veterans Affairs, the Department of Justice, and other HHS agencies like NIH and the Agency for Health Care Research and Quality (AHRQ)—to coordinate behavioral health activities and translate research findings into services.[51] For example, SAMHSA cooperated, along with the Health Resources and Services Administration (HRSA), the SAMHSA-HRSA Center for Integrated Solutions. This body promoted the integration of primary care and behavioral health services through training and technical assistance for treatment organizations.[52] The Behavioral

[46] PHSA §501(i) (42 U.S.C. §290aa(i)).

[47] 42 U.S.C. §290aa-1.

[48] PHSA §501(f)(2)(C) (42 U.S.C. §290aa(f)(2)(C)).

[49] HHS, *Tribal Consultation*, http://www.hhs.gov/about/agencies/iea/tribal-affairs/consultation/index.html. This committee is also consistent with several recent presidential policies including Executive Order 13175, "Consultation and Coordination with Indian Tribal Governments," *Public Papers of the Presidents of the United States: William J. Clinton* (Washington: GPO, 2000), U.S. President (G.W. Bush), "Memorandum on Government-to-Government Relationship with Tribal Governments," September 23, 2004, and U.S. President (Obama), "A Renewed Era of Federal-Tribal Relations," *2016 White House Tribal Nations Conference Progress Report*, January 2017.

[50] SAMHSA, *About Us; Interagency Activities*, https://www.samhsa.gov/about-us/interagency, accessed March 2019.

[51] See, for example, PHSA §501(d), PHSA §507(b), PHSA §515(b), and PHSA §520(b).

[52] HHS, SAMHSA, HRSA, *SAMHSA-HRSA Center for Integrated Health Solutions*, https://www.integration.samhsa.gov/. Beginning in 2020, the center is operated by the National Council for Behavioral Health through a contract with SAMHSA. It was renamed the Center of Excellence for Integrated Health Solutions.

Health Coordinating Council and the Interagency Coordinating Committee on the Prevention of Underage Drinking are other examples of formal collaborations with other agencies.

The 21st Century Cures Act of 2016 (Cures; P.L. 114-255) established the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). The committee is tasked with making recommendations to improve the coordination and administration of services for adults with serious mental illness and children with serious emotional disturbance. The committee provided recommendations in the first of two statutorily required reports to Congress submitted in December 2017.[53] According to statute, the ISMICC will sunset in 2023.[54]

Budget and Funding

The total amount of funding available to SAMHSA (i.e., total program level) traditionally includes discretionary budget authority provided in annual appropriations acts, Public Health Service (PHS) Program Evaluation Set-Aside funds,[55] Prevention and Public Health Fund (PPHF) transfers,[56] and data request and publications user fees.[57] The main source of funding for SAMHSA is the discretionary budget authority it receives through the annual appropriations process.[58] SAMHSA is funded through the Departments of Labor, Health and Human Services, and Education, and Related Agencies (Labor-HHS-ED) appropriations act.[59]

More information can be found at https://www.thenationalcouncil.org/integrated-health-coe/.

[53] HHS, *Interdepartmental Serious Mental Illness Coordinating Committee Releases its First Report to Congress*, News, Washington, DC, December 14, 2017, https://www.hhs.gov/about/news/2017/12/14/ismicc-releases-its-first-report-to-congress.html and ISMICC, *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*, Report to Congress, December 13, 2017, https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf.

[54] §6031 of Cures required the HHS Secretary, upon submission of the committee's second report, to make a recommendation to Congress as to whether operation of the committee should be extended beyond the six-year sunset.

[55] The PHS Evaluation Tap allows the HHS Secretary to redistribute a portion of eligible PHS agency appropriations for program evaluation across HHS. In the annual Labor-HHS-ED appropriations acts, Congress specifies the maximum percentage for the set-aside and directs specific amounts of funding from the tap to a number of HHS programs. See the "Public Health Service Evaluation Tap" section in CRS Report R45869, *Labor, Health and Human Services, and Education: FY2019 Appropriations*.

[56] The Patient Protection and Affordable Care Act (ACA) established the Prevention and Public Health Fund (PPHF) and provided it with a permanent annual mandatory appropriation. PPHF funds are to be transferred by the HHS Secretary for prevention, wellness, and public health activities. PPHF funds are available to the HHS Secretary on October 1 of each year, when the new fiscal year begins. The Administration's annual budget proposal for the PPHF reflects its intended distribution and use of the funds. For more information see CRS Report R44796, *The ACA Prevention and Public Health Fund: In Brief*.

[57] The Consolidated Appropriations Act, 2014 (P.L. 113-76) authorized SAMHSA to collect fees "for the costs of publications, data, data tabulations, and data analysis completed under [PHSA Title V] and provided to a public or private entity upon request, which shall be credited to this appropriation and shall remain available until expended for such purposes."

[58] Budget authority is the "authority provided by federal law to enter into financial obligations that will result in ... outlays involving federal funds." Discretionary budget authority "refers to outlays from budget authority that is provided in and controlled by appropriation acts." U.S. Government Accountability Office (GAO), A Glossary of Terms Used in the Federal Budget Process, GAO-05-734SP, September 1, 2005, http://www.gao.gov/products/GAO-05-734SP. SAMHSA receives more than 97% of its budget through discretionary budget authority in annual appropriations acts.

[59] Sometimes referred to as the *Labor-HHS* appropriations bill or simply the *Labor-H* bill.

SAMHSA's budget and appropriations fall under four categories: (1) mental health, (2) substance abuse treatment, (3) substance abuse prevention, and (4) health surveillance and program support. These categories roughly correspond with SAMHSA's four centers. CBHSQ activities, however, are integrated throughout the other centers and cross over multiple funding lines. CBHSQ receives much of its funding from the health surveillance and program support category in addition to a set-aside in the SABG.[60]

Table 1. SAMHSA Budget, by Fiscal Year

FY2016-FY2020 Discretionary Budget Authority, by Budget Category (Dollars in Millions)

Category	FY2016	FY2017	FY2018	FY2019	FY2020
Mental Health	1,133	1,145	1,454	1,519	1,645
Substance Abuse Treatment	2,111	2,627	3,676	3,735	3,757
Substance Abuse Prevention	211	222	248	205	206
Health Surveillance and Program Support	175	117	129	129	129
Total Discretionary Budget Authority	3,630	4,111	5,507	5,588	5,737

Source: SAMHSA, *Operating Plan*, FY2016-2020, available at https://www.samhsa.gov/about-us/budget

In FY2020, SAMHSA had a program level budget of $5.89 billion ($5.74 billion in discretionary budget authority).[61] SAMHSA supported 494 full-time employee equivalents in FY2019.[62] More detailed descriptions and funding levels for SAMHSA's programs and activities are available in SAMHSA's annual budget request.[63] For a list of SAMHSA authorizations and their funding levels, see **Table 1**, **Table 2**, and **Table 3**.

[60] SAMHSA, *Justification of Estimates for Appropriations Committees for FY2021*, pp. 274-279. Historically, the CBHSQ has received funding from transfers from the PHS Evaluation Tap and transfers from the Prevention and Public Health Fund (see, for example, the SAMHSA *Justification of Estimates for Appropriations Committees* for FY2017, pp. 293-294).

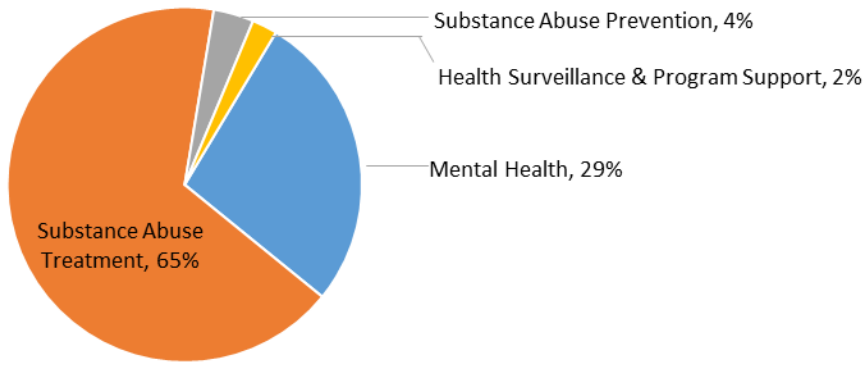
[61] The difference between the discretionary budget authority and total program level is attributed to the Public Health Evaluation Set-Aside Funds and funds from the Prevention and Public Health Fund and user fees. For more information, see CRS Report R45869, *Labor, Health and Human Services, and Education: FY2019 Appropriations*.

[62] SAMHSA, *FY2021 Justification of Estimates for Appropriations Committees*, p. 290.

[63] SAMHSA, *FY2021 Justification of Estimates for Appropriations Committees*.

Figure 3. SAMHSA Budget at a Glance

Percent of Budget by Category, FY2020



Source: CRS analysis based on SAMHSA, *Operating Plan for FY2020*.

Major Programs and Activities

SAMHSA's major programs and activities include two block grant programs, numerous activities known as Programs of Regional and National Significance (PRNS), several other grant programs, technical assistance to grantees, data collection and other related activities.

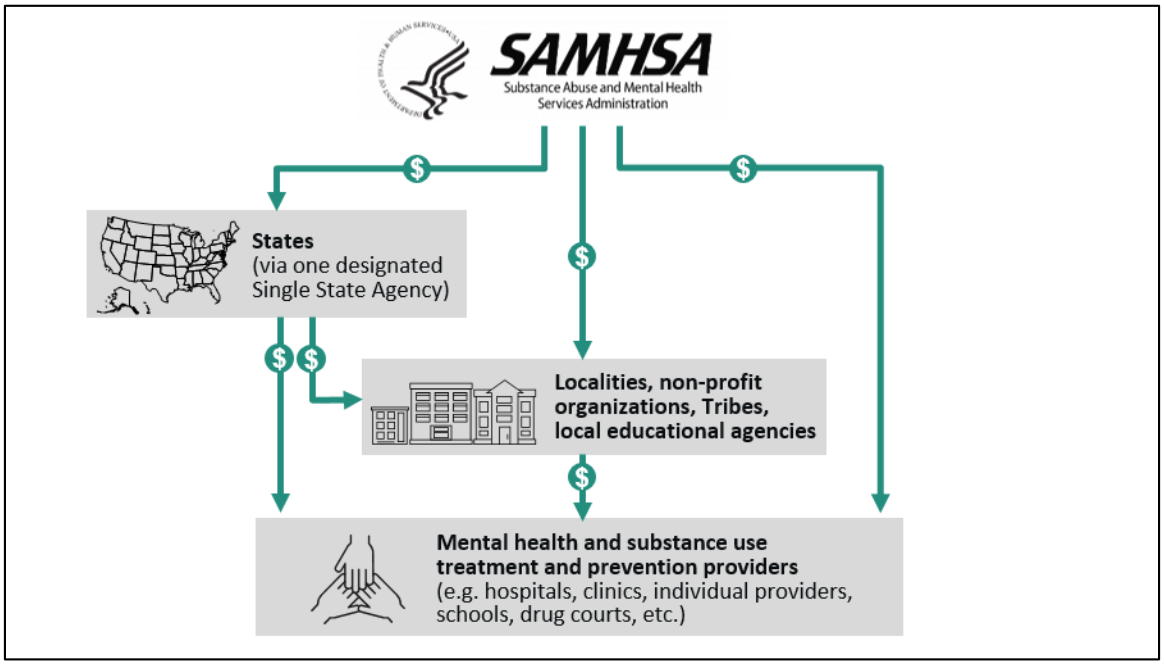
The majority of SAMHSA's programming consists of grants to support mental health and substance abuse treatment and prevention activities, including direct treatment services. The largest grants are awarded to states via a designated Single State Agency. The state may then distribute funds—often in the form of subgrants and contracts—to localities for redistribution or directly to treatment providers. Similarly, SAMHSA may award some grants directly to mental health and substance abuse service providers. For other grants, SAMHSA distributes the funds to local government entities, organizations, Indian tribes, or local educational agencies, for instance, who in turn support entities providing direct treatment or prevention activities (see **Figure 4**).

Some of SAMHSA's programs are directed through statute. Most of SAMHSA's activities are carried out under general authorities, though they may target specific substances of abuse, particular mental health issues, specified populations, or certain prevention or treatment activities. SAMHSA's general PRNS authority gives the agency, in consultation with states, flexibility to determine the specific problem the funds will be used to address, such as unique or emerging substance abuse issues in a particular state. This practice may also make it easier to provide coordinated care for those in need of multiple substance abuse treatment services. The dynamic nature of SAMHSA's PRNS authorities and the flexible uses of block grant funding, however, can make tracking activities and determining spending on specific issues challenging.[64]

[64] See textbox "Tracking SAMHSA Grants and Spending" later in this report for more information.

Figure 4. Distribution of SAMHSA Grants

Course of grant funding from SAMHSA to prevention and treatment providers



Source: Figure prepared by the Congressional Research Service.

Block Grants

SAMHSA's two biggest programs are block grant programs. One block grant supports substance abuse prevention and treatment services (the SABG) and the other supports mental health services (the MHBG). SAMHSA has estimated that the Substance Abuse Prevention and Treatment Block Grant (SABG) accounts for nearly a third of the expenses of state agencies responsible for substance abuse.[65] By comparison, SAMHSA's Community Mental Health Services Block Grant (MHBG) funds an average of 1% of the expenses for state mental health agencies.[66] The difference reflects the historical role federal and state governments have played in funding services in these two areas.[67] As behavioral health services have primarily been the responsibilities of states, the block grant programs administered by SAMHSA were designed to supplement these activities, not provide the primary source of financial support.

History

A predecessor to the current block grant programs, the Alcohol, Drug, and Mental Health Services (ADMS) block grant was one of seven block grants established by the Omnibus Budget

[65] SAMHSA, *Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015*, HHS Publication No. (SMA) SMA-17-5029, Rockville, MD, 2017, https://store.samhsa.gov/system/files/sma17-5029.pdf and SAMHSA, *Substance Abuse Prevention and Treatment Block Grant*, Fact Sheet, nd, https://www.samhsa.gov/sites/default/files/sabg_fact_sheet_rev.pdf. The Substance Abuse Prevention and Treatment Block Grant is sometimes referred to by the acronym "SAPT."

[66] SAMHSA, *Funding and Characteristics of Single State Agencies*, 2017.

[67] For more information, see CRS In Focus IF10870, *Psychiatric Institutionalization and Deinstitutionalization*.

Reconciliation Act of 1981 (OBRA).[68] This block grant consolidated several existing categorical grants for substance abuse and community mental health services in order to provide state and local governments more flexibility and control over funding. Shifting to a single block grant sought to enhance states' ability to meet localized needs, end duplication of effort in delivering services, and enable better coordination. The flexibility provided by the block grants replaced previous federal categorical grant authorizations that specified uses, including authorizations for establishing community mental health centers.[69] OBRA authorized ADMS block grant funds for FY1982 through FY1984 in proportion to the historical funding patterns of the original categorical grants. Due to the resulting inequities among states in per capita funding for substance abuse and mental health services, OBRA directed HHS to conduct a study that would produce a formula, considering population and state fiscal capacity, to more equitably distribute funds among states.

The 1984 ADAMHA Amendments renewed the block grants for three years with a new formula, while striving to maintain minimum existing levels for states.[70] The amendments included a "minor equity adjustment" that would hold harmless states that would have otherwise received decreased funding under the new calculation. Funds above the FY1984 hold-harmless level were to be allocated using a formula based equally on state population and relative per capita income.[71] The Amendments also required a nongovernmental entity to provide recommendations on the formula proposed by HHS. The resulting recommendations, from the Institute for Health and Aging (IHA), included phasing out the hold-harmless provisions, allocating funds based on populations at risk, and incorporating a state fiscal capacity measure.[72]

The Anti-Drug Abuse Act of 1988 revised the formula, based on the IHA recommendations, to phase out the hold-harmless provision, use total taxable resources as the measure of state fiscal capacity, and incorporate weighted age cohorts as a measure of population at risk.[73] The high-risk age cohorts, determined using an IHA study, were 25-64 years for alcohol abuse, 18-24 years for other drug abuse, and 25-44 for selected mental disorders. Later studies indicated that inequities in block grant distribution to states (regarding need for financial support for behavioral health services) persisted even after the recommendations were implemented.[74]

The 1992 ADAMHA Reorganization Act split the ADMS block grant into two separate block grants, one for mental health services (now the MHBG) and another for substance abuse services (the SABG).[75] The formulas for the two block grants were adjusted, in Sections 1918 and 1933 of the PHSA, to reflect the differences in the population in need of mental health and substance abuse services.[76] Hold-harmless provisions, state minimums, and maintenance of effort

[68] P.L. 97-35.

[69] Richard G. Frank and Sherry A. Glied, *Better But Not Well: Mental Health Policy in the United States Since 1950* (Baltimore, MD: The Johns Hopkins University Press, 2006), p. 60.

[70] P.L. 98-509.

[71] This hold-harmless provision assured that each state's block grant funding would not be less than the amount it received in FY1984.

[72] Dorothy Rice, Sander Kelman, and Leonard Miller, et al., *Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985*, U.S. Department of Health and Human Services, National Institute on Drug Abuse, Bethesda, MD, 1990. The Institute for Health and Aging is an institute within the University of California, San Francisco.

[73] P.L. 100-690

[74] General Accounting Office (now Government Accountability Office), T-HRD-91-38, *Substance Abuse Funding: Not Justified by Urban-Rural Differences in Need*, 1991.

[75] P.L. 102-321.

[76] General Accounting Office (now Government Accountability Office), T-HRD-91-32, *Mental Health Grants:*

requirements were reestablished.[77] The current block grant formulas have undergone minimal amendment since their formulation in 1992.

The Cures Act reauthorized the block grants in 2016. The law amended the stated purposes of the programs and application and expenditure requirements, though the formulas remained unchanged. Among the adjustments was a provision permitting states to combine their applications for the MHBG and SABG.[78] This change acknowledged that behavioral health treatment often includes both types of care, particularly for individuals with co-occurring mental health and substance use disorders.

Community Mental Health Services Block Grant (MHBG)

The Community Mental Health Services Block Grant (MHBG) supports community mental health services for adults with *serious mental illness* (SMI) and children with *serious emotional disturbance* (SED).[79] SAMHSA distributes MHBG funds to states (including the District of Columbia and specified territories)[80] according to a formula specified in statute.

Each state may distribute MHBG funds to local government entities and nongovernmental organizations to provide community mental health services for adults with SMI and children with SED in accordance with the state's plan. States have flexibility in the use of MHBG funds within the framework of the state plan and federal requirements. The state must designate a Single State Agency responsible for administering the grant and submit the state plan to the HHS Secretary every two years.

Definitions of Adults with SMI and Children with SED

The Alcohol, Drug Abuse and Mental Health Services Administration (ADAMHA) Reorganization Act of 1992 (P.L. 102-321), which established SAMHSA, did not define adults with SMI and children with SED. Instead it required SAMHSA to establish definitions through rulemaking, which SAMHSA did in 1993. The definitions are as follows:

Adults with Serious Mental Illness (SMI): "persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria ... that has resulted in functional impairment which substantially interferes with or limits one or more major life activities."

Children with Serious Emotional Disturbance (SED): "persons from birth up to age 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria ... that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities."

Source: Federal Register Volume 58, No 96, p. 29422 (May 20, 1993)

Each MHBG grantee must support a mental health planning council, which provides input on the state's plan for providing comprehensive community mental health services. A majority of members of the mental health planning council must be mental health service consumers or

Funding Not Distributed in Accordance with State Needs, 1991.

[77] Currently, the hold-harmless provision is set at the level received by the state in FY1998 for the mental health block grant, and the previous fiscal year for the substance abuse block grant. If there is a decrease in appropriation for the substance abuse block grant, states can get a proportionate decrease in their block grant amount. There is no similar provision for the mental health block grant.

[78] PHSA §1958 (42 C.F.R. 300x-68).

[79] SAMHSA's definitions of adults with SMI and children with SED were provided in a 1993 *Federal Register* notice (May 20, 1993; 58 FR 29422). See textbox on this page.

[80] Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, Northern Mariana Islands, Palau, the Marshall Islands, and Micronesia. See 42 C.F.R. §300x-64(b)(3).

family members (of children with SED); other members represent relevant state agencies (e.g., mental health, education, and social services). States may opt to have behavioral health planning councils, which are responsible for both mental health and substance abuse services.[81]

While use of funds is generally determined by the states, each state must expend at least 10% of its block grant funds each fiscal year (or at least 20% by the end of the succeeding fiscal year) to support evidence-based programs to address early serious mental illness (see above textbox). No more than 5% of the grant funding can be used for administrative expenses. For each of the 50 states and the District of Columbia, the MHBG allotment formula is based on the population at risk (weighted), cost of services, and available resources.[82] The MHBG allotment for each territory is proportional to the civilian population of the territory.[83] All states (including the District of Columbia) and territories have minimum allotments. While states do not technically need to provide matching funds, they are statutorily required to maintain spending on community mental health services.[84]

Public Health Service Act Title XIX, Part B, Subpart I authorizes the MHBG program. Provisions in PHSA Title XIX, Part B, Subpart III also apply to the MHBG. PHSA Section 1920 explicitly authorizes to be appropriated $533 million (rounded) annually for each of FY2018–FY2022 for the MHBG.[85]

Substance Abuse Prevention and Treatment Block Grant (SABG)

The Substance Abuse Prevention and Treatment Block Grant (SABG) supports services to prevent and treat substance use disorders. SAMHSA distributes SABG funds to states (including the District of Columbia and specified territories[86]) and one tribal entity according to a formula specified in statute.

Each state may distribute SABG funds to local government entities, administrative service organizations, and prevention and treatment service providers (among others) in accordance with the state's plan for expending SABG funds.[87] States have flexibility in the use of SABG funds within the framework of the state plan and federal requirements. The state must designate a Single State Agency responsible for administering the grant and submit an application containing the state plan to the HHS Secretary by the first of October preceding the fiscal year.[88]

[81] SAMHSA, *Grants; Block Grants; Community Mental Health Services Block Grant*, https://www.samhsa.gov/grants/block-grants/mhbg.

[82] PHSA §1918(a) (42 U.S.C. §300x-7(a)).

[83] PHSA §1918(c) (42 U.S.C. §300x-7(c)).

[84] Per Title VIII (§8001) of the 21st Century Cures Act—which amended PHSA §1915(b)—states may receive a waiver from the HHS Secretary for this requirement under certain circumstances.

[85] From 2003 when the authorization expired until reauthorization in 2016 under the Cures Act, the grant program operated under general authorities and continued to receive funding through the annual appropriations process.

[86] See footnote 80.

[87] PHSA §1932(b) (42 U.S.C. §300x-32(b)).

[88] PHSA §1932 (42 U.S.C. §300x-32). Of note, PHSA Section 1958 allows the Assistant Secretary to permit a joint application for the MHBG and SABG.

Block Grant Formula

The formula for calculating the grant amounts, for both the SABG and MHBG, is located in Sections 1918 and 1933 of the PHSA. The formula takes into account three measures: (1) the population in need of services, (2) costs of services in the state, and (3) fiscal capacity of the state. The first factor is intended to be a proxy for the extent of need for services in a state. The metric is based on the population of adults age 18-64 in the state. The second factor, which is the cost of services, is derived from the 1990 report of Health and Economics Research, Inc., and ranges from 0.9 to 1.1.[89] The third factor, which is the fiscal capacity of the state, is intended to adjust for differences in state capacity to pay for these services. This factor uses the three-year mean of the total taxable revenue of the state.

The three factors mentioned above are multiplied to produce a score for the state. To calculate the grant amount for a given state, that state's score is multiplied by the total available grant amount and divided by the sum of all the states' (and District of Columbia's) scores. The formula can be written as:

$$G_i = A\ (X_i / \sum X_i)$$

where

G_i = grant amount for the ith state,
A = total funds appropriated for distribution among the states, and
X_i = score for the ith state.

There is a hold-harmless provision and a state minimum provision for both grants.

While the use of funds is generally determined by states, each SABG grantee must expend at least 20% of its SABG allotment on primary prevention strategies.[90] In addition, each SABG grantee must enact laws that prohibit the sale or distribution of tobacco products to minors; enforce such laws; inspect tobacco outlets; and report annually to the HHS Secretary on past-year enforcement activities (and the extent of success achieved), as well as enforcement strategies for the coming grant year.[91]

For each of the 50 states and the District of Columbia, the SABG allotment formula is based on the MHBG formula and takes into account the population at risk (unweighted), cost of services, and available resources.[92] The SABG allotment for each territory is proportional to the civilian population of the territory.[93] All states (including the District of Columbia) and territories have minimum allotments. For Indian tribes and tribal organizations that request SABG funds directly (and that the HHS Secretary determines would be better served by means of direct grants), the grant amount is reserved from the state's SABG allotment based on the ratio of the state's allotment expended for the tribal entity in FY1991.[94] While states do not technically need to provide matching funds, they are statutorily required to maintain spending on substance use disorder services.[95]

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[89] G.C. Pope, *Adjusting the Alcohol, Drug Abuse, and Mental Health Services Block Grant Allocations for Poverty Population and Cost-of-Service*, Health Economics Research, Inc., Needham, MA, March 30, 1990.

[90] PHSA §1922(a)(1) (42 U.S.C. §300x-22(a)(1)). Primary prevention strategies refer to interventions designed to avoid manifestations of a disease before the health condition occurs or, in the case of the SABG authorization, "for individuals who do not require treatment for substance abuse."

[91] PHSA §1926 (42 U.S.C. §300x-26).

[92] PHSA §1933 (42 U.S.C. §300x-33). Population at risk means the population of adults between the ages of 18 and 64. Population at risk in the SABG formula includes the number of individuals age 18 to 24 *and* the number of individuals age 18 to 24 living in urban areas (in addition to the number of individuals age 25 to 64 in the state).

[93] PHSA §1933(c) (42 U.S.C. §300x-33(c)).

[94] PHSA §1933(d) (42 U.S.C. §300x-33(d)).

[95] Per Title VIII (§§8001-8002) of the 21st Century Cures Act—which amended PHSA §1915(b) and §1930—states may receive a waiver from the HHS Secretary for this requirement under certain circumstances and request a negotiated agreement to prevent a reduced SABG allotment if they do not meet these requirements.

PHSA Title XIX, Part B, Subpart II authorizes the SABG. Provisions in PHSA Title XIX, Part B, Subpart III also apply to the SABG. PHSA Section 1935 explicitly authorizes to be appropriated $1.86 billion (rounded) annually for each of FY2018–FY2022 for the SABG.

Issues Regarding Block Grant Formulas and Distribution

Determinations of block grant distribution—in the form of the funding formula—have been critiqued since the program's inception. The block grants represent the majority of funding SAMHSA provides to states. Despite their prominent role in SAMHSA operations, the formula determining funding levels has undergone little change since 1992. A number of issues have been raised regarding the current formulas. Economists and health policy experts have raised concerns about the appropriateness of this formula for ensuring equitable distribution of block grant funds between the states. The variables in the formula may not aptly represent state need for funding or for support for behavioral health activities for instance. Other critiques have questioned the formulas' adequacy in responding to public health needs surrounding substance abuse and mental illness. While demands on the behavioral health infrastructure may shift with drug epidemics for example, block grant levels remain relatively constant.

After the reauthorization of the block grants in 1992, the RAND Corporation evaluated the equity of the formula used in the SABG and MHBG.[96] The formula considers three factors: (1) the size of the population needing services, (2) the cost of services in the state, and (3) the fiscal capacity of the state. RAND concluded that the measures for two of the three components in the formula could be improved. Specifically, the population in need and the costs of services would be better indicated by different metrics. For example, RAND explained that the number of young adults in urban areas—which is double counted in the SABG formula—is not as indicative of substance abuse treatment need in a state as other empirically supported variables, such as high school graduation rate and residence in rural areas.[97] Cost estimates—the second variable in the formula—could also be improved by changing the current equation which is based on wages, rents, and average fees of practicing physicians. These variables are not sensitive to the specific labor needs of substance abuse services (since physicians do not provide most substance use treatment services) or to cost differences in rural and urban settings. RAND recommended changes in the block grant formula that would make allocations more equitable and also result in "big shifts in funding" compared to the current approach.

Pursuant to a provision in the Cures Act of 2016, SAMHSA and the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) again partnered with RAND to study the appropriateness of the current SAMHSA block grant formulas.[98] In their 2019 report, RAND again concluded that the formulas for the block grants could be revised to improve their accuracy.[99] More specifically, they noted that the population need and the cost of service indicators could both be updated to incorporate the best data available, such as state-level prevalence of adults with serious mental illness. They also recommended removing the current

[96] M. Audrey Burnam, Peter Reuter, John L. Adams, et al., *Review and Evaluation of Substance Abuse and Mental Health Services Block Grant Allotment Formula*, RAND Corporation, Santa Monica, CA, 1997.

[97] See footnote 92.

[98] SAMHSA, "Agency Information Collection Activities: Proposed Collection; Comment Request," 83 *Federal Register* 53492, October 23, 2018.

[99] J. Scott Ashwood Karen Chan Osilla, and Maria DeYoreo, et al., *Review and Evaluation of the Substance Abuse, Mental Health, and Homelessness Grant Formulas*, RAND, RR-2454-ASPEC, Santa Monica, CA, 2019, https://www.rand.org/pubs/research_reports/RR2454.html.

minimum allotment rules. No changes have been made since the release of this congressionally mandated report.

Tracking SAMHSA Grants and Spending

SAMHSA typically publishes information on grants through Funding Opportunity Announcements (FOAs). While much of the information on grants is available on SAMHSA's website, the agency does not provide a centralized database for searching and tracking grants. Starting in 2017, SAMHSA operates a map providing broad information on grant funding by State by fiscal year: https://www.samhsa.gov/grants-awards-by-state). Other sites useful in tracking grants include http://www.grants.gov, http://www.usaspending.gov, and https://taggs.hhs.gov/.

Congress is often interested in determining how much the U.S. government is spending on treating or preventing particular substance abuse and mental health disorders. This is not usually possible to calculate because of the manner in which SAMHSA receives its appropriations and distributes its grants. SAMHSA's block grants, for example, allow for significant flexibility in use by states. SAMHSA does not systematically collect data on how block grant funds are used and the agency does not make the state plans describing activities publicly available. SAMHSA has also invested significant resources in addressing the current opioid epidemic in the United Stated. In FY2019 the SAMHSA-administered State Opioid Response grants provided $1.5 billion to specifically address the opioid epidemic. This was in addition to three other opioid-specific programs that totaled over $100 million. Many states also used block grant funds, Targeted Capacity Expansion funds, and other grant funds for opioid-related activities making quantifying a total of funding expended on opioid-related activities difficult.

Other critiques have made similar recommendations regarding the block grant formulas. Some experts have recommended using data from major national epidemiological surveillance datasets that measure levels of mental illness and substance abuse in a state (rather than general population age distribution) to determine the population in need of services.[100] These may include data from the National Comorbidity Survey-Replication[101] for mental health needs, for example, or the National Survey on Drug Use and Health (NSDUH)[102] for mental health and substance abuse needs. Research also indicates that the cost-of-services measure currently used does not adequately represent interstate wage variations in occupations related to substance abuse and mental health.[103] The formula also does not consider variations in numbers of uninsured individuals across the states, and other federal funding (e.g., Medicare and Medicaid) that a state may also receive for mental health and substance abuse services.[104]

There are also questions as to whether a formula is the ideal approach to distributing substance abuse and mental health treatment funds. In their 2001 report *Choosing the Right Formula*, the National Academies of Science, Engineering, and Medicine (NASEM) described a tradeoff between providing stability in funding from one year to the next and flexibility to redirect funds to different jurisdictions as true needs change. Substance abuse needs may have significant regional differences and epidemics may shift over time, sometimes rapidly. Static funding may not adequately respond to fluctuating public health needs. At the same time, states may rely on federal funding to support essential behavioral health infrastructure. Consistent and reliable

[100] Burnam, et al., *Review and Evaluation of Block Grant Formula*, RAND, 1997.

[101] SAMHSA, The National Comorbidity Survey (NCS-1) studied the prevalence and correlates of mental disorders from 1990 to 1992. The NCS Replication (NCS-R) was carried out with a new national sample from 2001 to 2003 to study trends in a wide range of variables assessed in the baseline NCS-1.

[102] SAMHSA, NSDUH, which was formerly known as the National Household Survey on Drug Abuse (NHSDA), is designed to produce drug and alcohol use incidence and prevalence estimates and report the consequences and patterns of use and abuse in the general U.S. civilian population age 12 and older.

[103] RAND, *Review of Block Grant Formula*, 1997.

[104] Albert Woodward, *The Substance Abuse and Treatment Block Grant is Still Important Even with the Expansion of Medicaid*, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, CBHSQ Report, Rockville, MD, January 7, 2016.

funding streams may be necessary to maintain needed substance use and mental health services. Predictable funding may also be essential in establishing prospective public health strategies and achieving long-term behavioral health goals.

There have also been questions about whether the block grants supplement or supplant state funding for substance abuse and mental health initiatives.[105] While the block grants have historically represented a small percentage of state spending on behavioral health activities, there are no state matching requirements for these programs. Some have questioned whether increased federal funding results in a subsequent decrease in state spending on behavioral health initiatives. Research has demonstrated that state substance abuse spending is *positively* associated with substance abuse block grant allocation, however. One study found that for every $1.00 increase in state SABG funding, for example, state administered spending on alcohol treatment also increased by $0.80.[106] Other reports have found similar results; state investments in mental health and substance use treatment services increase in tandem with federal grant funding.[107] This suggests that federal block grant funding appears to have a positive correlation with state substance abuse treatment and prevention efforts and block grants may largely be used to supplement, not supplant, state funding.[108]

Other issues concern block grant funding not keeping up with health care inflation. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) estimated that the inflation-adjusted value—the actual purchasing power—of the SABG block grant funding decreased 24% between 2009 and 2019.[109]

[105] See, for example, Alexander Cowell, Dennis McCarty, and Albert Woodward, "Impact of Federal Substance Abuse Block Grants on State Substance Abuse Spending: Literature and Data Review," *The Journal of Mental Health Policy and Economics*, vol. 6 (2003), pp. 173-179 and U.S. Government Accountability Office, *Federal Grants: Design Improvements Could Help Federal Resources Go Further*, FAO/AIMD-97-7, December 1996.

[106] Cowell et al., "Impact of Federal Substance Abuse Block Grants on State Substance Abuse Spending," 2003.

[107] Tami Mark, Katharine Levit, and Rita Vandivort-Warren, et al., "Changes in US Spending on Mental Health and Substance Abuse Treatment, 1986-2005, And Implications for Policy," *Health Affairs*, vol. 30, no. 2 (February 2011).

[108] Substance use and mental health treatment services are supported through a number of funders and payers, including through federal grants, state accounts, Medicaid, Medicare, private health insurance, and patients. A discussion of the interplay between these entities is beyond the scope of this report. For more information on patterns of U.S. spending for these services across funders, see for example, Mark et al., "Changes in US Spending," *Health Affairs*, 2011 from footnote 107.

[109] National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), *Substance Abuse Prevention and Treatment (SAPT) Block Grant*, Washington, DC, March 2019, https://nasadad.org/wp-content/uploads/2019/03/SAPT-Block-Grant-Fact-Sheet-March-2019.pdf.

SAMHSA Charitable Choice Provisions

In 2000, the Children's Health Act of 2000 (P.L. 106-310) and the Consolidated Appropriations Act, 2001 (P.L. 106-554) added several provisions related to services provided through religious organizations to SAMHSA's authorities in the PHSA.[110] These provisions were part of several pieces of legislation enacted beginning in 1996 that sought to ensure that faith-based organizations could participate in federally funded social service programs on the same basis as other nongovernmental providers. These *Charitable Choice* rules make clear that religious organizations may receive public funding to offer social services without abandoning their religious character. The rules also outline certain qualifications involved in participation, such as restrictions on the use of public funds for religious activities and protections on the religious freedom of program beneficiaries.[111]

The SAMHSA Charitable Choice provisions enacted in 2000—later clarified through HHS rulemaking in 2003[112]—apply to SAMHSA's discretionary grants and certain block grants such as the SABG and Projects for Assistance in Transition from Homelessness (PATH) program.[113] Collectively, these Charitable Choice rules prohibit discrimination in awarding funds to potential grantees based on that organization's religious character; prohibit the government from requiring an organization to alter its internal governance or remove religious symbols as a condition of eligibility; and prohibit the use of public funds received directly by religious organizations for explicitly religious activities. The rules also specify that receipt of public funds does not alter the exemption that religious organizations have under Title VII of the Civil Rights Act of 1964, which allows such organizations to discriminate based on religion in certain employment decisions. The Charitable Choice provisions also prohibit religious organizations receiving public funds from discriminating against beneficiaries on the basis of religion. SAMHSA Charitable Choice provisions declare that if a service program beneficiary objects to the religious character of the service program participant, the program beneficiary must be referred to an alternative provider capable of providing the same service(s).[114]

Some controversy surrounding these programs has centered on the constitutionality of the federal government funding faith-based social service programs. On one hand, providing federal funding for religious activities may, under some circumstances, violate the Establishment Clause of the U.S. Constitution's First Amendment. The Establishment Clause of the First Amendment prohibits the government from providing certain types of support to religion and religious entities. On the other hand, denying generally available benefits to organizations based solely on their religious affiliation may violate the First Amendment's Free Exercise, which prohibits the government from unlawfully discriminating against religious exercise. Charitable Choice rules have sought to ensure that religious organizations are eligible on an equal basis for public funds while also ensuring those funds are not used for explicitly religious activities.

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[110] PHSA §581-584 (Part G of Title V) and §1955. Of note, there are two Title V parts G and two sections 581 and 582. The SAMHSA Charitable Choice rules pertain to the provisions entitled "Part G—Services Provided Through Religious Organizations" in Title V of the PHSA.

[111] SAMHSA's Charitable Choice regulations are found in 42 C.F.R. Part 54 (discretionary grants) and Part 54a (SABG and PATH grants). Of note, these regulations may not apply to all grant programs that SAMHSA administers, such as the Community Mental Health Block Grant (MHBG), for instance. The MHBG is, however, governed by general HHS Charitable Choice regulations found in 45 C.F.R. Part 87.

[112] Department of Health and Human Services, "Charitable Choice Regulations Applicable to States Receiving Substance Abuse Prevention and Treatment Block Grants, Projects for Assistance in Transition From Homelessness Formula Grants, and to Public and Private Providers Receiving Discretionary Grant Funding From SAMHSA for the Provision of Substance Abuse Services Providing for Equal Treatment of SAMHSA Program Participants," 68 *Federal Register* 56429-56449, September 30, 2003. See also, 42 C.F.R. Part 54; 42 C.F.R. Part 54a; 45 C.F.R. Part 87; and C.F.R. Part 96.

[113] Additionally, all of SAMHSA's programs are covered under the following executive orders (and associated rules amending or establishing regulations to implement those executive orders): Executive Order 13279, "Equal Protection of the Laws for Faith-Based and Community Organizations," 67 *Federal Register* 77139-77144, December 12, 2002 (for final rule, see footnote 112); Executive Order 13559, "Fundamental Principles and Policymaking Criteria for Partnerships With Faith-Based and Other Neighborhood Organizations (final rule published in 81 *Federal Register* 19353-19430, May 4, 2016); Executive Order 13831, "Establishment of a White House Faith and Opportunity Initiative," 83 *Federal Register* 20718-20717 (proposed rule published in 85 *Federal Register* 2974-2987, January 17, 2020).

[114] PHSA §582(f) (42 USC 290kk–1(f)). The responsibility for providing the alternative service rests with the appropriate federal, state, or local government that administers the program or is a program participant.

Finally, a 2015 investigation by the Government Accountability Office (GAO) found variations in how SAMHSA oversees grants and documents grant-related activities.[115] While states are required to discuss the manner in which they use block grant funds in their application or plan, it is unclear how SAMHSA surveys this information and whether they audit states for accuracy. SAMSHA does not publish this information publicly. An HHS OIG publication in 2017 noted that SAMHSA's reporting has improved since that GAO study.[116] While some concerns regarding SAMHSA's supervision of block grant activities remain, investigations into block grant spending largely demonstrate that states use the block grant funding as intended, despite historically little oversight.[117]

Programs of Regional and National Significance (PRNS)

In addition to the block grant programs, SAMHSA administers other programs supporting mental health and substance use treatment and prevention activities. PHSA Title V Part B requires the HHS Secretary to "address priority ... needs of regional and national significance" in mental health, substance abuse treatment, and substance abuse prevention. The statute instructs the HHS Secretary to do so "directly or through grants or cooperative agreements with States, political subdivisions of States, Indian tribes and tribal organizations, other public or private nonprofit entities."[118] SAMHSA administers grants and activities under these authorities commonly known as Programs of Regional and National Significance (PRNS).

SAMHSA's Programs of Regional and National Significance encompass numerous grants and activities within each of three areas: (1) substance abuse treatment, (2) substance abuse prevention, and (3) mental health. PRNS activities may include competitive grants, contracts, and cooperative agreements. PRNS programs are either determined by HHS and SAMHSA (sometimes at direction of the presidential administration) or by Congress through statutory authorizations/requirements or appropriations language. Some of the PRNS grants and activities have explicit authorizations in statute; at some point Congress enacted a law explicitly authorizing the PRNS program. Other PRNS initiatives have never had explicit authorizations and operate under SAMHSA's general PRNS authorities for mental health, substance abuse treatment, or substance abuse prevention. Commonly, Congress will codify existing programs without explicit authorizations through legislation. PRNS programs themselves may vary from year to year as existing programs are terminated or new programs are created, either at SAMHSA's discretion or at the direction of Congress.

PRNS grants and activities within each area fall into two categories, called "Capacity" and "Science and Service." Most PRNS programs are in the Capacity category. Capacity grants emphasize expanding service system activities. Those in the Science and Service category tend to focus on training and technical assistance. For example, within mental health PRNS, primary and behavioral health care integration activities appear under both categories: grants to community

[115] U.S. Government Accountability Office, *Mental Health: Better Documentation Needed to Oversee Substance Abuse and Mental Health Services Administration Grantees*, GAO-15-405, May 2015, http://www.gao.gov/products/GAP-15-405.

[116] Suzanne Murrin, *SAMHSA Has Improved Outcome Reporting for the Substance Abuse Prevention and Treatment Block Grant*, U.S. Department of Health and Human Services, Office of Inspector General, Memorandum Report, OEI-04-12-00160, Washington, DC, June 26, 2015, https://oig.hhs.gov/oei/reports/oei-04-12-00160.pdf.

[117] Cowell et al., "Impact of Federal Substance Abuse Block Grants on State Substance Abuse Spending," 2003.

[118] Mental health PRNS: PHSA §520A(a) (42 U.S.C. §290bb-32(a)). Substance abuse treatment PRNS: PHSA §509(a) (42 U.S.C. §290bb-2(a)). Substance abuse prevention PRNS: PHSA §516(a) (42 U.S.C. §290bb-22(a)).

mental health centers for treatment services appear under Capacity, and a competitive cooperative agreement for a training and technical assistance center appears under Science and Service.

Substance Abuse Treatment PRNS

The substance abuse treatment PRNS support states and communities in carrying out activities related to substance use treatment services. PHSA Section 509 authorizes the substance abuse treatment PRNS generally. Subsequent PHSA sections authorize specific substance abuse treatment PRNS programs. PHSA Section 509(f) authorizes to be appropriated $334 million (rounded) annually for each of FY2018–FY2022 to carry out the substance abuse treatment PRNS. **Table 1** lists FY2020 grant programs and activities categorized as substance abuse treatment PRNS; additional details (e.g., program descriptions and funding levels) are available in SAMHSA's FY2021 budget request.[119]

[119] SAMHSA, *FY2021 Justification of Estimates for Appropriations Committees*.

Table 1. FY2020 Substance Abuse Treatment PRNS

Program or Activity	Authorizing Law	Authorization of Appropriations
Substance Abuse Treatment PRNS General Authority	**PHSA §509**	**$333,806,000 for each of FY2018-FY2022**
Substance Abuse Treatment PRNS Capacity		
Opioid Treatment Programs/Regulatory Activities	—	—
Screening, Brief Intervention and Referral to Treatment	—	—
Targeted Capacity Expansion	—	—
Grants to Prevent Prescription Drug/Opioid Overdose[a]	PHSA §516 & §546	$36,000,000 for each of FY2019-FY2023
First Responder Training	PHSA §546	$36,000,000 for each of FY2019-FY2023
Improving Access to Overdose Treatment	PHSA §545	$5,000,000 for the period of FY2017-FY2019
Pregnant and Postpartum Women	PHSA §508	$29,931,000 for each of FY2019-FY2023
Building Communities of Recovery	PHSA §547	$5,000,000 for each of FY2019-FY2023
Recovery Community Services Program	—	—
Children and Families	PHSA §514	$29,605,000 for each of FY2018-FY2022
Treatment Systems for Homeless	PHSA §506	$41,304,000 for each of FY2018-FY2022
Minority AIDS	—	—
Criminal Justice Activities	—	—
Substance Abuse Treatment PRNS Science and Service		
Addiction Technology Transfer Centers	—	—
Minority Fellowship Program	PHSA §597	$12,669,000 for each of FY2018-FY2022
Peer Support TA Center	PHSA §547A	$1,000,000 for each of FY2019-FY2023
Treatment, Recovery, & Workforce Support	SUPPORT Act §7183	$5,000,000 for each of FY2019-FY2023
Emergency Department Alternatives to Opioids	SUPPORT Act §7091	$10,000,000 for each of FY2019-FY2021

Source: Public Health Service Act and SAMHSA, *FY2021 Justification of Estimates for Appropriations Committees*.

Notes: The FY2020 budget adds a new PRNS called "Grants to Develop Curricular for DATA Act Waivers" added by the SUPPORT for Patients and Communities Act of 2018 (P.L. 115-271).

a. Previously listed under CSAP in FY2018.

Example: Building Communities of Recovery

In 2016, the Comprehensive Addiction and Recovery Act (CARA; P.L. 114-198) authorized funding for recovery community organizations through a new Section 547 of the PHSA (within the authorizations for the Substance Abuse Treatment PRNS). This Building Communities of Recovery (BCOR) program provides funding for the development, enhancement, expansion, and delivery of peer recovery support services for substance abuse disorders. Grant support also enables links between recovery networks and other community organizations such as health care providers, the criminal justice system, and housing and employment services. The BCOR program supplanted previous SAMHSA peer professional workforce development programs.

Substance Abuse Prevention PRNS

The substance abuse prevention PRNS support states and communities in carrying out activities related to the prevention of substance use. PHSA Section 516 authorizes the substance abuse prevention PRNS generally. Subsequent PHSA sections authorize specific substance abuse prevention PRNS programs. PHSA Section 516(f) authorizes to be appropriated $211 million (rounded) annually for each of FY2018–FY2022 to carry out substance abuse prevention PRNS. **Table 2** lists FY2020 grants and activities categorized as substance abuse prevention PRNS; additional details (e.g., program descriptions and funding levels) are available in SAMHSA's FY2021 budget request.[120]

Table 2. FY2020 Substance Abuse Prevention PRNS

Program or Activity	Authorizing Law	Authorization of Appropriations
Substance Abuse Prevention PRNS General Authority	**PHSA §516**	**$211,148,000 for each of FY2018-FY2022**
Substance Abuse Prevention PRNS Capacity		
Strategic Prevention Framework	—	—
Federal Drug-Free Workplace	—	—
Minority AIDS	—	—
Sober Truth on Preventing Underage Drinking Act (STOP Act)	PHSA §519B[a]	$1,000,000 for each of FY2018-FY2022; $5,000,000 for each of FY2018-FY2022; $5,000,000 for each of FY2008-FY2010; $3,000,000 for each of FY2018-FY2022
Tribal Behavioral Health Grants	—	—
Substance Abuse Prevention PRNS Science and Service		
Center for the Application of Prevention Technologies	—	—
Minority Fellowship Program	PHSA §597	$12,669,000 for each of FY2018-FY2022
Science and Service Program Coordination	—	—

Source: Public Health Service Act and SAMHSA, *FY2021 Justification of Estimates for Appropriations Committees*.

a. PHSA §519B includes four authorizations of appropriations for various activities authorized in the provision. The authorization for appropriations for these are listed in the third column.

Example: Drug-Free Workplace and National Laboratory Certification

SAMHSA provides oversight of the Federal Drug-Free Workplace Program and the related National Laboratory Certification Program. The Federal Drug-Free Workplace Program aims to eliminate illegal drug use (and prescription drug misuse) in executive branch agencies and federally regulated industries by ensuring that employees are tested.[121] The National Laboratory Certification Program inspects and certifies the laboratories that conduct drug tests for executive branch agencies and federally regulated industries. Federally regulated industries include organizations receiving federal grants and organizations with federal contracts of $100,000 or

[120] Ibid.

[121] SAMHSA, *Programs; Drug-free Workplace; Drug Testing*, https://www.samhsa.gov/workplace/drug-testing, updated July 19, 2019.

more.[122] SAMHSA's Drug Testing Advisory Board (DTAB) advises the agency on its drug testing activities.[123]

Mental Health PRNS

The substance abuse treatment PRNS support states and communities in carrying out activities related to mental health prevention and treatment services. PHSA Section 520A authorizes the mental health PRNS. PHSA Section 520A(f) authorizes to be appropriated $395 million (rounded) annually for each of FY2018–FY2022 to carry out mental health PRNS. **Table 3** lists FY2020 grants and activities categorized as mental health PRNS; additional details (e.g., program descriptions and funding) are available in SAMHSA's FY2021 budget request.[124]

Table 3. FY2020 Mental Health PRNS

Program or Activity	Authorizing Law	Authorization of Appropriations
Mental Health PRNS General Authority	**PHSA §520A**	**$394,550,000 for each of FY2018-FY2022**
Mental Health PRNS Capacity		
Seclusion and Restraint	—	—
Youth Violence Prevention	PHSA §581	$100,000,000 for each of FY2002-FY2003
Project AWARE	—	—
Mental Health First Aid[a]	PHSA §520J	$14,693,000 for FY2018-FY2022
Healthy Transitions	—	—
Infant and Early Childhood Mental Health	PHSA §399Z-2	$20,000,000 for FY2018-FY2022
National Child Traumatic Stress Network	PHSA §582	$63,887,000 for each of FY2019-FY2023
Children and Family Programs	—	—
Consumer and Family Network Grants	—	—
Project LAUNCH	—	—
Mental Health System Transformation and Health Reform	—	—
Primary and Behavioral Health Care Integration	PHSA §520K	$51,878,000 for each of FY2018-FY2022
National Strategy for Suicide Prevention	PHSA §520L	$30,000,000 for FY2018-FY2022
Suicide Lifeline	PHSA §520E-3	$7,198,000 for each of FY2018-FY2022
GLS—Youth Suicide Prevention—States	PHSA §520E	$30,000,000 for each of FY2018-FY2022
GLS—Youth Suicide Prevention—Campus	PHSA §520E-2	$7,000,000 for each of FY2018-FY2022
GLS—Suicide Prevention Resource Center	PHSA §520C	$5,988,000 for each of FY2018-FY2022
AI/AN Suicide Prevention Initiative	—	—
Tribal Behavioral Health Grants	—	—
Homelessness Prevention Programs	—	—
Minority AIDS	—	—
Criminal and Juvenile Justice Programs	PHSA §520G	$4,269,000 for each of FY2018-FY2022

[122] Drug-Free Workplace Act of 1988 (P.L. 100-690, Title V, Subtitle D, as amended) (41 U.S.C. §§701 et seq.).

[123] SAMHSA, *About Us; Advisory Councils; Drug Testing Advisory Board (DTAB)*, https://www.samhsa.gov/about-us/advisory-councils/drug-testing-advisory-board-dtab, Updated March 27, 2019.

[124] SAMHSA, *FY2020 Justification of Estimates for Appropriations Committees*.

Program or Activity	Authorizing Law	Authorization of Appropriations
Assisted Outpatient Treatment for Individuals with SMI	P.L. 113-93 §224	$19,000,000 for each of FY2019-FY2020; $18,000,000 for each of FY2021-FY2022
Comprehensive Opioid Recovery Centers	PHSA §552	$10,000,000 for each of FY2019-FY2023
Assertive Community Treatment for Individuals with SMI	PHSA §520M	$5,000,000 for FY2018-FY2022
Strengthening Community Crisis Response Systems	PHSA §520F	$12,500,000 for FY2018-FY2022
Mental Health PRNS Science and Service		
Practice Improvement and Training	—	—
Consumer and Consumer Supporter TA Centers	—	—
Primary and Behavioral Health Care Integration Training and TA	PHSA §520K	$51,878,000 for each of FY2018-FY2022
Disaster Response	—	—
Homelessness	—	—
Minority Fellowship Program[b]	PHSA §597	$12,669,000 for each of FY2018-FY2022

Source: Public Health Service Act and SAMHSA, *FY2021 Justification of Estimates for Appropriations Committees*.

Notes:

a. Originally part of Project AWARE, Mental Health First Aid provides mental health awareness training to grantees. "Mental health awareness training" was codified in its own section (Sec 520J) by Cures. Mental health awareness training activities—including the Mental Health First Aid program—are treated as distinct from Project AWARE in the SAMHSA *FY2020 Justification of Estimates for Appropriations Committees*.

b. Minority Fellowship Program is included as a PRNS in three SAMHSA Centers: CMHS, CSAT, CSAP.

Example: Project LAUNCH

SAMHSA's Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) is a national initiative aimed at promoting the wellness of children from birth to eight years old. Project LAUNCH works "to ensure that the systems that serve them (including early childcare and education, home visiting, and primary care) are equipped to promote and monitor healthy social and emotional development" of young children.[125] It does this through behavioral health screenings for children, home visiting programs for families, and trainings for community providers. A multi-site evaluation completed in 2018 showed improved social and academic functioning among children, decreases in child problem behaviors, and enhanced community child and family-serving systems for participants in this program. Project LAUNCH operates under SAMHSA's general PRNS authorities—it does not have an explicit authorization in statute.

Other SAMHSA Grant Programs

In addition to the block grant programs and Programs of Regional and National Significance, SAMHSA also carries out several other statutorily required grant programs. These function similarly to statutorily required PRNS in that they target specific populations or substances of abuse. They are authorized in separate provisions from the PRNS in Title V of the PHSA, though SAMHSA will sometimes organize these programs with the PRNS when communicating about non-block-grant programs.

[125] SAMHSA, *FY2020 Justification of Estimates for Appropriations Committees*, p. 47.

Children's Mental Health Services

The Children's Mental Health Services program supports services for children with serious emotional disturbance. The program also supports efforts to identify and serve children at risk. In recent years, SAMHSA has awarded competitive grants to help states, local governments, tribes, and territories develop and implement systems of care; cooperative agreements to sustain and expand systems of care; and contracts to provide technical assistance and conduct evaluations. The systems of care approach focuses on delivering evidence-based interventions in the least restrictive setting.

PHSA Title V, Part E (Sections 561–565) authorizes the Children's Mental Health Services program.[126] PHSA Title V, Part E, requires the HHS Secretary to award grants to support "comprehensive community mental health services for children with a serious emotional disturbance." It specifies reporting requirements, technical assistance requirements, and the ages of children to be served, among other factors. PHSA Section 565 explicitly authorizes to be appropriated $119 million annually for each of FY2018-FY2022 to carry out the program.[127]

Projects for Assistance in Transition from Homelessness (PATH)

The Projects for Assistance in Transition from Homelessness (PATH) program supports services for people with serious mental illness (including those with co-occurring substance use disorders) who are homeless or at imminent risk of becoming homeless. The PATH program distributes funds to states (including the District of Columbia and specified territories) according to a formula. The states, in turn, make grants to local governments and private nonprofit organizations to support mental health and substance abuse treatment, case management, and other services. Up to 20% of the federal payments may be used for housing-related assistance. All services provided using PATH funding must be consistent with (and included in) the state's comprehensive mental health services plan (as required for participation in the mental health block grant).[128]

Each state's allotment is based on its population living in urbanized areas (as a percentage of the total U.S. population living in urbanized areas). A minimum allotment for each state is prescribed in statute (with exceptions for specified territories). States must provide matching funds of at least $1 for every $3 of federal funds. The 21st Century Cures Act required the Assistant Secretary to conduct a study of the PATH grant allotment formula and to submit a corresponding report to Congress by January 2018.[129]

PHSA Title V, Part C (Sections 521-535) authorizes the Projects for Assistance in Transition from Homelessness program.[130] PHSA Section 535 explicitly authorizes to be appropriated $65 million (rounded) annually for each of FY2018-FY2022.[131]

[126] PHSA Title V, Part E (42 U.S.C. §§290ff-290ff-4).

[127] PHSA §565(f)(1) (42 U.S.C. §290ff-4(f)(1)).

[128] The SAMHSA Charitable Choice provisions described on page 23 apply to the programs under PATH that provide substance abuse services. For more information, see HHS, "Charitable Choice Regulations Applicable to States," 68 *Federal Register* 56429-56449, September 30, 2003 and textbox footnotes on page 23.

[129] §9004(g)

[130] PHSA §§521-535 (42 U.S.C. §§290cc-21-290cc-35).

[131] PHSA §535 (42 U.S.C. §290cc-35).

Public Health Emergencies and Disaster Response

SAMHSA plays a role in helping to ensure "the nation is prepared to address the behavioral health needs that follow" natural and human-caused disasters and emergent events, including public health emergencies.[132]

SAMHSA operates a Disaster Technical Assistance Center (DTAC) as the foundation of its disaster response initiatives.[133] SAMHSA DTAC assists states, territories, tribes, and local entities with all-hazards disaster behavioral health response planning. The intent of this program is to improve both preparedness and response to disasters and emergent events. SAMHSA partners with the Federal Emergency Management Agency (FEMA) to jointly fund DTAC. SAMHSA DTAC uses appropriated funds for programs that support survivors of disasters as well as organizations and providers administering aid. For example, through an interagency agreement with FEMA, SAMHSA operates the Crisis Counseling Assistance and Training Program (CCP), which provides community-based behavioral health outreach and psycho-educational services.[134] In addition to oversight of the CCP, SAMHSA offers technical assistance and program guidance. Other SAMHSA DTAC initiatives include immediate crisis counseling via the Disaster Distress Helpline[135] and resource publication through the Disaster Behavioral Health Information Series (DBHIS) resource collections.[136]

For some public health emergencies—such as the opioid epidemic—SAMHSA plays a significant role in distributing grant funds for behavioral health prevention and treatment services; providing technical assistance to grantees and providers; and, in some cases, issuing rules and regulations. Provisions in the PHSA provide SAMHSA greater autonomy over grant management during public health emergencies. For example, PHSA Section 1957 allows states greater flexibility in meeting deadlines or other requirements for the MHBG, the SABG, PATH grant, or Protection and Advocacy for Individuals with Mental Illness grant in the case of a public health emergency. Funds made available for emergency response grants under PHSA Section 501 also remain available through the end of the fiscal year following the fiscal year for which the amounts are appropriated.

Treatment Systems for Homeless

The Treatment Systems for Homeless awards grants, contracts, and cooperative agreements to states, local governments, and communities to provide mental health and substance abuse services to individuals experiencing homelessness. Grants support activities such as the development and expansion of local systems that provide permanent housing or supportive services for adults, youth, families, and veterans. Some of the Treatment Systems for Homeless are joint initiatives managed by CMHS and CSAT.

PHSA Section 506 authorizes the Treatment Systems for the Homeless.[137] PHSA Section 506 explicitly authorizes to be appropriated $41 million (rounded) annually for each of FY2018-FY2022.[138]

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) program supports state-designated protection and advocacy (P&A) systems mandated to protect individuals with mental illness residing in care or treatment facilities from abuse, neglect, and violations of their

[132] SAMHSA *FY2020 Justification of Estimates for Appropriations Committees*, p. 84.

[133] SAMHSA, *Practitioner Training; Disaster Technical Assistance Center (DTAC)*, https://www.samhsa.gov/dtac.

[134] SAMHSA, *Practitioner Training; Disaster Technical Assistance Center (DTAC); Crisis Counseling Assistance Program (CCP)*, https://www.samhsa.gov/dtac/ccp.

[135] SAMHSA, *Find Treatment; Disaster Distress Helpline*, https://www.samhsa.gov/find-help/disaster-distress-helpline.

[136] SAMHSA, *Practitioner Training; Disaster Technical Assistance Center (DTAC); DBHIS* Collections, https://www.samhsa.gov/dtac/dbhis-collections.

[137] PHSA §506 (42 U.S.C. §§290aa-5).

[138] 42 U.S.C. §§290aa-5(e).

civil rights. The PAIMI program distributes funds to P&A systems in the states (including the District of Columbia and specified territories) and the American Indian Consortium according to a formula.[139]

Unlike many of SAMHSA's other formula grants, for which formulas are prescribed in statute, PAIMI's formula is prescribed by the HHS Secretary, subject to statutory requirements. Specifically, it must be based equally on (1) each state's population and (2) each state's population weighted by per capita income relative to the United States. A minimum allotment for each state is prescribed in statute. Exceptions to components of the formula and minimum allotment calculation are made for specified territories and the American Indian Consortium.[140]

State P&A systems were established under the Developmental Disabilities Assistance Act of 1975 (P.L. 94-103, as amended).[141] The PAIMI Act of 1986 (P.L. 99-319, as amended) authorized the formula grant to support P&A systems in serving the mentally ill.[142] Section 10827 of the PAIMI Act explicitly authorized appropriations for the PAIMI program through FY2003. Since that time, the program has continued to operate under its general authorities and has continued to receive funding through the annual appropriations process. The Cures Act required GAO to submit a report on programs funded by PAIMI grants to specified congressional committees by July 2018.[143]

Minority Fellowship Program

The SAMHSA-administered Minority Fellowship Program provides grants to professional associations (e.g., the American Psychiatric Association and the American Nurses Association) to offer stipends to minority doctoral students who are studying for degrees in a mental or behavioral health profession.[144] PHSA Section 597 requires the HHS Secretary to maintain a "Minority Fellowship Program" to award fellowships, which may include stipends, for post-baccalaureate training for mental health professionals in the fields of psychiatry, nursing, social work, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling. It authorizes to be appropriated $13 million (rounded) annually for each of FY2018-FY2022.[145]

[139] For purposes of the PAIMI program, "State" is defined in statute as each of the 50 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the U.S. Virgin Islands, and the "Trust Territory of the Pacific Islands" (42 U.S.C. §10802(7)). In some sections of the PAIMI Act, "Trust Territory of the Pacific Islands" has been replaced by "Marshall Islands, the Federated States of Micronesia, the Republic of Palau" (42 U.S.C. §10822(a)(1)(B), for example). The HHS Secretary is required to make an allotment to the American Indian Consortium (which represents the Navajo and Hopi Tribes in the Four Corners region of the Southwest) if the total amount appropriated for a fiscal year is at least $25 million (42 U.S.C. §10822(a)(2)(D)).

[140] 42 U.S.C. §10822.

[141] For example, see P.L. 106-402.

[142] P.L. 99-319 (42 U.S.C. §§10801-10827).

[143] §6023.

[144] Of note, the Health Resources and Services Administration (HRSA) within HHS also provides workforce development programming for behavioral health providers. See, for instance, *HRSA; Grants; Behavioral Health* at https://bhw.hrsa.gov/grants/behavioral-health.

[145] 42 U.S.C. §290ll(c).

Additional Opioid Grant Programs

State Targeted Response (STR) for the Opioid Crisis Grants

The State Targeted Response to the Opioid Crisis (Opioid STR) grant program provided nearly $1 billion to the states and territories over FY2017 and FY2018 to support activities related to the opioid epidemic. While the funds were appropriated to HHS generally, the responsibility for administering these grants was delegated to SAMHSA.[146] SAMHSA awarded grants to all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, Micronesia, Palau, and American Samoa.[147] The funds provided to each grantee were allocated based on a formula that considered two factors: (1) unmet need for opioid use disorder treatment and (2) drug poisoning deaths.

Section 7181 of the SUPPORT for Patients and Communities Act (SUPPORT Act; P.L. 115-271) reauthorized the Opioid STR grant for $500 million for each of FY2019 through FY2021. The SUPPORT Act was signed into law in October 2018 after the FY2019 Labor-HHS-Education appropriations bill (P.L. 115-245) was enacted, leaving the authorization for the STR grant expired when funding for FY2019 was appropriated. The grant program was not funded for FY2020.

State Opioid Response (SOR) Grants

Similar to the Opioid STR grants, the State Opioid Response (SOR) grants provided $1 billion in funding for states to address the opioid epidemic in FY2018.[148] The SOR grants sought to increase access to medication-assisted treatment and enhance state prevention, treatment, and recovery systems. The SOR grants followed similar distribution methods as the Opioid STR grants. The funds provided to each grantee were allocated based on a formula determined by the Secretary. The program included a 15% set-aside for the 10 states with the highest drug overdose mortality rates. The program also included a $50 million set-aside for tribes. For FY2019, the amount for the SOR grant program increased by $500 million—the same amount the Opioid STR grants were reduced. The grant program received level funding—$1.5 billion—for FY2020.

Data Collection and Related Activities

In addition to the activities described above, SAMHSA collects data and conducts related activities. Many of these activities are conducted—or coordinated—by the CBHSQ. Examples include the following:

- **Surveillance and data collection**: for example, the National Survey of Drug Use and Health (NSDUH), an annual household survey of drug use and other health information among the U.S. population age 12 or older.[149] Other

[146] U.S. Congress, House Committee of the Whole House on the State of the Union, *Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2017*, To accompany H.R. 5926, 114th Cong., 2nd sess., July 22, 2016, 114-699, p. 4, available at https://www.gpo.gov/fdsys/pkg/CRPT-114hrpt699/pdf/CRPT-114hrpt699.pdf.

[147] HHS, SAMHSA, *FY2018 Justification of Estimates for Appropriations Committees*, p. 207 and HHS, SAMHSA, *FY2019 Justification of Estimates for Appropriations Committees*, p. 218.

[148] H.R. 1625.

[149] For more information about the NSDUH, see CRS Report R43047, *Prevalence of Mental Illness in the United States: Data Sources and Estimates*.

examples include the National Survey of Substance Abuse Treatment Services (N-SSATS), an annual survey of all known substance abuse treatment facilities in the United States,[150] and the Drug Abuse Warning Network (DAWN), a nationally representative public health surveillance system that monitors drug-related visits to hospital emergency departments.[151]

- **Statistical and analytic support**: for example, the Substance Abuse and Mental Health Data Archive (SAMHDA), a repository for public access data files that provides public access and analysis.[152]
- **Performance and quality information systems activities**: for example, the Evidence-Based Practices Resource Center (EBP Resource Center), a searchable online database of mental health and substance abuse information supported by scientific research.[153] The EBP Resource Center aims to "provide communities, clinicians, policy-makers, and others" with "the information and tools they need to incorporate evidence-based practices into their communities or clinical settings."[154] Launched in April 2018, the EBP Resource Center replaced the National Registry of Evidence-based Programs and Practices—in existence since 1997—after the Cures Act codified and amended the responsibilities of SAMHSA to publicly provide information on evidence-based program and practices.[155]
- **Agency-wide initiatives**: for example, SAMHSA's collaboration with the Health Resources and Services Administration (HRSA) to develop consistent methods of identifying and tracking behavioral health workforce needs.

PHSA Section 505 requires the HHS Secretary, acting through the SAMHSA Administrator, to collect data on various topics. Specific requirements include conducting annual surveys and making summaries and analyses available to the public.[156] PHSA Title V includes numerous other references to collecting and disseminating data, embedded within larger programs. Under PHSA Title XIX, both block grant programs also require some data collection and evaluation activities.

National Mental Health Policy Laboratory

Through its National Mental Health Policy Laboratory, SAMHSA evaluates and disseminates information on best practices in the field. Title VII (Section 7001) of the Cures Act established

[150] SAMHSA, *National Survey of Substance Abuse Treatment Services (N-SSATS)*, https://www.samhsa.gov/data/data-we-collect/nssats-national-survey-substance-abuse-treatment-services.

[151] SAMHSA, *Substance Abuse & Mental Health Data Archive; Drug Abuse Warning Network*, https://www.datafiles.samhsa.gov/study-series/drug-abuse-warning-network-dawn-nid13516.

[152] SAMHSA, *Substance Abuse & Mental Health Data Archive*, https://www.datafiles.samhsa.gov/.

[153] SAMHSA, *Programs; Evidence-Based Practices Resource Center*, https://www.samhsa.gov/ebp-resource-center.

[154] SAMHSA, *Programs; EBP Resource Center; About the Evidence-Based Practices Resource Center;* https://www.samhsa.gov/ebp-resource-center/about.

[155] PHSA §543A (42 U.S.C. 290dd-2a). See also: SAMHSA, "Statement of Elinore F. Mccance-Katz, MD, PhD, Assistant Secretary for Mental Health and Substance Use Regarding the National Registry of Evidence-Based programs and Practices and SAMHSA's New Approach to Implementation of Evidence-Based Practices (EBPs)," press release, January 11, 2018, https://www.samhsa.gov/newsroom/press-announcements/201801110330.

[156] PHSA §505 (42 U.S.C. §290aa-4).

within SAMHSA a National Mental Health Policy Laboratory.[157] The statute requires the laboratory to facilitate the implementation of policy changes likely to improve the prevention and treatment of mental illness and substance use disorders, disseminate information on evidence-based practices, and periodically review SAMHSA programs to reduce duplication and make recommendations to improve effectiveness, among other responsibilities. The statute also allows the Assistant Secretary to award grants for (1) evaluating promising service delivery models and (2) expanding the use of evidence-based programs. In January 2018, SAMHSA announced the launch of the Policy Laboratory by naming its first director and officially establishing it as one of SAMHSA's Offices and Centers.[158]

Publications

SAMHSA publishes guidance, clinical best practices, and other resources on treatment, prevention, and recovery for mental and substance use disorders. Through the SAMHSA online store, clinicians, patients, and policymakers can access downloadable materials on a variety of topics.[159] SAMHSA offers series of treatment-related resources such as Treatment Improvement Protocols, SAMHSA Advisories, and Evidence-Based Practice Kits, among others. The SAMHSA Store, where many of these materials can be obtained, is managed through the Public Engagement Platform contract through the Office of Communications.[160]

Technical Assistance

SAMHSA provides technical assistance to help states, territories, tribes, and other behavioral health providers develop and strengthen behavioral health care services. Technical assistance typically includes instruction on the grant application process, consultation on grant management, and workforce development programs. SAMHSA may provide this technical assistance directly, through contract, or through a grant. SAMHSA operates several National Technical Assistance and Resource Centers to enhance grantee performance and improve quality of service delivery.[161] The agency also organizes and disseminates training and learning resources to facilitate the identification of evidence-based programs. Some of these activities are explicitly authorized in statute.

[157] PHSA §501A (42 U.S.C. 290aa-0).

[158] SAMHSA, "Leadership Announcement," press release, January 9, 2018, https://blog.samhsa.gov/2018/01/09/leadership-announcement and SAMHSA, *About Us; Who We Are; Offices and Centers: NMHSUPL*, https://www.samhsa.gov/about-us/who-we-are/offices-centers/nmhsupl.

[159] SAMHSA, *Publications and Digital* Products, https://store.samhsa.gov/.

[160] SAMHSA, *FY2020 Justification of Estimates for Appropriations Committees*, p. 287-289.

[161] SAMHSA, *SAMHSA's National Technical Assistance & Resource Centers*, Rockville, MD, https://www.samhsa.gov/sites/default/files/ta-center-brochure.pdf.

Appendix.

Table A-1. Abbreviations Used in This Report

Abbreviation	Definition
ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
ADMS	Alcohol, Drug, and Mental Health Services
AHRQ	Association for Health Care Research and Quality
Assistant Secretary	Assistant Secretary of Mental Health and Substance Use
BCOR	Building Communities of Recovery
BHSIS	Behavioral Health Services Information System
CARA	Comprehensive Addiction and Recovery Act
CBHSQ	Center for Behavioral Health Statistics and Quality
CMHS	Center for Mental Health Services
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
Cures	21st Century Cures Act
DAWN	Drug Abuse Warning Network
DTAB	Drug Testing Advisory Board
DTAC	Disaster Technical Assistance Center
EBP	Evidence-Based Practices
ED	Department of Education
GAO	Government Accountability Office
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHA	Institute for Health and Aging
ISMICC	Interdepartmental Serious Mental Illness Coordinating Committee
LAUNCH	Linking Actions for Unmet Needs in Children's Health
MHBG	Community Mental Health Services Block Grant
NASEM	National Academies of Science, Engineering, and Medicine
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIMH	National Institutes of Mental Health
N-MHSS	National Mental Health Services Survey
NSDUH	National Survey on Drug Use and Health
N-SSATS	National Survey of Substance Abuse Treatment Services
OBRA	Omnibus Budget Reconciliation Act
OCMO	Office of the Chief Medical Officer

Opioid STR	State Targeted Response to the Opioid Crisis
P&A	protection and advocacy
PAIMI	Protection and Advocacy for Individuals with Mental Illness
PATH	Projects for Assistance in Transition from Homelessness
PHS	Public Health Service
PHSA	Public Health Service Act
PPHF	Prevention and Public Health Fund
PRNS	Programs of Regional and National Significance
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHDA	Substance Abuse and Mental Health Data Archive
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	serious emotional disturbance
SMI	serious mental illness
SOR	State Opioid Response Grants
SUPPORT	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment Act
TEDS	Treatment Episode Data Set

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