Substance Abuse and Mental Health Services Administration (SAMHSA): Agency Overview and Reauthorization Issues

(name redacted)
Specialist in Health Policy

November 4, 2010

Congressional Research Service
7-....
www.crs.gov
R41477

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA), within the Department of Health and Human Services (HHS), provides federal funding to support community-based mental health and substance abuse prevention and treatment services. SAMHSA awards formula and competitive grants under its authorities in Title V of the Public Health Service Act (PHSA). The agency also administers the $1.8 billion Substance Abuse Prevention and Treatment (SAPT) block grant and the $420 million Community Mental Health Services (CMHS) block grant, both of which are authorized in PHSA Title XIX. SAMHSA's funding totaled almost $3.6 billion in FY2010. The agency's budget increased by 34% from FY2000 to FY2010. In real (i.e., inflation-adjusted) dollars, however, the funding increase over that period was only 6%. Funding for SAMHSA's two block grants, which together account for 62% of the agency's budget, has grown at a much slower pace than funding for its competitive grant programs.

SAMHSA was reauthorized in 2000, as part of the Children's Health Act (P.L. 106-310). The act amended SAMHSA's existing authorities to give the agency more flexibility to direct mental health and substance abuse funding; increased state flexibility to direct the use of block grant funds, creating several new competitive grant programs to expand mental health and substance abuse services for children and adolescents; and authorized appropriations through FY2003. It also added charitable choice provisions that allow faith-based organizations to compete for SAMHSA substance abuse funding without impairing their religious character. P.L. 106-310 required SAMHSA to submit two reports to Congress, one on providing coordinated care to individuals with co-occurring mental illness and substance abuse, and the other on efforts to improve the flexibility and accountability of the block grants.

Comprehensive reauthorization has not occurred since 2000. However, several laws have further expanded the agency's programs and activities in suicide prevention, underage drinking, and prescription drug abuse. The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) contained new authorizations for SAMHSA related to depression and behavioral health services for American Indians and Alaskan Natives, as well as additional provisions related to mental health and substance abuse.

While reauthorization has not moved out of committee, issues that may be of interest during the next reauthorization of SAMHSA include increased performance measurement and accountability for SAMHSA grants and programs, granting specific authority for the Access To Recovery program that provides vouchers for individuals to seek treatment services, improving the ability of communities to provide behavioral health services during disaster response, requiring collaboration between SAMHSA and other federal agencies, increasing SAMHSA's level of emphasis on primary prevention, increasing SAMHSA's role in expanding the number and diversity of the behavioral health provider workforce, and ensuring fairness of the formula used to distribute SAMHSA's block grants.

This report describes SAMHSA's history, organization, authority, and programs, and analyzes some of the issues that may be considered by Congress during a reauthorization of the agency. The appendixes include a table describing SAMHSA's authorizations and appropriations, a table with SAMHSA's funding from FY2000-FY2010, a matrix of SAMHSA's National Outcome Measures that aim to evaluate progress on substance abuse and mental health prevention and treatment indicators, and a list of SAMHSA resources.

Contents

Figures

Tables

Appendixes

Contacts

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA), within the Department of Health and Human Services (HHS), is the lead federal agency for increasing access to behavioral health services. SAMHSA funds community-based mental health and substance abuse treatment and prevention services and collects information on the incidence and prevalence of mental illness and substance abuse at the national and state level. These activities support SAMHSA's mission to improve the lives of people with substance abuse disorders and mental illnesses.

SAMHSA funds mental health and substance abuse services through formula and competitive grants. SAMHSA provides formula funding to states, U.S. territories, and the Red Lake Indian tribe, while competitive funding is awarded through numerous grant programs to states, territories, tribal organizations, local communities, and private entities. Under SAMHSA's charitable choice provisions, religious organizations are eligible to receive funding in order to provide substance abuse services without altering their religious character.

SAMHSA's two largest programs are the $1.8 billion Substance Abuse Prevention and Treatment (SAPT) block grant and the $421 million Community Mental Health Services (CMHS) block grant, which account for more than 60% of the agency's budget in FY2010. The SAPT block grant provides approximately 40% of the expenses of state agencies responsible for substance abuse prevention and treatment services.[1] By comparison, the CMHS block grant funds on average 2% of the expenses of state mental health agencies.[2] The difference reflects the historical role federal and state governments have played in funding services in these two areas, with states providing a much larger portion of mental health funding than substance abuse funding.

SAMHSA also collects data on mental health and substance abuse at the national and state level. These data provide information on the incidence and prevalence of mental illness and substance abuse, the availability and utilization of treatment services, and the outcomes of mental health and substance abuse prevention and treatment services. SAMHSA uses this information to monitor mental health and substance abuse trends and to help determine how resources should be directed. In addition, performance and outcome data are used to measure the impact of programs and interventions.

This report provides an overview of SAMHSA's organization and programs and includes some analysis of the agency's funding over the past decade. It also highlights some of the issues that may be addressed by Congress when it next considers legislation to reauthorize SAMHSA and its programs. SAMHSA was last reauthorized in 2000. Authorizations of appropriations for most of SAMHSA's grant programs expired at the end of FY2003, though many of them continue to receive funding. Comprehensive reauthorization of SAMHSA was discussed during the 110th Congress,[3] and reauthorizing legislation was introduced in the 111th Congress.[4] Possible

[1] National Association of State Alcohol and Drug Abuse Directors, *Fact Sheet: Substance Abuse Prevention and Treatment (SAPT) Block Grant*, June 2009, http://www.nasadad.org/resource.php?base_id=1756.

[2] NASMHPD Research Institute, Table 27: SMHA-Controlled Mental Health Revenues Dedicated to State Mental Health Agency Support Programs, by Revenue Source and by State, FY 2008 (in millions), http://www.nri-inc.org/projects/Profiles/RevExp2008/T27.pdf.

[3] SAMHSA, *Minutes of the 44th Meeting of the SAMHSA National Advisory Council*, September 2008.

[4] The SAMHSA Modernization Act of 2010 (H.R. 5466).

reauthorization issues include increased performance measurement and accountability for SAMHSA grants, granting specific authority for the Access to Recovery program, improving the ability of communities to provide behavioral health services during disaster response, requiring collaboration between SAMHSA and other federal agencies, increasing SAMHSA's level of emphasis on primary prevention, increasing SAMHSA's role in expanding the number and diversity of the behavioral health provider workforce, and ensuring fairness of the formula used to distribute SAMHSA's block grants. This report will be updated as warranted by legislative and other developments.

SAMHSA Authorization and Organization

SAMHSA and most of its programs and activities are authorized under Title V of the Public Health Service Act (PHSA). The SAPT and CMHS block grants are separately authorized under PHSA Title XIX Part B. SAMHSA has authority to administer several specific formula and competitive grant programs to support mental health and substance abuse prevention and treatment services, as well as general authorities for activities in these areas. Appropriations for the agency were reauthorized in 2000, as part of the Children's Health Act.[5] The act amended SAMHSA's existing authorities under Title V, added several new authorities, and authorized appropriations through FY2003. Congress has not taken up comprehensive reauthorization legislation since 2000, though it has added some new authorities to Title V and otherwise expanded the agency's programs and activities (see "New Authorizations Since 2000" below).

PHSA Title V authorizes SAMHSA programs under three centers: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP). 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.

SAMHSA funds competitive and formula grant programs. While the majority of SAMHSA programs provide funding through a competitive grant process, together these programs account for only one-third of the agency's budget. The five formula grants—primarily the two block grants—account for the other two-thirds of SAMHSA's budget. This mix of funding provides flexibility at both the federal and state levels. The formula block grants allow states the flexibility to allocate funding to address specific issues and populations within their jurisdictions, but they do not allow funding levels to be easily adjusted based on changing levels of need due to fixed statutory funding formulas (see "Block Grant Formula" below). By comparison, competitive grant programs are generally issue-specific. These grants allow SAMHSA to allocate funding for a particular issue, such as suicide prevention, to areas and populations with the greatest need.

Title V authorizes numerous competitive grant programs, some, but not all, of which receive funding through the annual appropriations process. For instance, Early Intervention Services for Children and Adolescents[6] and Grants for Emergency Mental Health Centers[7] have never received funds. In addition to the grant programs with specific statutory authority, which are often referred to as categorical grants, each center also has general authority, called Programs of Regional and

[5] P.L. 106-310, Titles XXXI-XXXIV.

[6] PHSA Sec. 514A.

[7] PHSA Sec. 520F.

National Significance (PRNS), to fund states and communities to address priority substance abuse and mental health needs. PRNS authorizes the center 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. Each center funds several grant programs that were created under its general (i.e., PRNS) authority. Examples of such PRNS programs include the Access to Recovery program and the Strategic Prevention Framework, described below.

Most SAMHSA programs are administered by one of the three centers and focus on mental health, substance abuse prevention, or substance abuse treatment. This structure encourages the development of programs that fit within a center, and can make it more difficult to implement programs that focus on both mental health and substance abuse. Several cross-cutting programs receive support separately from all three centers, including the National Registry of Evidence-based Programs and Practices, the SAMHSA Health Information Network, the Minority AIDS Program, and the Minority Fellowship Program. To better address cross-cutting issues, SAMHSA has also created connections between centers for programs with both mental health and substance abuse components. For instance, the co-occurring state incentive grant, which supports improvements to infrastructure and capacity for treating individuals with both mental health and substance abuse conditions, is administered by both CMHS and CSAT.

A brief description of each center follows, including a list of significant programs. As noted above, some programs are specifically authorized, and others are created and funded under the general PRNS authority. **Table A-1** in **Appendix A** at the end of the report includes a description of SAMHSA's program authorities—including current funding and appropriations history—within each of SAMHSA's centers. In addition, **Appendix C** includes links to SAMHSA websites with additional information on the agency's centers, programs, and grants.

SAMHSA History

In 1974, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) was established by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments (P.L. 93-282). ADAMHA was created to provide federal funding to states for substance abuse and mental health treatment services. In addition, ADAMHA was designated as the parent agency for three existing research agencies—the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Prior to the creation of ADAMHA, these research institutes were part of the National Institutes of Health (NIH).

In 1992, the ADAMHA Reorganization Act (P.L. 102-321) moved the three research institutes back to the NIH and renamed the agency SAMHSA to reflect its focus on funding community-based services. While the original mission of NIMH included programs for educating and training clinical personnel and for providing leadership to enhance the quality of treatment services, SAMHSA took on these responsibilities and NIMH retained its research activities.

Center for Substance Abuse Treatment

CSAT is authorized to develop, evaluate, and implement effective substance abuse treatment programs, and to improve the quality of services and access to services.[8] CSAT administers the formula-based SAPT block grant, as well as a much smaller formula grant for prescription drug monitoring. The center also administers several competitive grant programs that focus on treatment and recovery support services, homeless individuals, early detection, and criminal

[8] PHSA Sec. 507.

justice populations. Included below are brief descriptions of significant programs within CSAT that account for most of the center's funding. See **Table A-1** for a full list of authorized programs and funding within CSAT.

- *Substance Abuse Prevention and Treatment Block Grant*: Formula grants to states to plan, carry out, and evaluate activities to prevent and treat substance abuse.
- *Access to Recovery (ATR)*: Grants to states and tribal organizations to evaluate individuals with substance abuse issues and provide vouchers for treatment and recovery support services that can be redeemed with approved providers. This program is discussed below in the "Access to Recovery" section.
- *Screening, Brief Intervention, and Referral to Treatment (SBIRT)*: Grants to states and tribal organizations to integrate substance abuse screening, brief intervention, referral, and treatment services within general medical and primary care settings in order to identify individuals with or at risk for a substance abuse disorder.
- *Treatment Drug Courts*: Grants to adult, juvenile, and family drug courts and providers to fund substance abuse treatment, assessment, case management, and program coordination for those referred by the drug courts.
- *Grants for the Benefit of Homeless Individuals:* Grants to organizations to provide services for homeless individuals with a substance use disorder or who have co-occurring substance abuse and mental health disorders.
- *Minority AIDS:* Grants to community-based organizations to provide substance abuse treatment and related HIV/AIDS services targeting high-risk substance abusing populations.
- *Targeted Capacity Expansion*: Grants to states, local governments, and tribal entities to expand or enhance a community's ability to respond to a specific, well-documented substance abuse capacity problem.

Center for Substance Abuse Prevention

CSAP is authorized to support efforts to prevent substance abuse through public education, training, technical assistance, and data collection.[9] The center provides states with grants to support their strategic planning activities for substance abuse prevention, and maintains a registry of evidence-based prevention practices. It also administers competitive grant programs that focus on improving and expanding community-based substance abuse prevention activities, and preventing underage drinking, fetal alcohol disorders, and substance abuse in high-risk populations. Finally, CSAP administers a 20% prevention set-aside from the SAPT block grant. Included below are brief descriptions of significant programs within CSAP. See **Table A-1** for a full list of authorized programs and funding within CSAP.

- *Substance Abuse Prevention and Treatment Block Grant (20% prevention set-aside)*: Formula funding to support six primary prevention strategies: information dissemination, education, alternatives, problem identification and referral, community-based processes, and environmental strategies.

[9] PHSA Sec. 515.

- *Strategic Prevention Framework*: Grants to states, territories, and tribal organizations to implement a public health approach to substance abuse prevention through needs assessment, capacity building, strategic planning, evidence-based practices, and program evaluation.
- *Sober Truth on Preventing Underage Drinking (STOP)*: Grants to community based coalitions for underage-drinking programs in communities, and funding for the underage drinking prevention media campaign.
- *Minority AIDS:* Grants to organizations to *s*upport the delivery and sustainability of substance abuse and HIV prevention services in minority communities.
- *Fetal Alcohol Spectrum Disorder Center of Excellence*: Identifies and disseminates information about innovative techniques and effective strategies for preventing fetal alcohol spectrum disorder.

Center for Mental Health Services

CMHS is authorized to prevent mental illness and promote mental health by providing funds to evaluate, improve, and implement effective treatment practices; address violence among children; provide technical assistance to state and local mental health agencies; and collect data.[10] CMHS administers the formula-based CMHS block grant, as well as two other smaller formula grant programs that fund advocacy activities and homeless services. The center also administers several competitive grant programs focusing on children's mental health, youth violence prevention, support for the homeless, suicide and other prevention services, and mental health care system transformation. Included below are brief descriptions of significant programs within CMHS. See **Table A-1** for a full list of authorized programs and funding within CMHS.

- *Community Mental Health Services Block Grant*: Formula grants to states and territories to support community mental health services for adults with serious mental illness and children with serious emotional disturbance.
- *Protection and Advocacy for Individuals with Mental Illness (PAIMI)*: Formula grants to independent protection and advocacy agencies identified by states and territories to protect the mentally ill from abuse, neglect, and violations of their civil rights.
- *Projects for Assistance in Transition from Homelessness (PATH)*: Formula grants to states and territories to provide outreach, mental health, and other support services to homeless people with serious mental illness.
- *Services in Supportive Housing*: Grants to provide mental health and related wrap-around services for individuals and families experiencing chronic homelessness in coordination with existing housing programs.
- *Children's Mental Health Services*: Six-year grants to implement, improve, and expand systems of care to meet the needs of children with serious emotional disturbances and their families.

[10] PHSA Sec. 520.

- *National Child Traumatic Stress Network*: Funds a national network of experts to collaboratively develop and promote effective community practices for children and adolescents exposed to traumatic events.
- *Safe Schools/Healthy Students*: Grants to local educational agencies through the Department of Education to implement programs and services that focus on promoting healthy childhood development and preventing violence and alcohol and other drug abuse.
- *Youth Suicide Prevention*: Programs include suicide prevention grants to states, tribal organizations, and institutions of higher learning; a suicide prevention hotline; and a national suicide resource center.
- *Mental Health System Transformation Grants:* Grants to local communities to promote the adoption and implementation of permanent transformative changes in how communities manage and deliver mental health services.

Center for Behavioral Health Statistics and Quality

The Center for Behavioral Health Statistics and Quality (CBHSQ), formerly the Office of Applied Studies (OAS), collects and analyzes national and state-level data on mental health and substance abuse, including information on the incidence of substance abuse and mental health conditions in the United States, and the characteristics of those who suffer from these problems.[11] CBHSQ also collects information on substance abuse prevention and treatment providers, including the cost, quality, and effectiveness of services. This information is collected using a variety of surveys, surveillance systems, and other studies, which are summarized below.

- *National Survey on Drug Use and Health (NSDUH)*: Annual survey that collects data on illicit drug use, non-medical use of prescription drugs, and alcohol and tobacco use among individuals ages 12 and over. NSDUH is the primary source of information on the prevalence, patterns, and consequences of alcohol, tobacco, and illegal drug use in the general U.S. civilian, non-institutionalized population.
- *Drug Abuse Warning Network (DAWN)*: A public health surveillance system that provides estimates of the number of drug-related visits to hospital emergency departments in large metropolitan areas and provides information on drug-related deaths in 40 metropolitan areas based on medical examiner data.
- *Drug and Alcohol Services Information System (DASIS)*: This system provides information collected through the following three components:
    - *Treatment Episode Data Set (TEDS):* Data submitted by states on the demographic and substance abuse characteristics of admissions to facilities that are licensed or certified by the state substance abuse agency to provide treatment services.
    - *National Survey of Substance Abuse Treatment Services (N-SSATS):* Annual survey that collects data on private and public alcohol and drug abuse treatment facilities and services across the country.

[11] PHSA Sec. 505 authorizes SAMHSA's data collection activities.

- *Inventory of Substance Abuse Treatment Services (I-SATS):* A listing of public and private substance abuse treatment facilities in the United States.

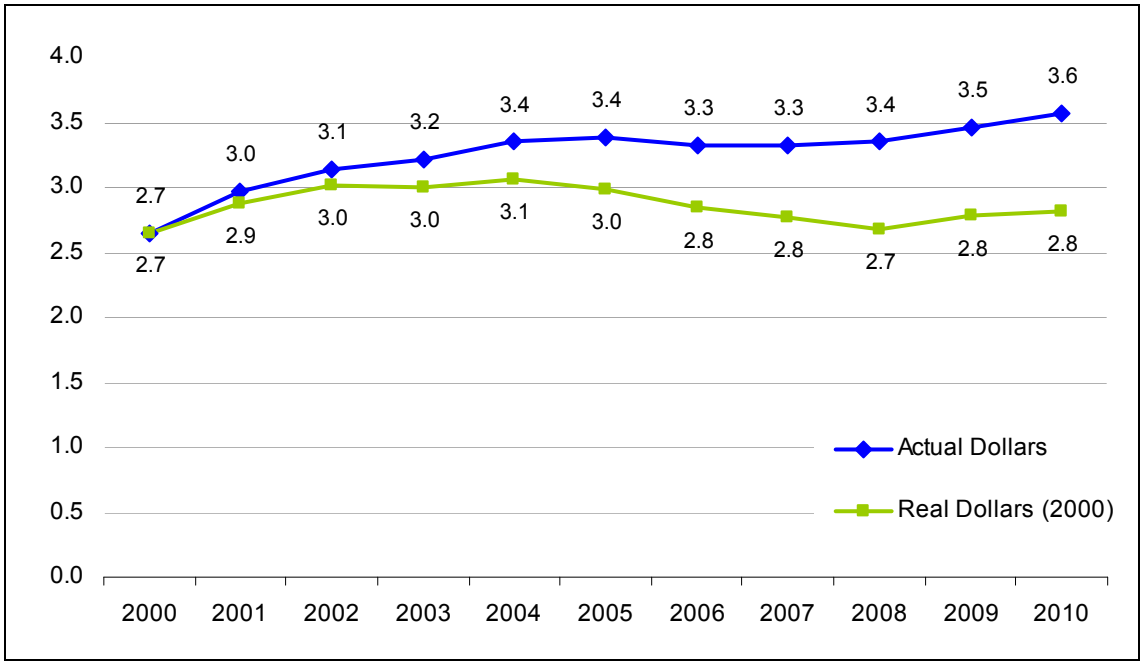
SAMHSA Funding

SAMHSA's budget totaled $3.563 billion in FY2010, and the agency's budget request for FY2011 would add an additional $111 million to that total. Substance abuse activities account for 69% of the funding in SAMHSA's budget, while 28% of the funding is for mental health activities. The remaining 3% of funding supports program management. For both substance abuse and mental health activities, the two block grants constitute the largest portion of funding, and together made up 62% of SAMHSA's budget in FY2010. **Table A-2** in **Appendix A** shows SAMHSA funding for the period from FY2000 through the FY2011 budget request, including funding totals for mental health and substance abuse activities and funding for major programs.

Figure 1 compares SAMHSA's funding from FY2000 through FY2010 before and after adjusting for inflation. While actual SAMHSA funding has increased most years since FY2000, the trend line for inflation-adjusted agency funding is relatively flat between FY2000 and FY2010. Overall, the agency's funding in actual dollars increased by 34% over the period FY2000-FY2010. In real (i.e., inflation-adjusted) dollars, however, the funding increase over that period was only 6%.

Figure 1. SAMHSA Funding in Real and Actual Dollars, FY2000-FY2010

(dollars in billions)



Source: Prepared by CRS using SAMHSA budget justification documents.

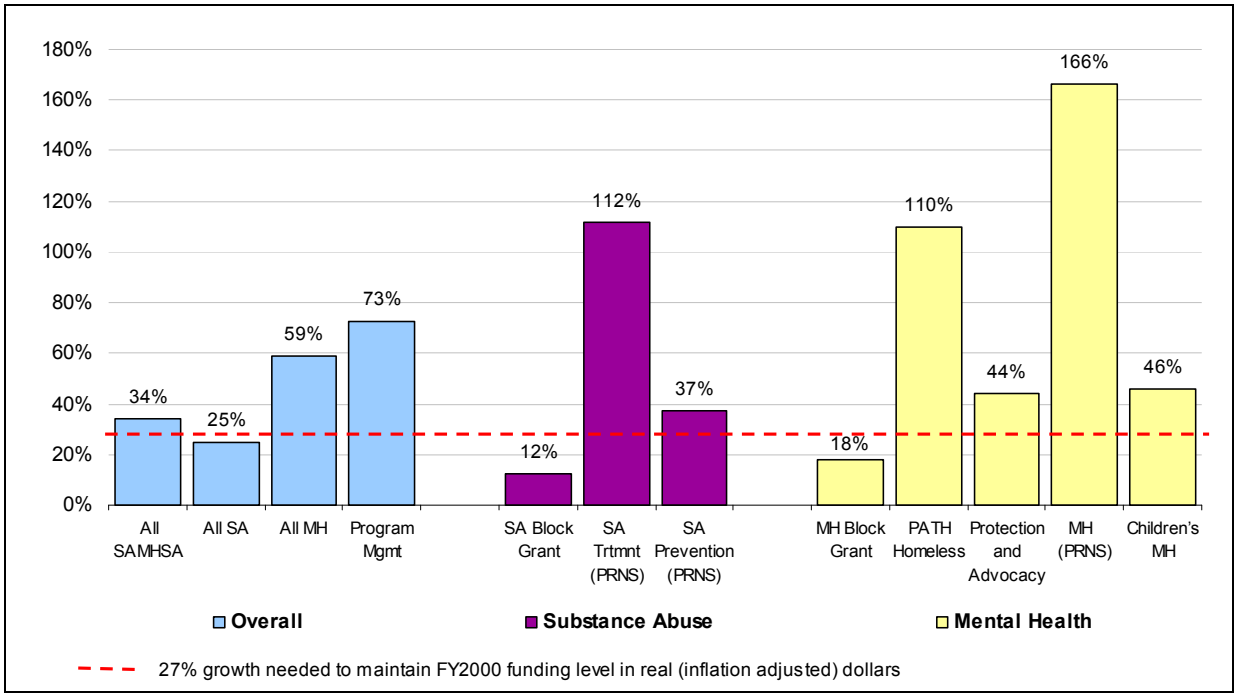
Notes: Real dollar amounts have been calculated using the U.S. Department of Labor's Bureau of Labor Statistics Consumer Price Index (CPI) inflation calculator.

Within SAMHSA, funding growth since FY2000 varies significantly among programs. **Figure 2** below shows the percentage increase in SAMHSA's funding from FY2000 to FY2010, including

funding for specific programs, program areas, and the agency's overall budget. The dotted line shows the 27% increase in funding needed to keep pace with inflation over that 10-year period. Programs with funding increases under the dotted line have experienced a decline in real (i.e., inflation-adjusted) funding since FY2000. Overall, CMHS-administered mental health programs have grown at more than twice the rate of substance abuse programs, which are administered by CSAT and CSAP. In addition, program management funding, which supports SAMHSA staff, has grown more than funding for mental health and substance abuse programs.

On the program level, funding for both the mental health and substance abuse block grants has increased very little since FY2000, with growth rates below the 27% needed to keep up with inflation. In contrast, programs under the PRNS budget lines, which include all competitive grant programs except Children's Mental Health, have received the largest funding increases. [12] From FY2000 to FY2010, mental health PRNS grew by 166% and substance abuse treatment PRNS grew by 112%. Substance abuse prevention PRNS grew much less, increasing by 37% from FY2000 to FY2010. Unlike the block grant funding, which is largely directed by states, the PRNS funding primarily supports priorities identified by SAMHSA. After the PRNS funding, the PATH formula grant grew the most, with a 110% increase in funding from FY2000 to FY2010. See **Table A-2** in **Appendix A** for funding levels by program area for each year.

Figure 2. SAMHSA Funding Growth, FY2000-FY2010



Source: Prepared by CRS using SAMHSA budget justification documents.

Notes: Inflation calculated using the U.S. Department of Labor's Bureau of Labor Statistics Consumer Price Index (CPI) inflation calculator.

[12] SAMHSA's PRNS budget lines include competitive grant programs created under general (i.e., PRNS) authority and competitive grant programs with specific PHSA authorizations.

SAMHSA Reauthorization in 2000

As already noted, SAMHSA was last reauthorized in 2000. The reauthorization language was incorporated in the Children's Health Act of 2000 (see text box below).[13] The act amended SAMHSA's existing authorities under Title V, added several new authorities, and authorized appropriations through FY2003. Congress has not taken up comprehensive reauthorization legislation since 2000, though it has enacted a number of laws that have added new authorities to Title V and otherwise expanded the agency's programs and activities (see "New Authorizations Since 2000" below). The following key provisions were included in the 2000 reauthorization, which

- increased flexibility for SAMHSA to direct mental health and substance abuse funding by rewriting and standardizing the general authority (i.e., PRNS) for each center and eliminating several existing categorical grant programs;
- increased flexibility for states to direct the use of block grant funds to treat mental health and substance abuse disorders;
- added new categorical grant programs, primarily with a focus on expanding and improving mental health and substance abuse services for children and adolescents; and
- added "charitable choice" provisions that allow religious organizations to receive funding from SAMHSA for the provision of substance abuse prevention and treatment services (see "Charitable Choice" text box below).

The new categorical programs included ones to support community-based prevention and treatment services for youth at risk due to violence, substance abuse, or mental illness, and to support services for youth in the justice and child welfare systems. Other SAMHSA programs created during the reauthorization provide support for homeless individuals and adults in the justice system with substance abuse and/or mental illness, and authorize funding for the prevention and treatment of methamphetamine abuse. See **Table A-1** for a description of all authorized programs within SAMHSA.

Additionally, the Children's Health Act included two sets of provisions related to the use of restraint and seclusion on residents at certain types of facilities.[14] The first set of provisions,[15] which apply to hospitals, nursing homes, and other medical facilities that receive federal funding, specify that restraint and seclusion may only be used to ensure the physical safety of a patient and can only be implemented under the written order of a physician or other qualified provider.[16] These facilities are required to report deaths resulting from restraint and seclusion to the appropriate agency specified by the Secretary within one week of the death. The second set of

[13] P.L. 106-310, Titles XXXI-XXXIV.

[14] Restraint refers to the restricting the movement of a person's limbs, head or body by the use of mechanical or physical devices for the purpose of preventing injury to self or others. Seclusion refers to the isolation and containment of residents who pose an imminent threat of physical harm to themselves or others.

[15] PHSA Secs. 591-593.

[16] The restraint and seclusion provisions in the Children's Health Act do not override federal and state laws and regulations that provide greater patient protection, such as the restraint and seclusion regulations issued in 1999 by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) for hospitals participating in the Medicare and Medicaid programs (42 CFR 482 Subpart B).

provisions,[17] which applies to community-based residential treatment centers for youth, specifies that restraint and seclusion may only be used in emergencies and to ensure immediate safety, and it prohibits the use of mechanical restraints. These facilities are required to report deaths occurring as a result of use of restraint to an agency specified by the Secretary within 24 hours of the death.[18]

The 2000 reauthorization law also required SAMHSA to produce two reports for Congress. The first report, released in 2002, is on the efforts of the agency and the states to provide coordinated prevention and treatment services for co-occurring substance abuse and mental health problems. In the report, SAMHSA identified barriers to treatment for co-occurring disorders, summarized the best practices for treatment of people with co-occurring disorders, and provided a five-year plan for improving services for these people. The plan focused on implementation of best practices for prevention and treatment of co-occurring disorders in states and communities with support from SAMHSA, including funding from the block grants and a new co-occurring disorder grant program.[19]

The second report, delivered in 2005, discusses SAMHSA's efforts to improve the flexibility and accountability of the block grants. The report describes the extent to which states can direct block grant funding to priority mental health and substance abuse services in order to meet the specific needs in that state. It also describes the performance data that SAMHSA collects to measure the effect of the block grant funding on patient outcomes in each state.[20] See the "Performance Measurement and Accountability" section later in this report for additional information.

Children's Health Act of 2000 (P.L. 106-310)

Reauthorized SAMHSA Programs

- Mental health and substance abuse block grants
- Comprehensive community mental health services for children with serious emotional disturbance
- Projects for Assistance in Transition from Homelessness (PATH)
- Protection and Advocacy for Individuals with Mental Illness (PAIMI)
- Programs of Regional and National Significance (PRNS; general authority for CSAT, CSAP & CMHS)

Significant New SAMHSA Programs

- Child anti-violence initiatives
- Services for juvenile offenders with serious emotional disturbances
- Jail diversion programs for adults
- Integrated treatment programs for co-occurring disorders
- Emergency mental health centers
- Suicide prevention
- Mental illness awareness training
- Methamphetamine and amphetamine treatment initiative
- Restraint and seclusion
- Child welfare and mental health service integration

SAMHSA Reports to Congress

- Services for co-occurring substance abuse and mental health problems
- Program performance and accountability

[17] PHSA Secs. 595, 595A, and 595B.

[18] 42 CFR 483 Subpart G (2003).

[19] SAMHSA, "*Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders*," November 2002, at http://www.samhsa.gov/reports/congress2002/index.html.

[20] SAMHSA, "*A Report Required by Congress on Performance Partnerships: A Discussion of SAMHSA's Efforts to Increase Accountability Based on Performance in Its Block Grant Programs by Instituting National Outcome Measures*," September 2005, at http://www.nationaloutcomemeasures.samhsa.gov/./PDF/performance_partnership.pdf.

The 2000 reauthorization legislation incorporated two additional titles, both of which impact SAMHSA. First, the Drug Addiction Treatment Act (DATA) of 2000[21] expanded the options for treating opioid (heroin) addiction beyond traditional treatment programs (i.e., methadone maintenance clinics). The act permits qualified physicians to dispense or prescribe specifically approved opioid treatment medications in their offices. SAMHSA is responsible for approving physicians to participate in the program.[22]

Second, the Methamphetamine Anti-Proliferation Act of 2000[23] established several new programs to combat methamphetamine abuse, including increased criminal penalties, enhanced law enforcement, and new research. The act also authorized a new SAMHSA grant program to expand methamphetamine treatment services in areas with high levels of abuse.[24] In addition, it required the SAMHSA-administered National Survey on Drug Use and Health to collect information on methamphetamine and other illicit drug use in rural and metropolitan areas.

New Authorizations Since 2000

Congress has enacted a number of laws since the 2000 reauthorization that have further expanded SAMHSA's statutory authority. These new authorizations have built on existing programs that focus on specific issues, such as suicide prevention, underage drinking, and prescription drug abuse. In addition, the Patient Protection and Affordable Care Act of 2010 (PPACA),[25] as amended by the Health Care and Education Reconciliation Act (HCERA),[26] contained new authorizations for SAMHSA, as well as additional provisions related to mental health and substance abuse, which are discussed in the next section of this report.

The Garrett Lee Smith Memorial Act of 2004[27] authorized three significant suicide prevention programs at SAMHSA—two grant programs and a resource center. These programs support the planning, implementation, and evaluation of organized activities involving statewide youth suicide early intervention and prevention strategies; provide grants to institutions of higher education to reduce student mental and behavioral health problems; support a national suicide prevention hotline; and fund a national technical assistance center for suicide prevention. For links to information on Garrett Lee Smith grantee activities, see **Appendix C**.

In addition, two laws passed since 2000 authorize efforts to reduce and prevent underage drinking. The No Child Left Behind Act of 2001[28] required SAMHSA to provide consultation to the Secretary of Education in awarding grants to local educational agencies for reducing alcohol abuse in secondary schools. In addition, the 2005 Sober Truth on Preventing Underage Drinking (STOP) Act[29] authorized SAMHSA to award grants for designing, evaluating, and disseminating

[21] P.L. 106-310, Title XXXV.

[22] More information on SAMHSA's administration of the DATA 2000 program is at http://buprenorphine.samhsa.gov/.

[23] P.L. 106-310, Title XXXVI.

[24] PHSA Sec. 514.

[25] P.L. 111-148.

[26] P.L. 111-152.

[27] P.L. 108-355.

[28] P.L. 107-110, Sec. 4129.

[29] P.L. 109-422.

community-wide approaches to preventing and reducing underage drinking, and for preventing underage drinking at institutions of higher education. This act also required SAMHSA to participate in the Interagency Coordinating Committee on the Prevention of Underage Drinking, which is intended to guide federal policy and program development related to underage drinking. SAMHSA has been providing leadership for this committee.

The National All Schedules Prescription Electronic Reporting Act (NASPER) of 2005,[30] which was enacted in response to growing concern about the abuse of prescription drugs regulated under the Controlled Substances Act,[31] authorized a SAMHSA formula grant program for states to establish or improve an existing prescription drug monitoring program (PDMP). A PDMP is a statewide electronic database that collects prescriber and patient information on controlled substances dispensed by pharmacists in order to monitor prescription drug abuse, addiction, and diversion.[32] SAMHSA's NASPER program is similar to a grant program administered by the U.S. Department of Justice, the Harold Rogers Prescription Drug Monitoring Program (HRPDMP).[33] The HRPDMP provides grants to states for planning, implementation, or enhancement of PDMPs.

The Patient Protection and Affordable Care Act

PPACA (P.L. 111-148) contained several provisions relating to mental health and substance abuse services, including new SAMHSA authorities. Other provisions not directly related to SAMHSA still change the landscape of mental health and substance abuse services, which in turn could impact SAMHSA programs.

PPACA provisions directly related to SAMHSA include three new programs and new grant requirements for Indian tribes and tribal organizations. PPACA authorizes SAMHSA to establish national centers of excellence for depression to focus on treatment of depressive disorders,[34] and to establish demonstration projects to provide coordinated and integrated services through the co-location of primary and specialty care services in community-based mental and behavioral health settings.[35] In addition, through reauthorization of the Indian Health Care Improvement Act, PPACA requires SAMHSA to simplify access to grant funding for Indian tribes, and authorizes the agency to establish a demonstration program to test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide.[36]

[30] P.L. 109-60.

[31] P.L. 91-513, Title II.

[32] The controlled prescription drugs that are most often abused include painkillers such as codeine and oxycontin; depressants, including sleeping pills and anti-anxiety drugs; and stimulants such as ritalin, which is used to treat attention-deficit hyperactivity disorder (ADHD).

[33] Additional information on HRDMP and prescription drug monitoring programs can be found on the Department of Justice's website at http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm.

[34] PHSA Sec. 520B.

[35] PHSA Sec. 520K.

[36] P.L. 111-148, Sec. 10221.

Other mental health and substance abuse provisions in PPACA focus on expanding the behavioral health workforce and improving access to behavioral health services. Workforce provisions include grant programs for recruitment and education of behavioral health providers,[37] as well as a grant program to educate primary care providers about preventive medicine, health promotion, chronic disease management, evidence-based therapies and techniques, and mental and behavioral health services in order to encourage primary care providers to incorporate these elements into their practice.[38] These workforce provisions are subject to appropriations.[39] PPACA also requires that the health plans available through state-based exchanges, beginning in 2014, include mental health and substance abuse services, and that they be offered at parity with medical/surgical coverage.[40]

Strategic Direction

SAMHSA has been guided by two long-term planning documents that addressed its strategic direction through FY2011 with regard to allocation of its discretionary funds and evaluation of its grant programs. These documents are the *SAMHSA Strategic Plan, FY2006-FY2011*, and the *Data Strategy Plan, FY2007-FY2011*. In October 2010, SAMHSA released a new document – *Leading Change: A Plan for SAMHSA's Roles and Actions, 2011-2014*. This new plan outlines eight strategic initiatives that the agency will use to guide its work over the next few years. The strategic initiatives capture many of the priorities in the earlier strategic plan, but also include newly emerging issues.

SAMHSA Strategic Plan, FY2006-FY2011

SAMHSA's Strategic Plan contains a Priorities Matrix,[41] which lists the mental health and substance abuse priority areas addressed by the agency, along with the cross-cutting principles SAMHSA applies to each issue area. Most of the priority areas in this matrix are policy issues that span the work of its three centers. They include individual health concerns like co-occurring mental health and substance abuse disorders, suicide, behavioral health issues for individuals with hepatitis and HIV/AIDS; societal issues like homelessness, and criminal justice; and systems-level issues like treatment capacity and workforce development. The principles that cut across these priorities include use of evidence-based practices, evaluation, collaboration, cultural competence, stigma reduction, and cost-effectiveness.

[37] United States Public Health Sciences Track (PHSA Secs. 271-274) and Mental and Behavioral Health Education and Training Grants (PHSA Secs. 756-757).

[38] Primary Care Extension Program (PHSA Sec. 5405).

[39] See the following CRS reports for information on appropriations and discretionary funding in PPACA: CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*; and CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (PPACA)*.

[40] See the following CRS reports for information on PPACA, including provisions related to workforce and parity: CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*; and CRS Report R41249, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*.

[41] SAMHSA, *Strategic Plan FY2006-FY2011*, April 2006, http://www.samhsa.gov/About/SAMHSAStrategicPlan.pdf.

SAMHSA Data Strategy, FY2007-FY2011

The Data Strategy Plan discusses SAMHSA's National Outcome Measures (NOMs) (see **Appendix B**). The NOMs are a set of performance measures that track mental health and substance abuse outcomes on the state and program level. SAMHSA introduced the NOMs in order to monitor progress in mental health and substance abuse and to help determine the impact of the block grant funding and other grant programs. The NOMs are organized across 10 domains and apply to the agency's mental health, substance abuse prevention, and substance abuse treatment activities. The domains include reduced morbidity, employment/education, crime and criminal justice, stability in housing, social connectedness, access/capacity, retention, perception of care, cost effectiveness, and use of evidence-based practices. For additional discussion of data and performance, see the "Performance Measurement and Accountability" section below.

SAMHSA Strategic Initiatives, 2011-2014

SAMHSA's eight strategic initiatives (see text box below), which are described in *Leading Change: A Plan for SAMHSA's Roles and Actions*,[42] echo many of the priorities and cross- cutting principles found in the Strategic Plan and Data Strategy, such as prevention, justice, homelessness, data and outcomes, and public support. However, the initiatives also reflect new priorities, such as military families, health care reform, and jobs and the economy. SAMHSA chose these initiatives in order to focus resources on areas where they could have the greatest impact. For each of the eight initiatives, SAMHSA has identified a lead within the agency responsible for that initiative. SAMHSA's FY2011 budget request reflects priorities from the strategic initiatives with proposals focusing on prevention, homelessness, and data collection.[43]

SAMHSA's Strategic Initiatives

1. Prevention of substance abuse and mental illness
2. Trauma and justice
3. Military families
4. Health care reform implementation
5. Housing and homelessness
6. Health information technology
7. Data, outcomes, and quality
8. Public awareness and support

[42] SAMHSA, *Leading Change: A Plan for SAMHSA's Roles and Actions, 2011-2014*, October 2010, Draft, http://www.samhsa.gov/about/sidocs/SAMHSA_SI_paper.pdf.

[43] SAMSHA FY2011 Budget Justification at http://www.samhsa.gov/Budget/FY2011/SAMHSA_FY11CJ.pdf.

Current Reauthorization Issues

It has been a decade since Congress passed comprehensive SAMHSA reauthorization legislation. As shown in **Table A-1** in **Appendix A**, most of the authorizations of appropriations for SAMHSA's programs expired at the end of FY2003. Legislation to reauthorize SAMHSA was introduced in the 111th Congress, but has not moved out of committee.[44] This last section of the report briefly describes several issues that could be considered during congressional debate on SAMHSA reauthorization.

Issues that may be of interest during reauthorization of SAMHSA include increased performance measurement and accountability for SAMHSA grants and programs, granting specific authority for the Access To Recovery program that provides vouchers for individuals to seek treatment services and that was created under SAMHSA's general authority, improving the ability of communities to provide behavioral health services during disaster response, requiring collaboration between SAMHSA and other federal agencies, increasing SAMHSA's level of emphasis on primary prevention, increasing SAMHSA's role in expanding the number and diversity of the behavioral health provider workforce, and ensuring fairness of the formula used to distribute SAMHSA's block grants.[45]

Reauthorization Issues

- Performance measurement and accountability
- Access to Recovery
- Disaster response
- Collaboration with other federal agencies
- Focus on prevention and early intervention
- Workforce issues
- Block grant formula

Performance Measurement and Accountability

The National Outcome Measures (NOMs) were developed by SAMHSA in order to create a standard set of measures and definitions by which to track the progress of states and programs in improving mental health and reducing substance abuse. The NOMs are organized across 10 domains and apply to the agency's mental health, substance abuse prevention, and substance abuse treatment activities. For instance, substance abuse prevention NOMs under the reduced mortality domain measure alcohol use in the past 30 days, perceived risk of harm from alcohol use, disapproval of peer alcohol use, and age of first alcohol use. See **Appendix B** for the complete matrix of NOMs, by domain.

[44] The SAMHSA Modernization Act of 2010 (H.R. 5466), introduced by Representatives Patrick Kennedy (D-RI) and Gene Green (D-TX), includes comprehensive reauthorization of SAMHSA programs, extending most authorizations of appropriations through FY2015. In addition to reauthorizing existing programs, the bill includes new grant programs to integrate mental health and substance use disorder services into primary care settings, address the mental health needs of older adults, and recruit and retain qualified mental health and substance use professionals. The bill also requires the Secretary to study whether block grant funding is distributed accurately based on need and to recommend changes in such distribution, if necessary.

[45] CRS selected issues that may be of interest during reauthorization based on a variety of factors, including issues raised in the SAMHSA Modernization Act of 2010 (e.g., performance measurement and accountability and the behavioral health workforce), gaps in behavioral health response exposed during recent disasters (e.g., disaster response), and recent research and reports related to the federal role in behavioral health (prevention and early intervention). The issues discussed in this report are not an exhaustive list of items that may be addressed during a comprehensive reauthorization of SAMHSA programs.

In FY2008, SAMHSA began requiring states to report state-level NOMs data as a condition of receiving block grant funding. SAMHSA also uses the NOMs, as well as other performance measures, to track and manage each of its programs. Currently, SAMHSA, as well as the states themselves, use the NOMs to monitor progress on improving mental health and substance abuse services, and to identify areas in need of additional attention.

SAMHSA currently does not tie state funding to the mental health and substance abuse outcomes reported in the NOMs data. Holding states accountable for the mental health and substance abuse services by linking NOMs performance to funding could improve program performance and state outcomes. Options for applying an accountability system include establishing national goals for some or all of the NOMs and setting state-specific goals for the NOMs. However, given the variability in data collection among the states, as well as variability in the types and severity of substance abuse problems within each state, requiring states to meet a national goal may not be realistic. Each state could instead be required to show improvement on performance measures over time. That would allow SAMHSA to take into account the baseline performance and the different mental health and substance abuse landscape in each state.

Access to Recovery

The Access to Recovery (ATR)[46] program is an initiative proposed by former President George W. Bush in FY2003 that awards grants to states and tribes for providing vouchers to clients for the purchase of substance abuse clinical treatment services and recovery support services. Recovery support services are those services that support individuals as they obtain treatment for substance abuse. They include care coordination, child care, transportation, and work preparation. The ATR program is not directly authorized in statute, instead it is carried out under CSAT's general PRNS authority. Funding for the program has remained flat at just under $100 million each year since it began in FY2004. However, SAMHSA has requested an increase of almost $10 million for FY2011 to fund up to four new ATR grants.[47]

In FY2004, SAMHSA awarded three-year ATR grants to an initial cohort of 15 grantees. Another round of three-year grants were awarded to 24 grantees in FY2007. SAMHSA recently announced that it was awarding 30 new ATR grants, each one for up to four years. The annual amount of each grant ranges from $2 million to $4 million.[48] In FY2007, SAMHSA began an assessment to determine the effectiveness of the ATR program. SAMHSA anticipates releasing the results of the assessment in late 2010.

A centerpiece of the ATR program is the use of vouchers to fund substance abuse treatment and support services, which is different from other SAMHSA programs that provide states or other entities with direct grant funding for services and programs. Under the ATR program, states use program funds to evaluate patients and provide vouchers for the patient to obtain treatment services from an approved provider of his or her choice. Because ATR's vouchers represent an indirect source of federal funding for service providers, faith-based providers may participate in the program without restrictions on the incorporation of religious activities. For more information

[46] ATR program details are available at http://atr.samhsa.gov.

[47] SAMHSA FY2011 Budget Justification at http://www.samhsa.gov/Budget/FY2011/SAMHSA_FY11CJ.pdf.

[48] Substance Abuse and Mental Health Services Administration, "SAMHSA awards $379 million for Access to Recovery grants," press release, October 8, 2010, http://www.samhsa.gov/newsroom/advisories/1010081330.aspx.

on the conditions under which faith-based providers may receive SAMHSA funding, see the text box on the agency's charitable choice provisions.

Charitable Choice

The 106th Congress enacted two laws with charitable choice provisions that apply to substance abuse prevention and treatment services funded by SAMHSA.[49] The intent of these provisions is to permit faith-based organizations to compete on equal terms for SAMHSA substance abuse funding without impairing the religious character of such organization and without diminishing the religious freedom of program beneficiaries.

Under SAMHSA's charitable choice provisions, *direct* federal funds may not be used for inherently religious activities, such as worship or religious instruction. However, a religious organization may retain its religious character and continue to carry out its religious mission provided such activities are conducted separately, in time and location, from the substance abuse services for which it receives direct funding. Moreover, religious organizations that receive SAMHSA funding may continue to consider job applicants' religious beliefs in hiring decisions. Such organizations may not discriminate against individuals seeking substance abuse services on the basis of religion, and must provide individuals who object to the organization's religious character with an alternative service provider.

If federal funds are provided *indirectly*, the courts have ruled that religious activities do not have to be excluded from the social services supported by those funds because it is the beneficiary and not the government that selects the faith-based provider. Thus, the government is not responsible for any religious activities that might accompany the social services that the funds support. ATR vouchers are an indirect source of funds, therefore, faith-based organizations that provide substance abuse prevention and treatment services under the ATR program may incorporate religion into those services.

Disaster Response

SAMHSA played a significant role in providing mental health and substance abuse services after hurricanes Katrina and Rita hit the Gulf Coast states in 2005. During 2010, the Haiti earthquake and the Deepwater Horizon oil spill in the Gulf of Mexico again highlighted the mental health impact of disasters and the resulting need for services. In the wake of these recent incidents, some experts believe that effective disaster assistance must build upon the existing behavioral health resources in affected communities.[50] However, many communities may not have the necessary infrastructure to support the surge in need after a disaster.

SAMHSA currently has authority to provide emergency behavioral health assistance through three mechanisms: the Crisis Counseling Assistance and Training Program (CCP), SAMHSA Emergency Response Grants (SERG), and supplemental appropriations. The CCP provides short-term federal assistance to state and local governments to address mental health needs when there is a presidentially declared disaster.[51] States apply for funds by preparing a formula-based needs assessment within 10 days of the date of the disaster declaration. There is no matching requirement, and requested CCP funds must supplement, not supplant, existing local or state

[49] SAMHSA's charitable choice provisions are located in PHSA Secs. 581-584 and Sec. 1955, which were added by the Children's Health Act of 2000 (P.L. 106-310) and the Consolidated Appropriations Act (P.L. 106-554), respectively. The provisions added by the two laws are broadly similar and apply to the competitive and formula grant programs under PHSA Title V and the two block grants under Title XIX. Implementing regulations are at 45 CFR Parts 54 and 54a.

[50] Katherine Yun, Nicole Lurie, and Pamela S. Hyde, "Moving Mental Health into the Disaster-Preparedness Spotlight," *New England Journal of Medicine*, August 11, 2010.

[51] The Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act) provides authority, when there is a presidentially declared disaster, for federal assistance to state and local governments to address the mental health needs of victims (42 USC § 5183).

resources. While CCP provides funds for up to nine months after a disaster, the regulations permit extensions in certain cases.[52]

SAMHSA may also redirect some of its funding through the SERG authority to make non-competitive grants to address emergency substance abuse or mental health needs in communities without a presidentially declared disaster. In order to receive funding, a state must certify that a mental health or substance abuse emergency exists, and the emergency must be the direct consequence of a clear precipitating event, such as a natural disaster. Like CCP funding, states may receive SERG grants only if no other resources are available to adequately address the need. Apart from CCP and SERG, if Congress provides SAMHSA with supplemental funds for disaster response, these funds could be used under SAMHSA's existing authorities to support behavioral health treatment services.

In addition to the disaster-specific authorities described above, SAMHSA has multiple programs that focus on building local mental health and substance abuse infrastructure and capacity. For instance, the Mental Health System Transformation Grant supports transformative changes in how communities manage and deliver mental health services, and the Targeted Capacity Expansion program provides funding for communities to build capacity to address gaps in substance abuse treatment services. These programs do not have specific authorizations, but are instead administered under SAMHSA's general authorities (i.e., PRNS). By improving the availability and delivery of behavioral health services in states and communities, these programs also build a stronger base for providing services after a disaster.[53]

Collaboration with Other Federal Agencies

Numerous federal agencies play a role in the provision of mental health and substance abuse services. While SAMHSA focuses on community-based prevention and treatment services for individuals with mental health and substance abuse conditions, other federal agencies, such as the Department of Education (ED) and the Indian Health Service (IHS), also support and/or provide these services to specific populations or provide related services, such as housing and education. There are few statutory requirements by which these federal agencies are required to work with SAMHSA.[54] However, some experts believe that due to the wide range of socioeconomic risk factors for mental health and substance abuse disorders, as well as the negative socioeconomic effects of these disorders, there needs to be more collaboration between SAMHSA and other federal agencies.[55]

Collaboration between SAMHSA and other federal agencies has been used to prevent duplication of efforts and provide a platform for sharing expertise. For example, SAMHSA and the

[52] 44 C.F.R. § 206.171.

[53] Information on SAMHSA's disaster response programs can be found at http://www.samhsa.gov/disaster.

[54] PHSA Sec. 501 authorizes SAMHSA to collaborate with the National Institutes of Health to disseminate the research findings of NIDA, NIAAA, and NIMH to service providers in order to improve the delivery of services and to promote the coordination of programs conducted by other federal agencies, including the Social Security Administration, Centers for Medicare and Medicaid Services, Department of Education, and Department of Justice, as appropriate, related to the problems of individuals suffering from mental illness or substance abuse. PHSA Sec. 581 requires SAMHSA to work in consultation with ED to administer a program to prevent violence in schools (see **Table A-1**).

[55] National Association of School Psychologists, Position Statement on Interagency Collaboration to Support the Mental Health Needs of Children and Families, July 2006.

Department of Veterans Affairs (VA) work together to provide a 24-hour suicide prevention hotline for veterans.[56] The VA built upon the existing national suicide hotline administered by SAMHSA in order to create veteran-specific suicide prevention services. The veteran suicide hotline utilizes the national hotline number and training resources, but routes veterans to counselors with additional training in working with veterans. In addition, SAMHSA works with the ED to administer the Safe Schools/Healthy Students program,[57] which provides grants to schools for violence and substance abuse prevention activities.

Additional collaboration with federal agencies, including those described below, may improve SAMHSA's ability to reach at-risk populations and provide support services to those with mental health and substance abuse conditions. The Department of Justice and ED serve youth with substance abuse and mental health problems who are also the focus of many SAMHSA programs. The Centers for Disease Control and Prevention's (CDC) Injury Prevention and Control Program works on prevention and surveillance in the fields of violence, suicide, and mental health. IHS also serves a population that has significant substance abuse problems, along with issues of access to mental health care. VA provides health care to veterans many of whom suffer from mental illness and substance abuse. In addition, the U.S. Department of Housing and Urban Development provides housing services, a support service also provided through some SAMHSA programs for individuals with mental health and substance abuse conditions, including homeless individuals (see **Table A-1**).

Focus on Prevention and Early Intervention

The 1999 Surgeon General's Report on Mental Health[58] and the 2003 President's New Freedom Commission Report[59] framed mental health as a public health issue. The reports advised applying a public health approach that would emphasize prevention and early intervention, rather than focusing on individuals who have become severely ill and expensive to treat. The reports also recommended a wholesale transformation of the nation's approach to mental health care involving consumers and providers, policymakers at all levels of government, and both the public and private sectors.

These recommendations are echoed in a 2009 report by the Institute of Medicine (IOM) on preventing mental, emotional, and behavioral health problems among young people. Several years after the Surgeon General's Report and the President's New Freedom Commission, the IOM report stated: "No concerted federal presence or clear national leadership currently exists to advance the use of prevention and promotion approaches to benefit the mental health of the nation's young people."[60]

[56] The Joshua Omvig Veterans Suicide Prevention Act (P.L. 110-110) authorized VA to establish a suicide prevention hotline for veterans; however, it did not require collaboration with SAMHSA. Additional information on the veteran suicide prevention hotline can be found at http://www.suicidepreventionlifeline.org/Veterans/Default.aspx.

[57] See the Safe Schools/Healthy Students website for more information at http://www.sshs.samhsa.gov/default.aspx.

[58] The 1999 Surgeon General's Report on Mental Health can be accessed online at http://www.surgeongeneral.gov/library/mentalhealth/home.html.

[59] The 2003 President's New Freedom Commission Report can be accessed online at http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html.

[60] Mary Ellen O'Connel, Thomas Boat, and Kenneth E. Warner, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, National Research Council and Institute of Medicine, Washington, DC, 2009, http://books.nap.edu/openbook.php?record_id=12480&page=R1.

In response to these and other reports, SAMHSA has implemented a number of new prevention initiatives for mental health and substance abuse. For instance, the agency has funded states to develop plans that would transform the individual-focused behavioral health care system into a more public health oriented system. SAMHSA also created the Strategic Prevention Framework (SPF) in 2004, which includes a five-step process for preventing substance abuse in communities.[61] This framework has been applied through the SPF State Incentive Grants, the prevention set-aside in the SAPT block grant, and the HIV prevention program in CSAP. In 2008, SAMHSA launched the Linking Actions for Unmet Needs in Children's Health (LAUNCH) Initiative, which provides grants to states and tribal organizations to promote and enhance the wellness of young children by increasing capacity to develop infrastructure and implement prevention/promotion strategies necessary to promote wellness for young children aged zero to eight. This program currently focuses on mental health; however, SAMHSA has proposed expanding the focus to include substance abuse prevention in FY2011.

SAMHSA also supports some early intervention efforts. In order to identify and treat mental illness and substance abuse early, SAMHSA encourages states to reduce system fragmentation and increase services available to people living with mental illness. SAMHSA also funds treatment programs that function as a safety net for at-risk populations such as pregnant and postpartum women, vulnerable youth, and homeless individuals.

Notwithstanding recent efforts to increase prevention and early intervention activities, SAMHSA's budget still reflects a greater emphasis on substance abuse treatment over prevention, with more overall funding and larger increases over the past ten years for treatment services. As shown in **Figure 2**, funding for substance abuse prevention PRNS has grown 37% in the past decade, a relatively flat funding trend after accounting for inflation, while funding for substance abuse treatment PRNS has more than doubled. In FY2010, funding for substance abuse treatment PRNS was more than twice the level of funding for substance abuse prevention PRNS (see **Table A-2**). SAMHSA's budget does not similarly break out treatment and prevention for mental health.

Workforce Issues

A 2006 IOM report[62] identified the inadequacy of the training and number of mental health and substance abuse treatment providers and recommended building, maintaining, and ensuring a competent and qualified behavioral health workforce. While SAMHSA has the authority to collect and analyze workforce data as well as support training programs for providers, historically, the agency has provided limited support for workforce training through the relatively small Minority Fellowship Program (MFP), which provides fellowships for minority mental health care providers. This program falls under SAMHSA's general authority (i.e., PRNS), and its funding level is subject to annual congressional appropriations.

[61] The five steps in the Strategic Prevention Framework are 1) conduct a community needs assessment, 2) mobilize and/or build capacity, 3) develop a comprehensive strategic plan, 4) implement evidence-based prevention programs and infrastructure development activities, and 5) monitor process and evaluate effectiveness. Additional information about the Strategic Prevention Framework can be found at http://prevention.samhsa.gov/about/spf.aspx.

[62] Institute of Medicine, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, Washington, DC, 2006, http://books.nap.edu/openbook.php?record_id=11470.

As discussed above, PPACA contained several provisions aimed at increasing and improving the health workforce, including the behavioral health workforce.[63] While not located within SAMHSA, these newly authorized programs could mitigate some of the issues identified in the 2005 IOM report regarding the shortage of mental health and substance abuse providers. However, these programs are also subject to the annual appropriations process.[64]

Block Grant Formula

SAMHSA's mental health and substance abuse prevention and treatment block grants are distributed using a formula that is in statute. As detailed later in this section, concerns have been raised by economists and health policy experts about the appropriateness of this formula to ensure that the distribution of block grant funding to the states matches the need in each state.

History of SAMHSA Block Grants

The Alcohol, Drug, and Mental Health Services (ADMHS) block grant was one of seven block grants established by the Omnibus Budget Reconciliation Act of 1981 (OBRA).[65] This block grant consolidated several existing categorical grant programs for substance abuse and community mental health services in order to provide state and local governments with more flexibility and control over funding, to enhance their ability to meet localized needs, to end duplication of effort in delivering services, and to enable more coordination. OBRA authorized ADMHS block grant funds for FY1982 through FY1984 in proportion to the historical funding patterns of the original categorical grants. To better match block grant funding with the need in each state, OBRA also directed HHS to conduct a study that would produce a funding allocation formula, considering population and state fiscal capacity.

The 1984 ADAMHA Amendments[66] included an allocation formula and reauthorized funding for the block grants for three years with a "minor equity adjustment" to hold harmless states that would have otherwise received decreased funding under the new calculation. Funds above the hold-harmless level (i.e., the amount states received in FY1984) were to be allocated using a formula based equally on state population and relative per capita income. The law also required a non-governmental entity to provide recommendations on the formula proposed by HHS. The resulting recommendations, from the Institute for Health and Aging (IHA),[67] included phasing out the hold-harmless provisions, allocating funds based on populations at risk, and incorporating a state fiscal capacity measure.

The 1988 Anti-Drug Abuse Act[68] revised the block grant formula, based on the IHA recommendations, to phase out the hold-harmless provision, use total taxable resources as the

[63] United States Public Health Sciences Track (PHSA Sections 271-274), Mental and Behavioral Health Education and Training Grants (PHSA Sections 756-757), Primary Care Extension Program (PHSA Sec. 5405).

[64] See the following CRS reports for information on appropriations and discretionary funding in PPACA: CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*; and CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (PPACA)*.

[65] P.L. 97-35.

[66] P.L. 98-509.

[67] IHA is an institute within the University of California, San Francisco.

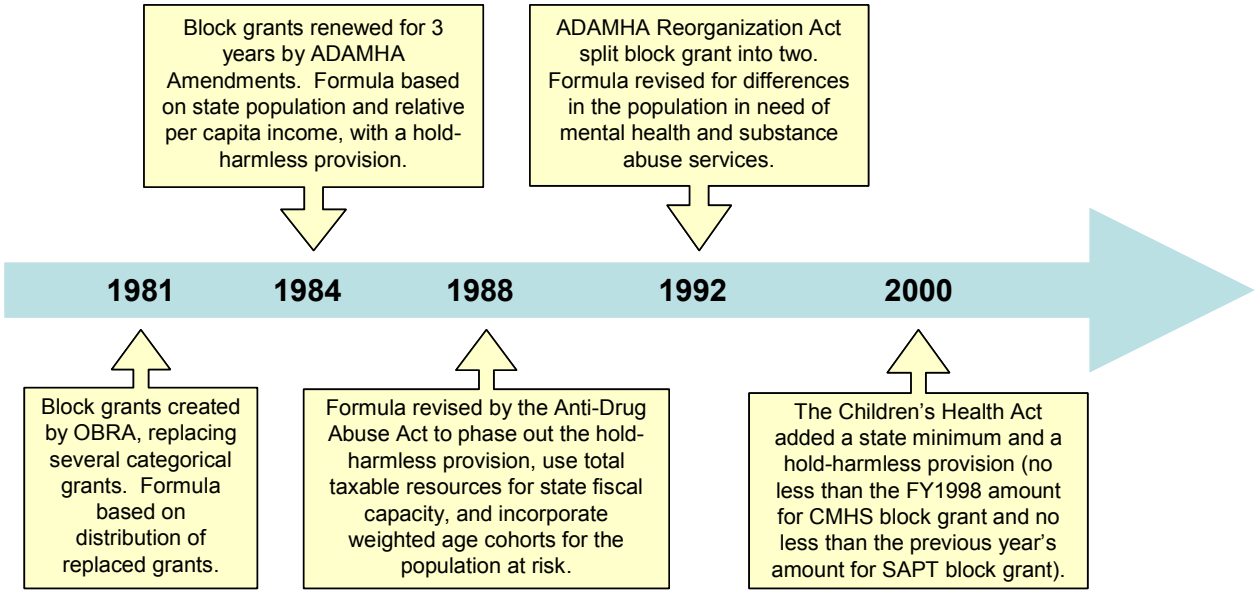
[68] P.L. 100-690.

measure of state fiscal capacity, and incorporate weighted age cohorts as a measure of population at risk. 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 the inequalities in matching block grant funding to need persisted even after the IHA recommendations were implemented.[69]

The 1992 ADAMHA Reorganization Act[70] split the ADMHS block grant into two separate block grants, one for community mental health services (CMHS block grant) and another for substance abuse prevention and treatment services (SAPT block grant). The population-at-risk component of the formula was further adjusted to reflect the differences in the population in need of mental health and substance abuse services.[71]

The 2000 Children's Health Act again revised the block grant formulas by reintroducing hold-harmless provisions for both block grants.[72] For the SAPT block grant, the new provisions specify that a state must receive no less than the previous year's allocation plus a defined portion of any funding increase for the program. If there is a decrease in appropriations for the SAPT block grant, each state gets a proportionate decrease in their block grant allocation. For the CMHS block grant, the new provisions provide only that a state must not receive less than the FY1998 allotment.

Figure 3. Block Grant Timeline



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

[70] P.L. 102-321.

[71] General Accounting Office (now Government Accountability Office), T-HRD-91-32, *Mental Health Grants: Funding Not Distributed in Accordance with State Needs*, 1991.

[72] P.L. 106-310, Title XXXII, Sec. 3205 (CMHS block grant) and Title XXXIII, Sec. 3304 (SAPT block grant).

Current Formula

The formula for calculating a state's SAPT and CMHS block grant allocations[73] takes into account three measures: (1) the population-at-risk in the state; (2) the costs of services in the state; and (3) the fiscal capacity of the state.

The first factor, population-at-risk, is intended to be a proxy for the extent of need for services in a state. For the SAPT block grant, this factor is an average of two ratios equally weighted. The first ratio is the number of individuals age 18-24 plus the number of individuals of the same age group who reside in urban areas in a state, divided by the sum of the same populations for all the states. The second ratio is the number of individuals ages 25-64 in a state divided by the sum of the same populations of all the states. For the CMHS block grant, this factor is calculated based on the state population of individuals ages 18-24, 25-44, 45-64, and over 65, with a different weight applied to each age group. The second factor, cost of services, is derived from the 1990 report of Health and Economics Research, Inc., and ranges from 0.9 to 1.1.[74] 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, the state's score is divided by the sum of all the states' (and District of Columbia's) scores and that value is then multiplied by the total amount appropriated for the grant program.[75] The formula can be written as:

$$G_i = A\left(X_i / \sum_{i=1}^{51} X_i \right)$$

{i(state) = 1, 2, ..., 51}

where

G_i = grant amount for the i^{th} state

A = total funds appropriated for distribution among the states

X_i = score for the i^{th} state

Issues Regarding Current Formula

A number of issues have been raised regarding the current formula. First, the formula does not consider variations in numbers of uninsured individuals across the states, nor does it take into

[73] PHSA Secs. 1918 and 1933.

[74] 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.

[75] Pradip K. Muhuri and Jerome L. Ducrest, *Block Grants and Formula Grants: A Guide for Allotment Calculations*, U.S. Department of Health and Human Services, Substance Abuse Mental Health Services Administration, Office of Applied Studies, August 2007, http://www.oas.samhsa.gov/BG_documentation_070809_final_psg.pdf.

account other federal funding (e.g., Medicare and Medicaid) that a state may also receive for mental health and substance abuse services. Second, experts recommend using data from national surveys that measure the level of mental illness and substance abuse in a state (rather than population age distribution) to determine the population in need of services.[76] These surveys include the National Comorbidity Survey-Replication[77] for mental health needs, and NSDUH[78] for substance abuse needs, both of which are administered by SAMHSA. Third, research indicates that the currently used cost-of-services measure does not adequately represent interstate wage variations in occupations related to substance abuse and mental health.[79]

[76] Burnam et al., Review and Evaluation of Substance Abuse and Mental Health Services Block Grant Allotment Formula, RAND Corporation, 1997.

[77] 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.

[78] 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 aged 12 and older.

[79] Burnam et al., Review and Evaluation of Substance Abuse and Mental Health Services Block Grant Allotment Formula, RAND Corporation, 1997.

Appendix A. SAMHSA Authorizations and Funding

Table A-1 below summarizes the statutory authorizations for each of SAMHSA's programs. The table is organized by the three operating centers within SAMHSA—the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS)—which mimics the organization of the authorizations under PHSA Title V. Authorizations not within Title V (e.g., block grants) are listed at the end of each section and at the end of the table.

Each table entry includes the PHSA section number (or relevant public law and section number for the few authorizations not in the PHSA), the title and a brief description of the program's authorization, and the year it was created. Here is a list of the authorizing legislation for the programs summarized in the table, organized by year:

- 1986: Protection and Advocacy for Individuals with Mental Illness Act, P.L. 99-319
- 1988: Anti-Drug Abuse Act, P.L. 100-690
- 1990: Stewart B. McKinney Homeless Assistance Amendments Act, P.L. 101-645
- 1992: Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act, P.L. 102-321
- 2000: Children's Health Act, P.L. 106-310
- 2004: Garrett Lee Smith Memorial Act, P.L. 108-355
- 2005: National All Schedules Prescription Electronic Reporting Act, P.L. 109-60
- 2005: Sober Truth on Preventing Underage Drinking (STOP) Act, P.L. 109-422
- 2010: Patient Protection and Affordable Care Act, P.L. 111-148

The final three columns show the authorization of appropriations for each program, the FY2010 funding level, and a list of the fiscal years for which funding has been appropriated since FY2000, which is when many of the programs were created. Typically, an authorization of appropriations specifies the funding level for the first fiscal year, and authorizes the appropriation of "such sums as may be necessary" (SSN) in subsequent fiscal years. Almost all of the authorizations of appropriations expired in FY2003; however, funding continues to be appropriated for these programs. If funding was not appropriated for FY2010, the table notes this with an "NF" for not funded. It is also noted if the program has not received any funding since FY2000. In several instances, programs created in FY2000 have never received funding.

Table A-2 below shows SAMHSA funding, by program area, for the period FY2000 through the FY2011 budget request. The funding amounts shown in the table include direct appropriations to SAMHSA plus additional funds transferred to the agency by the HHS Secretary under the PHS Program Evaluation Set-Aside, authorized by PHSA Sec. 241.

Table A-1. SAMHSA Program Descriptions, Authorizations of Appropriations, and Funding

PHSA Section	Title and Program Description	Year Created	Authorization of Appropriations	Actual FY2010 Funding	Years Funded Since 2000
	Center for Substance Abuse Treatment (CSAT)				
Sec. 399O	**National All Schedules Prescription Electronic Reporting (NASPER)**. Formula grants to states to establish or improve prescription drug monitoring programs that collect data on potentially addictive controlled substances dispensed by pharmacists. Grants also support the development of a set of best practices for these monitoring programs.	2005	FY2005-FY2006: $15,000,000 each year FY2008-FY2010: $10,000,000 each year	$2,000,000	2009-2010
Sec. 506	**Grants for the Benefit of Homeless Individuals**. Funds the development of comprehensive drug/alcohol and mental health treatment systems for the homeless.	1992	FY2001: $50,000,000 FY2002-FY2003: SSN	$42,750,000	2002-2010
Sec. 509	**Priority Substance Abuse Treatment Needs of Regional and National Significance (PRNS)**. General authority to provide grants and fund activities intended to increase knowledge on best practices, provide training and technical assistance, and increase capacity of states and local entities to provide for necessary substance abuse treatment services.	1992	FY2001: $300,000,000 FY2002-FY2003: SSN	$452,629,000	2002-2010
Sec. 508	**Residential Treatment Programs for Pregnant and Postpartum Women**. Grants to expand the availability of comprehensive, high quality residential treatment services for pregnant and postpartum women who suffer from alcohol and other drug use problems, and for their minor children impacted by perinatal and environmental effects of maternal substance use and abuse.	1992	FY2001-FY2003: SSN	$16,000,000	2004-2010
Sec. 514[a]	**Substance Abuse Treatment Services for Children and Adolescents**. Grants, contracts, or cooperative agreement for providing substance abuse treatment services, early intervention, programs to prevent the use of methamphetamine and inhalants, and for creating centers of excellence to assist states and local jurisdictions in providing appropriate care for adolescents who are involved with the juvenile justice system and have a serious emotional disturbance.	2000	FY2001: $40,000,000 FY2002-FY2003: SSN	$30,678,000	2002-2010
Sec. 514A	**Early Intervention Services For Children and Adolescents**. Grants to provide early intervention substance abuse services for children and adolescents.	2000	FY2001: $20,000,000 FY2002-FY2003: SSN	NF	None
Sec. 514[a]	**Methamphetamine and Amphetamine Treatment Initiative**. Grants to expand methamphetamine treatment services in areas with high prevalence of abuse.	2000	FY2000: $10,000,000 FY2001-FY2002: SSN	NF	None
Secs. 1921-1935	**Substance Abuse Prevention and Treatment Performance Partnership Block Grant**. Provides funding to States by formula to plan, carry out, and evaluate activities to prevent and treat substance abuse.	1992	FY2001: $2,000,000,000 FY2002-FY2003: SSN	$1,719,391,000	2000-2010

PHSA Section	Title and Program Description	Year Created	Authorization of Appropriations	Actual FY2010 Funding	Years Funded Since 2000
	Center for Substance Abuse Prevention (CSAP)				
Sec. 516	**Priority Substance Abuse Prevention Needs of Regional and National Significance (PRNS)**. General authority to provide grants and fund activities intended to increase knowledge on best practices, provide training and technical assistance, and increase capacity of states and local entities to provide for necessary substance abuse prevention efforts.	1986	FY2001: $300,000,000 FY2002-FY2003: SSN	$185,388,000	2002-2010
Sec. 519	**Services for Children of Substance Abusers**. Grants to provide evaluations, treatment and referrals to children of substance abusers.	1992	FY2001: $50,000,000 FY2002-FY2003: SSN	NF	None
Sec. 519A	**Grants for Strengthening Families**. Grants to provide early intervention and substance abuse prevention services for individuals of high-risk families and their communities.	2000	FY2001: $3,000,000 FY2002-FY2003: SSN	NF	None
Sec. 519B	**Programs to Reduce Underage Drinking**. Funding to establish the Interagency Committee on the Prevention of Underage Drinking, conduct research on underage drinking, and support a national media campaign to prevent underage drinking. Grants to design, test, evaluate and disseminate effective strategies to maximize the effectiveness of community-wide approaches to preventing and reducing underage drinking. Grants to institutions of higher education to prevent and reduce the rate of underage alcohol consumption including binge drinking.	2005	FY2007-FY2010: $18,000,000 each year	$7,000,000	2008-2010
Sec. 519C	**Services for Individuals with Fetal Alcohol Syndrome**. Grants to provide services to individuals diagnosed with fetal alcohol syndrome or alcohol-related birth defects.	2000	FY2001: $25,000,000 FY2002-FY2003: SSN	NF	None
Sec. 519D	**Center of Excellence on Services for Individuals with Fetal Alcohol Syndrome and Alcohol-Related Birth Defects and Treatment for Individuals with Such Conditions and their Families**. Grants to establish centers of excellence to study prevention and treatment strategies for fetal alcohol syndrome and alcohol-related birth defects.	2000	FY2001: $5,000,000 FY2002-FY2003: SSN	$9,821,000	2002-2010
Sec. 519E	**Prevention of Methamphetamine Abuse and Addiction**. Grants to support expansion of methamphetamine prevention interventions and/or infrastructure development. This program helps localities to expand prevention interventions that are effective and evidence-based and/or increase capacity through infrastructure development. The goal is to intervene effectively to prevent, reduce or delay the use and/or spread of methamphetamine abuse.	2000	FY2001: $10,000,000 FY2002-FY2003: SSN	NF	2002-2009

PHSA Section	Title and Program Description	Year Created	Authorization of Appropriations	Actual FY2010 Funding	Years Funded Since 2000
	Center for Mental Health Services (CMHS)				
Sec. 520A	**Priority Mental Health Needs of Regional and National Significance (PRNS)**. General authority to provide grants and fund activities intended to increase knowledge on best practices, provide training and technical assistance, and increase capacity of states and local entities to provide for necessary substance abuse prevention efforts.	1988	FY2001: $300,000,000 FY2002-FY2003: SSN	$179,865,000	2002-2010
Sec. 520B	**National Centers Of Excellence For Depression**. Grants to national centers of excellence for depression to engage in activities related to the treatment of depressive disorders, including identifying and supporting implementation of evidence-based practices, providing training and technical assistance to mental health professionals, and conducting educational activities to reduce stigma and raise awareness of treatments.	2010	FY2010-FY2015: $100,000,000 each year FY2016-FY2010: $150,000,000 each year	NF	None
Sec. 520C	**Youth Interagency Research, Training, And Technical Assistance Centers**. Grants to establish up to four research, training, and technical assistance centers to support mental health and substance abuse services within the justice system, and to establish one center to support youth suicide early intervention and prevention.	2000	FY2001: $4,000,000 FY2002-FY2003: SSN FY2005: $3,000,000 FY2006: $4,000,000 FY2007: $5,000,000	$4,957,000	2005-2010
Sec. 520D	**Services for Youth Offenders**. Grants to provide aftercare services to youth offenders who have been discharged from the justice system and have serious emotional disturbances.	2000	FY2001: $40,000,000 FY2002-FY2003: SSN	NF	None
Sec.520E	**Youth Suicide Early Intervention and Prevention Strategies**. Grants to states and tribal organizations to develop and implement statewide or tribal youth suicide prevention and early intervention strategies. Efforts must involve public/private collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations.	2004	FY2005: $7,000,000 FY2006: $18,000,000 FY2007: $30,000,000	$29,738,000	2005-2010
Sec.520E-1	**Suicide Prevention For Children and Adolescents**. Grants to complement suicide prevention and early intervention strategies developed in Sec. 520E.	2000	FY2001: $75,000,000 FY2002-FY2003: SSN	NF	None
Sec. 520E-2	**Mental and Behavioral Health Services on Campus**. Grants to institutions of higher education to enhance services for students with mental and behavioral health problems, such as depression, substance abuse, and suicide attempts.	2000	FY2005: $5,000,000 FY2006: $5,000,000 FY2007: $5,000,000	$4,975,000	2005-2010
Sec. 520F	**Centers for Emergency Mental Health**. Grants to support designation of hospitals and health centers as Emergency Mental Health Centers.	2000	FY2001: $25,000,000 FY2002-FY2003: SSN	NF	None

PHSA Section	Title and Program Description	Year Created	Authorization of Appropriations	Actual FY2010 Funding	Years Funded Since 2000
Sec. 520G	**Grants for Jail Diversion Programs**. Grants to states and tribal organizations to promote the transformation of systems to improve services for justice-involved adults with mental illness. Grantees are expected to act through agreements with other public and nonprofit entities to develop and implement programs to divert individuals with a mental illness from the criminal justice system to community-based services.	2000	FY2001: $10,000,000 FY2002-FY2003: SSN	$6,684,000	2002-2010
Sec. 520H	**Improving Outcomes For Children and Adolescents Through Services Integration Between Child Welfare and Mental Health Services**. Grants to states and tribal organizations to provide integrated child welfare and mental health services for children and adolescents in the child welfare system or at risk for becoming part of the system, and for parents or caregivers with a mental illness or a mental illness and a co-occurring substance abuse disorder.	2000	FY2001: $10,000,000 FY2002-FY2003: SSN	NF	None
Sec. 520I	**Grants for the Integrated Treatment of Serious Mental Illness and Co-occurring Substance Abuse**. Grants to provide integrated treatment services for individuals with a serious mental illness and co-occurring substance abuse disorder.	2000	FY2001: $40,000,000 FY2002-FY2003: SSN	NF	None
Sec. 520J	**Mental Health Training Grants**. Grants for training school and emergency services personnel to enhance awareness and identification of mental illness.	2000	FY2001: $25,000,000 FY2002-FY2003: SSN	NF	None
Sec. 520K	**Awards For Co-locating Primary And Specialty Care In Community-Based Mental Health Settings**. Grants to community mental health programs for demonstration projects to provide coordinated and integrated services to adults with mental illnesses who have co-occurring primary care conditions and chronic diseases through the co-location of primary and specialty care services in community-based mental and behavioral health settings.	2010	FY2010: $50,000,000 FY2011-FY2014: SSN	NF	None
Secs. 521-535	**Projects for Assistance in Transition from Homelessness (PATH)**. Grants to states to provide outreach, mental health and other support services to homeless people with serious mental illness. Outreach is focused on homeless individuals who are not pursuing needed mental health treatment on their own.	1990	FY2001-FY2003: $75,000,000 each year	$65,047,000	2002-2010
Secs. 561-565	**Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances**. Six-year grants to states and tribal organizations to implement, improve and expand systems of care to meet the needs of children with serious emotional disturbances and their families. This approach emphasizes culturally competent care, family driven and youth guided practice, and multi-agency collaboration.	1992	FY2001: $100,000,000 FY2002-FY2003: SSN	$121,316,000	2000-2010
Sec. 581	**Children and Violence**. Grants to fund local communities to assist children in dealing with violence. (Funds are awarded under the Department of Education's Safe Schools/ Healthy Students program.)	2000	FY2001: $100,000,000 FY2002-FY2003: SSN	$94,502,000	2002-2010

PHSA Section	Title and Program Description	Year Created	Authorization of Appropriations	Actual FY2010 Funding	Years Funded Since 2000
Sec. 582	**Grants to Address the Problems of Persons Who Experience Violence and Related Stress (Child Traumatic Stress Initiative)**. Grants to improve treatment and services for children and adolescents who have experienced traumatic events. Addresses child trauma issues by creating a national network of grantees that work collaboratively to develop and promote effective community practices for children and adolescents exposed to a wide array of traumatic events.	2000	FY2001: $50,000,000 FY2002-FY2006: SSN	$40,800,000	2002-2010
Secs. 1911-1920	**Community Mental Health Services Performance Partnership Block Grants**. Formula grants to states to support community mental health services for adults with serious mental illness and children with serious emotional disturbance.	1992	FY2001: $450,000,000 FY2002-FY2003: SSN	$399,735,000	2000-2010
P.L. 99-319	**Protection and Advocacy for Individuals with Mental Illness (PAIMI)**. Formula grants to support independent protection and advocacy program in each state. PAIMI programs help protect individuals with mental illness from abuse, neglect, and violations of their civil rights. The programs investigate and use legal and other remedies to correct verified incidents.	1986	FY1992: $19,500,000 FY1993-FY2003: SSN	$36,380,000	2000-2010
	Other Authorities				
Sec. 501	**Program Management**. Funding to support SAMHSA's staff who plan, direct, and administer the agency's programs.	1992	Not Applicable	$79,197,000	2000-2010
Sec. 506A	**Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans**. Grants to provide alcohol and drug prevention or treatment services for Indians and Native Alaskans.	2000	FY2001: $15,000,000 FY2002-FY2003: SSN	NF	None
Sec. 506B	**Grants for Ecstasy and Other Club Drugs Abuse Prevention**. Grants to carry out education and other community-based programs to prevent abuse of "club drugs" by youth.	2000	FY2001: $10,000,000 Subsequent years: SSN	NF	None
P.L. 111-148, Sec. 10221	**Indian Tribes Access to SAMHSA Grants**. To simplify the grant application process for Indian tribes and tribal organizations, and to ensure that state grant funding is proportionately directed to serve the Indian population in the state.	2010	SSN (no years specified)	NF	None
P.L. 111-148, Sec. 10221	**Indian Youth Life Skills Development Demonstration Program**. Demonstration program to test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide.	2010	FY2010-FY2014: $1,000,000 each year	NF	None

Source: SAMHSA budget justification documents, FY2000-FY2011.

Notes: SSN = such sums as may be necessary; NF = not funded.

a. There are two sections 514 in the PHSA. The first (substance abuse treatment services for children and adolescents) was added by Sec. 3104 of P.L. 106-310; the second (methamphetamine treatment) was added by Sec. 3632 of the same law.

Table A-2. SAMHSA Funding, FY2000-FY2011

(dollars in millions)

	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	Request FY2011
Substance Abuse												
Substance Abuse Block Grant	1,600	1,665	1,725	1,754	1,779	1,776	1,757	1,759	1,759	1,779	1,799	1,799
PRNS Treatment[a]	214	256	291	317	419	422	399	399	400	412	453	487
PRNS Prevention[a]	147	175	197	197	199	199	193	193	194	201	202	223
Prescription Drug Monitoring	0	0	0	0	0	0	0	0	0	2	2	2
Subtotal, Substance Abuse	**1,961**	**2,108**	**2.213**	**2,268**	**2,397**	**2,397**	**2,349**	**2,350**	**2,353**	**2,394**	**2,455**	**2,510**
Mental Health												
Mental Health Block Grant	356	420	433	437	434	433	428	428	421	421	421	421
PATH Homeless Formula Grant	31	37	40	43	50	55	54	54	53	60	65	70
PRNS Mental Health[a]	136	203	230	245	241	274	263	263	299	344	362	374
Children's Mental Health Services	83	92	97	98	102	105	104	104	102	108	121	126
Protection and Advocacy	25	30	32	34	35	34	34	34	35	36	36	36
Subtotal, Mental Health	**631**	**782**	**832**	**857**	**862**	**901**	**883**	**884**	**911**	**969**	**1,005**	**1,028**
Program Management	59	88	91	87	92	94	92	93	93	100	102	136
Emergency Response and Recovery	0	28	10	0	0	0	0	0	0	0	0	0
St. Elizabeth's Hospital	0	0	0	0	0	0	0	0	0	1	1	0
Data Evaluation	0	0	0	0	0	0	0	0	0	3	0	0
TOTAL	**2,651**	**2,966**	**3,146**	**3,212**	**3,351**	**3,392**	**3,324**	**3,327**	**3,356**	**3,466**	**3,563**	**3,674**

Source: SAMHSA budget justification documents, FY2000-FY2011.

Notes: Funding includes direct SAMHSA appropriations and PHS evaluation set-aside funds (i.e., funds transferred by the HHS Secretary to SAMHSA, pursuant to PHSA Sec. 241).

a. PRNS = Programs of Regional and National Significance. These budget lines include funding for programs created under general (i.e., PRNS) authority, and programs with specific PHSA authorizations. Note that the Children's Mental Health Services Program (PHSA Secs. 561-565) has its own budget line.

Appendix B. SAMHSA National Outcome Measures

Domain	Outcome	Measures		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/harm of use ▶ Age of first use ▶ Perception of disapproval/attitude ▶
	Improved Level of Functioning	UNDER DEVELOPMENT	NOT APPLICABLE	NOT APPLICABLE
Employment/Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy ▶ Attendance/enrollment ▶ ATOD-related suspensions and expulsions
Crime and Criminal Justice	Decreased Criminal Justice Involvement	UNDER DEVELOPMENT	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries ▶ Alcohol and drug-related crime ▶
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness [1]	Clients reporting positively about social connectedness ▶	UNDER DEVELOPMENT	Family communication around drug use ▶
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served ▶ Penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity ▶
Retention	Increased Retention in Treatment-Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies ▶ Percentage youth seeing, reading, watching, or listening to a prevention message ▶
	Reduced Utilization of Psychiatric Inpatient Beds-Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care [2]	Clients reporting positively about outcomes ▶	UNDER DEVELOPMENT	UNDER DEVELOPMENT
Cost Effectiveness	Cost Effectiveness (Average Cost) [2]	UNDER DEVELOPMENT	UNDER DEVELOPMENT	(SAPT) Percent of prevention set-aside funds spent on evidence-based practices; (PRNS) cost per unit improved [3]
Use of Evidence-Based Practices	Use of Evidence-Based Practices [2]	UNDER DEVELOPMENT	UNDER DEVELOPMENT	Total number of evidence-based programs and strategies ▶

Source: SAMHSA (http://www.nationaloutcomemeasures.samhsa.gov/NOMS.aspx?menuID=2&font=).

Appendix C. Useful SAMHSA Resources

SAMHSA Website: http://www.samhsa.gov

SAMHSA Grant Awards by State: http://www.samhsa.gov/statesummaries/index.aspx

FY2011 Budget Justification: http://samhsa.gov/Budget/FY2011/SAMHSA_FY11CJ.pdf

National Outcome Measures: http://www.nationaloutcomemeasures.samhsa.gov

2000 Reauthorization Language: http://www.samhsa.gov/legislate/Sept01/childhealth_toc.htm

Center for Mental Health Services: http://www.samhsa.gov/about/cmhs.aspx

Center for Substance Abuse Prevention: http://www.samhsa.gov/about/csap.aspx

Center for Substance Abuse Treatment: http://www.samhsa.gov/about/csat.aspx

Center for Behavioral Health Statistics and Quality: http://www.samhsa.gov/about/cbhsq.aspx

SAMHSA Report on Co-occurring Disorders: http://www.oas.samhsa.gov/CoD/CoD.pdf

SAMHSA Report on Performance Partnerships:
http://www.nationaloutcomemeasures.samhsa.gov/./PDF/performance_partnership.pdf

SAMHSA Funding Opportunities: http://www.samhsa.gov/grants/

Garrett Lee Smith Grantee Activities: http://www.sprc.org/grantees/statetribe/desc/showAllState.asp (state grantees)

http://www.sprc.org/grantees/statetribe/desc/showAllTribal.asp (tribal grantees)

http://www.sprc.org/grantees/campus/desc/show_alldescription.asp (campus grantees)

Author Contact Information

(name redacted)
Specialist in Health Policy
/redacted/@crs.loc.gov, 7-....

Acknowledgments

This report was coauthored by Bonnie L. Norton, Presidential Management Fellow, who is no longer at CRS.