DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2022

Substance Abuse and Mental Health Services Administration

Justification of Estimates for Appropriations Committees

SAMHSA
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Letter from the Acting Assistant Secretary for Mental Health and Substance Use

I am pleased to present the Substance Abuse and Mental Health Services Administration (SAMHSA) fiscal year (FY) 2022 Budget Request. SAMHSA is requesting a total of $9.7 billion. As the primary federal agency responsible for addressing the mental and substance use disorders that affect millions of Americans, SAMHSA takes seriously its responsibility to ensure that evidence-based care is reaching all communities in our nation. Now, more than ever, we must ensure individuals living with these conditions gain access to high quality and equitable prevention, intervention, treatment, and recovery services.

Consistent with the goals of the American Rescue Plan Act, SAMHSA's budget demonstrates a commitment to addressing pressing public health challenges, including the overdose epidemic and serious mental illness. This budget aligns with the Administration's priorities to address mental and substance use disorders in children, adults, families, and communities. Through a sustained focus on implementing evidence-based practices, SAMHSA's budget aims to improve the lives of people across the United States and its territories.

SAMHSA's FY 2022 budget request includes investments to:

- Expand access to care for opioid use disorders (OUD) through continued investment in FDA-approved pharmacotherapies for OUD, also known as medication-based treatments in conjunction with psychosocial supports, recovery supports, and strategies to prevent opioid misuse and overdose through evidence-based approaches, including the use of the life-saving opioid overdose antidote, naloxone.
- Significantly increase the Community Mental Health Block Grant by $825 million and the Substance Abuse Prevention and Treatment Block Grant by $1.7 billion from FY 2021 Enacted. This Budget Request builds on investments in the Coronavirus Response and Relief Supplemental Appropriations Act and the American Rescue Plan Act. In addition, the Budget Request includes a new 10% set aside within the SABG for recovery support services in order to expand the continuum of care both upstream and downstream.
- Begin implementation of the National Suicide Hotline Designation Act of 2020, requiring that the current National Suicide Prevention Lifeline's 10-digit number be replaced by a new three-digit dialing code -988- for suicide prevention and mental health crisis services. This Budget Request will provide Lifeline-member call centers with resources to help meet both the operational needs during the pandemic and the implementation of 988 as call volume is anticipated to grow substantially.
- Expand Certified Community Behavioral Health Clinic services that provide integrated mental health, substance use, and physical healthcare to those living with SMI, offer 24/7 crisis intervention services and provide access to wrap-around, evidence-based interventions that will support community living for those affected by mental and substance use disorders.

In FY 2022, SAMHSA maintains a strong commitment to enhancing the delivery of a clinically sound, evidence-based, effective and full continuum of services. SAMHSA continues to streamline its business operations to ensure an optimization of service provision across America's communities. The work SAMHSA does is vital to the health of this country and this budget supports our mission to reduce the impact of substance use and mental illness on America's communities.

Tom Coderre
Acting Assistant Secretary for Mental Health
and Substance Use

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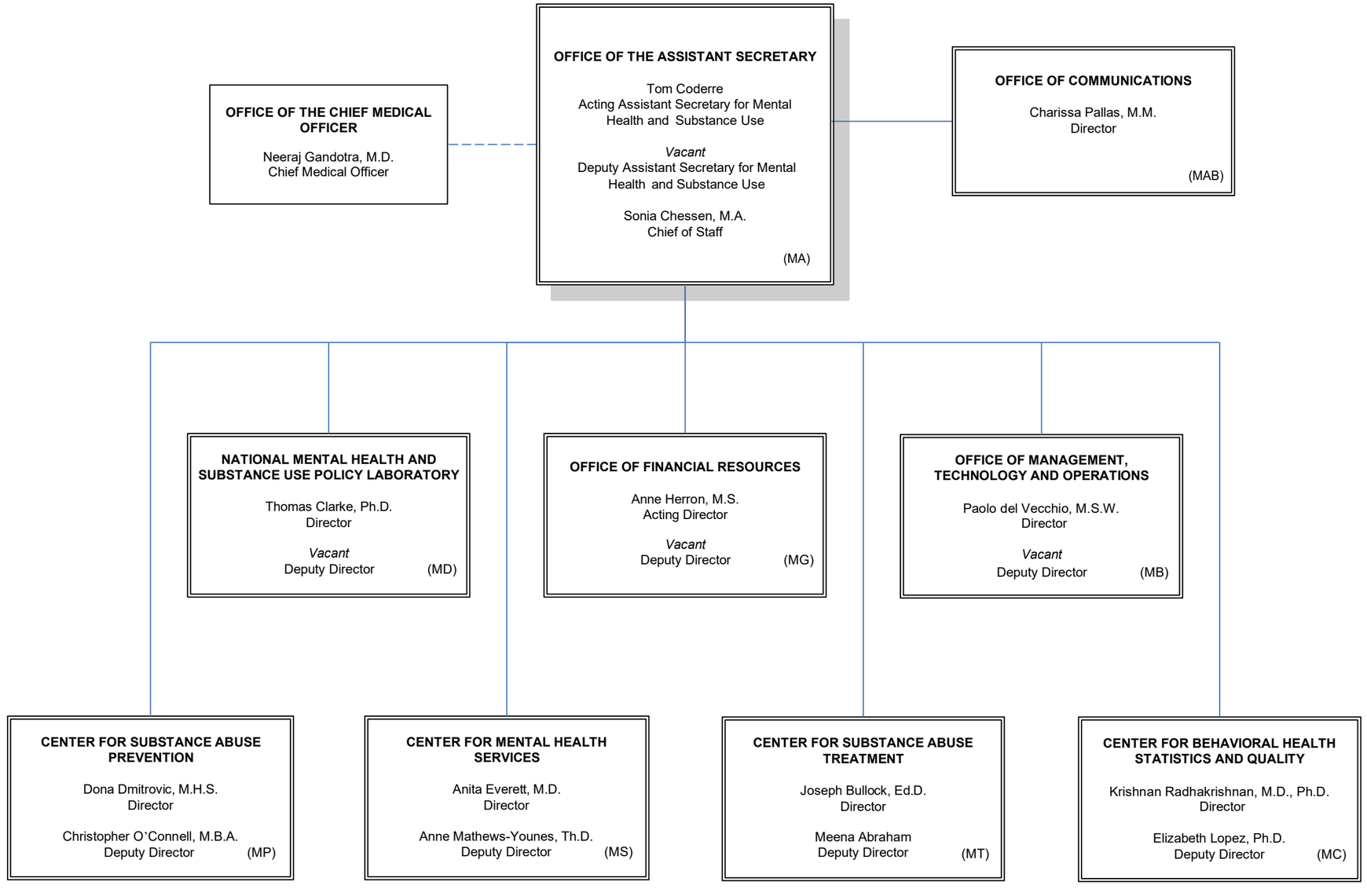
Organizational Structure:
Substance Abuse and Mental Health Services Administration (SAMHSA)



Performance Budget Overview Executive Summary

Introduction

Prevention, treatment, and support to help people recover from mental and/or substance use disorders are essential strategies for the health and prosperity of individuals, families, communities, and the country. Individuals and families across the nation are struggling with the consequences of living with mental and substance use disorders. In 2019, National Survey on Drug Use and Health (NSDUH) data estimated 35.8 million Americans aged 12 or older, or 13.0 percent, were current (past month) illicit drug users. In addition, an estimated 20.6 percent of adults ages 18 and older had some type of mental illness in the past year (51.5 million) and 5.2 percent (13.1 million) of adults had serious mental illness. SAMHSA has a unique responsibility to focus on these preventable and treatable conditions, which, if unaddressed, lead to significant individual, societal, and economic consequences.

Mission

SAMHSA's mission is to reduce the impact of substance use and mental illness on America's communities. SAMHSA accomplishes this through providing leadership and resources – programs, policies, information and data, funding, and personnel – to advance mental and substance use disorder prevention, treatment, and recovery services in order to improve individual, community, and public health.

Overview of Budget Request

The FY 2022 budget request is $9.7 billion, an increase of $3.7 billion from the FY 2021 Enacted budget. The budget request aims to address critical national priorities including combating the nation's opioid crisis, addressing serious mental illness, developing and implementing strategies to prevent suicide, expanding access to telehealth, and expanding school-based mental health services.

Key Budget Highlights

State Opioid Response Grants

The FY 2022 Budget Request is $2.3 billion, an increase of $750 million from the FY 2021 Enacted budget. Of this amount, $75 million is set-aside for tribes and increase of $25 million over the 2021 Enacted level. Overdose deaths have accelerated during the COVID-19 pandemic. The Centers for Disease Control and Prevention (CDC) provisional data estimates 90,000 drug overdose deaths in the United States in the 12 months ending in September 2020, the highest number ever recorded in a 12-month period. This grant program aims to address the opioid crisis by increasing access to medication-assisted treatment using FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment needs, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs). Funding is awarded to states and territories via formula. The program includes a 15 percent set-aside for the 10 states with the highest mortality rates related to drug overdose deaths. States and communities across the country are also dealing with rising rates of stimulant use and its negative health, social, and economic consequences. To address the growing methamphetamine crisis, the budget continues to allow the use of State Opioid Response grants to include methamphetamine and other stimulants to give states and tribes flexibility to address their unique community needs.

Substance Abuse Prevention and Treatment Block Grant (SABG)

The FY 2022 Budget Request is $3.5 billion, which is an increase of $1.7 billion from FY 2021 Enacted. This Budget Request builds on investments in the Coronavirus Response and Relief Supplemental Appropriations Act and the American Rescue Plan Act. SABG helps states in addressing the opioid epidemic and other substance use treatment and prevention needs through support of prevention, treatment and other services (e.g., recovery support services) not covered by commercial insurance and non-clinical activities and services that address the critical needs of state substance abuse prevention and treatment service systems.

The SABG seeks to improve the health and lives of individuals with substance use disorders. The SABG supports state prevention, treatment and recovery systems' infrastructure and capacity, thereby increasing availability of services, development and implementation of evidence-based practices, development and collection of specific outcome measures, and development and maintenance of state data management systems. Also, the SABG provides staffing requirements, resources, and federal guidance that can be leveraged to sustain and improve state systems. This funding will further contribute to the development and maintenance of successful state

collaborations with other agencies and stakeholders concerned with preventing, treating and recovering from substance use disorders.

It is imperative that our addiction crisis response evolves from an acute short-term individual-focused treatment response to a broader community recovery response. Addiction is a chronic illness, and recovery often is a life-long process where external community and social determinants of health play a vital role in its sustainability. The Budget Request includes a new 10 percent set aside within the SABG for recovery support services in order to significantly expand the continuum of care both upstream and downstream. This new set-aside will support the development of local recovery community support institutions (i.e. recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries); develop strategies and educational campaigns, trainings, and events to reduce addiction/recovery-related stigma and discrimination at the local level; provide addiction treatment and recovery resources and support system navigation; make accessible peer recovery support services that support diverse populations and are inclusive of all pathways to recovery; and collaborate and coordinate with local private and non-profit clinical health care providers, the faith community, city, county, state, and federal public health agencies, and criminal justice response efforts.

Substance Abuse Treatment Programs of National and Regional Significance (PNRS)

The FY 2022 Budget Request is $651 million, which is an increase of $154 million above the FY 2021 Enacted. CDC provisional data shows a 28 percent increase in the deaths related to overdoses in the past year. The FY 2022 budget includes increased funding for opioid treatment and recovery support activities, services, naloxone training and distribution, services for pregnant and post-partum women, and workforce training to expand access to evidence-based treatment and recovery support services.

Community Mental Health Services Block Grant (MHBG)

The FY 2022 Budget Request is $1.6 billion, which is an increase of $825 million above the FY 2021 Enacted. This funding continues to serve as a safety net for mental health services for some of the nation's most vulnerable populations. This Budget Request builds on investments in the Coronavirus Response and Relief Supplemental Appropriations Act and the American Rescue Plan Act. The COVID pandemic and the change in the daily lives of Americans have taken a toll on people's mental health and created new barriers for those seeking mental health care. Stress and anxiety about the pandemic, coupled with job losses, losses of income, medical insurance, childcare, and the loss of loved ones have a devastating effect on mental health. By statute, MHBG funds must be used to address the needs of adults with serious mental illness (SMI) and children with serious emotional disturbances (SED).

SAMHSA will maintain the ten percent set-aside for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The set-aside helps reduce costs to society, as intervening early helps prevent deterioration of functioning in individuals experiencing a first episode of serious mental illness.

The budget also includes a set-aside of $75 million of MHBG funds to support state efforts to build much needed crisis systems to address the needs of individuals in mental health crisis in a high quality, expeditious manner. The development of these services will promote 24/7 access to well-trained mental health professionals in the time of acute mental health crisis. This funding supports the partnering of behavioral health providers with law enforcement.

Criminal and Juvenile Justice Programs - Treatment of Mental Disorders in Prisons

The FY 2022 Budget Request is $51 million which is an increase of $45 million from the FY 2021 Enacted. Data indicate that a significant number of individuals who come in contact with law enforcement and the criminal justice system have a mental or substance use disorder. This proposed increase aligns with the Administration's goal to address mental health needs among incarcerated youth and adults by providing services to ensure their successful transition into the community post-incarceration. This funding will establish pre-release relationships with community mental health providers and key stakeholders. With a commitment to health equity, SAMHSA will award a new cohort of grants to support the provision of services by community-based behavioral health providers both within jails/prisons and post-incarceration. This activity will address the unmet treatment needs of incarcerated individuals and allow these individuals to continue access services from the same community-based providers post-incarceration for a seamless transition of care. The needs of individuals returning to society include the social determinants of recovery (i.e. housing, employment, access to health care) and other supportive resources for successful transition from incarceration. This funding will support up to 100 grantees to provide screening, assessment, treatment, and linkage to services for those with mental disorders in jails/prisons. Special importance will be paid towards ensuring a commitment to racial and economic justice, trauma-informed approaches, as well as cultural humility. SAMHSAwill also continue its existing criminal justice portfolio that focuses on early diversion and alternatives to incarceration.

Certified Community Behavioral Health Clinics (CCBHCs) Expansion Grants

The FY 2022 Budget Request is $375 million, which is an increase of $125 million from the FY 2021 Enacted. This funding will support a new cohort of 158 grants and 22 continuation grants. While effective treatment and supportive services exist, many individuals with mental/substance use disorders do not receive the help they need. When they do try to access services, they may face significant delays and/or get connected to incomplete, disconnected, or uncoordinated care. Even people who receive some services, such as medication or psychotherapy, often do not have access to the complete range of supports they need, such as help to get them through a crisis, manage co-occurring physical health problems, find and sustain employment, and maintain a safe place to live in the community.

The CCBHC Expansion program is designed to increase access to and improve the quality of community mental and substance use disorder treatment services. CCBHCs funded under this program must provide access to services for individuals with serious mental illness (SMI) or substance use disorders (SUD), including opioid use disorders; children and adolescents with serious emotional disturbance (SED); and individuals with co-occurring mental and substance use disorders. This program will improve the mental health of individuals across the nation by

providing comprehensive community-based mental and substance use disorder services; treatment of co-occurring disorders; advance the integration of mental/substance use disorder treatment with physical health care; assimilate and utilize evidence-based practices on a more consistent basis, and promote improved access to high quality care.

Data from intake to most recent reassessment for individuals served in the CCBHC program demonstrate that as of January 2020, clients have a 61.6 percent reduction in hospitalization and a 62.1 percent reduction in Emergency Department (ED) visits. Additionally, the data demonstrates that 15.2 percent had an increase in employment or started going to school, and a 30.4 percent increase in mental health functioning in everyday life.

Project AWARE

The FY 2022 Budget Request is $191 million, which is an increase of $61 million from the FY 2021 Enacted. Project AWARE is comprised of the Project AWARE State Education Agency (SEA) grants, ReCAST grants, and the Mental Health Awareness Training (MHAT) grants. This funding level would support 106 additional grants across the three programs. Project AWARE SEA grants are awarded to State Education Agency/Authorities to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services. In FY 2021, a state may receive an additional AWARE grant if they propose to work with different Local Education Agencies/Authorities. Education agencies/authorities that serve AI/AN children and youth are also eligible to apply for AWARE funding.

The MHAT grants train school personnel, emergency first responders, law enforcement, veterans, armed services members and their families to recognize the signs and symptoms of mental disorders, particularly serious mental illness (SMI) and/or serious emotional disturbances (SED).

ReCAST assists high-risk youth and families to promote resilience and equity in communities struggling with civil unrest, trauma, and violence through implementation of evidence-based violence prevention and community youth engagement programs and linkages to trauma-informed mental health services.

Suicide Prevention Activities

The FY 2022 Budget Request is $173 million, which is an increase of $78 million above the FY 2021 Enacted. According to 2018 CDC data, suicide is the 10th leading cause of death in the United States. Suicide is a critical public health issue involving multiple psychological and social factors. Suicide rates have increased steadily for individuals of all ages. This increase will be directed towards the Suicide Lifeline program. The National Suicide Hotline Designation Act of 2020 requires that the current National Suicide Prevention Lifeline's 10-digit number be replaced by a new three-digit dialing code 9-8-8 for suicide prevention and mental health crisis services. The 9-8-8 code, an easier number to remember, will be available nationally by July 16, 2022. SAMHSA is working with states to establish 9-8-8 system in their jurisdictions; and this number may be available in some areas sooner than 2022. This Budget Request will provide Lifeline-member call centers with resources to help meet both the operational needs during the pandemic and the implementation of 9-8-8 across the U.S. This funding will be used to strengthen the infrastructure

of the existing Lifeline to increase the capacity of Lifeline centers to answer calls, chats, and texts, and provide specialized services.

Assisted Outpatient Treatment (AOT) for Individuals with SMI

The FY 2022 Budget Request is $21 million, which is an increase of $420,000 above the FY 2021 Enacted. AOT is the practice of delivering outpatient treatment under court order to adults with SMI who meet specific criteria, such as a prior history of repeated hospitalizations or arrest. AOT involves petitioning local courts through a civil process to order individuals to enter and remain in treatment within the community for a specified period of time. Funding will help to identify evidence based AOT practices that support improved outcomes, including outreach and engagement, clinical treatment and supportive services, and due process protections.

Substance Abuse Prevention Programs of National and Regional Significance (PNRS)

The FY 2022 Budget Request is $217 million, which is an increase of $8 million above the FY 2021 Enacted. The Budget Request includes increased funding for activities that address youth substance use, HIV and Hepatitis C prevention, Tribal Behavioral Health, and workforce development.

Health Surveillance and Program Support

The FY 2022 Budget Request is $172 million, which is an increase of $10 million above the FY 2021 Enacted. The FY 2022 Budget Request includes increased funding for data collection and additional FTE to improve program performance.

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Overview of Performance

Consistent with the Government Performance and Results Modernization Act of 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) continues to refine its use of performance and evaluation data to measure impact and mitigate risk. Data-driven performance reviews help SAMHSA leadership analyze outcome data and learn the extent to which strategies work or need improvement. As impact is measured and reported, SAMHSA seeks to identify the conditions that foster success, address barriers, enable collaboration across programs, and promote overall efficiency.

SAMHSA collects critical performance data on both output and outcome measures. Data on services programs include diagnoses, abstinence from substance use, mental health functioning, overall physical health, criminal justice involvement, stable housing, social connectedness, and employment. Additionally, SAMHSA collects data on the number of people served, the number trained, and the number of training events held.

SAMHSA also maintains its commitment to utilize these performance data to manage and monitor its robust portfolio of grants. In FY 2017, SAMHSA reconfigured its approach to uniform data collection with the successful launch and implementation of SAMHSA's Performance Accountability and Reporting System (SPARS). This system provides a common data and reporting system for all SAMHSA discretionary grantees and allows for programmatic technical assistance on use of the data to enhance grantee performance monitoring and improve the quality of service delivery. In FY 2018, SAMHSA strengthened its internal evaluation ability through the creation of an Office of Evaluation in the Center for Behavioral Health Statistics and Quality. This Office partners with the National Mental Health and Substance Use Policy Laboratory to ensure that all SAMHSA programs are evaluated for effectiveness and that findings related to the most effective evidence-based practices to treat mental illness and substance use disorders are disseminated to the field. SAMHSA will continue its efforts to improve upon data collection to better inform service delivery.

Substance Abuse and Mental Health Services Administration

All Purpose Table

(Dollars in millions)

Account and Program Name	FY 2020		FY 2021		FY 2022	
	Final 1/	COVID-19 Supplemental /2	Enacted	Supplemental Funding /3	President's Budget	+/- FY 2021
Mental Health						
Programs of Regional and National Significance	$529.661		$558.923	$60.000	$753.176	$194.253
Children's Mental Health Services	125.000		125.000		125.000	0.000
Set-Aside for Youth in Prodrome Phase of Psychosis (non-add)	*12.500*		*12.500*		*12.500*	*0.000*
Projects for Assistance in Transition from Homelessness	64.635		64.635		64.635	0.000
Protection and Advocacy for Individuals with Mental Illness	36.146		36.146		36.146	0.000
Community Mental Health Services Block Grant	722.571		757.571	1,500.000	1,582.571	825.000
Budget Authority (non-add)	*701.532*		*736.532*	*1,500.000*	*1,561.532*	*825.000*
PHS Evaluation Funds (non-add)	*21.039*		*21.039*		*21.039*	--
Certified Community Behavioral Health Clinics	200.000		250.000	420.000	375.000	125.000
Total, Mental Health	**1,678.013**		**1,792.275**	**1,980.000**	**2,936.528**	**1,144.253**
Budget Authority (non-add)	*1,644.974*		*1,759.236*	--	*2,903.489*	*1,144.253*
Prevention and Public Health Fund (non-add)	*12.000*		*12.000*	--	*12.000*	--
PHS Evaluation Funds (non-add)	*21.039*		*21.039*	--	*21.039*	--
Substance Abuse Prevention						
Programs of Regional and National Significance	206.469		208.219		216.667	8.448
Total, Substance Abuse Prevention	**206.469**		**208.219**	--	**216.667**	**8.448**
Substance Abuse Treatment						
Programs of Regional and National Significance	479.677		496.677		650.864	154.187
PHS Evaluation Funds (non-add)	*2.000*		*2.000*		*2.000*	--
State Opioid Response Grants	1,500.000		1,500.000		2,250.000	750.000
Set-Aside for Tribes (non-add)	*50.000*		*50.000*		*75.000*	*25.000*
Substance Abuse Prevention and Treatment Block Grant	1,858.079		1,858.079	1,500.000	3,508.079	1,650.000
Budget Authority (non-add)	*1,778.879*		*1,778.879*	*1,500.000*	*3,428.879*	*1,650.000*
PHS Evaluation Funds (non-add)	*79.200*		*79.200*		*79.200*	--
Total, Substance Abuse Treatment	**3,837.756**		**3,854.756**	**1,500.000**	**6,408.943**	**2,554.187**
SAT Budget Authority (non-add)	*3,756.556*		*3,773.556*	--	*6,327.743*	*2,554.187*
SAT PHS Evaluation Funds (non-add)	*81.200*		*81.200*	--	*81.200*	--
Health Surveillance and Program Support						
Health Surveillance and Program Support	126.258		126.258	--	130.913	4.655
Data Request and Publications User Fees	1.500		1.500	--	1.500	--
Public Awareness and Support	13.000		13.000	--	13.260	0.260
Performance and Quality Information Systems	10.000		10.000	--	10.200	0.200
Behavioral Health Workforce Data and Development	1.000		1.000	--	1.000	--
PHS Evaluation Funds (non-add)	*1.000*		*1.000*	--	*1.000*	--
Drug Abuse Warning Network	10.000		10.000	--	15.000	5.000
PHS Evaluation Funds (non-add)	--		--	--	--	--
COVID-19 Supplemental	--	425.000	--	4,330.000	--	--
Total, Health Surveillance and Program Support	**161.758**	**425.000**	**161.758**	**4,330.000**	**171.873**	**10.115**
HSPS Budget Authority (non-add)	*128.830*		*128.830*	*4,330.000*	*138.945*	*10.115*
HSPS PHS Evaluation Funds (non-add)	*31.428*		*31.428*	--	*31.428*	--
Data Request and Publications User Fees(non-add)	*1.500*		*1.500*	--	*1.500*	--
TOTAL, SAMHSA Program Level	**5,883.996**	**425.000**	**6,017.008**	**7,810.000**	**9,734.011**	**3,717.003**
Nonrecurring Expenses Fund (NEF)	**--**		**--**	**--**	**--**	**--**
Less Funds from Other Sources:						
Prevention and Public Health Fund (non-add)	*-12.000*		*-12.000*		*-12.000*	--
PHS Evaluation Funds	*-133.667*		*-133.667*		*-133.667*	--
Data Request and Publications User Fees	*-1.500*		*-1.500*		*-1.500*	--
TOTAL, SAMHSA Budget Authority	**5,736.829**	**425.000**	**5,869.841**	**7,810.000**	**9,586.844**	**3,717.003**

1/ Reflects amounts appropriated and any reprogrammings or reallocations notified to congress.

2/ Excludes $5.0 million in permissive transfers or allotments from the Public Health and Social Services Emergency Fund (PHSSEF) to SAMHSA for Disaster Distress Helpline which are shown in PHSSEF.

3/ This column includes both supplemental funding and mandatory funds appropriated in the American Rescue Plan Act of 2021, P.L. 117-2 post-transfer and post-reallocation.

Budget Exhibits

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Appropriation Language

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

MENTAL HEALTH

For carrying out titles III, V, and XIX of the PHS Act with respect to mental health, and the Protection and Advocacy for Individuals with Mental Illness Act, [$1,759,236,000: Provided, That of the funds made available under this heading, $71,887,000 shall be for the National Child Traumatic Stress Initiative] $2,903,489,000: Provided further, That notwithstanding section 520A(f)(2) of the PHS Act, no funds appropriated for carrying out section 520A shall be available for carrying out section 1971 of the PHS Act: Provided further, That in addition to amounts provided herein, $21,039,000 shall be available under section 241 of the PHS Act to supplement funds otherwise available for mental health activities and to carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1920(b) activities shall not exceed 5 percent of the amounts appropriated for subpart I of part B of title XIX: Provided further, That of the funds made available under this heading for subpart I of part B of title XIX of the PHS Act, [$35,000,000] $75,000,000 shall be available to support evidence-based crisis systems: Provided further, That up to 10 percent of the amounts made available to carry out the Children's Mental Health Services program may be used to carry out demonstration grants or contracts for early interventions with persons not more than 25 years of age at clinical high risk of developing a first episode of psychosis: Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated in this Act for fiscal year [2021: Provided further, That States shall expend at least 10 percent of the amount each receives for carrying out section 1911 of the PHS Act to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset] 2022: Provided further, That [$250,000,000] $375,000,000 shall be available until September 30, [2023] 2024 for grants to communities and community organizations who meet criteria for Certified Community Behavioral Health Clinics pursuant to section 223(a) of Public Law 113–93: Provided further, That none of the funds provided for section 1911 of the PHS Act shall be subject to section 241 of such Act: Provided further, That of the funds made available under this heading, [$21,000,000] $21,420,000 shall be to carry out section 224 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 42 U.S.C. 290aa 22 note).

SUBSTANCE ABUSE TREATMENT

For carrying out titles III and V of the PHS Act with respect to substance abuse treatment and title XIX of such Act with respect to substance abuse treatment and prevention, and the SUPPORT for Patients and Communities Act, [$3,773,556,000] $6,327,743,000: Provided, That [$1,500,000,000] $2,250,000,000 shall be for State Opioid Response Grants for carrying out activities pertaining to opioids and stimulants undertaken by the State agency responsible for administering the substance abuse prevention and treatmentblock grant under subpart II of part B of title XIX of the PHS Act (42 U.S.C. 300x–21 et seq.): Provided further, That of such amount [$50,000,000] $75,000,000 shall be made available to Indian Tribes or tribal organizations:

Provided further, That 15 percent of the remaining amount shall be for the States with the highest mortality rate related to opioid use disorders: Provided further, That of the amounts provided for State Opioid Response Grants not more than 2 percent shall be available for Federal administrative expenses, training, technical assistance, and evaluation: Provided further, That of the amount not reserved by the previous three provisos, the Secretary shall make allocations to States, territories, and the District of Columbia according to a formula using national survey results that the Secretary determines are the most objective and reliable measure of drug use and drug-related deaths[: Provided further, That the Secretary shall submit the formula methodology to the Committees on Appropriations of the House of Representatives and the Senate not less than 15 days prior to publishing a Funding Opportunity Announcement]: Provided further, That prevention and treatment activities funded through such grants may include education, treatment (including the provision of medication), behavioral health services for individuals in treatment programs, referral to treatment services, recovery support, and medical screening associated with such treatment: Provided further, That each State, as well as the District of Columbia, shall receive not less than $4,000,000: Provided further, That in addition to amounts provided herein, the following amounts shall be available under section 241 of the PHS Act: (1) $79,200,000 to supplement funds otherwise available for substance abuse treatment activities to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX; and (2) $2,000,000 to evaluate substance abuse treatment programs: Provided further, That each State that receives funds appropriated under this heading in this Act for carrying out subpart II of part B of title XIX of the PHS Act shall expend not less than 10 percent of such funds for recovery support services: Provided further, That none of the funds provided for section 1921 of the PHS Act or State Opioid Response Grants shall be subject to section 241 of such Act.

SUBSTANCE ABUSE PREVENTION

For carrying out titles III and V of the PHS Act with respect to substance abuse prevention, [$208,219,000] $216,667,000.

HEALTH SURVEILLANCE AND PROGRAM SUPPORT

For program support and cross-cutting activities that supplement activities funded under the headings "Mental Health", "Substance Abuse Treatment", and "Substance Abuse Prevention" in carrying out titles III, V, and XIX of the PHS Act and the Protection and Advocacy for Individuals with Mental Illness Act in the Substance Abuse and Mental Health Services Administration, [$128,830,000] $138,945,000: Provided, That in addition to amounts provided herein, $31,428,000 shall be available under section 241 of the PHS Act to supplement funds available to carry out national surveys on drug abuse and mental health, to collect and analyze program data, and to conduct public awareness and technical assistance activities: Provided further, That, in addition, fees may be collected for the costs of publications, data, data tabulations, and data analysis completed under title V of the PHS Act and provided to a public or private entity upon request, which shall be credited to this appropriation and shall remain available until expended for such purposes: Provided further, That amounts made available in this Act for carrying out section 501(o) of the PHS Act shall remain available through September 30, [2022] 2023: Provided further, That funds made available under this heading may be used to supplement program support funding provided under the headings "Mental Health", "Substance Abuse Treatment", and "Substance Abuse Prevention".

Language Analysis

Language Provision	Explanation
For carrying out titles III, V, and XIX of the PHS Act with respect to mental health, and the Protection and Advocacy for Individuals with Mental Illness Act, [$1,759,236,000] *$2,903,489,000*: [*Provided*, That of the funds made available under this heading, $81,887,000 shall be for the National Child Traumatic Stress Initiative:]	Identifies the purpose for which funds can be used for mental health. Language regarding the National Child Traumatic Stress Initiative is removed because a separate funding proviso is unnecessary and duplicative.
[2021: Provided further, That States shall expend at least 10 percent of the amount each receives for carrying out section 1911 of the PHS Act to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset] 2022:	Language is removed because the 10 percent set-aside for early serious mental illness is Section 1920 of the authorization and therefore is unnecessary.
Provided further, That in addition to amounts provided herein, $21,039,000 shall be available under section 241 of the PHS Act to *supplement funds otherwise available for mental health activities and to* carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1920(b) activities shall not exceed 5 percent of the amounts appropriated for subpart I of part B of title XIX:	Sets the amount of Public Health Service Evaluation Fund dollars allocated to supplement the budget authority for programs for mental health activities and programs authorized under title XIX as well as under titles III and V.

Language Provision	Explanation
Provided further, That in addition to amounts provided herein, the following amounts shall be available under section 241 of the PHS Act: (1) $79,200,000 *to supplement funds otherwise available for substance abuse treatment activities* to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX;	Sets the amount of Public Health Service Evaluation Fund dollars allocated to supplement the budget authority available for programs and activities authorized under title XIX, titles III and V, and substance use disorder treatment activities.
[: Provided further, That the Secretary shall submit the formula methodology to the Committees on Appropriations of the House of Representatives and the Senate not less than 15 days prior to publishing a Funding Opportunity Announcement]:	Language is removed for Administrative flexibility
Provided further, That each State that receives funds appropriated under this heading in this Act for carrying out subpart II of part B of title XIX of the PHS Act shall expend not less than 10 percent of such funds for recovery support services:	Requires states to expend 10 percent of SABG funds on recovery support services.

Amounts Available for Obligation

(Whole dollars)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
General Fund Discretionary Appropriation:			
Appropriation	$5,736,829,000	$5,869,841,000	$9,586,844,000
Across-the-board reductions	---	---	---
Subtotal, Appropriation	5,736,829,000	5,869,841,000	9,586,844,000
Subtotal, adjusted appropriation	5,736,829,000	5,869,841,000	9,586,844,000
Subtotal, adjusted appropriation	5,736,829,000	5,869,841,000	9,586,844,000
Total, Discretionary Appropriation	**5,736,829,000**	**5,869,841,000**	**9,586,844,000**
Mandatory Appropriation:			
Transfer from the Prevention and Public Health Funds	12,000,000	12,000,000	12,000,000
Subtotal, adjusted mandatory appropriation	12,000,000	12,000,000	12,000,000
Offsetting collections from:			
Federal Source	133,667,000	133,667,000	133,667,000
Data Request and Publications User Fees	1,500,000	1,500,000	1,500,000
Unobligated balance, start of year	---	---	---
Unobligated balance, end of year	---	---	---
Unobligated balance, lapsing	---	---	---
Total obligations	**$5,883,996,000**	**$6,017,008,000**	**$9,734,011,000**

Summary of Changes

(Whole dollars)

2021 Enacted	
Total estimated budget authority	$5,869,841,000
(Obligations)	5,869,841,000
2022 President's Budget	
Total estimated budget authority	$9,586,844,000
(Obligations)	9,586,844,000
Net Change	**+$3,717,003,000**

	FY 2021 Enacted	FY 2021 PB FTE	FY 2022 PB BA	FY 2022 +/- FY 2021 FTE	FY 2022 +/- FY 2021 BA
Increases:					
A. Built-in:					
1. Annualization of 2020 commissioned corps pay increase	$5,649,942	---	$5,777,065	---	+127,123
2. Annualization of 2020 civilian pay increase	75,320,999	---	75,885,907	---	+564,908
Subtotal, Built-in Increases	**80,970,941**	**---**	**81,662,972**	**---**	**+692,031**
A. Program:					
1. Mental Health	1,759,236,000	---	2,903,489,000	---	+1,144,253,000
2. Substance Abuse Prevention	208,219,000	---	216,667,000	---	+8,448,000
3.Substance Abuse Treatment	3,773,556,000	---	6,327,743,000	---	+2,554,187,000
4. Health Surveillance and Program Support	128,830,000	---	138,945,000	---	+10,115,000
Subtotal, Program Increases	5,869,841,000	---	9,586,844,000	---	**+3,717,003,000**
Total Increases	**---**	**---**	**---**	**---**	**+3,717,695,031**
Decreases:					
A. Built-in:					
1. Absorption of built-in increases				---	-692,031
Subtotal, Built-in Decreases				**---**	**-692,031**
B. Program:					
1. Health Surveillance and Program Support	---	---	---	---	---
2. Mental Health	---	---	---	---	---
3. Substance Abuse Prevention	---	---	---	---	---
4.Substance Abuse Treatment	---	---	---	---	---
Subtotal, Program Decreases	---	---	---	**---**	**---**
Total Decreases	**---**	**---**	**---**	**---**	**-692,031**
Net Change	---	---	---	---	**+$3,717,003,000**

Budget Authority by Activity

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY2022 President's Budget
Mental Health			
Programs of Regional and National Significance	$529,661	$558,923	$753,176
Children's Mental Health Services	125,000	125,000	125,000
Set-Aside for Youth in Prodrome Phase of Psychosis (non-add)	*12,500*	*12,500*	*12,500*
Projects for Assistance in Transition from Homelessness	64,635	64,635	64,635
Protection and Advocacy for Individuals with Mental Illness	36,146	36,146	36,146
Community Mental Health Services Block Grant	722,571	757,571	1,582,571
Budget Authority (non-add)	*701,532*	*736,532*	*1,561,532*
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*21,039*
Certified Community Behavioral Health Clinics	200,000	250,000	375,000
Total, Mental Health	**1,678,013**	**1,792,275**	**2,936,528**
Substance Abuse Prevention			
Programs of Regional and National Significance	206,469	208,219	216,667
Total, Substance Abuse Prevention	**206,469**	**208,219**	**216,667**
Substance Abuse Treatment			
Programs of Regional and National Significance	479,677	496,677	650,864
State Opioid Response Grants	1,500,000	1,500,000	2,250,000
Set-Aside for Tribes (non-add)		*50,000*	*75,000*
Substance Abuse Prevention and Treatment Block Grant	1,858,079	1,858,079	3,508,079
Budget Authority (non-add)	*1,778,879*	*1,778,879*	*3,428,879*
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*
Total, Substance Abuse Treatment	**3,837,756**	**3,854,756**	**6,408,943**
Health Surveillance and Program Support			
Health Surveillance and Program Support	126,258	126,258	130,913
Data Request and Publications User Fees	1,500	1,500	1,500
Public Awareness and Support	13,000	13,000	13,260
Performance and Quality Information Systems	10,000	10,000	10,200
Behavioral Health Workforce Data and Development	1,000	1,000	1,000
PHS Evaluation Funds (non-add)	*1,000*	*1,000*	*1,000*
Drug Abuse Warning Network	10,000	10,000	15,000
Total, Health Surveillance and Program Support	**161,758**	**161,758**	**171,873**
TOTAL, SAMHSA Program Level	**5,883,996**	**6,017,008**	**9,734,011**
Nonrecurring Expenses Fund (NEF)	--		
Less Funds from Other Sources:			
Prevention and Public Health Fund (non-add)	*-12,000*	*-12,000*	*-12,000*
PHS Evaluation Funds	*-133,667*	*-133,667*	*-133,667*
Data Request and Publications User Fees	*-1,500*	*-1,500*	*-1,500*
TOTAL, SAMHSA Budget Authority	**5,736,829**	**5,869,841**	**9,586,844**
FTEs	**452**	**484**	**615**

Substance Abuse and Mental Health Services Administration

Authorizing Legislation

Activity	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
1. Grants for the Benefit of Homeless PHS Act, Section 506	$ 41,304,000	$ 36,386,000	$ 41,304,000	$ 37,114,000
2. Residential Treatment Programs for Pregnant and Postpartum Women PHS Act, Section 508	$ 29,931,000	$ 32,931,000	$ 29,931,000	$ 49,397,000
3. Priority Substance Abuse Treatment Needs of Regional and National Significance PHS Act, Section 509	$ 333,806,000	$ 496,677,000	$ 333,806,000	$ 650,864,000
4. Substance Abuse Treatment Services for Children and Adolescents PHS Act, Section 514	$ 29,605,000	$ 29,605,000	$ 29,605,000	$ 30,197,000
5. Priority Substance Abuse Prevention Needs of Regional and National Significance PHS Act, Section 516	$ 211,148,000	$ 208,219,000	$ 211,148,000	$ 216,667,000
6. Sober Truth on Preventing Underage Drinking PHS Act, Section 519B	$ 7,000,000	$ 10,000,000	$ 7,000,000	$ 10,000,000
7. Priority Mental Health Needs of Regional and National Significance PHS Act, Section 520A	$ 394,550,000	$ 466,036,000	$ 394,550,000	$ 645,353,000
8. Suicide Prevention Technical Assistance Center PHS Act, Section 520C	$ 5,988,000	$ 9,000,000	$ 5,988,000	$ 9,180,000
9. Youth Suicide Early Intervention and Prevention Strategies PHS Act, Section 520E	$ 30,000,000	$ 36,427,000	$ 30,000,000	$ 36,916,000
10. Mental Health and Substance Use Disorder Services on Campus PHS Act, Section 520E-2	$ 7,000,000	$ 6,488,000	$ 7,000,000	$ 6,618,000
11. National Suicide Prevention Lifeline Program PHS Act, Section 520E-3	$ 7,198,000	$ 24,000,000	$ 7,198,000	$ 74,480,000

Substance Abuse and Mental Health Services Administration

Authorizing Legislation

Activity	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
12. Grants for Jail Diversion Programs PHS Act, Section 520G.....	$ 4,269,000	$ 6,269,000	$ 4,269,000	$ 51,394,000
13. Mental Health Awareness Training PHS Act, Section 520J.....	$ 14,693,000	$ 23,963,000	$ 14,693,000	$ 35,945,000
14. Promoting Integration of Primary and Behavioral Health Care PHS Act, Section 520K.....	$ 51,878,000	$ 54,868,000	$ 51,878,000	$ 55,922,000
15. Adult Suicide Prevention PHS Act, Section 520L.....	$ 30,000,000	$ 23,200,000	$ 30,000,000	$ 42,554,000
16. Assertive Community Treatment Grant Program PHS Act, Section 520M.....	$ 5,000,000	$ 9,000,000	$ 5,000,000	$ 9,000,000
17. Projects for Assistance in Transition From Homelessness PHS Act, Section 535(a).....	$ 64,635,000	$ 64,635,000	$ 64,635,000	$ 65,928,000
18. First Responder Training PHS Act, Section 546.....	$ 36,000,000	$ 42,000,000	$ 36,000,000	$ 63,000,000
19. Building Communities of Recovery PHS Act, Section 547.....	$ 5,000,000	$ 10,000,000	$ 5,000,000	$ 20,000,000
20. Community Mental Health Services for Children with Serious Emotional Disturbances PHS Act, Section 565(f)(1).....	$ 119,026,000	$ 125,000,000	$ 119,026,000	$ 127,500,000
21. Grants to Address the Problems of Persons Who Experience Violence Related Stress PHS Act, Section 582.....	$ 63,887,000	$ 718,887,000	$ 63,887,000	$ 81,887,000

Substance Abuse and Mental Health Services Administration

Authorizing Legislation

Activity	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
22. Community Mental Health Services Block Grants PHS Act, Section 1911.....	$ 532,571,000	$ 757,571,000	$ 532,571,000	$ 1,582,571,000
23. Substance Abuse Prevention and Treatment Block Grants PHS Act, Section 1921.....	$ 1,858,079,000	$ 1,858,079,000	$ 1,858,079,000	$ 3,508,079,000
24. Assisted Outpatient Treatment Grant Program for Individuals With SMI Section 224 of the Protecting Access to Medicare Act of 2014.....	$ 18,000,000	$ 21,000,000	$ 18,000,000	$ 21,420,000
25. Protection and Advocacy for Individuals with Mental Illness* Section 117 of the Protection and Advocacy of Mentally Ill Individuals Act of 1986.....	$ -	$ 36,146,000	$ -	$ 36,869,000
26. Heath Surveillance PHS Act, Section 501, 505.....	Permanent	$ 126,258,000	Permanent	$ 130,913,000
27. Public Awareness and Support PHS Act, Section 501, 509, 516, 520A.....	Indefinite	$ 13,000,000	Indefinite	$ 13,260,000
28. Performance and Quality Improvement Systems PHS Act, Section 501, 509, 516, 520A.....	Indefinite	$ 10,000,000	Indefinite	$ 10,200,000
* Sunset date: 2003				

Appropriation History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
FY 2010					
General Fund Appropriation:					
Base P.L. 111-117	$3,393,882,000	$3,429,782,000	$3,419,438,000	$3,431,116,000	/1
Subtotal	$3,393,882,000	$3,429,782,000	$3,419,438,000	$3,431,116,000	
FY 2011					
General Fund Appropriation:					
Base P.L. 112-10	$3,541,362,000	$3,565,360,000	$3,576,184,000	$3,386,311,000	
Subtotal	$3,541,362,000	$3,565,360,000	$3,576,184,000	$3,386,311,000	
FY 2012					
General Fund Appropriation:					
Base P.L. 112-74	$3,386,903,000	$3,096,914,000	$3,354,637,000	$3,347,020,000	/2
Subtotal	$3,386,903,000	$3,096,914,000	$3,354,637,000	$3,347,020,000	
FY 2013					
General Fund Appropriation:					
Base S.R. 112-176	$3,151,508,000	---	$3,472,213,000	$3,172,154,778	/3
Subtotal	$3,151,508,000	---	$3,472,213,000	$3,172,154,778	
FY 2014					
General Fund Appropriation:					
Base S.R. 113-071	$3,347,951,097	---	$3,529,944,000	$3,434,935,000	/4
Subtotal	$3,347,951,097	---	$3,529,944,000	$3,434,935,000	
FY 2015					
General Fund Appropriation:					
Base P.L. 113-235	$3,297,669,000	---	$3,431,878,000	$3,474,045,000	/5
Subtotal	$3,297,669,000	---	$3,431,878,000	$3,474,045,000	
FY 2016					
General Fund Appropriation:					
Base P.L. 114-113	$3,395,663,000	$3,642,710,000	$3,314,817,000	$3,634,269,000	/6
Subtotal	$3,395,663,000	$3,642,710,000	$3,314,817,000	$3,634,269,000	
FY 2017					
General Fund Appropriation:					
21st Century Cures Act				$500,000,000	/7
Base P.L. 115-31	$3,488,783,000	$4,211,603,000	$3,739,577,000	$3,611,003,000	/8
Subtotal	$3,488,783,000	$4,211,603,000	$3,739,577,000	$4,111,003,000	

Appropriation History Table (cont'd)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
FY 2018					
General Fund Appropriation:					
21st Century Cures Act.....				$500,000,000	/7
Base P.L. 115-141.....	$3,770,668,000	$4,193,936,000	$4,279,092,000	$4,513,327,000	/9
Subtotal.....	$3,770,668,000	$4,193,936,000	$4,279,092,000	$5,013,327,000	
FY 2019					
General Fund Appropriation:					
Base P.L. 115-245.....	$3,425,887,000	$5,319,561,000	$5,592,827,000	$5,596,829,000	/10
Subtotal.....	$3,425,887,000	$5,319,561,000	$5,592,827,000	$5,596,829,000	
FY 2020					
General Fund Appropriation:					
Base.....	$5,534,908,000	$5,870,996,000	$5,856,496,000	$5,736,829,000	/11
Subtotal.....	$5,534,908,000	$5,870,996,000	$5,856,496,000	$5,736,829,000	
FY 2021					
General Fund Appropriation:					
Base.....	$5,597,651,000	$5,830,829,000	$5,853,840,000	$5,869,841,000	/12
Subtotal.....	$5,597,651,000	$5,830,829,000	$5,853,840,000	$5,869,841,000	
FY 2022					
General Fund Appropriation:					
Base.....	$9,586,844,000	---	---	---	/13
Subtotal.....	$9,586,844,000	---	---	---	

1/ Reflects a $508 thousand transfer to HHS.

2/ Reflects a 0.189 percent across-the-board Rescission from the P.L. 112-74, and $953,809 Ryan White transfer.

3/ Reflects the annualized level provided by the continuing resolution.

4/ Reflects the whole year appropriation.

5/ Reflects the whole year appropriation.

6/ Reflects the whole year appropriation.

7/ Reflects the additional amount provided to the Secretary of Health and Human Services to carry out the authorizations in the 21st Century Cures Act (Public Law 114–67), at a rate for operations of $500,000,000.

8/ Reflects the whole year appropriation.

9/ Reflects the Annualized Continuing Resolution.

10/ Reflects the whole year approation.

11/ Reflects the whole year approation.

12/ Reflects the whole year approation.

13/ Reflects the whole year approation.

Substance Abuse and Mental Health Services Administration
Appropriations Not Authorized by Law
(Whole dollars)

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2021
Protection and Advocacy for Individuals with Mental Illness Act P.L. 99-319, Sec. 117.....	2003	$ 19,500,000	$ 36,146,000	$ 36,146,000
TOTAL, SAMHSA Budget Authority.....		$ 19,500,000	$ 36,146,000	$ 36,146,000

Mental Health

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Mental Health Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Programs of Regional and National Significance	$529,661	$558,923	$753,176	$194,253
Prevention and Public Health Fund (non-add)	11,542	12,000	12,000	-
Children's Mental Health Services	125,000	125,000	125,000	-
Projects for Assistance in Transition From Homelessness	64,635	64,635	64,635	+0
Protection and Advocacy For Individuals with Mental Illness	36,146	36,146	36,146	+0
Certified Community Behavioral Health Clinics	200,000	250,000	375,000	+125,000
Community Mental Health Services Block Grant	722,571	757,571	1,582,571	+825,000
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*21,039*	-
Total, Mental Health	**1,678,013**	**1,792,275**	**2,936,528**	**+1,144,253**

The Mental Health FY 2022 Budget Request is $2.9 billion, an increase of $1.1 billion from the FY 2021 Enacted.

Mental Health Appropriation
Programs of Regional and National Significance (PRNS)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Capacity				
National Child Traumatic Stress Network	$68,887	$71,887	$81,887	$10,000
Project AWARE	102,001	107,001	155,502	48,501
Project AWARE: State Grants(non-add)	*92,001*	*94,501*	*136,752*	*42,251*
Project AWARE: Civil Unrest(non-add)	*10,000*	*12,500*	*18,750*	*6,250*
Mental Health Awareness Training	22,963	23,963	35,945	11,982
Healthy Transitions	28,951	29,451	29,451	--
Children and Family Programs	7,229	7,229	7,229	--
Consumer and Family Network Grants	4,954	4,954	4,954	--
Project LAUNCH	23,605	23,605	23,605	--
MH System Transformation and Health Reform	3,779	3,779	3,779	--
Primary and Behavioral Health Care Integration	49,877	52,877	52,877	--
Suicide Prevention Programs	90,034	102,046	179,667	77,621
National Strategy for Suicide Prevention	*18,200*	*23,200*	*23,200*	--
Zero Suicide (non-add)	*14,000*	*18,800*	*18,800*	--
Zero Suicide AI/AN(non-add)	*2,200*	*2,400*	*2,400*	--
All Other NSSP (non-add)	*2,000*	*2,000*	*2,000*	--
GLS - Youth Suicide Prevention - States	35,427	36,427	36,427	--
Budget Authority (non-add)	*23,885*	*24,427*	*24,427*	--
Prevention and Public Health Fund (non-add)	*11,542*	*12,000*	*12,000*	--
GLS - Youth Suicide Prevention - Campus	*6,488*	*6,488*	*6,488*	--
GLS - Suicide Prevention Resource Center	*7,988*	*9,000*	*9,000*	--
Suicide Lifeline	*19,000*	*24,000*	*101,621*	*77,621*
AI/AN Suicide Prevention Initiative	*2,931*	*2,931*	*2,931*	--
Homelessness Prevention Programs	30,696	30,696	30,696	--
Minority AIDS	9,224	9,224	9,224	--
Criminal and Juvenile Justice Programs	6,269	6,269	51,394	45,125
Seclusion & Restraint	1,147	1,147	1,147	--
Assisted Outpatient Treatment for Individuals with SMI	19,000	21,000	21,420	420
Assertive Community Treatment for Individuals with SMI	7,000	9,000	9,000	--
Comprehensive Opioid Recovery Centers	2,000	--	--	--
Tribal Behavioral Health Grants	20,000	20,750	20,750	--
Infant and Early Childhood Mental Health	7,000	8,000	8,000	--
Subtotal, Capacity	**504,616**	**532,878**	**726,527**	**193,649**
Science and Service:				-
Primary and Behavioral Health Care Integration TTA	1,991	1,991	1,991	-
Practice Improvement and Training	7,828	7,828	7,828	--
Consumer and Consumer Support TA Centers	1,918	1,918	1,918	--
Disaster Response	1,953	1,953	1,953	--
Homelessness	2,296	2,296	2,296	--
MH Minority Fellowship Program	9,059	10,059	10,663	604
Subtotal, Science and Service	**25,045**	**26,045**	**26,649**	**604**
Total, PRNS	**529,661**	**558,923**	**753,176**	**194,253**

National Child Traumatic Stress Network

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022 +/- FY 2021
National Child Traumatic Stress Network.....	$68,887	$71,887	$81,887	$10,000

Authorizing Legislation .....……Section 582 of the Public Health Service Act
FY 2022 Authorization $63,887,000
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities .....States, Local Governments, Tribes, Institutions of Higher Education, and Community Organizations

Program Description and Accomplishments

Child traumatic stress is a pervasive and potentially life changing experience that affects tens of thousands of children each year and is a serious public health challenge. Child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations that overwhelm their ability to cope with what they have experienced. Child traumatic stress can interfere with a wide range of childhood developmental capabilities, including social and educational functioning. There is strong evidence that the negative impact of child trauma may lead to early childhood mental health, chronic medical, and social development problems - if not recognized and addressed early in life.[1] Epidemiological study results estimates as many as 80 percent of children and adolescents are exposed to traumatic events by the age of 23, with many exposed to multiple traumatic events.[2] While the effects of trauma and exposure to violence are found in all child and adolescent populations and service sectors, it is particularly prominent among youth with mental illness and/or drug/alcohol addiction involved in the child welfare, and juvenile justice systems. Studies show that youth in foster care can have rates of Post-Traumatic Stress Disorder that are nearly double those of combat veterans.[3]

Established in 2000, the National Child Traumatic Stress Initiative (NCTSI) aims to improve behavioral health services and interventions for children and adolescents exposed to traumatic events. SAMHSA has provided funding for a national network of grantees known as the National Child Traumatic Stress Network (NCTSN) to develop and promote effective community practices for children and adolescents exposed to a wide array of traumatic events. The NCTSN has grown from a collaborative network of 17 centers to 116 funded and over 150 affiliate centers located nationwide in universities, hospitals, and a range of diverse community-based organizations with thousands of national and local partners. The NCTSN's mission is to raise the standard of care and improve access to evidence-based services for children experiencing trauma, their families, and communities. A component of this work has been the development of resources and delivery of training and consultation to support the development of trauma-

[1] Kerker, B.D., Zhang, J., Nadeem, E., Stein, R.E., Hurlburt, M.S., Heneghan, A., Landsverk, J., McCue Horwitz S (2015). Adverse childhood experiences and mental health, chronic medical conditions, and development in young children. Academy of Pediatrics, 13(15), 00173-00174.
[2] Fairbank, J.A. (2008). The epidemiology of trauma, and trauma related disorders in children and youth. PTSD Research Quarterly, (10), 1050-1835.
[3] Pecora, P.J. Kessiler, R.C., Williams, J. O'Brien, K., Downs, A.C., English E., Holmes, K. (2005). Improving family foster care: Findings from the northwest foster care alumni study. Casey Family Programs, Retrieved from https;/www.casey.org/resources/publications/ImprovingFamilyCare.htm.

informed child-serving systems. Network members work together within and across diverse settings, including a wide variety of governmental and non-governmental organizations.

The NCTSN continues to be a principal source of child trauma information and training for the nation. In FY 2020, NCTSN grantee sites provided trauma-informed training to over 570,000 individuals. Since its inception, the NCTSN has provided training on best practices and other aspects of child trauma to over 2 million participants throughout the country. The NCTSI Learning Center now has over 250,000 users accessing evidence-based child trauma resource.

Data collected in FY 2020 demonstrate that the current NCTSN grantees provided screening to over 45,569 individuals and evidence-based treatment to over 50,000 children, adolescents, and family members. Over eighty percent reported positive functioning at six months. In addition, thousands more youth and families have benefited indirectly from the training and consultation provided by NCTSN grantees to organizations that deliver evidence-based trauma interventions to various communities throughout the country.

In FY 2019, SAMHSA supported 100 grant continuations and provided supplemental awards for mental health services for unaccompanied migrant children, with a special focus on children who were separated from a parent or family unit and subsequently classified as unaccompanied migrant children; mental health services for children in Puerto Rico; and expanded access to tribal populations. In FY 2020, SAMHSA funded 100 grant continuations, awarded a new cohort of 16 grants, and provided supplemental funding for mental health services for unaccompanied migrant children, and the NCTSI Coordinating Center for increased coordination of training in evidence-based and trauma informed treatments and practices and dissemination of evidence-based and trauma-informed interventions and treatments. In FY 2021, SAMHSA will support 34 grant continuations and award a new cohort of 97 grants.

Funding History

Fiscal Year	Amount
FY 2018	$53,887,000
FY 2019	$63,887,000
FY 2020	$68,887,000
FY 2021 Enacted	$71,887,000
FY 2022 Budget Request	$81,887,000

Budget Request

The FY 2022 budget request is $81.9 million, an increase of $10.0 million from the FY 2021 Enacted level. SAMHSA requests funding to support 127 grant continuations and 24 new grants for the improvement of mental disorder treatment, services, and interventions for children and adolescents exposed to traumatic events and to provide trauma-informed services for children and adolescents as well as training for the child-serving workforce.

Outputs and Outcomes Table

Program: National Child Traumatic Stress Network

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.2.02a Percentage of children receiving trauma informed services who report positive functioning at 6-month follow-up (Outcome)	FY 2020: 79.2 % Target: 74 % (Target Exceeded)	70 %	70 %	Maintain
3.2.23 Unduplicated count of the number of children and adolescents receiving trauma-informed services (Outcome)	FY 2020: 40,369 Target: 59,023 (Target Not Met)	40,000	45,000	+ 5,000
3.2.24 Number of child-serving professionals trained in providing trauma-informed services (Outcome)	FY 2020: 294,580 Target: 276,791 (Target Exceeded)	294,000	296,000	+ 2,000

Project AWARE

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Project AWARE and MHAT	$124,964	$130,964	$191,447	$60,483
Project AWARE	102,001	107,001	155,502	48,501
Project AWARE State Grants (non-add)	*92,001*	*94,501*	*136,752*	*42,251*
Project AWARE - Civil Unrest (non-add)	*10,000*	*12,500*	*18,750*	*6,250*
Mental Health Awareness Training	22,963	23,963	35,945	11,982

Authorizing Legislation ..... Sections 520A, and 520J of the Public Health Service Act
FY 2022 Authorization ..... Project AWARE: $394,550,000; MHAT: $14,693,000
Allocation Method ..... Competitive Grants/Contracts
Eligible Entities ..... State and Local Education Agencies, Local Governmental Entities, Community Organizations and Provider Organizations, Community Colleges, Networks, National Non-Profit Organizations, States and Tribes

Program Description and Accomplishments

In any given year the percentage of young people with mental, emotional, behavioral (MEB) disorders is estimated to be between 14 and 20 percent. MEB disorders among young people interfere with their ability to accomplish normal developmental tasks such as developing healthy interpersonal relationships, succeeding in school, and transitioning to the workforce (IOM 2007). Project AWARE is designed to identify children and youth in need of mental health services, increase access to mental health treatment, and promote mental health literacy among teachers and school personnel.

Project AWARE is made up of three components: Project AWARE State Education Agency (SEA) grants, Mental Health Awareness Training (MHAT) Grants, and Resilience in Communities after Stress and Trauma (ReCAST) grants.

Project AWARE SEA grants are awarded to State Education Agencies to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services. The program also includes a focus on the specific needs affecting rural communities. These communities struggle with access to mental health services in schools and access to qualified health professionals to provide such services.

In FY 2020, Project AWARE grantees trained more than 53,900 teachers, parents, first responders, school resource officers, and other adults who interact with youth to recognize and respond to the signs of mental health and substance use issues. COVID initially slowed down grantees' ability to provide training. Since many activities now had to be conducted virtually, time was needed to get the digital infrastructure in place to ensure virtual participation. Grantees provided mental health literacy training to 238,505 community members. In FY 2020, Project AWARE grantees in their first year of grant activities trained over 10,500 individuals in the mental health and related professions. Over the course of this program over 282,000 at-risk youth have been identified and referred for mental health services and supports.

The MHAT grants train school personnel, emergency first responders, law enforcement, veterans, armed services members and their families to recognize the signs and symptoms of mental disorders, particularly serious mental illness (SMI) and/or serious emotional disturbances (SED).

In FY 2020, MHAT grantees trained 37,693 individuals in mental health or related professions in mental health literacy programs. Grantees provided mental health literacy training to 73,306 community members. Over 107,500 individuals have been referred to mental health services and supports as a result of the MHAT grant.

ReCAST grants assist high-risk youth and families and promote resilience in communities that have recently faced civil unrest through implementation of evidence-based violence prevention, and community youth engagement programs, as well as linkages to trauma-informed behavioral health services. ReCAST grantees developed culturally responsive approaches to build capacity with community-based partners.

In FY 2020, ReCAST grantees trained, 4,252, members of the mental health workforce in trauma informed approaches. Over 24,700 community stakeholders were trained in trauma-informed approaches, including violence prevention and mental health literacy. ReCAST grantees provided 17,621 at-risk youth and their family members with high-quality trauma-informed mental health services. Nearly 1,600 new partnerships were established among local municipal organizations and community agencies to support high-risk youth and their families.

In FY 2019, SAMHSA awarded 6 new AWARE-SEA and 18 new MHAT grants and supported the continuation of 173 grants, (24 AWARE, 138 MHAT, and 11 ReCAST grants).

In FY 2020, SAMHSA funded 197 continuation grants (30 AWARE, 156 MHAT, and 11 ReCAST grants) and a new cohort of 31 grants (15 AWARE and 16 MHAT grants).

In FY 2021, SAMHSA will support 79 continuation grants (42 AWARE, 34 MHAT, and three ReCAST grants) and a new cohort of 157 grants (seven AWARE, 142 MHAT and eight ReCAST).

Funding History

Fiscal Year	Amount
FY 2018	$90,964,000
FY 2019	$91,964,000
FY 2020	$124,964,000
FY 2021 Enacted	$130,964,000
FY 2022 Budget Request	$191,447,000

Budget Request

The FY 2022 budget request is $191.4 million, an increase of $60.5 million from the FY 2021 Enacted level. Funding for this program will support Project AWARE State Grants, ReCAST, MHAT grants, and technical assistance on the provision of school-based mental health services.

Outputs and Outcomes Table

Program: Project AWARE

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.2.39 Number of individuals who have received training in prevention or mental health promotion (Outcome)	FY 2020: 215,198 Target: 58,229 (Target Exceeded)	215,000	240,000	+25,000
3.2.51 Number of individuals referred to mental health or related interventions (Output)	FY 2020: 32,624 Target: 65,208 (Target Not Met)	32,000	37,000	+5,000

Healthy Transitions

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Healthy Transitions	$28,951	$29,451	$29,451	$0

Authorizing Legislation……Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities ..... States and Tribes

Program Description and Accomplishments

Youth and young adults with Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI), along with those with co-occurring mental illness and drug/alcohol addiction, face a more difficult transition to adulthood than do their peers. Nearly 20 percent of young adults aged 18 to 25 living in U.S. households had a diagnosable mental health condition in the past year. Of these, more than 1.3 million had a serious disorder, such as schizophrenia, bipolar disorder, and major depression, that compromised their ability to function. Compared to their peers, these young people were significantly more likely to experience homelessness,[4] be arrested,[5] drop out of school,[6] and be unemployed.[7] It is important to identify these young people, develop appropriate outreach and engagement processes, and facilitate access to effective clinical and supportive interventions. Outreach and engagement are essential to these youth and young adults, and their families, as many are disconnected from social and other community supports.

The Healthy Transitions program provides grants to states and tribes to improve access to mental disorder treatment and related support services for young people aged 16 to 25 who either have, or are at risk of developing, a serious mental health condition. Grantees use these funds to provide services and supports to address serious mental health conditions, co-occurring disorders, and risks for developing serious mental health conditions among youth 16 – 25 years old. This will be accomplished by increasing awareness, screening and detection, outreach and engagement, referrals to treatment, coordination of care and evidence-informed treatment for this age group. Healthy Transitions will increase awareness about early indications of signs and symptoms for serious mental health concerns; identify action strategies to use when a serious mental health concern is detected; provide training to provider and community groups to improve services and supports specific to this age group; enhance peer and family supports, and develop effective services and interventions for youth, young adults and their families as these young people transition to adult roles and responsibilities. Since 2014, a total of 9,097 youth in 22 states, five territories, and six tribes have been served.

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[4] Embry, L. E., Vander Stoep, A., Evens, C., Ryan, K. D., & Pollock, A. (2009). Risk factors for homelessness in adolescents released from psychiatric residential treatment. Journal of the American Academy of Child and Adolescent Psychiatry, 39(10), 1293-1299.

[5] Davis, M., Banks, S. M., Fisher, W. H., Gershenson, B.,& Grudzinskas, A. J. (2007). Arrests of adolescents clients of a public mental health system during adolescence and young adulthood. Psychiatric Services, 58(11), 1454-1460.

[6] Planty, M., Hussar, W., Snyder, T., Provasnik, S., Kena, G., Dinkes, R., Kemp, J. (2008). The condition of education 2008 (NCES 2008-031).

[7] Newman, L., Wagner, M., Cameto, R., & Knokey, A. M. (2009). *The post-high school outcomes of youth with disability up to 4 years after high school: A report from the national longitudinal transition study-2 (NLTSC)* (NCSER 2009-3017). Menlo Park, CA: SRI International.

FY 2019 data for grantee participants showed a 7.3 percent decrease in psychological distress, a 23.8 percent improvement in functional outcomes, an increase in being in excellent or in very good health, and an increase in rates of employment (full or part-time). In addition, from baseline to 6-month follow-up there was a 14.6 percent decrease in the number of nights young adults reported being homeless.

In FY 2019, SAMHSA awarded 15 new Healthy Transitions grants and 10 continuation grants. In FY 2020, SAMHSA funded 25 continuation grants and awarded a new cohort of two grants. In FY 2021, SAMHSA will support 27 grant continuations.

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Funding History

Fiscal Year	Amount
FY 2018	$25,951,000
FY 2019	$25,951,000
FY 2020	$28,951,000
FY 2021 Enacted	$29,451,000
FY 2022 Budget Request	$29,451,000

Budget Request

The FY 2022 budget request is $29.5 million, level with the FY 2021 Enacted. SAMHSA requests funding to improve access to mental disorder treatment and related support services for young people, aged 16 to 25, who either have, or are at risk of developing a serious mental health condition. SAMHSA's budget request will support 27 continuation grants and fund a new cohort of grants.

Outputs and Outcomes Table

Program: Healthy Transitions

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.2.34 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2020: 58.6 % Target: 66.7 % (Target Not Met)	58.6 %	58.6 %	Maintain
3.2.35 Percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2020: 36 % Target: 35 % (Target Exceeded)	35 %	35 %	Maintain
3.2.36 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2020: 34.6 % Target: 66.7 % (Target Not Met)	34 %	34 %	Maintain

Children and Family Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Children and Family Programs	$7,229	$7,229	$7,229	--

Authorizing Legislation..... Section 520A of the Public Health Service Act
FY 2022 Authorization.....$394,550,000
Allocation Method..... Competitive Grants/Contracts/ Interagency Agreements
Eligible Entities..... Tribes

Program Description and Accomplishments

Without early identification, intervention, treatment, and support, children with serious emotional disturbance (SED) are likely to face challenges at home, in school, and in their psychosocial development. It is a public health priority that these children and their families have access to effective, evidence-based services, and support.

SAMHSA's Children and Family Programs provide funding for the Circles of Care grant program. Initially funded in 1998, the Circles of Care Program is a three-year infrastructure/planning grant that seeks to promote mental disorder treatment equity by providing American Indian/Alaska Native (AI/AN) communities with tools and resources to design and sustain their own culturally competent system of care approach for children. The Circles of Care program reflects the unique history and needs of individual AI/AN communities and promotes the idea of building on cultural strengths. The program increases capacity and community readiness to address the mental health issues of children and their families through the provision of evidence-based treatment services and supports. This grant program is of critical importance as there are significant mental health needs in AI/AN communities. For example, suicide is the second leading cause of death for Indian youth ages 15 to 24.

Through Circles of Care, SAMHSA has improved the availability, accessibility, and acceptability of behavioral health services for native youth. In FY 2019, 1,100 individuals received training in mental health practices and activities that aligned with the goals of the program. In addition, 288 organizations collaborated and coordinated resources with other organizations.

In FY 2019, SAMHSA supported 14 Circles of Care continuation grants. In FY 2020, SAMHSA funded a new cohort of 18 Circles of Care grants and supported one continuation grant. In FY 2021, SAMHSA will support 18 continuation grants continuations and award three new grants.

Funding History

Fiscal Year	Amount
FY 2018	$7,229,000
FY 2019	$7,229,000
FY 2020	$7,229,000
FY 2021 Enacted	$7,229,000
FY 2022 Budget Request	$7,229,000

Budget Request

The FY 2022 budget request is $7.2 million, level with the FY 2021 Enacted level. SAMHSA requests funding to enhance and improve the quality of existing services and promote the use of culturally competent services and support for children and youth with, or at risk for, serious mental health conditions, and their families. This funding will support 21 Circles of Care continuation grants.

The output and outcome measures for Children and Family Programs are part of the Mental Health - Other Capacity Activities Outputs and Outcomes table shown on page 89.

Consumer and Family Network Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Consumer and Family Network Grants.....	$4,954	$4,954	$4,954	--

Authorizing Legislation……Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities .....Community Organizations

Program Description and Accomplishments

Across the healthcare arena, there is growing recognition and evidence that client-centered care positively influences an individual's health outcomes, improves quality and efficacy of care received, and provides feedback to drive service and systems improvements. As with other health disciplines, people with serious mental illness (SMI) and their family members should have meaningful involvement in all aspects of their health care and treatment, including behavioral health care.

The Consumer and Family Network Programs provide consumers, families, and youth with opportunities to participate meaningfully in the development of policies, programs, and quality assurance activities related to mental health systems across the United States. The Consumer and Family Network Programs support two primary grant programs, the Statewide Consumer Network (SCN) Program and the Statewide Family Network (SFN) Program.

The SCN grant program focuses on the needs of adults (18 years and older) with SMI by strengthening the capabilities of statewide consumer-run organizations. These entities serve an important role in engaging consumers of mental health services, caregivers, policy makers, and providers in improving and transforming the mental health and related systems in their states. This network is a sustainable mechanism for integrating the consumer voice in state mental health and allied systems to: (1) expand service system capacity; (2) support policy and program development; and (3) enhance peer support. This program promotes skill development with an emphasis on leadership and business management, as well as on coalition/partnership-building and economic empowerment, as part of the recovery process for consumers.

The SFN grant program provides education and training to increase family organizations' capacity for policy and service development. This is accomplished by: (1) strengthening organizational relationships and business management skills; (2) fostering leadership skills among families of children and adolescents with SED; and (3) identifying and addressing the technical assistance needs of children and adolescents with SED and their families. The SFN program focuses on families, parents, and the primary caregivers of children, youth, and young adults.

In FY 2020, SCN grantees trained 8,672 individuals in the mental health and related workforce.

In FY 2020, SFN grantees trained 19,762 individuals in the mental health and related workforce and 12,344 consumers and family members were involved in ongoing mental health-related planning and advocacy activities.

In FY 2019, SAMHSA supported 14 SCN continuations and 8 new grants, 11 SFN continuations and 18 new grants. In FY 2020, SAMHSA funded 21 SCN and 28 SFN continuation grants. In FY 2021, SAMHSA will support eight SCN and 18 SFN grant continuations and award a new cohort of 12 SCN and10 SFN grants.

Funding History

Fiscal Year	Amount
FY 2018	$4,954,000
FY 2019	$4,954,000
FY 2020	$4,954,000
FY 2021 Enacted	$4,954,000
FY 2022 Budget Request	$4,954,000

Budget Request

The FY 2022 budget request is $5.0 million, level with the FY 2021 Enacted level. SAMHSA requests funding for 19 new SFN, nine new SCN, and 22 continuation grants that promote consumer, family, and youth participation in the development of policies, programs, and quality assurance activities related to mental health systems reform across the United States.

The output and outcome measures for Consumer and Family Network Programs are part of the Mental Health - Other Capacity Activities Outputs and Outcomes table shown on page 89.

Project LAUNCH

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Project LAUNCH	$23,605	$23,605	$23,605	--

Authorizing Legislation……..... Section 520A of the Public Health Act
FY 2022 Authorization.....$394,550,000
Allocation Method.....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... States and Tribes

Program Description and Accomplishments

Researchers estimate that between 9.5 percent and 14.2 percent of children from birth to age five experience an emotional or behavioral disturbance. Studies also show that half of all lifetime cases of mental illness begin before age 14.[8] Young children experiencing mental, emotional, or behavioral challenges are at high risk for preschool expulsion. In fact, the preschool expulsion rate is more than three times the expulsion rate of students in kindergarten through 12th grade. Boys are more than four times as likely to be expelled as girls; and African American preschoolers are almost twice as likely to be expelled as Caucasian preschoolers.[9] School suspensions and expulsions have shown to increase the likeliness of later life negative outcomes. Research has shown that prevention and early treatment of mental disorders is more beneficial and cost-effective than waiting to address these issues later in life. Integrating behavioral health into primary care and childcare settings, increasing screening for developmental and social/emotional issues, and training people who interact with young children to promote optimal development and mental health are all critical elements to ensure children start life with the tools and skills needed to succeed.

Established in 2008, Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is a national initiative that has funded a total of 90 grantees in nine cohorts: this includes grantees in 38 states; 23 tribal entities; 4 US territories; 3 Alaska/native communities; and the District of Columbia. Project LAUNCH Expansion grantees are five alumni states that are engaged in replication of successful Project LAUNCH prevention strategies in new communities within each state. All grantees are funded for a total of four or five years.

The purpose of the Project LAUNCH initiative is to promote the wellness of young children, from birth to eight years of age, by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Project LAUNCH pays particular attention to the social and emotional development of young children and works to ensure that the systems that serve them (including childcare and education, home visiting, and primary care) are equipped to promote and monitor healthy social and emotional development. The program also ensures that the systems intervene to prevent, recognize early signs of, and address mental, emotional, and behavioral disorders in early childhood and into the early elementary grades**.**

[8] Brauner, Cheryl, and Cheryll Stephens. "Estimating the Prevalence of Early Childhood Serious Emotional/Behavioral Disorders: Challenges and Recommendations." Public Health Reports 121.3 (2006): 303-10.
[9] Gilliam, W. (2005). Pre-kindergarteners left behind: Expulsion rates in state prekindergarten systems. Foundation for Child Development.

Program Evaluation

As of 2020, cumulative performance data for the program (2008-2020) indicate that more than 248,450 children and parents have been screened or assessed for behavioral health concerns across a range of diverse settings (e.g., primary care, childcare, and home visiting). Child screenings are a critical step in the early recognition of social emotional concerns and create a pathway to prevention and treatment services. Adult screenings include screening for perinatal depression, substance use, and a range of social needs. More than 105,900 community providers have been trained on milestones of social/emotional development, early detection of behavioral health issues, and best practices for mental health treatment. Over 211,900 children and parents/caregivers have received evidence-based mental health-related services through the grant program, and approximately 11,300 new partnerships have been developed between organizations in order to improve care coordination and access to quality mental health services for young children and families.

A multi-site evaluation of Project LAUNCH was completed in 2018 (https://www.acf.hhs.gov/opre/research/project/cross-site-evaluation-of-project-launch-linking-actions-for-unmet-needs-in). Phase one of the evaluation used a meta-analytical approach to assess the implementation of the program. The findings indicated that grantees successfully improved community- and state-level child and family-serving systems. In addition, grantees demonstrated improved social and academic functioning among young children, and over 75 percent reported decreases in problem behaviors. Phase two of the multi-site evaluation involved a quasi-experimental design, exploring whether children in 10 communities served by Project LAUNCH differed in social and emotional wellbeing from children in 10 socio-demographically matched communities. Results indicated that children living in Project LAUNCH communities received more developmental screening and supports than children living in matched comparison communities. Additionally, children served in LAUNCH communities had less need for early intervention services related to attachment, initiative and other indicators of resilience, particularly for young children ages birth to three. Parents in Project LAUNCH communities reported more involvement with their children and less parenting frustrations.

In FY 2019, SAMHSA supported 14 Project LAUNCH continuation grants and 16 new Project LAUNCH grants. In addition, SAMHSA awarded the National Center of Excellence for Infant and Early Childhood Mental Health Consultation (CoE-IECMHC) to advance the implementation of high quality IECMHC across the nation through the development of tools, resources, training, and mentorship to the infant and early childhood mental health field.

In FY 2020, SAMHSA supported 30 continuation grants and the CoE-IECHMHC. In FY 2021, SAMHSA will support 30 continuation grants and the CoE-IECMHC.

Funding History

Fiscal Year	Amount
FY 2018	$23,605,000
FY 2019	$23,605,000
FY 2020	$23,605,000
FY 2021 Enacted	$23,605,000
FY 2022 Budget Request	$23,605,000

Budget Request

The FY 2022 budget request is $23.6 million, level with the FY 2021 Enacted level. This funding will support 30 continuation grants and the CoE-IECMHC to improve health outcomes for young children and support children at high risk for mental illness and their families in order to prevent future disability. This funding request will provide continued screening, prevention, early intervention for behavioral health issues and referrals to high quality treatment for children and families in 30 communities across the U.S. through the CoE-IECMJH.

Outputs and Outcomes Table

Program: Mental Health-Project LAUNCH

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.3.94 Number of persons served (Output)	FY 2020: 9,370 Target: 12,916 (Target Not Met)	9,300	9,370	+70
2.3.95 Number of persons trained in mental illness prevention or mental health promotion (Outcome)	FY 2020: 5,953 Target: 10,790 (Target Not Met)	5,900	5,900	Maintain
2.4.00 Number of 0-8 year old children screened for mental health or related interventions (Outcome)	FY 2020: 8,788 Target: 11,497 (Target Not Met)	8,700	8,700	Maintain
2.4.01 Number of 0-8 year old children referred to mental health or related interventions (Outcome)	FY 2020: 2,163 Target: 4,141 (Target Not Met)	2,160	2,160	Maintain

Mental Health System Transformation and Health Reform

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Mental Health System Transformation and Health Reform.....	$3,779	$3,779	$3,779	--

Authorizing Legislation……Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities ..... States and Tribes

Program Description and Accomplishments

There is a significant gap between the number of people with SMI, such as schizophrenia, bipolar disorder, and major depression, who want to work (66 percent) and the number of these individuals who are employed (less than 20 percent). The benefits of steady competitive employment for this population are substantial and include increased income, improved adherence with treatment for mental illness, enhanced self-esteem, reduced use of substances, and improved quality of life.[10] The Transforming Lives through Supported Employment Grant program is the remaining component of the Mental Health System Transformation program. This program was implemented to help states foster the adoption and implementation of permanent transformative changes in how public mental health services are organized, managed, and delivered throughout the United States.

The program began in FY 2014 as a focused effort to enhance state and community capacity to provide evidence-based supported employment programs for adults and youth with SMI or SED. These grants help people achieve their goals for competitive employment, building paths to self-sufficiency and recovery. They also support treatment and service providers and employers to prioritize employment as a standard of care by developing and maintaining sustained competitive employment opportunities for people with SMI or SED, primarily using the evidence-based Individual Placement and Support (IPS) model of supported employment. The grant program helps states to identify and implement the structural and financing changes that are essential to make evidence-based supported employment programs sustainable statewide.

FY 2020 program data show that 4,371 members in the mental health and related workforce were trained and 518 programs or organizations implemented mental health practices consistent with program goals. In addition, over 50 percent of individuals served by the program were employed or in school at six-month follow-up; while, 61 percent reported positive functioning and 68 percent had a permanent place to live. Across the five years of the program, the number of individuals employed increased by over 110 percent.

In FY 2019, SAMHSA awarded seven new grants. In FY 2020, SAMHSA supported seven continuation grants. In FY 2021, SAMHSA will fund seven grant continuations.

[10] IPS Supported Employment: The Evidence-based Practice for Employment. (n.d.). Retrieved August 4, 2015

Funding History

Fiscal Year	Amount
FY 2018	$3,779,000
FY 2019	$3,779,000
FY 2020	$3,779,000
FY 2021 Enacted	$3,779,000
FY 2022 Budget Request	$3,799,000

Budget Request

The FY 2022 budget request is $3.8 million, level with the FY 2021 Enacted level. SAMHSA requests funding to support the continuation of seven Transforming Lives through Supported Employment grants that will enhance state and community capacity to provide evidence-based supported employment programs and mutually compatible and supportive evidence-based practices for adults and youth with SMI/SED and co-occurring mental and substance use disorders.

Outputs and Outcomes Table

Program: Mental Health System Transformation Grants and Health Reform

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.2.11 Number of persons in the mental health and related workforce trained in specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2020: 310 Target: 3,574 (Target Not Met)	310	310	Maintain
1.2.21 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2020: 62.7 % Target: 63.6 % (Target Not Met)	62.7 %	62.7 %	Maintain
1.2.22 Percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2020: 54.1 % Target: 63 % (Target Not Met)	54 %	54 %	Maintain
1.2.23 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2020: 31.6 % Target: 52.8 % (Target Not Met)	31.6 %	31.6 %	Maintain

Primary and Behavioral Health Care Integration

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Primary and Behavioral Health Care Integration	$51,868	$54,868	$54,868	$0
Primary and Behavioral Health Care Integration	*49,877*	*52,877*	*52,877*	-
Primary and Behavioral Health Care Integration TTA	*1,991*	*1,991*	*1,991*	-

Authorizing Legislation……Section 520K of the Public Health Service Act
FY 2022 Authorization $51,878,000
Allocation Method ..... Competitive Grants/Cooperative Agreements
Eligible Entities ..... Qualified Community Mental Health Programs, States or State Agency

Program Description and Accomplishments

Adults with SMI, such as schizophrenia, bipolar disorder, and major depression, experience high rates of morbidity and mortality. These rates are due, in large part, to elevated incidence and prevalence of cardiovascular disease, obesity, diabetes, hypertension, and dyslipidemia in people with SMI.[11] Physical health problems among people with SMI affect an individual's quality of life and contribute to premature death. Empirical findings indicate the clear link between early mortality among people with SMI and the lack of access to primary care services.[12]

The Primary and Behavioral Health Care Integration (PBHCI) Portfolio began in FY 2009 to address this intersection between primary care and treatment for mental illness and co-occurring disorders. This program awards grants to community mental health centers and states. This program also supports the coordination and integration of primary care services and publicly funded community behavioral health services for individuals with SMI or co-occurring mental illness and drug/alcohol addiction served by the public mental health system. The PBHCI program seeks to improve health outcomes for people with SMI and co-occurring mental illness and drug/alcohol addiction by encouraging grantees to engage in necessary collaboration, expand infrastructure, and increase the availability of primary healthcare and wellness services for individuals with SMI or co-occurring mental illness and drug/alcohol addiction. In FY 2017, PBHCI changed its name to Promoting the Integration of Primary and Behavioral Health Care (PIPBHC). In FY 2019, SAMHSA funded a new technical assistance grant, the National Center of Excellence for Integrated Health Solutions (CIHS), for up to $1,889,486 a year for up to five years. The purpose of this program is to advance the implementation of high quality, evidence-based treatment for individuals with co-occurring physical and mental health conditions, including substance use disorders. The goal of this grant is to ensure that these services are provided in the most effective manner possible. Technical assistance and training will be available to communities, individual practitioners, providers, and states on evidence-based and effective strategies to address the integration of primary and mental health care for individuals with mental disorders or co-occurring mental and substance use disorders. In 2020, CIHS provided training to 23,880 individuals in the mental health and related workforce. Of those, 88 percent of these individuals were able to demonstrate improvement in knowledge, attitudes, and beliefs related to prevention and mental health promotion.

[11] Forman-Hoffman, Muhuri, Novak, Pemberton, Ault, and Mannix (August 2014) CBHSQ Data Review: Psychological Distress and Mortality among Adults in the U.S. Household Population.
[12] E. Chesney et al., Risks of all-cause and suicide mortality in mental disorders: a meta-review, World Psychiatry; 2014: 13:1153-160.

Program Evaluation

From 2015-2020, SAMHSA, in collaboration with Mathematica, conducted a cross-site grantee evaluation of PBHCI cohorts 1 - 8. Health outcome data indicated substantial improvements in physical health among clients. Diabetes and hypertension were comparable to national benchmarks. Clients also showed improvement in functioning and psychological distress. At 18 months of program participation, approximately 75 percent of clients had stable housing, 80 percent reported feeling socially connected and approximately 55 percent reported feeling healthy overall. Emergency room visits for psychiatric or emotional conditions and feelings of severe psychological distress were reduced. There was some improvement in substance misuse, however, rates of tobacco use remained high.

The evaluation found that nearly 90 percent of grantees in cohorts 6-8 implemented screenings for physical health conditions and at least 80 percent provided preventative services and referrals for psychosocial services. Peer support staff played an important role in helping to integrate supportive care functions within agency settings. Wellness, physical and/or primary care, and mental health/substance use disorder services were provided by peer staff to clients. Wellness services included tobacco cessation, nutrition and/or exercise, and chronic disease self-management programming.

In FY 2019, SAMHSA continued support for 15 PBHCI and 13 PIPBHC grants, awarded 6 new PIPBHC grants, and one new CIHS grant. In FY 2020, SAMHSA funded one PBHCI and 19 PIPBHC continuation grants, one CHIS continuation, and four new PIPBHC grants. In FY 2021, SAMHSA will fund one PBHCI and 23 PIPBHC grant continuations, one CHIS grant continuation, and a new cohort of one new PIPBHC.

Funding History

Fiscal Year	Amount
FY 2018	$51,868,000
FY 2019	$51,868,000
FY 2020	$51,868,000
FY 2021 Enacted	$54,868,000
FY 2022 Budget Request	$54,868,000

Budget Request

The FY 2022 budget request is $54.9 million, level with the FY 2021 Enacted level. SAMHSA requests funding to support the continuation of 24 PIPBHC grants and one CIHS grant. The funding will also fund a new cohort of two PIPBHC grants.

Outputs and Outcomes Table

Program: Primary & Behavioral Health Care Integration (PBHCI)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.2.41 Increase the percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2020: 59.1 % Target: 57.4 % (Target Exceeded)	57.4 %	57.4 %	Maintain
3.2.42 Increase the percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2020: 28 % Target: 27.7 % (Target Exceeded)	27.7 %	27.7 %	Maintain
3.2.43 Increase the percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2020: 68.4 % Target: 71 % (Target Not Met but Improved)	71 %	71 %	Maintain

Suicide Prevention Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Suicide Prevention	$90,034	$102,046	$179,667	$77,621
Suicide Lifeline (non-add)	*19,000*	*24,000*	*101,621*	*77,621*
GLS - Youth Suicide Prevention - States (non-add)	*35,427*	*36,427*	*36,427*	-
Budget Authority (non-add)	*23,885*	*24,427*	*24,427*	-
Prevention & Public Health Fund (non-add)	*11,542*	*12,000*	*12,000*	-
GLS - Youth Suicide Prevention - Campus (non-add)	*6,488*	*6,488*	*6,488*	-
GLS - Suicide Prevention Resource Center (non-add)	*7,988*	*9,000*	*9,000*	-
AI/AN Suicide Prevention Initiative (non-add)	*2,931*	*2,931*	*2,931*	-
National Strategy for Suicide Prevention (non-add)	*18,200*	*23,200*	*23,200*	-
Zero Suicide (non-add)	*14,000*	*18,800*	*18,800*	-
Zero Suicide -AI/AN (non-add)	*2,200*	*2,400*	*2,400*	-
All Other National Strategy for Suicide Prevention (non-add)	*2,000*	*2,000*	*2,000*	-

Program Description and Accomplishments

SAMHSA supports the goals and objectives of the National Strategy for Suicide Prevention (NSSP) through the Suicide Prevention Programs highlighted below. Research has shown that implementing comprehensive public health approaches that make suicide prevention a priority within health and community systems can reduce the rates of death by suicide as well as suicide attempts. The NSSP supports this type of comprehensive approach and is an important step toward reducing suicide.

Approximately 47,511 Americans died by suicide in 2019. From 1999 through 2019, the age adjusted suicide rate increased by over 30 percent from 10.5 to 13.9 per 100,000. In 2008, suicide became the 10th leading cause of death in the United States and has remained so through 2019. Suicide is the second leading cause of death between age 10-34 and the fourth leading cause of death for ages 35-54. Among Native Americans, suicide is the 8th leading cause of death. Suicide is the first leading cause of death among Native Americans age 10-14-year-olds and the second leading cause of death among 35-44-year-olds. The 2019 National Survey on Drug Use and Health reported that approximately 1.4 million Americans age 18 and over attempted suicide over the previous 12 months, 12 million seriously considered suicide, and 3.5 million made a plan. While youth have the highest rate of suicide attempts, middle-aged adults have the highest number of deaths by suicide nationwide, and middle aged and older adults have the highest rates of death by suicide. The nation's suicide prevention efforts must address the issues of suicidal thoughts, plans, attempts, and deaths among both adults and youth to reduce suicide in America.

National Strategy for Suicide Prevention

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
National Strategy for Suicide Prevention	$18,200	$23,200	$23,200	$0
Zero Suicide (non-add)	*14,000*	*18,800*	*18,800*	-
Zero Suicide -AI/AN (non-add)	*2,200*	*2,400*	*2,400*	-
All Other National Strategy for Suicide Prevention (non-add)	*2,000*	*2,000*	*2,000*	-

Authorizing Legislation ..... Section 520L of the Public Health Service Act
FY 2022 Authorization $30,000,000
Allocation Method .....Competitive Grants
Eligible Entities ..... Community –based primary care or behavioral health entity, Federally Recognized, American Indian/Alaska Native tribe or tribal organizations, State mental health or public health agency

Program Description and Accomplishments

Suicide has been increasing in the United States, particularly in adults and older adults. Suicide rates rose by over 30 percent during 1999-2019. With the rising rates of suicide among adults, particularly middle-aged and older adults, focusing on preventing suicide among adults is urgently required in order to reduce suicides nationally. The baby boomer generation has had high rates of suicide throughout the generational lifecycle and is entering the stage of life that has historically had the highest rate of suicide. There is a high risk that without significant targeted intervention toward adults, including older adults, the number of suicides in the United States could continue to increase.

The 2012 National Strategy for Suicide Prevention (NSSP) seeks to reduce the overall suicide rate and number of suicides in the U.S. nationally. The NSSP grant program supports the efforts of states, tribes, primary and behavioral healthcare organizations, public health agencies, and emergency departments to implement the NSSP. While the NSSP addresses all age groups and populations with specific needs, the goals and objectives of the NSSP grants focus on preventing suicide and suicide attempts among adults over the age of 25 who comprised more than 41,000 of the more than 48,000 suicides in the United States in 2018.

In FY 2017, Congress appropriated $9.0 million to implement the Zero Suicide program in health care systems, including a $2.0 million tribal set-aside. The Zero Suicide model is a comprehensive, multi-setting approach to suicide prevention in health systems. The purpose of this program is to implement suicide prevention and intervention programs for individuals who are 25 years of age or older by systematically applying evidence-based approaches to screening and risk assessment, developing care protocols, collaborating for safety planning, providing evidence-based treatments, maintaining continuity of care during high risk periods, and improving care and outcomes for such individuals who are at risk for suicide being seen in health care systems.

In FY 2019, SAMHSA supported the continuation of five NSSP grants and 15 Zero Suicide continuation grants. In FY 2020, SAMHSA awarded 15 Zero Suicide continuation grants, a new cohort of five NSSP grants, and a new cohort of 15 Zero Suicide grants. In FY 2021, SAMHSA will support the continuation of five NSSP grants, 30 Zero Suicide continuation grants, and a new cohort of 10 Zero Suicide grants.

Funding History

Fiscal Year	Amount
FY 2018	$11,000,000
FY 2019	$11,200,000
FY 2020	$18,200,000
FY 2021 Enacted	$23,200,000
FY 2022 Budget Request	$23,200,000

Budget Request

The FY 2022 budget request is $23.2 million, level with the FY 2021 Enacted level. This funding will support 40 Zero Suicide continuation grants and five NSSP continuation grants. The grants support states in implementing the NSSP goal to prevent suicide. States use NSSP funding to support efforts such as raising suicide awareness, establishing emergency room referral processes, and improving clinical care practice standards.

Garrett Lee Smith Youth Suicide Prevention – State/Tribal and Campus

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
GLS - Youth Suicide Prevention - States	$23,885	$24,427	$24,427	$0
Prevention & Public Health Fund (non-add)	*11,542*	*12,000*	*12,000*	-
GLS - Youth Suicide Prevention - Campus	6,488	6,488	6,488	-

Authorizing Legislation ..... Sections 520E and 520E-2 of the Public Health Service Act
FY 2022 Authorization $30,000,000; $7,000,000
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities ..... States and Tribes

Program Description and Accomplishments

In the fall of 2003, Garrett Lee Smith, son of Sen. Gordon and Sharon Smith, died by suicide in his apartment in Utah where he attended college. He was one day shy of 22 years old. Like most suicides, Garrett's came unexpectedly. As many families have tragically experienced, depression is not rare or peculiar, but can be deadly. It affects one in six Americans at some point. Hardly a family goes untouched.[13]

The Garrett Lee Smith (GLS) Memorial Act authorizes SAMHSA to manage two significant youth suicide prevention programs and one resource center. The GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program has awarded 230 grants to 50 states and the District of Columbia, 63 unique tribes/tribal organizations, and two territories. These grants develop and implement youth suicide prevention and early intervention strategies involving public-private collaboration among youth-serving institutions. As of FY 2020, the GLS Campus Suicide Prevention program has awarded 309 grants to 269 institutions of higher education, including tribal colleges and universities, to prevent suicide and suicide attempts.

Performance Evaluation

SAMHSA's evaluation of national youth suicide prevention efforts (age 10 to 24) have shown that counties implementing SAMHSA funded GLS youth suicide prevention activities have lower rates of youth suicide deaths than similar counties not implementing such activities. This impact is maintained for two years and the impact appears directly related to years of continued funding. Approximately 50 percent of the counties in America have received at least one year of funding since the program started in 2005.

Previous evaluation results have shown that counties who implemented GLS-supported activities had lower rates of suicide attempts among youth than matched counties that did not in the year following suicide prevention activities.

Since 2005, over 1.6 million individuals participated in over 66,000 training events or educational seminars provided by grantees. In FY 2020, 158,764 youth were screened for suicide risk, 27,231 youth

[13] http://www.jaredstory.com/garrett_smith.html

were referred to services, and 64.7 percent received services. Grantees' efforts are reducing the likelihood of at-risk youth falling through the gaps in the system.

In FY 2019, SAMHSA supported the continuation of 19 GLS State/Tribal grants, 41 GLS Campus grants, and awarded 31 new GLS State/Tribal grants and 22 new GLS Campus grants. In FY 2020, SAMHSA funded 38 GLS State/Tribal continuation grants [32 with direct budget authority and six with Prevention and Public Health Funds (PPHF)], 46 GLS Campus continuation grants, awarded a new cohort of 10 GLS State and Tribal grants with PPHF, and 16 GLS Campus grants. In FY 2021, SAMHSA will support 43 GLS State/Tribal continuation grants, 37 GLS Campus continuation grants, and award a new cohort of six GLS State and Tribal grants and 25 GLS Campus grants.

Funding History

Fiscal Year	Amount
FY 2018	$41,915,000
FY 2019	$41,915,000
FY 2020	$41,915,000
FY 2021 Enacted	$42,915,000
FY 2022 Budget Request	$42,915,000

Budget Request

The FY 2022 budget request is $42.9 million, level with the FY 2021 Enacted level. SAMHSA requests funding for the continuation of 47 GLS State/Tribal grants and 41 GLS Campus grants, and a new cohort of two GLS State and Tribal grants, and 16 new GLS Campus grants to continue developing and implementing youth suicide prevention and early intervention strategies involving public-private collaboration among youth serving institutions.

Garrett Lee Smith Suicide Prevention Resource Center

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
GLS - Suicide Prevention Resource Center	$7,988	$9,000	$9,000	$0

Authorizing Legislation……... Section 520C of the Public Health Service Act
FY 2022 Authorization $5,988,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities ..... Domestic Public and Private Nonprofit Entities, Tribal and Urban Indian Organizations, Community and Faith-Based Organizations

Program Description and Accomplishments

In addition to the above programs that build suicide prevention capacity, SAMHSA also supports the Suicide Prevention Resource Center (SPRC). The purpose of this program is to build national capacity for preventing suicide by providing technical assistance, training, and resources to assist states, tribes, organizations, and SAMHSA grantees to develop suicide prevention strategies (including programs, interventions, and policies that advance the National Strategy for Suicide Prevention (NSSP)), with the overall goal of reducing suicides and suicidal behaviors in the nation. This work includes support of the public-private National Action Alliance for Suicide Prevention and working to advance high-impact objectives of the NSSP.

SAMHSA's SPRC has played an important role in transforming suicide prevention and treatment across the lifespan, particularly for those at high risk for suicide. Efforts to advance suicide prevention include:

- Developing and promoting the adoption of evidence-based resources, tools, and online trainings to support strategic, comprehensive, best practice suicide prevention programs around the country;

- Building the capacity of suicide prevention programs nationwide by providing consultation, training, and resources to states, AI/AN communities, colleges and universities, health systems, and organizations serving groups at higher risk for suicide;

- Improving care for those at risk for suicide, including promoting the Zero Suicide model for safer suicide care in health and behavioral health care systems; and

- Providing leadership and operational support, which brings together more than 250 national partners from the public and private sectors to advance implementation of the goals and objectives of the National Strategy.

Performance Evaluation

SAMHSA's SPRC provides free online courses to prepare the clinical workforce to address suicide risk in effective ways. In FY 2020, a total of 22,877 individuals received training in the following areas:

- Counseling on Access to Lethal Means
- Locating and Understanding Date
- Preventing Suicide in Emergency Department Patients
- Strategic Planning for Suicide Prevention

In FY 2020, the SPRC continued its work in advancing the Zero Suicide Framework. Efforts include:

Care Transitions virtual learning lab (interactive online resource that provides more guidance on discharge planning, based on CT report from AASP)

Treatment videos released: "Treating Suicidal Patients during COVID-19", a video series with expert advice on treating patients at risk of suicide during the COVID-19 pandemic. Adapted from an SPRC webinar, the series includes three brief videos on initiating and maintaining remote contact with clients, assessing suicide risk, and developing a safety plan remotely.

Delivered webinar hosted by SMI Advisor, titled "Zero Suicide: Taking a Systems Approach to Suicide Prevention in Health Care" focusing on evidence-based interventions for suicide screening and intervention in SMI populations.

SAMHSA's SPRC worked with state agencies, communities, and organizations in all 50 states, the District of Columbia, several U.S. territories, and over 140 SAMHSA grantees to build leadership, capacity, and coordination for strategic, evidence-based suicide prevention across the country.

In addition, SAMHSA's SPRC collaborates closely with a number of national and regional TA centers that focus on issues related to suicide prevention, such as mental health, injury prevention, substance use prevention and treatment, violence prevention, and others. SPRC's collaboration included contacts with the coordinating offices of SAMHSA's Mental Health Technology Transfer Centers (TTCs), Prevention TTCs, and Addiction TTCs; Service Member, Veterans, and their Families TA Center; Center for Integrated Health Solutions; and HRSA's National Center for Fatality Review and Prevention.

In FY 2020, approximately 24,308 individuals were exposed to mental health awareness messaging through SPRC, which includes downloading the following resources from SPRC's website:

- After a Suicide: A toolkit for Schools (second edition)
- Suicide Prevention Resources for Teens
- The Role of High School Teachers in Preventing Suicide
- The Role of High School Mental Health Providers in Preventing Suicide
- Zero Suicide Documents, such as Zero Suicide Data Elements Worksheet; Zero Suicide Work plan Template; What is Zero Suicide?; Quick Guide to Getting Started
- Lived Experience: What it is and How to Include It
- Aftercare That Makes a Difference
- The Patient Safety Screener: A Brief Tool to Detect Suicide Risk in Acute Care Settings

FY 2019, SAMHSA supported one continuation grant. In FY 2020, SAMHSA funded one new grant to promote the implementation of the NSSP and enhance the nation's mental health infrastructure. In addition, funding supported the development and dissemination of resources for families and friends of

individuals at risk of suicide, as well as the development of specialized training for LGBTQ youth. In FY 2021, SAMHSA will support one grant continuation.

Funding History

Fiscal Year	Amount
FY 2018	$5,988,000
FY 2019	$5,988,000
FY 2020	$7,988,000
FY 2021 Enacted	$9,000,000
FY 2022 Budget Request	$9,000,000

Budget Request

The FY 2022 budget request is $9.0 million, level with the FY 2021 Enacted. This funding will support one continuation grant. The Suicide Prevention Resource Center will provide states, tribes, government agencies, private organizations, colleges and universities, and suicide survivors and mental health consumer groups with access to information and resources that support program development, intervention implementation, and adoption of policies that prevent suicide.

National Suicide Prevention - Lifeline

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Suicide Lifeline	$19,000	$24,000	$101,621	$77,621

Authorizing Legislation ..... Section 520E-3 of the Public Health Service Act
FY 2022 Authorization $7,198,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities ..... States, Tribes, Community Organizations

Program Description and Accomplishments

To prevent death and injury as the result of suicide attempts, individuals need rapid access to suicide prevention and crisis intervention services. Launched in 2005, the National Suicide Prevention Lifeline (Lifeline), 1-800-273-TALK, coordinates a network of more than 175 crisis centers across the United States by providing suicide prevention and crisis intervention services for individuals seeking help at any time, day or night. In July of 2020, the Federal Communications Commission (FCC) designated the number 988 as the nation's new, three-digit, national suicide prevention and mental health crisis number. By July 16, 2022, 988 must become operational across the country and must automatically funnel calls to the National Suicide Prevention Lifeline. 1-800-273-TALK will remain operational for the foreseeable future. Some telecommunication providers have already made 988 operational for almost 100 million Americans. The National Suicide Hotline Designation Act of 2020 provides States with the authority to collect fees from voice providers to support 988, similar to the method used in many regions to finance 911.

The Lifeline routes calls from anywhere in the country to a network of certified local crisis centers that can then link callers to local emergency, mental health, and social services resources. In FY 2018, the Lifeline averaged 185,367 calls per month for a total of 2,224,408 calls answered. In FY 2019, call volume averaged 179,575 per month for a total of 2,154,903 calls answered. In FY 2020, call volume averaged 182,086 per month for a total of 2,185,036 calls answered.

Since FY 2007, SAMHSA has collaborated with the Department of Veterans Affairs (VA) to ensure that veterans, service members, and their families who call the Lifeline and "press 1" have 24/7 access to the VA's Veterans Crisis Line.

SAMHSA evaluation studies have found that when a sample of suicidal callers who received follow-up calls from the Lifeline are asked, "…to what extent did calling the crisis hotline stop you from killing yourself?" a total of 82 percent responded either "a lot" (59 percent) or "a little" (22 percent).

Lifeline evaluations have been the primary vehicle for collaborating with the crisis centers to adopt standards and guidelines based on evaluation results. These evaluation-driven standards and guidelines have, to date, focused on suicide risk assessment, imminent risk protocols, emergency intervention, and follow-up procedures; and have advanced improvements in practice that are lifesaving. Hotline

evaluation efforts will continue to focus on imminent risk and follow up for suicidal callers and suicidal persons accessing the crisis chat service.

In FY 2019, SAMHSA supported the continuation of the Suicide Lifeline grant and provided $5.4 million in supplemental funding to enhance access to the Lifeline and strengthen the capacity of the Lifeline network to answer calls as rapidly as possible. In addition, SAMHSA awarded two new Crisis Center Follow-up grants to provide an integrated hub that: (1) ensures systematic follow-up of suicidal persons who contact a NSPL Crisis Center; (2) provides enhanced coordination of crisis stabilization, crisis respite, and hospital emergency department services; and (3) enhances coordination with mobile on-site crisis response. The Crisis Center Follow-up grant program was initiated after SAMHSA evaluation results showed that while there were significant decreases in suicidal ideation during the Lifeline all, at four to six weeks follow-up 42 percent of suicidal callers were found to have experienced a recurrence of suicidal ideation but less than 25 percent had seen a mental health professional during this same time period. With the resources provided, the Crisis Center Follow-up grantees provide a hub that will not lose track of a person in a suicidal crisis as they interface with crisis systems. It is expected that this program will promote continuity of care to safeguard the well-being of individuals who are at risk of suicide.

FY 2020 data for the Crisis Center Follow-up Expansion grant program indicates 7,542 individuals were screened for mental health and suicidal concerns, 1,055 individuals were referred to services, and 84.1 percent received services.

In FY 2020, SAMHSA funded the continuation of the Suicide Lifeline and provided $12 million in COVID supplemental funding to continue to enhance and increase the capacity and strengthen the Lifeline Network in states with highest need, as well as strengthening the Lifeline's back up centers. SAMHSA also provided a supplement of $7 million using CARES Act funding to initiate a text service and to expand Lifeline's crisis chat capacity. In addition, SAMHSA funded the continuation of two Crisis Center Follow-up grants and used CARES Act funding to provide multi-year funding to three additional Crisis Center Follow-up Expansion grants. In FY 2021, SAMHSA will award a new grant for the Suicide Lifeline and provide a $7 million supplement. In addition, SAMHSA will support two Crisis Center Follow-up grant continuations as well as the three multiyear funded grants funded in FY 2020.

Funding History

Fiscal Year	Amount
FY 2018	$7,198,000
FY 2019	$12,000,000
FY 2020	$19,000,000
FY 2021 Enacted	$24,000,000
FY 2022 Budget Request	$101,621,000

Budget Request

The FY 2022 budget request is $101.6 million, an increase of $77.6 million from the FY 2021 Enacted level. SAMHSA is requesting funding to strengthen the National Suicide Prevention Lifeline (NSPL), which is a critical public health intervention to address suicide risk. As the backbone of 9-8-8, the NSPL serves as a critical safety net. When local crisis centers are unable to answer incoming contacts from individuals in distress, the NSPL utilizes a subnetwork of national backup centers to ensure capacity can meet demand. As preparation for 9-8-8's launch intensifies, the $102 million requested will enhance the Suicide Lifeline's infrastructure. These investments will help address challenges in meeting current

call/chat/text demand and expand capacity to manage the expected volume influx beginning in July 2022, as required by the National Suicide Hotline Designation Act of 2020. This funding will be used to strengthen the infrastructure of the existing Lifeline to increase the capacity of Lifeline centers to answer calls, chats, and texts, and provide specialized services. In addition, SAMHSA is requesting funding to fund two new Lifeline Crisis Center Follow-up grants that will focus on providing follow-up to suicidal people discharged from emergency rooms and inpatient units.

In addition to NSPL's infrastructure enhancements, SAMHSA recognizes that local crisis centers – which face funding challenges and are often staffed by unpaid volunteers – also need support to ensure a successful 9-8-8 launch next July. The National Suicide Hotline Designation Act provides states with the authority to collect fees from voice providers to support 9-8-8, similar to the method used in many regions to finance 911. In the short time since the National Suicide Hotline Designation Act was signed into law in October 2020, several states are already deliberating the new authority to levy fees on cell phone bills to support the answering of 9-8-8 calls and related mental health crisis services. The FY 2021 Appropriations Act also instituted for the first time a five percent set-aside to the SAMHSA Mental Health Block grant. This crisis set-aside is used to support crisis services planning and development in every state and MHBG grant recipient. SAMHSA will continue to assess the needs of local crisis centers as the 9-8-8 launch continues and as state planning efforts advance.

While 988 affords an opportunity to significantly strengthen mental health crisis care, its success hinges on our nation's crisis infrastructure.

American Indian/Alaska Native Suicide Prevention Initiative

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
American Indian/Alaska Native Suicide Prevention Initiative..	$2,931	$2,931	$2,931	$0

Authorizing Legislation ..... Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method ..... Contracts
Eligible Entities ..... Not applicable

Program Description and Accomplishments

The Tribal Training and Technical Assistance Center (Tribal TTA Center) is an innovative training and technical assistance project that helps tribal communities facilitate the development and implementation of comprehensive and collaborative community-based prevention plans to reduce violence, bullying, substance misuse, and suicide among American Indian/Alaska Native (AI/AN) youth. These plans mobilize tribal communities' existing social and educational resources to meet their goals.

From 2015 to 2020, 486 tribal communities have received specialized technical assistance and support in suicide prevention and related areas. In addition, more than 20,965 members of these communities received training in prevention and mental health promotion.

In FY 2018, SAMHSA awarded a new contract to support this activity and awarded one Mental Health Transfer Technology Center (MHTTC) for Tribal Affairs to develop and maintain a collaborative network to support resource development and dissemination, training and technical assistance, and workforce development to the field and CMHS grant recipients. The MHTTC Tribal Affairs Center will coordinate and manage CMHS's national efforts to ensure that high-quality, effective mental health disorder treatment and recovery support services, and evidence-based practices are available for all individuals with mental disorders including, in particular, those with serious mental illness.

In FY 2019, SAMHSA continued support for this activity through the existing contract and the continuation of the MHTTC Tribal Affairs Center. In FY 2020, SAMHSA will fund the existing contract and the continuation of the MHTTC Tribal Affairs Center. In FY 2021, SAMHSA will fund a new contract and the existing continuation of the MHTTC Tribal Affairs Center.

Funding History

Fiscal Year	Amount
FY 2018	$2,931,000
FY 2019	$2,931,000
FY 2020	$2,931,000
FY 2021 Enacted	$2,931,000
FY 2022 Budget Request	$2,931,000

Budget Request

The FY 2022 budget request is $2.9 million, level with the FY 2021 Enacted. This funding will support the continuation of the MHTTC Tribal Affairs Center and continuation of the contract to provide comprehensive, broad, focused, and intensive training and technical assistance to federally recognized tribes and other AI/AN communities in order to address and prevent mental illness and alcohol/other drug addiction, prevent suicide, and promote mental health through the contract continuation.

Outputs and Outcomes Table

Program: Suicide Prevention

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.3.59 Number of individuals trained in youth suicide prevention (Outcome)	FY 2020: 73,110 Target: 170,533 (Target Not Met)	73,000	73,000	Maintain
2.3.60 Number of youth screened (Output)	FY 2020: 137,790 Target: 195,517 (Target Not Met)	137,790	137,790	Maintain
2.3.61 Number of calls answered by the suicide hotline (Output)	FY 2019: 2,138,084 Target: 1,877,020 (Target Exceeded)	2,138,084	2,186,000	Maintain
3.1.01 Number of individuals screened for mental health or related interventions (Intermediate Outcome)	FY 2020: 798,525 Target: 254,868 (Target Exceeded)	798,525	798,525	Maintain
3.1.02 Number of individuals referred to mental health or related services (Intermediate Outcome)	FY 2020: 107,252 Target: 68,603 (Target Exceeded)	107,252	110,000	+2,748
3.1.03 Number of organizations that establish management information/information technology system links across multiple agencies (Intermediate Outcome)	FY 2020: 0 Target: 3	3	3	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
	(Target Not Met)			
3.1.04 Number of organizations or communities that demonstrate improved readiness to change their systems (Intermediate Outcome)	FY 2020: 71 Target: 215 (Target Not Met)	71	71	Maintain
3.2.37 Number of youths referred to mental health or related services (Output)	FY 2020: 99,026 Target: 75,700 (Target Exceeded)	99,000	100,000	Maintain
3.5.11 Percentage of respondents who say calling the lifeline stopped you from killing yourself a lot or a little (Outcome)	FY 2019: 76.0 Target: 82.0 (Target Not Met)	76.0	82.0	Maintain

Homelessness Prevention Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Homelessness	$32,992	$32,992	$32,992	$0
Homelessness Prevention Programs	*30,696*	*30,696*	*30,696*	-
Homelessness	*2,296*	*2,296*	*2,296*	-

Authorizing Legislation……...Sections 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities .....States, Domestic Public and Community Organizations, Private Nonprofit Entities, and Community-based Public or Nonprofit Entities

Program Description and Accomplishments

Although significant progress has been made over the last decade to reduce homelessness in specific communities and with specific populations, the number of people experiencing homelessness between 2019 and 2020 increased by just 2.2 percent (12,751 people). The increase in overall homelessness can be attributed to an increase in the number of unsheltered individuals.

Many factors contribute to homelessness, including lack of affordable housing, foreclosures, rising housing costs, job loss, underemployment, domestic violence, mental illness, and addiction. Services are needed to link individuals to permanent housing and coordinate benefits, treatment, and supportive services. Many of these factors have been exacerbated by the COVID-19 pandemic.

According to HUD, 580,466 individuals experienced homelessness on any given night in 2020 in the United States.[14] In addition, the number of individuals experiencing chronic homelessness was 105,583.[15] Additionally, the number of veterans experiencing homelessness was 37,252.[16] About 20 percent of individuals experiencing homelessness have a serious mental illness (SMI) and 15 percent struggle with chronic substance use and misuse.[17]

In FY 2018, SAMHSA initiated the CMHS-funded Treatment for Individuals Experiencing Homelessness (TIEH) program, to support the development and/or expansion of the local implementation of an infrastructure that integrates behavioral health treatment and recovery support services for individuals, youth, and families with a serious mental illness (SMI), serious emotional disturbance (SED), or co-occurring disorder (i.e., SMI and substance use disorder [SUD] or a SED and SUD) who are experiencing homelessness.

The goal of the TIEH program is to increase capacity and provide accessible, effective, comprehensive, coordinated, integrated, and evidence-based treatment services, peer support and other recovery support services, and linkages to sustainable permanent housing.

[14].Ibid.
[15].Ibid.
[16] Ibid.
[17] The U.S. Department of Housing and Urban Development, 2017 CoC Homeless Populations and Subpopulations Reports. Available at https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2017.pdf

FY 2020 data from the Treatment for Individuals Experiencing Homelessness (TIEH) grant program indicated that the number of individuals served by the program was 3,631. Moreover, the number of individuals who were homeless decreased 31.4 percent, and the rate of improvement in social connectedness increased by about 50 percent. Data also shows that 9,616 individuals were screened for mental health or mental health related interventions.

In FY 2019, SAMHSA supported 16 Cooperative Agreements to Benefit Homeless Individuals (CABHI) and 24 TIEH grant continuations, awarded 19 new TIEH grants, and technical assistance activities. In FY 2020, SAMHSA funded 43 TIEH continuation grants, five new TIEH grants, and one new Housing and Homeless Resource Center (HHRC) and technical assistance activities. In FY 2021, SAMHSA will support 48 TIEH, one HHRC grant continuations and technical assistance activities.

Funding History

Fiscal Year	Amount
FY 2018	$32,992,000
FY 2019	$32,992,000
FY 2020	$32,992,000
FY 2021Enacted	$32,992,000
FY 2022 Budget Request	$32,992,000

Budget Request

The FY 2022 budget request is $33.0 million, level with the FY 2021 Enacted. With this funding, SAMHSA will support 48 continuation grants and technical assistance activities to increase capacity and provide accessible, effective, comprehensive, coordinated, integrated, and evidence-based treatment services, peer support and other recovery support services, and linkages to sustainable and permanent housing. Grantees will expand access to treatment and connect homeless individuals experiencing Serious Mental Illness with safe, secure housing.

Outputs and Outcomes Table

Program: Homelessness Prevention Programs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.4.23 The number of clients served (Output)	FY 2020: 3,634 Target: 3,521 (Target Exceeded)	3,521	3,758	+237
3.4.24 Percentage of homeless clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2020: 30.3 % Target: 20 % (Target Exceeded)	34.4 %	34.4 %	Maintain
3.4.25 Percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2020: 34.4 % Target: 70 % (Target Not Met but Improved)	31.1 %	36.1 %	+5 %

Minority AIDS

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Minority AIDS	$9,224	$9,224	$9,224	--

Authorizing Legislation ..... Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities ..... Community and faith-based organizations, Tribes, Urban, Indian organizations, Hospitals, Public and private universities and colleges

Program Description and Accomplishments

The Minority AIDS Initiative - Service Integration grant program (MAI-SI) is designed to meet the health needs of some of America's most vulnerable individuals. Adults with serious mental illness (SMI) receiving public specialty mental health services are not tested for HIV regularly[18]MAI-SI makes HIV testing and treatment, PrEP and PEP, and Hepatitis vaccination and treatment available to this underserved population. Grantees include HIV/AIDS providers expanding mental health services to their clients.

The Centers for Disease Control and Prevention (CDC) reports significantly higher rates of HIV/AIDS among racial/ethnic minorities compared with the general population. Only approximately 7 percent of people with severe mental illness receive HIV testing. And there are significant racial disparities: Asians/Pacific Islanders were 53 percent less likely and blacks were 82 percent more likely to be tested (ibid). African Americans accounted for 45 percent and Hispanics accounted for 23 percent of all HIV/AIDS cases diagnosed in 2013.[19] Psychiatric and psychosocial complications are frequently not diagnosed nor addressed at the time of HIV diagnosis or through the course of the disease process. When untreated, these complications are associated with increased morbidity and mortality, impaired quality of life, and numerous medical issues such as non-adherence with the treatment regimen.

The MAI-SI program enhances and expands the provision of effective, culturally competent, HIV/AIDS-related mental health services in racial and ethnic minority communities for people with a serious mental illness or co-occurring disorder who are living with or at high risk for HIV/AIDS.

In FY 2018, SAMHSA awarded a new cohort of 18 grants focused on integrated evidence-based, culturally competency mental and substance use disorder treatment with HIV primary care and prevention services. The population of focus is individuals with a serious mental illness (SMI) or co-occurring disorder living with or at risk for HIV and/or hepatitis in at-risk populations, including racial and ethnic minority communities. The goal of this grant program is to reduce the incidence of HIV and improve overall health outcomes for individuals with SMI or co-occurring disorder.

Required activities under this grant include HIV and hepatitis prevention services to include screening, risk assessment, prevention counseling, rapid testing, PrEP and hepatitis vaccination within a behavioral

[18] https://pubmed.ncbi.nlm.nih.gov/28093055/
[19] Centers for Disease Control and Prevention. HIV Surveillance Report. (2013); vol. 25. Published February 2015. Accessed May 8, 2015 from http://www.cdc.gov/hiv/library/reports/surveillance.

health setting. Grantees provide evidence-based mental and substance use disorder (SUD) treatment and practices that are trauma-informed and recovery-oriented. Grantees also implement outreach strategies to inform individuals of available behavioral health services and HIV and hepatitis primary care and prevention services. Grantees offer peer support and case management services to coordinate all aspects of care.

Grantees collect data at baseline, 6-month reassessment, and discharge. FY 2019 reassessment data show 53 percent of individuals receiving services are not experiencing serious psychological distress; 62 percent reported an increase in everyday functioning; and 29 percent of individuals were being retained in the community.

In FY 2019, SAMHSA continued support for 18 continuations grants. In FY 2020 and FY 2021, SAMHSA supported 18 grant continuations.

Funding History

Fiscal Year	Amount
FY 2018	$9,224,000
FY 2019	$9,224,000
FY 2020	$9,224,000
FY 2021 Enacted	$9,224,000
FY 2022 Budget Request	$9,224,000

Budget Request

The FY 2022 budget request is $9.2 million, level with the FY 2021 Enacted level. SAMHSA will fund a new cohort of 18 grants focused on individuals with mental disorders and/or co-occurring disorders living with or at risk for HIV/AIDS.

Outputs and Outcomes Table

Program: Minority AIDS Initiative Service Integration

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.5.02 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2020: 67.3 Target: 61.8 (Target Exceeded)	67.0	67.0	Maintain
3.5.03 Percentage of clients receiving services who had a permanent place to live in the community at six-month follow-up. (Outcome)	FY 2020: 62.4 Target: 61.7 (Target Exceeded)	61.7	61.7	Maintain
3.5.04 Percentage of clients receiving services who are currently employed at six-month follow-up. (Outcome)	FY 2020: 38.7 Target: 36.4 (Target Exceeded)	38.7	38.7	Maintain

Criminal and Juvenile Justice Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Criminal and Juvenile Justice Programs.....	$6,269	$6,269	$51,394	$45,125

Authorizing Legislation……Sections 520G of the Public Health Service Act
FY 2022 Authorization $4,269,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities .....Tribal Court Administrator, the Administrative Office of the Courts, the Single State Agency for Alcohol and Drug Abuse, the State Mental Health Agency, the Designated State Drug Court Coordinator, and Local Governmental Units

Program Description and Accomplishments

Data indicate that a significant number of individuals that come in contact with law enforcement and the criminal justice system have a mental or substance use disorder. More than half of all prison and jail inmates (i.e., people in state and federal prisons and local jails) meet criteria for having a mental health problem; 6 in 10 meet criteria for a substance abuse problem; and more than one-third meet criteria for having both a substance abuse and mental health problem.[20] Approximately 250,000 individuals with serious mental illness (SMI) are incarcerated at any given time—about half arrested for non-violent offenses, such as trespassing or disorderly conduct. In addition, during street encounters, police officers are almost twice as likely to arrest someone who appears to have a mental illness. A Chicago study of thousands of police encounters found that 47 percent of people with a mental illness were arrested, while only 28 percent of individuals without a mental illness were arrested for the same behavior.[21] The costs associated with incarceration are high: state corrections budgets alone account for $39.0 billion in taxpayer costs.[22,23] There is a clear and largely unmet need for effective behavioral health services and supports that are accessible before, during, and after incarceration and continue in the community as needed for this high-risk, population.

The purpose of SAMHSA's Early Diversion grants is to establish or expand programs that divert adults with a serious mental illness (SMI) or a co-occurring disorder (COD) from the criminal justice system to community-based services prior to arrest and booking. Special consideration is given to applicants proposing to use grant funding to support early diversion services for veterans.

Performance Evaluation

SAMHSA completed an evaluation of the first cohort of Behavioral Health Treatment Courts Collaborative (BHTCC) grantees in September 2014. Findings of the evaluation demonstrate that

[20] U.S. Department of Justice, Office of Justice Programs. (2006) *Mental health problems of prison and jail inmates*. Retrieved, March 25, 2011, from http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf
[21] The Role of Mental Health Courts in System Reform. (2003) The Bazelon Center for Mental Health Law. http://heinonline.org/HOL/LandingPage?handle=hein.journals/udclr7&div=10&id=&page=
[22] Pew Center on the States. (2011). State of recidivism: The revolving door of America's prisons. Washington, DC: The Pew Charitable Trusts. http://www.pewtrusts.org/en/research-and-analysis/reports/0001/01/01/state-of-recidivism
[23] Henrichson, C., & Delaney, R. (2012). The price of prisons: What incarceration costs taxpayers. New York: Vera Institute of Justice.

grantees built multi-agency workgroups or collaborative to oversee programs. Because of the grant funding, all grant recipients expanded access to specialty courts. Most grant recipients anticipated continuing new screening and assessment processes addressing a broader array of behavioral health needs after grant funding ended. Program innovations were divided into four main groups, including court and treatment provider collaboration, court and community case management, unified cross-court screening and referral, and meaningful peer involvement. BHTCC served over 2,997[24] individuals, with 77 percent of them identified as having co-occurring mental illness and drug/alcohol addiction and with nearly two thirds reporting violence or trauma exposure in their lives. Based on performance data reporting, alcohol and other drug use by program participants declined by 53 percent at six months[25]. Nearly 79 percent of participants either maintained good physical health or reported physical health improvements in the same time period. In addition, employment rates increased from 29 percent to 45 percent over the first six months, with monthly mean income increasing by $217.

In FY 2018, the Law Enforcement and Behavioral Health Partnerships (Early Diversion) grant program was initiated and funded 12 new grants. In FY 2019, these grantees screened over 1,400 clients and referred over 1,000 individuals to mental health services.

In FY 2019, SAMHSA continued support for 11 Early Diversion grant continuations and technical assistance and evaluation activities. In FY 2020, SAMHSA funded 11 grant continuations, awarded a new cohort of seven grants, and conducted technical assistance activities. In FY 2021, SAMHSA will support 18 grant continuations, and conduct technical assistance activities.

Funding History

Fiscal Year	Amount
FY 2018	$4,269,000
FY 2019	$4,269,000
FY 2020	$6,269,000
FY 2021 Enacted	$6,269,000
FY 2022 Budget Request	$51,394,000

Budget Request

The FY 2022 budget request is $51.4 million, an increase of $45.1 million from the FY 2021 Enacted level. This proposed increase aligns with the Administration's goal to address mental health needs among incarcerated youth and adults by providing services to ensure their successful transition into community post-incarceration. This funding will establish pre-release relationships with community mental health providers and key stakeholders. With a commitment to health equity, SAMHSA will award a new cohort of grants to support provision of services by community-based behavioral health providers both within jails/prisons and post-incarceration. This activity will address the unmet treatment needs of incarcerated individuals and allow these individuals to continue to access services from the same community-based providers post-incarceration. The needs of individuals returning to society include the social determinants of recovery (i.e. housing, employment, access to health care) and other supportive resources for successful transition from incarceration. This funding will support up to 100 grantees to provide screening, assessment, treatment, and linkage to services for those with

[24] Cohort 2 data through November 15, 2017
[25] Calculated as the change in percentage of individuals reporting alcohol or drug use from baseline to six-month follow-up.

mental disorders in jails/prisons. Special importance will be paid towards ensuring a commitment to racial and economic justice, trauma-informed approaches, as well as cultural humility.

SAMHSA will also support the continuation of 18 Early Diversion grants and the continuation of the technical assistance center.

Outputs and Outcomes Table

Program: Criminal and Juvenile Justice

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.5.06 Percentage of clients receiving services who report positive functioning at 6 month follow-up (Outcome)	FY 2020: 57.1 Target: 40.0 (Target Exceeded)	57.0	57.0	Maintain
3.5.07 Percentage of clients receiving services who had a permanent place to live in the community at six-month follow-up. (Outcome)	FY 2020: 38.9 Target: 40.0 (Target Not Met)	40.0	40.0	Maintain
3.5.09 Number of individuals screened for mental health or related interventions. (Output)	FY 2020: 2,405.0 Target: 1,438.0 (Target Exceeded)	2,400.0	2,700.0	+300

Practice Improvement and Training

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Practice Improvement and Training	$7,828	$7,828	$7,828	--

Authorizing Legislation ..... Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method ..... Competitive Grants/Contracts
Eligible Entities ..... 105 Nationally Recognized Historically Black Colleges and Universities

Program Description and Accomplishments

SAMHSA facilitates health integration by engaging in activities that support mental health system transformation. The Practice Improvement and Training programs address the need for disseminating key information, such as evidence-based mental health practices, to the mental health delivery system.

The purpose of the Historically Black Colleges and Universities-Center for Excellence (HBCU-CFE) program is to network the 105 HBCUs throughout the United States and promote behavioral health workforce development through expanding knowledge of best practices, developing leadership, and encouraging community partnerships that enhance the participation of African Americans in substance use disorder treatment and mental health professions. The comprehensive focus of the HBCU-CFE program simultaneously expands service capacity on campuses and in other treatment venues.

SAMHSA has worked to strengthen its clinical and science-based approach to addressing serious mental illness. In FY 2018, SAMHSA developed a Clinical Support Services TA Center to address SMI. This TA Center focuses specifically on the clinical treatment of SMI, including the use of medications.

In FY 2019, SAMHSA continued support for the HBCU grant program and the Clinical Support Services TA Center. In FY 2020 and FY 2021, SAMHSA will fund the HBCU grant program and the Clinical Support Services TA Center.

Funding History

Fiscal Year	Amount
FY 2018	$7,828,000
FY 2019	$7,828,000
FY 2020	$7,828,000
FY 2021 Enacted	$7,828,000
FY 2022 Budget Request	$7,828,000

Budget Request

The FY 2022 budget request is $7.8 million, level with the FY 2021 Enacted level. Funding will support the continuation of the HBCU program, the continuation of the Clinical Support Services TA Center for SMI and provide supplemental funding for the school safety program.

The output and outcome measures for Practice Improvement and Training are part of the Mental Health - Science and Service Activities Outputs and Outcomes table shown on page 90.

Consumer and Consumer-Supporter TA Centers

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Consumer and Consumer-Supporter Technical Assistance Centers..	$1,918	$1,918	$1,918	--

Authorizing Legislation ..... Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method ..... Competitive Grants
Eligible Entities ..... Community Organizations

Program Description and Accomplishments

Consumer-centered services and supports, such as peer specialists, are vital to improving the quality and outcomes of health and behavioral healthcare services for people with mental disorders including SMI. First funded in 1992, the purpose of Consumer and Consumer-Supporter Technical Assistance (TA) Centers is to provide technical assistance to facilitate quality improvement of the mental health system by specific promotion of consumer-directed approaches for adults with SMI.

Such approaches maximize consumer self-determination, promote long-term recovery, and assist individuals with SMI to increase their community involvement through work, school, and social connectedness. This program also improves collaboration among consumers, families, providers, and administrators. It helps to transform community mental health services into a more consumer and family driven model.

In FY 2020, the Consumer and Consumer-Supporter TA Centers provided training to approximately 16,167 people. These trainings covered a range of topics, including peer support, the Wellness Recovery Action Plan, Emotional CPR, financial literacy, and collaborative leadership. In addition, the Consumer and Consumer-Supporter TA Centers provided support and expertise to consumer organizations that led to these organizations obtaining over $334 thousand in funding (non-grant). Due to this grant, 123 consumers and family members holding positions within consumer or family organizations participated in mental health-related planning and systems improvement.

In FY 2019 SAMHSA supported the continuation of five grants. In FY 2020, SAMHSA funded a new cohort of five grants. In FY 2021, SAMHSA will support five grant continuations.

Funding History

Fiscal Year	Amount
FY 2018	$1,918,000
FY 2019	$1,918,000
FY 2020	$1,918,000
FY 2021 Enacted	$1,918,000
FY 2022 Budget Request	$1,918,000

Budget Request

The FY 2022 budget request is $1.9 million, level with the FY 2021 Enacted. SAMHSA's funding request will support five continuation grants to provide technical assistance to facilitate the quality improvement of the mental health system by promoting consumer-directed approaches for adults with SMI.

The output and outcome measures for Consumer and Consumer-Supporter TA Centers are part of the Mental Health - Science and Service Activities Outputs and Outcomes table shown on page 90.

Disaster Response

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Disaster Response	$1,953	$1,953	$1,953	--

Authorizing Legislation ..... Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method ..... Competitive Grants/Contracts
Eligible Entities ..... Domestic Public or Private Non-Profit Entities

Program Description and Accomplishments

Natural and human caused disasters and emergent events, including the COVID-19 pandemic; wildfires in California, Colorado, and Washington; hurricanes and tropical storms along the coast; and midwestern floods and tornadoes; strike without warning. These unexpected disasters and events leave individuals, families, and whole communities struggling to rebuild.

SAMHSA helps ensure that the nation is prepared to address, as well as respond to the behavioral health needs that follow these disasters or events. SAMHSA focuses on three major programs; the Crisis Counseling Assistance and Training Program (CCP), the Disaster Distress Helpline (DDH) and the Disaster Technical Assistance Center (DTAC). These programs use appropriated funds to support survivors of natural and man-made disasters.

SAMHSA provides Disaster Behavioral Health expertise around natural disasters, and emerging public health initiatives to develop and disseminate innovative consultation and technologies to communities, federal partners, and other stakeholders. SAMHSA, through an interagency agreement with the Federal Emergency Management Agency (FEMA), operates the CCP. This program assists individuals and communities to recover from presidentially declared disasters through the provision of community-based behavioral health outreach and psycho-educational services. SAMHSA provides technical assistance, program guidance and monitoring, and oversight of the CCP. SAMHSA funds the DDH, the nation's first permanent hotline dedicated to providing immediate disaster crisis counseling. SAMHSA and FEMA jointly fund the DTAC, designed to provide additional technical assistance, strategic planning, consultation, and logistical support.

During FY 2020, the CCP Online Data Collection and Evaluation System showed the following contacts and encounters funded by 73 CCP grants:

- 502,154 in-person brief educational supportive contacts;
- 193,810 telephone contacts and 610,071 e-mail contacts;
- 138,320 individual and family crisis counseling encounters (lasting 15 to 60 minutes or more) serving 177,038 individuals; and
- 9,342 group encounters (public education and group counseling) serving 244,415 individuals.

Individual and family crisis counseling encounters were most often conducted with adults ages 40 to 64 (45 percent) followed by adults ages 65 and older (26 percent) and adults ages 18-39 (21 percent). Individual and family encounters occurred most often with female (58 percent) disaster survivors and most (59 percent) were conducted in Spanish due to the large CCP grant running in Puerto Rico. The three most common risk factors reported by counseling participants were other financial loss (18 percent), past trauma (17 percent), home damaged or destroyed (10 percent). Across the four major health concern categories (behavioral, emotional, physical, and cognitive), the highest number of reported disaster event reactions fell within the emotional category and was "anxious/fearful" (n = 80,638). The next most prevalent reaction was "preoccupied with death/destruction" (n= 56,478) under the behavioral category.

SAMHSA's Disaster Distress Helpline is a toll-free, multilingual crisis systems service available 24/7 via telephone (1-800-985-5990) and Short Message Service (SMS) (text 'TalkWithUs' to 66746) to residents in the United States and its territories who are experiencing emotional distress resulting from disasters. In FY 2020, SAMHSA responded to over 48,000 calls and received close to 120,000 text messages to the Disaster Distress Helpline. SAMHSA has seen an over 300 percent increase in its Disaster Distress Helpline call volume this year during the Covid-19 pandemic, compared to the year prior. In addition, SAMHSA's Disaster App (available on Apple and android platforms) provides evidence-informed and evidence-based resources in the Disaster Kit, along with additional partner resources and information on local mental health and substance use treatment facilities. It has the ability to share content anonymously and can function with limited Internet connectivity.

In FY 2020, SAMHSA continued support for the National Disaster Distress Helpline. In FY 2021, SAMHSA will fund a new National Disaster Distress Helpline grant and continue to support the DTAC contract.

Funding History

Fiscal Year	Amount
FY 2018	$1,953,000
FY 2019	$1,953,000
FY 2020	$1,953,000
FY 2021 Enacted	$1,953,000
FY 2022 Budget Request	$1,953,000

Budget Request

The FY 2022 budget request is $2.0 million, level with the FY 2021 Enacted. SAMHSA requests funding to continue the support of a nationally available disaster distress crisis counseling telephone line and the Disaster Technical Assistance Center.

The output and outcome measures for Disaster Response are part of the Mental Health - Science and Service Activities Outputs and Outcomes table shown on page 90.

Seclusion and Restraint

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Seclusion and Restraint	$1,147	$1,147	$1,147	--

Authorizing Legislation ..... Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method ..... Contracts
Eligible Entities ..... Not Applicable

Program Description and Accomplishments

People die because of the inappropriate use of seclusion and restraint practices, countless others are injured, and many people are traumatized by coercive practices. Children with emotional and behavioral issues are more frequently subjected to restraints in schools than students with other disabilities, often leading to serious physical injuries and emotional trauma for both students and staff. Coercive practices, such as seclusion and restraint, impede recovery and well-being.

The purpose of the MHTTC Network is technology transfer—disseminating and implementing evidence-based practices for mental disorders into the field. The MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office. The collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. It works with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals.

In FY 2019, SAMHSA supported the continuation for the 11 MHTTC grants. In FY 2020, SAMHSA funded 11 MHTTC continuation grants, and will fund the same amount in FY 2021.

Funding History

Fiscal Year	Amount
FY 2018	$1,147,000
FY 2019	$1,147,000
FY 2020	$1,147,000
FY 2021 Enacted	$1,147,000
FY 2022 Budget Request	$1,147,000

Budget Request

The FY 2022 budget request is $1.1 million, level with the FY 2021 Enacted level. SAMHSA's funding request will provide support for the continuation of the 11 MHTTC grants.

Assertive Community Treatment for Individuals with Serious Mental Illness

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Assertive Community Treatment for Adults with SMI.....	$7,000	$9,000	$9,000	--

Authorizing Legislation .....Sections 520M of the Public Health Service Act
FY 2022 Authorization $5,000,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities. ..... States, local governments, Indian tribes or tribal organizations, mental health systems, or health care facilities

Program Description and Accomplishments

The Assertive Community Treatment (ACT) for Individuals with SMI program is authorized under the 21st Century Cures Act. ACT is an evidence-based practice considered to be one of the most effective approaches to deliver services to individuals with the most severe impairments associated with SMI[26] and has been disseminated by SAMHSA for widespread use through its Evidence-based Toolkit series[27] beginning in 2008. ACT was developed to reduce re-hospitalization and improve outcomes in community settings. It is designed as an integrated care approach to provide a comprehensive array of services, including medication management and other supportive services, directly rather than through referrals. An ACT team is composed of 10-12 multidisciplinary behavioral health staff, including psychiatrists, nurses, social workers, addiction counselors, employment/vocational supports, and peer specialists. These practitioners work together to deliver comprehensive, individualized, and recovery-oriented treatment and case management services to approximately 100 people with SMI in community settings. Caseloads are approximately one staff member to every 10 individuals. Services are provided 24 hours, 7 days a week and as long as needed, wherever they are needed. Teams often find they can anticipate and avoid crises.

FY 2020 data indicated that the number of individuals served by the program who reported improved functioning in everyday life increased by 52.5 percent, the number of individuals who had a stable place to live increased from 48 to 60 percent, and the rate of improvement in social connectedness increased by almost 44.8 percent. Data also showed that 582 individuals received evidence-based mental health related services and 528 individuals in the mental health workforce received training in mental health practices consistent with the goals of the program.

In FY 2019, SAMHSA supported seven continuation grants. In FY 2020, SAMHSA funded seven continuation grants and award three new ACT grants. In FY 2021, SAMHSA will support 10 grant continuations and funded a new cohort of two ACT grants.

[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3589962/
[27] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Funding History

Fiscal Year	Amount
FY 2018	$5,000,000
FY 2019	$5,000,000
FY 2020	$7,000,000
FY 2021 Enacted	$9,000,000
FY 2022 Budget Request	$9,000,000

Budget Request

The FY 2022 budget request is $9.0 million, level with the FY 2021 Enacted. This funding will support the continuation of 12 grants to advance the ACT approach to address the needs of those living with SMI.

Outputs and Outcomes Table

Program: Assertive Community Treatment Grants

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.4.13 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2020: 61.5 Target: 50.0 (Target Exceeded)	50.0	50.0	Maintain
3.4.14 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2020: 23.8 Target: 28.0 (Target Not Met)	23.0	23.0	Maintain
3.4.15 Percentage of clients receiving services who have a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2019: 45.8 Target: 45.8 (Baseline)	45.8	45.8	Maintain

Assisted Outpatient Treatment for Individuals with Serious Mental Illness

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Assisted Outpatient Treatment for Individuals with Serious Mental Illness..	$19,000	$21,000	$21,420	$420

Authorizing Legislation .....Section 224 of the Protecting Access to Medicare Act of 2014,
FY 2022 Authorization $18,000,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities……States and communities

Program Description and Accomplishments

Recent data show that one in 25 Americans live with a serious mental illness (SMI), such as schizophrenia, bipolar disorder and major depression. Less than half of adults with diagnosable mental disorders receive the treatment they need. Without access to and receipt of evidence-based mental health services, mental health issues can negatively affect all areas of a person's life.

In an effort to increase access to evidence-based mental health services for individuals with SMI, in April 2014, Congress passed the Protecting Access to Medicare Act of 2014 (PAMA), which authorized a four-year pilot program to award grants for Assisted Outpatient Treatment (AOT) programs for individuals with SMI. This authorization was extended in the 21st Century Cures Act. AOT is the practice of delivering outpatient treatment under court order to adults with SMI who meet specific criteria, such as a prior history of non-adherence to treatment repeated hospitalizations or arrest. AOT involves petitioning local courts through a civil process to order individuals to enter and remain in treatment within the community for a specified period of time. This program will help to identify evidence-based AOT practices that support improved outcomes, including outreach and engagement, clinical treatment and supportive services, and due process protections.

In FY 2016, SAMHSA implemented the AOT grant program and awarded 17 grants to eligible entities, such as a county, city, mental health system, mental health court, or any other entity with authority under the law of the state in which the grantee is located. This four-year pilot program is intended to implement and evaluate new AOT programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a SMI. This program is designed to work with families and courts to allow these individuals to obtain treatment while continuing to live in the community and their homes. Grants were awarded to applicants that have not previously implemented an AOT program.

SAMHSA will continue to consult with the National Institute of Mental Health, the Attorney General, and the Administration for Community Living on this pilot program. In addition, SAMHSA will work with families and courts in the implementation of this program.

Program Evaluation

Grantee performance data from SAMHSA's Performance Accountability Reporting System (SPARS) was used to capture outcomes in the four areas listed below:

1. Cost savings and public health outcomes including substance misuse, hospitalization, and use of services
    - 9.8 percent of AOT program participants reported spending at least one day in the hospital for mental health care in the past 30 days at their most recent reassessment compared to 65.3 percent at intake.
    - 7.3 percent of AOT program participants reported spending at least one day in the emergency department for a psychiatric or emotional problem in the past 30 days at their most recent reassessment compared to 33.2 percent at intake.
    - 25 percent of AOT program participants reported using illegal substances 30 days before their most recent reassessment compared to 33.3 percent at intake.
2. Rates of Incarceration
    - 7.1 percent of AOT program participants reported spending one or more nights in a correctional facility in the past 30 days at their most recent reassessment compared to 12.7 percent at intake.
3. Rates of Homelessness
    - 7.0 percent of AOT program participants reported spending one or more homeless nights in the past 30 days at their most recent reassessment compared to 13.6 percent at intake.
4. Patient and family satisfaction with program participation
    - 91.8 percent of AOT program participants agreed or strongly agreed with the statement "I liked the services I received here" at their most recent reassessment.

In FY 2019, SAMHSA funded 18 continuation grants. In FY 2020, SAMHSA funded a new cohort of 17 grants and four continuation grants. In FY 2021, SAMHSA will support 20 grant continuations and award a new cohort of three grants.

Funding History

Fiscal Year	Amount
FY 2018	$15,000,000
FY 2019	$15,000,000
FY 2020	$19,000,000
FY 2021 Enacted	$21,000,000
FY 2022 Budget Request	$21,420,000

Budget Request

The FY 2022 budget request is $21.4 million, an increase of $420,000 from the FY 2021 Enacted level. This funding will support a new cohort of three grants and 20 grant continuations to improve the health and social outcomes for individuals with SMI and continuation of the technical assistance center.

Outputs and Outcomes Table

Program: Assisted Outpatient Treatment for Individuals with Serious Mental Illness

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.4.06 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2020: 70.0 Target: 70.0 (Target Met)	70.0	70.0	Maintain
3.4.07 Percentage of clients receiving services who are maintained at six-month follow-up. (Outcome)	FY 2020: 88.7 Target: 80.9 (Target Exceeded)	80.9	89.0	+8.1
3.4.08 Number of people in the mental health and related workforce trained in mental health-related practices/activities. (Output)	FY 2020: 2,724.0 Target: 2,180.0 (Target Exceeded)	2,180.0	2,180.0	Maintain
3.4.09 Number of consumers/family members who provide mental health-related services. (Output)	FY 2020: 72.0 Target: 99.0 (Target Not Met)	72.0	72.0	Maintain

* Trained consumer/family members providing mental health-related services can assist in the attainment of treatment goals and promote improved role functioning in the home and in community settings. The number of consumers/family members providing mental-health related services reflects the AOT program's access to these services, which could be a potential indicator of overall positive AOT outcomes for individuals with serious mental illness.

Outputs and Outcomes Table

Program: Mental Health – Other Capacity Activities [28]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.5.00 Number of people in the mental health and related workforce trained in mental health-related practices/activities that are consistent with the goals of the grant (Output)	FY 2020: 28,746.0 Target: 22,124.0 (Target Exceeded)	28,746.0	28,746.0	Maintain
3.5.01 Number of consumers/family members representing consumer/family organizations who are involved in ongoing mental health-related planning and advocacy activities as a result of the grant (Output)	FY 2020: 12,334.0 Target: 15,812.0 (Target Not Met)	12,334.0	12,334.0	Maintain

[28] Includes the following: Children and Family, Consumer and Family Network, Consumer and Consumer-Supporter TA Centers, Practice Improvement Training, and Disaster Response.

Outputs and Outcomes Table

Program: Mental Health - Science and Service Activities

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.4.06 Number of people trained by CMHS Science and Service Programs (Output)	FY 2020: 30,983 Target: 19,356 (Target Not Met)	30,983	30,983	Maintain
1.4.14 Number of calls answered by the Disaster Distress Hotline (Output)	FY 2020: 56,756 Target: 11,820 (Target Exceeded)	56,700	56,700	Maintain
1.4.15 Number of text messages answered by the Disaster Distress Hotline (Output)	FY 2020: 117,042 Target: 18,468 (Target Exceeded)	117,000	117,000	Maintain

Tribal Behavioral Health Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Tribal Behavioral Health Grants.....	$20,000	$20,750	$20,750	$0

Authorizing Legislation……... Section 520A of the Public Health Service Act
FY 2022 Authorization $394,550,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities……... Tribes

Program Description and Accomplishments

Suicide is now the first leading cause of death among American Indian/Alaska Native (AI/AN) youth ages ten to 14 years, and the second leading cause of death among American Indian/Alaska Native (AI/AN) youth ages 15 to 24.[29] Further, AI/AN high school students report higher rates of suicidal behaviors than the general population of U.S. high school students.[30] These behaviors include serious thoughts of suicide, suicide plans, suicide attempts, and medical attention for a suicide attempt. However, the risk of suicide is not the same in all AI/AN youth demographic groups. For instance, AI/AN youth raised in urban settings have a smaller risk of having thoughts of suicide than AI/AN youth raised on tribal reservations (21 percent and 33 percent, respectively).[31]

Consistent with the goals of the Tribal Behavioral Health Agenda, the Tribal Behavioral Health Grant (TBHG/Native Connections (NC) program addresses the high incidence of substance use and suicide among AI/AN populations. Starting in FY 2014, this program supports tribal entities with the highest rates of suicide by providing effective and promising strategies that address substance use, trauma, and suicide and by promoting the mental health of AI/AN young people.

The first cohort of TBHG/NC grants was provided to 20 tribes or tribal organizations with high rates of suicide. These five-year grants help grantees develop and implement a plan that addresses suicide and substance misuse, thereby promoting mental health among tribal youth. In addition, SAMHSA's Tribal Training and Technical Assistance Center (http://www.samhsa.gov/tribal-ttac) provides training and education to AI/AN grantees and organizations serving AI/AN populations to support their ability to achieve their goals.

This initiative takes a comprehensive, culturally appropriate approach to help improve the lives of and opportunities for AI/AN youth. In addition to the Department of Health and Human Services, multiple agencies, including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing AI/AN youth.

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[29] Centers for Disease Control and Prevention. Fatal injury data, 2010. Web-based Injury Statistics Query and Reporting System. Available at www.cdc.gov/injury/wisqars/fatal.html. Accessed May 27, 2014.
[30] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Available at http://www.cdc.gov/healthyyouth/yrbs/index.htm. Accessed May 27, 2014.
[31] Freedenthal, S. & Stiffman, A. R. (2004). Suicidal Behavior in Urban American Indian Adolescents: A Comparison with Reservation Youth in a Southwestern State. Suicide and Life-Threatening Behavior, 34(2), 160-171.

In FY 2016, SAMHSA expanded activities through the braided TBHG/NC funding ($15.0 million in the Substance Abuse Prevention appropriation and $15.0 million in Mental Health appropriation) to allow tribes the flexibility to implement community-based strategies to address trauma, prevent substance misuse, and promote mental health and resiliency among youth in tribal communities.

In FY 2019, SAMHSA supported 109 grant continuations, 26 new grants, and technical assistance activities. In FY 2020, SAMHSA funded 121 grant continuations, technical assistance activities and 40 new grants (jointly funded CSAP/CMHS). In FY 2021, SAMHSA will support 124 grant continuations and award a new cohort of six grants and technical assistance activities.

Funding History

Fiscal Year	Amount
FY 2018	$15,000,000
FY 2019	$20,000,000
FY 2020	$20,000,000
FY 2021 Enacted	$20,750,000
FY 2022 Budget Request	$20,750,000

Budget Request

The FY 2022 budget request is $20.8 million, level with the FY 2021 Enacted. This request, combined with $21.1 million in the Substance Abuse Prevention will support technical assistance activities, 117 continuation grants and award a new cohort of six grants that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families.

As a braided activity, SAMHSA is tracking separately any amounts spent or awarded under Tribal Behavioral Health Grants through the distinct appropriations and ensure that funds are used for purposes consistent with legislative direction and intent of these appropriations.

Outputs and Outcomes Table

Program: Tribal Behavioral Health

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.4.12 Percentage of youth age 10 - 24 who received mental health or related services after screening, referral or attempt (Output)	FY 2020: 47 Target: 42 (Target Exceeded)	47	47	Maintain
2.4.13 Number of programs/organizations that implemented specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2020: 3,076 Target: 6,880 (Target Not Met)	3,000	3,000	Maintain

Minority Fellowship Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Minority Fellowship Program	$9,059	$10,059	$10,663	$604

Authorizing Legislation…… Section 597 of the PHS Act
FY 2022 Authorization $12,669,000
Allocation Method ..... Grants/Contracts
Eligible Entities. .....……Organizations that represent individuals obtaining post-baccalaureate training (including for master's and doctoral degrees) for mental and substance use disorder treatment professionals, including in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling

Program Description and Accomplishments

SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance use disorder treatment services for minority populations that are underserved. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, marriage and family therapy, mental health counseling, psychology; and substance use/addiction counseling. In 2006, the program expanded to include marriage and family therapists and later added professional counselors. Professional guilds receive competitively awarded grants, and then competitively award the stipends to post-graduate students pursuing a degree in that professional field. The MFP program has had a variety of focus including youth and addiction counselors. In FY 2019, SAMHSA supported seven continuation grants and the technical assistance contract. In FY 2020, SAMHSA funded seven continuation grants, the technical assistance contract, and awarded one new grant to a current grantee to focus on interdisciplinary work. In FY 2021, SAMHSA will support eight grant continuations and the technical assistance contract.

Funding History

Fiscal Year	Amount
FY 2018	$8,059,000
FY 2019	$8,059,000
FY 2020	$9,059,000
FY 2021 Enacted	$10,059,000
FY 2022 Budget Request	$10,663,000

Budget Request

The FY 2022 budget request is $10.7 million, an increase of $604,000 from the FY 2021 Enacted level. SAMHSA requests funding to support eight continuation grants, a new cohort of one grant and the technical assistance contract.

Infant and Early Childhood Mental Health

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Infant and Early Childhood Mental Health.....	$7,000	$8,000	$8,000	--

Authorization Legislation..... Section 399Z-2 of the Public Health Service Act
FY 2022 Authorization $20,000,000
Allocation Method .....Competitive Grants
Eligible Entities……Human Services Agencies and Non-profit Institutions

Program Description and Accomplishments

Nearly one in seven US children aged 2 to 8 years has a mental, behavioral, or developmental disorder.[32] It is also estimated that approximately 9.5 to 14.2 percent of children birth to 5 years old experience emotional, relational, or behavioral disturbance.[33] Without proper intervention, these early childhood disorders can have negative impacts on all areas of a child's development. Young children whose social and emotional development is compromised are at higher risk for school problems and juvenile delinquency later in life.[34] Rising rates of substance-exposure in infants also require more intensive early childhood services to help improve the trajectories of the families where substance misuse is present.

The authorization for this program was added to the Public Health Service Act by an amendment in the 21st Century Cures Act. The first funding for this program was provided in FY 2018. The purpose of this program is to improve outcomes for children, from birth to 12 years of age, who are at risk for, show early signs of, or have been diagnosed with a mental illness, including a serious emotional disturbance. Grantees improve outcomes for children through training early childhood providers and clinicians to identify and treat behavioral health disorders of early childhood, including in children with a history of in utero exposure to substances such as opioids, stimulants or other drugs that may impact development, and through the implementation of evidence-based multigenerational treatment approaches that strengthen caregiving relationships.

SAMHSA expects this program will increase access to a range of evidence-based and culturally appropriate infant and early childhood mental health services and will aid in addressing the national shortage of mental health professionals with infant and early childhood expertise.

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[32] Bitsko, RH, Holbrook, JR, Kaminski, J, Robinson, LR, Ghandour, R, Smith, C, Peacock, G. (2016) Health-care, Family and Community Factors associated with Mental, Behavioral and Developmental Disorders in Early Childhood – United States, 2011-2012. MMWR.; 65(9); 221-226. Available from https://www.cdc.gov/ncbddd/childdevelopment/features/key-finding-factors-mental-behavioral-developmental-early-childhood.html.

[33] Brauner, C. B., & Stephens, C. B. (2006). Estimating the prevalence of early childhood serious emotional/behavioral disorders: Challenges and recommendations. Public Health Reports, 121(3), 303–310. Available from www.ncbi.nlm.nih.gov/pmc/articles/PMC1525276

[34] Jones, D. E., Greenberg, M., & Crowley, M. (2015). Early Social-Emotional Functioning and Public Health: The Relationship Between Kindergarten Social Competence and Future Wellness. American Journal of Public Health, 105(11), 2283–2290. http://doi.org/10.2105/AJPH.2015.302630

Because the wellbeing of caregivers dramatically impacts the development of infants and young children, this program also promotes a multigenerational approach that supports caregivers and other family members of infants and young children.

In FY 2018 to 2020, grantees:

- Trained more than 3,500 clinicians and early childhood providers on evidence-based mental health treatments for infants and young children;
- Screened and assessed over 4,700 young children for developmental and behavioral disorders (including screening parents for behavioral health issues such as depression and substance misuse);
- Referred approximately 2,450 children and parents for treatment; and
- Provided infant and early childhood mental health treatment (including multigenerational therapies) to approximately 2,461 children and families.

In FY 2019, SAMHSA supported the continuation of nine grants. In FY 2020, SAMHSA continued to support nine continuation grants and awarded a new cohort of four grants. In FY 2021, SAMHSA will support 13 grant continuations and provide supplement to support COE-CMHC technical assistance.

Funding History

Fiscal Year	Amount
FY 2018	$5,000,000
FY 2019	$5,000,000
FY 2020	$7,000,000
FY 2021 Enacted	$8,000,000
FY 2022 Budget Request	$8,000,000

Budget Request

The FY 2022 budget request is $8.0 million, level with the FY 2021 Enacted. Funding will support the continuation of 13 grants and award a new cohort of two grants to increase access to a range of evidence-based and culturally appropriate infant and early childhood mental health services.

Outputs and Outcomes Table

Program: Infant and Early Childhood Mental Health

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.4.16 Number of children screened for mental health or related interventions (Output)	FY 2020: 4,719 Target: 2,500 (Target Exceeded)	4,700	4,700	Maintain
3.4.17 Number of children referred to mental health or related interventions (Output)	FY 2020: 2,339 Target: 1,034 (Target Exceeded)	2,300	2,300	Maintain
3.4.18 Number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the program. (Output)	FY 2020: 3,537 Target: 1,889 (Target Exceeded)	3,500	3,500	Maintain

Substance Abuse and Mental Health Services Administration

Mental Health

PRNS Mechanism Table Summary

(Dollars in thousands)

Program Activity	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Programs of Regional & National Significance						
Grants/Cooperative Agreements						
Continuations	765	352,562	643	378,511	870	494,884
New/Competing	203	120,210	334	131,821	243	212,315
Supplements*	---	18,902	---	8,552	---	500
Subtotal	968	491,674	977	518,884	1,113	707,698
Contracts						
Continuations	7	37,681	4	35,398	7	45,478
New/Competing	---	305	3	4,641	---	---
Subtotal	7	37,987	7	40,039	7	45,478
Total, Mental Health PRNS	**975**	**$529,661**	**984**	**$558,923**	**1,120**	**$753,176**

* Excluding Supplements number count to avoid duplication.

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Capacity:						
National Child Traumatic Stress Network						
Grants						
Continuations	100	$51,663	34	$16,147	127	$66,377
New/Competing	16	7,516	97	52,200	24	11,652
Supplements*	---	6,000	---	---	---	---
Subtotal	116	65,180	131	68,347	151	78,029
Contracts						
Continuations	---	3,707	---	3,540	---	3,858
New/Competing	---	---	---	---	---	---
Subtotal	---	3,707	---	3,540	---	3,858
Total ,National Child Traumatic Stress Network	**116**	**68,887**	**131**	**71,887**	**151**	**81,887**
Project AWARE						
Grants						
Continuations	197	84,930	79	85,117	220	126,717
New/Competing	31	33,758	157	39,323	136	55,661
Supplements*	---	275	---	75	---	50
Subtotal	228	118,963	236	124,515	356	182,428
Contracts						
Continuations	---	6,001	---	6,449	---	9,019
New/Competing	---	---	---	---	---	---
Subtotal	---	6,001	---	6,449	---	9,019
Total, Project AWARE	**228**	**124,964**	**236**	**130,964**	**356**	**191,447**
Healthy Transitions						
Grants						
Continuations	25	25,381	27	27,243	27	27,266
New/Competing	2	2,000	---	---	1	798
Supplements*	---	---	---	---	---	---
Subtotal	27	27,381	27	27,243	28	28,064
Contracts						
Continuations	---	1,570	---	2,208	---	1,387
New/Competing	---	---	---	---	---	---
Subtotal	---	1,570	---	2,208	---	1,387
Total, Healthy Transitions	**27**	**28,951**	**27**	**29,451**	**28**	**29,451**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Children and Family Programs						
Grants						
Continuations	1	375	18	5,534	21	6,467
New/Competing	18	5,509	3	930	---	---
Subtotal	19	5,884	21	6,464	21	6,467
Contracts						
Continuations	---	1,345	---	765	---	762
New/Competing	---	---	---	---	---	---
Subtotal	---	1,345	---	765	---	762
Total, Children and Family Programs	**19**	**7,229**	**21**	**7,229**	**21**	**7,229**
Consumer and Family Network Grants						
Grants						
Continuations	49	4,647	26	2,466	22	2,071
New/Competing	---	---	22	2,070	28	2,650
Subtotal	49	4,647	48	4,537	50	4,721
Contracts						
Continuations	---	307	---	417	---	233
New/Competing	---	---	---	---	---	---
Subtotal	---	307	---	417	---	233
Total, Consumer and Family Network Grants	**49**	**4,954**	**48**	**4,954**	**50**	**4,954**
Project LAUNCH						
Grants						
Continuations	31	22,420	31	22,287	31	22,493
New/Competing	---	---	---	---	---	---
Supplements*	---	---	---	---	---	---
Subtotal	31	22,420	31	22,287	31	22,493
Contracts						
Continuations	---	1,185	---	1,318	---	1,112
New/Competing	---	---	---	---	---	---
Subtotal	---	1,185	---	1,318	---	1,112
Total, Project LAUNCH	**31**	**23,605**	**31**	**23,605**	**31**	**23,605**
Mental Health System Transformation and Health Reform						
Grants						
Continuations	3	3,589	3	3,593	3	3,601
New/Competing	---	---	---	---	---	---
Supplements*	---	---	---	---	---	---
Subtotal	3	3,589	3	3,593	3	3,601
Contracts						
Continuations	---	190	---	186	---	178
New/Competing	---	---	---	---	---	---
Subtotal	---	190	---	186	---	178
Total, Mental Health System Transformation and	**3**	**3,779**	**3**	**3,779**	**3**	**3,779**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Primary and Behavioral Health Care Integration						
Grants						
Continuations	20	39,469	24	47,732	24	47,818
New/Competing	4	8,000	1	2,000	2	2,569
Supplements*	---	---	---	---	---	---
Subtotal	24	47,469	25	49,732	26	50,387
Contracts						
Continuations	---	2,408	---	3,145	---	2,490
New/Competing	---	---	---	---	---	---
Subtotal	---	2,408	---	3,145	---	2,490
Total, PBHCI	**24**	**49,877**	**25**	**52,877**	**26**	**52,877**
National Strategy for Suicide Prevention						
Grants						
Continuations	15	7,792	35	16,768	45	21,658
New/Competing	20	8,965	10	4,840	---	---
Supplements*	---	450	---	450	---	450
Subtotal	35	17,208	45	22,058	45	22,108
Contracts						
Continuations	---	992	---	1,142	---	1,092
New/Competing	---	---	---	---	---	---
Subtotal	---	992	---	1,142	---	1,092
Total, National Strategy for Suicide Prevention	**35**	**18,200**	**45**	**23,200**	**45**	**23,200**
GLS - Youth Suicide Prevention - States						
Grants						
Continuations	38	26,459	43	30,195	47	32,638
New/Competing	10	7,448	6	4,305	2	2,074
Subtotal	48	33,907	49	34,500	49	34,712
Contracts						
Continuations	---	1,520	---	1,927	---	1,715
New/Competing	---	---	---	---	---	---
Subtotal	---	1,520	---	1,927	---	1,715
Total, GLS - States	**48**	**35,427**	**49**	**36,427**	**49**	**36,427**
GLS - Youth Suicide Prevention - Campus						
Grants						
Continuations	46	4,526	37	3,631	41	4,061
New/Competing	16	1,600	25	2,538	16	2,046
Subtotal	62	6,126	62	6,169	57	6,108
Contracts						
Continuations	---	362	---	319	---	380
New/Competing	---	---	---	---	---	---
Subtotal	---	362	---	319	---	380
Total, GLS - Campus	**62**	**6,488**	**62**	**6,488**	**57**	**6,488**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
GLS - Suicide Prevention Resource Center						
Grants						
Continuations	---	---	1	7,587	1	7,587
New/Competing	1	7,587	---	970	---	989
Subtotal	1	7,587	1	8,557	1	8,576
Contracts						
Continuations	---	401	---	443	---	424
New/Competing	---	---	---	---	---	---
Subtotal	---	401	---	443	---	424
Total, GLS - Suicide Prevention Resource Center	**1**	**7,988**	**1**	**9,000**	**1**	**9,000**
Suicide Lifeline						
Grants						
Continuations	3	5,969	2	667	1	21,973
New/Competing	---	---	1	15,151	3	74,864
Supplements*	---	12,077	---	7,000	---	---
Subtotal	3	18,046	3	22,818	4	96,836
Contracts						
Continuations	---	950	---	1,182	---	4,785
New/Competing	---	4	---	---	---	---
Subtotal	---	954	---	1,182	---	4,785
Total, Suicide Lifeline	**3**	**19,000**	**3**	**24,000**	**4**	**101,621**
AI/AN Suicide Prevention Initiative						
Grants						
Continuations	1	500	1	500	1	500
New/Competing	---	---	---	---	---	---
Subtotal	1	500	1	500	1	500
Contracts						
Continuations	1	2,431	---	144	1	2,431
New/Competing	---	---	1	2,287	---	---
Subtotal	1	2,431	1	2,431	1	2,431
Total, AI/AN	**2**	**2,931**	**2**	**2,931**	**2**	**2,931**
Homelessness Prevention Programs						
Grants						
Continuations	43	23,572	48	26,788	48	26,751
New/Competing	5	3,500	---	---	1	322
Supplements*	---	---	---	---	---	---
Subtotal	48	27,071	48	26,788	49	27,073
Contracts						
Continuations	1	3,625	1	3,908	1	3,623
New/Competing	---	---	---	---	---	---
Subtotal	1	3,625	1	3,908	1	3,623
Total, Homelessness Prevention Programs	**49**	**30,696**	**49**	**30,696**	**50**	**30,696**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Comprehensive Opioid Recoverty Centers						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	2	1,700	---	---	---	---
Subtotal	2	1,700	---	---	---	---
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	300	---	---	---	---
Subtotal	---	300	---	---	---	---
Total, Comprehensive Opioid Recoverty Centers	**2**	**2,000**	**---**	**---**	**---**	**---**
Minority AIDS						
Grants						
Continuations	18	8,685	18	8,671	---	---
New/Competing	---	---	---	---	18	8,789
Subtotal	18	8,685	18	8,671	18	8,789
Contracts						
Continuations	---	539	---	553	---	435
New/Competing	---	---	---	---	---	---
Subtotal	---	539	---	553	---	435
Total, Minority AIDS	**18**	**9,224**	**18**	**9,224**	**18**	**9,224**
Criminal and Juvenile Justice Programs						
Grants						
Continuations	11	3,455	18	5,800	18	5,718
New/Competing	7	2,261	---	---	---	43,100
Subtotal	18	5,716	18	5,800	18	48,818
Contracts						
Continuations	1	553	---	315	1	2,576
New/Competing	---	---	1	155	---	---
Subtotal	1	553	1	469	1	2,576
Total, Criminal and Juvenile Justice Programs	**19**	**6,269**	**19**	**6,269**	**19**	**51,394**
Seclusion and Restraint						
Grants						
Continuations	11	1,043	11	1,080	11	1,093
New/Competing	---	---	---	---	---	---
Subtotal	11	1,043	11	1,080	11	1,093
Contracts						
Continuations	---	104	---	67	---	54
New/Competing	---	---	---	---	---	---
Subtotal	---	104	---	67	---	54
Total, Seclusion and Restraint	**11**	**1,147**	**11**	**1,147**	**11**	**1,147**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Assertive Community Treatment for Individuals with SMI						
Grants						
Continuations	7	4,740	10	6,736	12	8,166
New/Competing	3	1,995	2	1,356	---	410
Subtotal	10	6,735	12	8,092	12	8,576
Contracts						
Continuations	---	265	---	908	---	424
New/Competing	---	---	---	---	---	---
Subtotal	---	265	---	908	---	424
Total, Assertive Community Treatment for	**10**	**7,000**	**12**	**9,000**	**12**	**9,000**
Assisted Outpatient Treatment for Individuals with						
Grants						
Continuations	4	2,849	20	17,436	20	17,616
New/Competing	17	15,114	3	2,396	3	2,746
Supplements*	---	100	---	75	---	---
Subtotal	21	18,063	23	19,906	23	20,363
Contracts						
Continuations	---	937	---	522	---	1,057
New/Competing	---	---	---	572	---	---
Subtotal	---	937	---	1,094	---	1,057
Total, AOT for Individuals with SMI	**21**	**19,000**	**23**	**21,000**	**23**	**21,420**
Tribal Behavioral Health Grants						
Grants						
Continuations	120	10,105	124	16,647	117	17,156
New/Competing	40	7,251	6	1,452	6	889
Subtotal	160	17,356	130	18,100	123	18,045
Contracts						
Continuations	1	2,643	---	1,022	1	2,705
New/Competing	---	1	1	1,629	---	---
Subtotal	1	2,644	1	2,650	1	2,705
Total, Tribal Behavioral Health Grants	**161**	**20,000**	**131**	**20,750**	**124**	**20,750**
Infant and Early Childhood Mental Health						
Grants						
Continuations	9	4,431	13	6,354	13	6,408
New/Competing	4	1,949	1	1,252	2	1,216
Subtotal	13	6,380	14	7,606	15	7,623
Contracts						
Continuations	---	620	---	394	---	377
New/Competing	---	---	---	---	---	---
Subtotal	---	620	---	394	---	377
Total, Infant and Early Childhood Mental Health	**13**	**7,000**	**14**	**8,000**	**15**	**8,000**
Subtotal, Capacity	**952**	**$504,616**	**961**	**$532,878**	**1,096**	**$726,527**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Science and Service:						
Primary and Behavioral Health Care Integration TA						
Grants						
Continuations	1	1,889	1	1,889	1	1,889
New/Competing	---	---	---	---	---	---
Supplements*	---	---	---	---	---	---
Subtotal	1	1,889	1	1,889	1	1,889
Contracts						
Continuations	---	102	---	102	---	102
New/Competing	---	---	---	---	---	---
Subtotal	---	102	---	102	---	102
Total, PBHCI TA	**1**	**1,991**	**1**	**1,991**	**1**	**1,991**
Practice Improvement & Training						
Grants						
Continuations	5	4,995	5	5,476	5	5,605
New/Competing	---	50	---	---	---	---
Supplements*	---	---	---	---	---	---
Subtotal	5	5,045	5	5,476	5	5,605
Contracts						
Continuations	1	2,783	1	2,352	1	2,223
New/Competing	---	---	---	---	---	---
Subtotal	1	2,783	1	2,352	1	2,223
Total, Practice Improvement & Training	**6**	**7,828**	**6**	**7,828**	**6**	**7,828**
Consumer and Consumer-Supporter TA Centers						
Grants						
Continuations	---	---	5	1,806	5	1,828
New/Competing	5	1,806	---	---	---	---
Subtotal	5	1,806	5	1,806	5	1,828
Contracts						
Continuations	---	112	---	112	---	90
New/Competing	---	---	---	---	---	---
Subtotal	---	112	---	112	---	90
Total, CCSTAC	**5**	**1,918**	**5**	**1,918**	**5**	**1,918**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Disaster Response						
Grants						
Continuations	---	828	---	---	---	1,019
New/Competing	---	13	---	1,038	---	---
Subtotal	---	841	---	1,038	---	1,019
Contracts						
Continuations	1	1,112	1	915	1	934
New/Competing	---	---	---	---	---	---
Subtotal	1	1,112	1	915	1	934
Total, Disaster Response	**1**	**1,953**	**1**	**1,953**	**1**	**1,953**
Homelessness						
Grants						
Continuations	---	1,416	1	2,138	1	2,188
New/Competing	1	800	---	---	---	---
Subtotal	1	2,215	1	2,138	1	2,188
Contracts						
Continuations	---	81	---	158	---	108
New/Competing	---	---	---	---	---	---
Subtotal	---	81	---	158	---	108
Total, Homelessness	**1**	**2,296**	**1**	**2,296**	**1**	**2,296**
Minority Fellowship Program						
Grants						
Continuations	7	6,833	8	8,221	8	8,221
New/Competing	1	1,388	---	---	1	1,537
Supplements*	---	---	---	952	---	---
Subtotal	8	8,221	8	9,174	9	9,758
Contracts						
Continuations	1	838	1	885	1	905
New/Competing	---	---	---	---	---	---
Subtotal	1	838	1	885	1	905
Total, Minority Fellowship Program	**9**	**9,059**	**9**	**10,059**	**10**	**10,663**
Subtotal, Science and Service	**23**	**25,045**	**23**	**26,045**	**24**	**26,649**
Total, Mental Health PRNS	**975**	**$529,661**	**984**	**$558,923**	**1,120**	**$753,176**

* Excluding Supplements number count to avoid duplication.

Grant Awards Table

(Whole dollars)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	968	977	1113
Average Awards	$507,928	$531,099	$635,848
Range of Awards	$15,000 - $6,000,000	$15,000 - $6,000,000	$15,000 - $6,000,000

Children's Mental Health Services

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Children's Mental Health Services.....	$125,000	$125,000	$125,000	$---

Authorizing Legislation..... Sections 561 of the Public Health Service Act
FY 2022 Authorization..... $119,026,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities……. States, Tribes, Communities, Territories

Program Description and Accomplishments

It is estimated that over 7.4 million children and youth in the United States have a serious mental disorder. Unfortunately, only 41 percent of those in need of mental health services actually receive treatment.[35] Created in 1992, SAMHSA's Children's Mental Health Initiative (CMHI) addresses this gap by supporting "systems of care" (SOC) for children and youth with serious emotional disturbances (SED) and their families to increase their access to evidence-based treatment and supports.

The 21st Century Cures Act reauthorized the CMHI through FY 2022. It is estimated that approximately 9-13 percent of America's youth have a SED, the term analogous to serious mental illness when applied to children. CMHI provides grants to assist states, local governments, tribes, and territories in their efforts to deliver services and supports to meet the needs of children and youth with SED.

CMHI supports the development, implementation, expansion, and sustainability of comprehensive, community-based services that use the SOC approach. SOC is a strategic approach to the delivery of services and supports that incorporates family-driven, youth-guided, strength-based, and culturally and linguistically competent care in order to meet the physical, intellectual, emotional, cultural, and social needs of children and youth throughout the U.S. The SOC approach helps prepare children and youth for successful transition to adulthood and assumption of adult roles and responsibilities. Services are delivered in the least restrictive environment with evidence-supported treatments and interventions. Individualized care management ensures that planned services and supports are delivered with an appropriate, effective, family-driven, and youth-guided approach. This approach has demonstrated improved outcomes for children at home, at school, and in their communities. For example, CMHI grantee data show that suicide attempt rates significantly decreased within 12 months after children and youth accessed CMHI-related SOC services. The proportion of children and youth who received good grades (defined as an average grade of C or better on the previous report card) significantly increased after 12 months of services, and arrest rates significantly decreased after 12 months of

[35] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2016 National Survey on Drug Use and Health.

children and youth beginning SOC-related services and supports.[36] In addition, the CMHI program seeks to address behavioral health disparities for children and youth with SED/Serious Mental Illness (SMI) from racial and ethnic minorities by promoting clear and culturally competent strategies to improve their access, use of services, and outcomes.

SAMHSA funding ensures that grantees will continue to expand and sustain CMHI SOC values, principles, infrastructure, and services throughout their states, tribes, and territories. A central focus of these efforts is ensuring collaboration between the CMHI SOC and other child-and youth-serving systems (e.g., Child Welfare, Juvenile Justice, and Education). SAMHSA also strongly encourages efforts by CMHI SOC grantees to coordinate with other SAMHSA programs, such as those supported by the Community Mental Health Services Block Grant (MHBG)and Substance Abuse Prevention and Treatment Block Grant (SABG)**.**

CMHI is in the final year of the national evaluation contract for the 2015 cohort, which is designed to provide information on: (1) the mental health outcomes of children and youth, and their families; (2) the implementation, process, and sustainability of SOC; and (3) critical and emerging issues in children's and youth's mental health. The evaluation includes an SOC assessment that describes the infrastructure and an assessment of outcomes derived from direct SOC services. A service experience study evaluates: (1) change in service use patterns of children and their families; (2) differences in client satisfaction between groups of children (and their families) in the SOC communities who receive an evidence-based treatment and those who do not; and (3) retention in services.

The Annual Report to Congress for this program provides national data indicating that CMHI SOCs are successful and result in many favorable outcomes for children, youth, and their families, including the following:

- **Significant, overall improvement in mental, emotional, and behavioral functioning from intake to follow-up.**
    - 12% decrease in total symptoms.
    - 12% decrease for externalizing symptoms.
    - 15% decrease for internalizing symptoms.
    - 11% decrease for attention problems.

- **Significant overall functional improvement from intake to follow-up:** Impairment rate decreased from 21.9% to 18.2%, improvement by 3.7%.

- **Improvement in Overall Health:** More children, youth, and young adults were healthy overall at follow-up (87.6%) compared to intake (81.5%), which represents a significant positive percent change of 7.46%.

[36] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, (2016). *The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program, Report to Congress 2016.* https://store.samhsa.gov/shin/content//PEP18-CMHI2016/PEP18-CMHI2016.pdf.

- **Improvement in Everyday Functioning:** Children, youth, and young adults functioning in everyday life significantly improved at follow-up (67.6%) compared to intake (41.2%), which represents a positive change of 64.0%.

- **Improvement in Psychological Distress:** More children, youth, and young adults reported no serious psychological distress at follow-up (89.1%) compared to intake (75.8%), which represents a positive change of 17.5%.

- **Improvement in Illegal Substance Use:** More children, youth, and young adults reported that they were not using illegal substances at follow-up (78.8%) compared to intake (74.0%), which represents a positive change of 6.6%.

- **Improvement in Retention in Community:** More children, youth, and young adults were retained in the community at follow-up (92.0%) compared to intake (85.3%), which represents a 10.4%.

- **Improvement in Education/Employment:** More children, youth, and young adults were attending school regularly or were currently employed at follow-up (90.4%) compared to intake (83.3%), which represents an 8.5% improvement.

- **Improvement in Social Connectedness:** More children, youth, and young adults reported being more socially connected at follow-up (89.2%) compared to intake (76.1%), which represents a significant positive percent change of 17.3%.

In FY 2019, SAMHSA supported 49 continuation grants, 28 new grants, and 2 contracts. In FY 2020, SAMHSA supported 44 continuation grants, 30 new grants, and a new technical assistance center. In FY 2021, SAMHSA will support 63 continuation grants, and award a new cohort of 10 new grants, and a technical assistance center.

Set-aside for Early Intervention Demonstration Program for Youth and Young Adults at Clinical High Risk for Psychosis

In FY 2018, SAMHSA implemented the Community Programs for Outreach with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P) often referred to as the "prodrome phase;" which is when a disease process has begun but is not yet diagnosable or inevitable. SAMHSA awarded 21 grants funded from a 10 percent set-aside of the base CMHI program . The program addresses if community-based intervention during this phase can prevent the development of psychosis. Grantees focus on youth and young adults who are identified to be at clinical high risk for developing a fist episode of psychosis. Grantees focus on this population in order to support the development and implementation of evidence-based programs providing community outreach and psychosocial interventions for youth and young adults in the prodrome phase of psychotic illness.

In FY 2019, SAMHSA funded 21 continuation grants funded from the 10 percent set-aside. In FY 2020, SAMHSA funded 21 continuation grants. In FY 2021, SAMHSA will support 21 continuation grants and award a new cohort of 10 grants.

Funding History

Fiscal Year	Amount
FY 2018	$125,000,000
FY 2019	$125,000,000
FY 2020	$125,000,000
FY 2021 Enacted	$125,000,000
FY 2022 Budget Request	$125,000,000

Budget Request

The FY 2022 budget request is $125.0 million, level with the FY 2021 Enacted. The budget requests will support the continuations of 10 Clinical High Risk for psychosis (CHR-P) grants and fund a new cohort of 20 grants under the 10 percent set-aside. In addition, funding will support 67 CMHI continuation grants, a new cohort of eight CMHI grants, and a technical assistance center.

Outputs and Outcomes Table

Program: Children's Mental Health Initiative Measure

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.2.16 Number of children with severe emotional disturbance that are receiving services from the Children's Mental Health Initiative (Output)	FY 2020: 11,332 Target: 12,690 (Target Not Met)	11,300	11,300	Maintain
3.2.25 Percentage of children receiving services who report positive social support at 6 month follow-up (Outcome)	FY 2020: 77.8 % Target: 87.1 % (Target Not Met)	77.0 %	77.0 %	Maintain
3.2.26 Percentage of children receiving Systems of Care mental health services who report positive functioning at 6 month follow-up (Outcome)	FY 2020: 63.0 % Target: 63.4 % (Target Not Met)	63.4 %	63.4 %	Maintain
3.2.27 Number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the program (Output)	FY 2020: 54,578 Target: 75,624 (Target Not Met)	54,500	54,500	Maintain

SAMHSA/Mental Health
Children's Mental Health Services
Mechanism Table

(Dollars in thousands)

Program Activity	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Children's Mental Health Services						
Grants/Cooperative Agreements						
Continuations	65	$74,925	85	$98,966	78	$100,893
New/Competing	31	43,496	20	19,804	28	18,147
Subtotal	96	118,421	105	118,770	106	119,040
Contracts						
Continuations	---	6,579	---	6,230	---	5,960
New/Competing	---	---	---	---	---	---
Subtotal	---	6,579	---	6,230	---	5,960
Total, Children's Mental Health Services	**96**	**$125,000**	**105**	**$125,000**	**106**	**$125,000**

Grant Awards Table

(Whole dollars)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	96	105	106
Average Awards	$1,233,547	$1,131,140	$1,123,016
Range of Awards	$330,000 - $2,000,000	$330,000 - $2,000,000	$330,000 - $2,000,000

Projects for Assistance in Transition from Homelessness

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
PATH	$64,635	$64,635	$64,635	$

Authorizing Legislation..... Section 535(a) of the Public Health Service Act
FY 2022 Authorization..... $64,635,000
Allocation Method ..... Formula Grants
Eligible Entities.....States and Territories

Program Description and Accomplishments

The Projects for Assistance in Transition from Homelessness (PATH) program was originally authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 and has been reauthorized as part of the Public Health Service Act. The PATH program supports 56 grants to the 50 states, the District of Columbia, Puerto Rico, Guam, American Samoa, the United States Virgin Islands, and the Northern Mariana Islands, as well as centralized activities such as technical assistance and evaluation.

PATH was reauthorized by the 21st Century Cures Act in December 2016. PATH funds community-based outreach, mental illness and substance use disorder treatment services, case management, assistance with accessing housing, and other supportive services. PATH helps to engage people with SMI into mental disorder treatment as well as persons with SMI with a co-occurring substance use disorder. PATH outreach workers are specialized in engaging those who are most vulnerable in their communities and who are least likely to seek out services on their own. PATH's primary goal is to bring the most vulnerable into the service system and to connect them with the mainstream resources and supportive services that they need in order to access and sustain stable housing, build social connections, and access treatment and services to support their recovery.

In 2020, an estimated 580,466 individuals experienced homelessness on an average night, an increase of 2.2 percent, from 2019[37] The U.S. Department of Housing and Urban Development (HUD) defines a person as homeless if he or she "lacks a fixed, regular, and adequate nighttime residence". On a single night each year, communities count and report their homeless population to HUD, including people who are unsheltered (in places not intended for human habitation such as sidewalks, parks, cars, or abandoned buildings) and people who are sheltered (in emergency shelters or transitional programs). [38] Data suggest that approximately 20 percent of individuals experiencing homelessness have a serious mental illness (SMI).[39] Mental illness affects

37 The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2020). The 2020 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. Available at: https://www.huduser.gov/portal/sites/default/files/pdf2020-AHAR-Part-1.pdf
38 The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2020). The 2020 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. Available at: https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf
39 The U.S. Department of Housing and Urban Development, 2020 CoC Homeless Populations and Subpopulations Reports. Available at https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2020.pdf

individuals' abilities to maintain stable relationships, perform daily living activities, and maintain stable employment. Symptoms of mental disorders also often cause individuals to become estranged from family members and caregivers, leaving them without a support system. As a result, individuals with a mental illness are more likely to experience homelessness than those without mental illness and experience homelessness longer than the rest of the homeless population.

PATH program's efforts to identify primary care, behavioral disorder treatment, and housing for individuals who experience chronic homelessness is two to three times more cost effective than having them in the criminal justice system or treating them via other costly healthcare settings (e.g., emergency rooms, critical care units).

Government wide efforts to target the most vulnerable, including people experiencing chronic homelessness and veterans, may have served to reduce the number of people on the streets. In 2010, 106,107 of the people identified in the Point in Time (PIT) survey administered annually by HUD were experiencing chronic homelessness. By 2016, the number of people experiencing chronic homelessness was at its lowest, at 77,486. The following year, 2017, the number of individuals with chronic patterns of homelessness increased to 86.705. In 2018, the number increased to 88,640 followed by another increase in to 96,141 in 2019. This year is the first time since 2011 that the number of people with chronic patterns of homelessness exceeded 100,000. The number of people experiencing chronic homelessness in 2020 increased to 110,528, approximately 15 percent from 2019. The recent increase was driven by a considerable increase in the number of sheltered individuals with chronic patterns of homelessness. [40]

Veterans were first tracked in the 2011 Continuum of Care Homeless Assistance Programs report on homeless populations and subpopulations. That year, 65,455 veterans were identified during the PIT. By 2020, that number had dropped to 37,253 or by 57 percent. This may be attributed to the additional resources created at the federal level to address veteran homelessness.

In FY 2020, PATH program staff contacted 116,109 persons experiencing homelessness; of those 60,455 were actively enrolled in PATH at some point during the reporting period.

40 The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2020). The 2020 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. Available at: https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf

Of the 66,458 people who were actively enrolled in PATH in 2019, 26,963 were experiencing co-occurring drug/alcohol use disorders. Of those enrolled in PATH, 29,186 were receiving community mental health services, 6,793 received substance use disorder treatment and 8,847 received referrals to substance use disorder treatment services in the community. PATH provided housing/moving assistance to 2,311 individuals, housing eligibility determination services to 14,988 individuals, and one-time rent eviction support services to 1,258 individuals. In addition, 17,234 PATH clients were referred to permanent housing and of those, 7,581 were able to attain permanent housing. Of the 12,597 PATH clients who were referred to temporary housing, 8,094 attained the temporary housing. Services provided by the PATH program fill gaps in existing community resources and play a crucial role in communities' strategic plans to end homelessness.

Funding History

Fiscal Year	Amount
FY 2018	$64,635,000
FY 2019	$64,635,000
FY 2020	$64,635,000
FY 2021 Enacted	$64,635,000
FY 2022 Budget Request	$64,635,000

Budget Request

The FY 2022 budget request is $64.6 million, level with the FY 2021 Enacted. This formula-based funding to all fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands will continue to provide PATH services in over 500 communities to support outreach workers and mental health specialists who engage with individuals living with SMI or those living with both SMI and drug/alcohol addiction and are homeless or at imminent risk of becoming homeless. The services provided by the program help ensure that these individuals have an opportunity to access stable housing, improve their health and wellness, lead self-directed lives, and achieve their full potential.

Outputs and Outcomes Table

Program: Projects for Assistance in Transition from Homelessness

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.4.15 Percentage of enrolled homeless persons in the Projects for Assistance in Transition from Homelessness (PATH) program who receive community mental health services (Intermediate Outcome)	FY 2020: 65 % Target: 64 % (Target Exceeded)	64 %	64 %	Maintain
3.4.16 Number of homeless persons contacted (Outcome)	FY 2020: 127,256 Target: 125,000 (Target Exceeded)	125,000	125,000	Maintain
3.4.17 Percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome)	FY 2020: 57 % Target: 57 % (Target Met)	57 %	57 %	Maintain
3.4.20 Number of Projects for Assistance in Transition from Homelessness (PATH) providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits (Output)	FY 2020: 2,647 Target: 2,214 (Target Exceeded)	2,647	2,647	Maintain

Substance Abuse and Mental Health Services Administration
FY 2022 PATH Formula Grant Estimate Allotments
Appropriation Amount $64,635,000, State-Territory Total $61,597,847
CFDA # 93.150

State or Territory	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget	FY 2022 +/- FY 2021
Alabama	$613,087	$613,059	$613,059	$ -
Alaska	300,000	300,000	300,000	-
Arizona	1,349,348	1,349,288	1,349,288	-
Arkansas	303,956	303,942	303,942	-
California	8,813,505	8,813,107	8,813,107	-
Colorado	1,019,165	1,019,120	1,019,120	-
Connecticut	799,408	799,372	799,372	-
Delaware	300,000	300,000	300,000	-
District of Columbia	300,000	300,000	300,000	-
Florida	4,334,533	4,334,339	4,334,339	-
Georgia	1,670,086	1,670,011	1,670,011	-
Hawaii	300,000	300,000	300,000	-
Idaho	300,000	300,000	300,000	-
Illinois	2,705,316	2,705,195	2,705,195	-
Indiana	1,011,549	1,011,504	1,011,504	-
Iowa	334,573	334,559	334,559	-
Kansas	377,407	377,391	377,391	-
Kentucky	468,924	468,904	468,904	-
Louisiana	733,078	733,046	733,046	-
Maine	300,000	300,000	300,000	-
Maryland	1,271,592	1,271,535	1,271,535	-
Massachusetts	1,558,935	1,558,865	1,558,865	-
Michigan	1,729,644	1,729,567	1,729,567	-
Minnesota	811,023	810,987	810,987	-
Mississippi	300,000	300,000	300,000	-
Missouri	893,819	893,779	893,779	-
Montana	300,000	300,000	300,000	-
Nebraska	300,000	300,000	300,000	-
Nevada	615,965	615,938	615,938	-
New Hampshire	300,000	300,000	300,000	-

Substance Abuse and Mental Health Services Administration
FY 2022 PATH Formula Grant Estimate Allotments
Appropriation Amount $64,635,000, State-Territory Total $61,597,847
CFDA # 93.150

State or Territory	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget	FY 2022 +/- FY 2021
New Jersey	2,138,248	2,138,153	2,138,153	-
New Mexico	300,000	300,000	300,000	-
New York	4,233,324	4,223,135	4,223,135	-
North Carolina	1,379,673	1,379,612	1,379,612	-
North Dakota	300,000	300,000	300,000	-
Ohio	1,986,586	1,986,497	1,986,497	-
Oklahoma	452,853	452,833	452,833	-
Oregon	631,039	631,011	631,011	-
Pennsylvania	2,367,006	2,366,900	2,366,900	-
Rhode Island	300,000	300,000	300,000	-
South Carolina	680,251	680,221	680,221	-
South Dakota	300,000	300,000	300,000	-
Tennessee	909,811	909,771	909,771	-
Texas	4,995,795	4,995,571	4,995,571	-
Utah	591,503	591,476	591,476	-
Vermont	300,000	300,000	300,000	-
Virginia	1,472,281	1,472,215	1,472,215	-
Washington	1,329,229	1,329,170	1,329,170	-
West Virginia	300,000	300,000	300,000	-
Wisconsin	836,690	836,653	836,653	-
Wyoming	300,000	300,000	300,000	-
Puerto Rico	891,161	891,121	891,121	-
Guam	50,000	50,000	50,000	-
Virgin Islands	50,000	50,000	50,000	-
American Samoa	50,000	50,000	50,000	-
Northern Mariana Islands	50,000	50,000	50,000	-

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
PAIMI	$36,146	$36,146	$36,146	$

Authorizing Legislation……. The PAIMI Act, 42 U.S.C. 10801 et seq.
FY 2022 Authorization..... $19,500,000
Allocation Method ..... Formula Grants
Eligible Entities……...States and Territories

Program Description and Accomplishments

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program ensures that the most vulnerable individuals with significant mental illness and significant emotional impairment , especially those residing in public and private residential care and treatment facilities, are free from abuse, including inappropriate restraint and seclusion, neglect, and rights violations while receiving appropriate mental disorder treatment and discharge planning services.

The Protection and Advocacy for Individuals with Mental Illness Act of 1986, as amended by the Children's Health Act of 2000, extended the protections of the Developmental Disabilities (DD) Assistance Act of 1975 to individuals with significant mental illness (adults) and significant emotional impairments (children/youth) at risk for abuse, neglect, and rights violations while residing in public or private care treatment facilities; or living in a community setting, including their own homes. The PAIMI Act authorized the same governor-designated state protection and advocacy (P&A) systems established under the DD Assistance Act of 1975 to receive PAIMI Program formula grant awards from SAMHSA.

The PAIMI Program supports legal-based advocacy services that are provided by the 57 governor-designated P&A systems, which include states, territories, and the District of Columbia. Each system is mandated to: (1) ensure that the rights of individuals with mental illness who are at risk of abuse, neglect, and rights violations while residing in public or private care or treatment facilities or living in a community setting are protected;(2) protect and advocate for the rights of these individuals through activities that ensure the enforcement of the Constitution and federal and state statutes; and (3) investigate incidents of abuse and/or neglect of individuals with mental illness. The priority for services are for individuals who are an in-patient or resident of public or private care and treatment facilities for individuals with mental illness.

In FY 2020, the 57 state PAIMI Programs:

- Served 9,821 PAIMI-eligible individuals/clients: 345 ages 0 to 10, 1,821 ages 11 to 22, 6,866 age 23-64, 659 age 65 and older, and 130 individuals whose age is unknown. Grantees helped these individuals file 7,688 complaints alleging abuse, neglect, and/or rights violations.

- Resolved 94 percent of abuse allegations, 91 percent of neglect allegations, and 95 percent of rights violations allegations, and attained outcomes that resulted in positive change for the clients served. These positive outcomes included receipt of appropriate medical and mental disorder treatment; safer, cleaner facility environment; discharge into an appropriate community-based setting; and discharge from a nursing facility.

In FY 2020, SAMHSA funded 57 annual grants to states and territories as well as the training and technical assistance activities for the grantees. In FY 2021, SAMHSA anticipates the same funding at the same level as FY 2020 for 57 annual grants.

Funding History

Fiscal Year	Amount
FY 2018	$36,146,000
FY 2019	$36,146,000
FY 2020	$36,146,000
FY 2021 Enacted	$36,146,000
FY 2022 Budget Request	$36,146,000

Budget Request

The FY 2022 budget request is $36.1 million, level with the FY 2021 Enacted. PAIMI programs will continue to focus on addressing abuse and neglect issues for vulnerable populations and advocate for the rights of individuals with mental illness as well as continue to assist individuals with serious mental illness increase access to treatment.

Outputs and Outcomes Table

Program: Protection and Advocacy for Individuals with Mental Illness

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.4.12 Number of people served by the PAIMI program (Outcome)	FY 2020: 9,821 Target: 10,450 (Target Not Met)	9,821	9,821	Maintain
3.4.19 Number attending public education/constituency training and public awareness activities (Output)	FY 2020: 267,308 Target: 100,000 (Target Exceeded)	267,308	267,308	Maintain
3.4.21 Percentage of complaints of alleged abuse, neglect, and rights violations substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, elimination of other barriers to personal decision-making, as a result of Protection and Advocacy for Individuals with Mental Illness (PAIMI) involvement (Outcome)	FY 2020: 93 % Target: 89 % (Target Exceeded)	93 %	93 %	Maintain

Substance Abuse and Mental Health Services Administration
FY 2022 PAIMI Formula Grant Estimate Allotments
Appropriation $36,146,000, State-Territory Total $35,333,102
CFDA # 93.138

State or Territory	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget	FY 2022 +/- FY 2021
Alabama	$454,402	$458,033	$458,033	$ -
Alaska	428,000	428,000	428,000	-
Arizona	641,505	654,516	654,516	-
Arkansas	428,000	428,000	428,000	-
California	3,043,159	3,019,439	3,019,439	-
Colorado	450,031	451,860	451,860	-
Connecticut	428,000	428,000	428,000	-
Delaware	428,000	428,000	428,000	-
District of Columbia	428,000	428,000	428,000	-
Florida	1,801,228	1,823,324	1,823,324	-
Georgia	931,818	936,003	936,003	-
Hawaii	428,000	428,000	428,000	-
Idaho	428,000	428,000	428,000	-
Illinois	1,031,488	1,024,388	1,024,388	-
Indiana	588,634	590,974	590,974	-
Iowa	428,000	428,000	428,000	-
Kansas	428,000	428,000	428,000	-
Kentucky	428,000	428,000	428,000	-
Louisiana	428,000	428,000	428,000	-
Maine	428,000	428,000	428,000	-
Maryland	462,191	461,915	461,915	-
Massachusetts	500,628	499,913	499,913	-
Michigan	869,127	870,556	870,556	-
Minnesota	448,703	448,602	448,602	-
Mississippi	428,000	428,000	428,000	-
Missouri	540,864	537,485	537,485	-
Montana	428,000	428,000	428,000	-
Nebraska	428,000	428,000	428,000	-
Nevada	428,000	428,000	428,000	-
New Hampshire	428,000	428,000	428,000	-

Substance Abuse and Mental Health Services Administration
FY 2022 PAIMI Formula Grant Estimate Allotments
Appropriation $36,146,000, State-Territory Total $35,333,102
CFDA # 93.138

State or Territory	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget	FY 2022 +/- FY 2021
New Jersey	670,077	658,968	658,968	-
New Mexico	428,000	428,000	428,000	-
New York	1,476,892	1,441,606	1,441,606	-
North Carolina	917,038	927,784	927,784	-
North Dakota	428,000	428,000	428,000	-
Ohio	1,011,130	1,014,623	1,014,623	-
Oklahoma	428,000	428,000	428,000	-
Oregon	428,000	428,000	428,000	-
Pennsylvania	1,040,125	1,035,077	1,035,077	-
Rhode Island	428,000	428,000	428,000	-
South Carolina	463,238	467,601	467,601	-
South Dakota	428,000	428,000	428,000	-
Tennessee	590,472	599,542	599,542	-
Texas	2,437,992	2,449,916	2,449,916	-
Utah	428,000	428,000	428,000	-
Vermont	428,000	428,000	428,000	-
Virginia	677,110	679,379	679,379	-
Washington	578,507	581,605	581,605	-
West Virginia	428,000	428,000	428,000	-
Wisconsin	490,949	490,174	490,174	-
Wyoming	428,000	428,000	428,000	-
Puerto Rico	512,416	507,319	507,319	-
American Samoa	229,300	229,300	229,300	-
Guam	229,300	229,300	229,300	-
American Indian Consortium	229,300	229,300	229,300	-
Northern Mariana Islands	229,300	229,300	229,300	-
Virgin Islands	229,300	229,300	229,300	-

Certified Community Behavioral Health Clinic (CCBHC)

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Certified Community Behavioral Health Clinic.....	$200,000	$250,000	$375,000	$125,000

Authorizing Legislation.....Section 520A of the Public Health Service Act
FY 2022 Authorization..... $150,000,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities……Certified Community Behavioral Health Clinics, Community-based Behavioral Health Clinics

Program Description and Accomplishments

It is estimated that more than 13 million adults 18 and older had a serious mental illness (SMI), more than 17 million adults misused prescription drugs, and about 19 million adults had an illicit drug or alcohol use disorder in the past year.[41] While effective treatment and supportive services exist, many individuals with behavioral health conditions do not receive the help they need. When they do try to access services, they may face significant delays and/or get connected to incomplete, disconnected, or uncoordinated care. Even people who receive some services, such as medication or talk therapy, often do not have access to the complete range of supports they need, such as help to get them through a crisis, manage co-occurring physical health problems, find and sustain employment, and maintain a safe place to live in the community.

Congress created a new approach to addressing these issues through Certified Community Behavioral Health Clinics (CCBHCs) as a part of the Protecting Access to Medicare Act of 2014. CCBHC's ensure access to and coordination of care so that individuals receive timely diagnosis, treatment, and recovery support services. Through this program, HHS has established criteria for clinics to be certified as CCBHCs. These criteria cover six administrative areas that CCBHCs must address to be certified: (1) staffing; (2) availability and accessibility of services; (3) care coordination; (4) scope of services; (5) quality and other reporting; and (6) organizational authority. In FY 2016, SAMHSA assisted 24 states through planning grants to be eligible for a CCBHC demonstration, and in FY 2017, CMS launched the demonstration program, which supported CCBHCs in eight states through a Medicaid prospective payment system.

The CCBHC-Expansion (CCBHC-E) program is designed to increase access to and improve the quality of community behavioral health services. CCBHC's funded under this program must provide access to services for individuals with serious mental illness (SMI) or substance use disorders (SUD, including opioid disorders; children and adolescents with serious emotional disturbance (SED); and individuals with co-occurring mental and substance use disorders (COD). Crisis services are a required element of the CCBHC model. SAMHSA expects that this program will improve the behavioral health of individuals across the nation by providing increased access to a good range of services. These include comprehensive community-based mental and substance

41 SAMHSA, Center for Behavioral Health Statistics and Quality. (2017, September 7). Results from the 2016 National Survey on Drug Use and Health: Detailed tables. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf

use disorder services; treatment of co-occurring disorders; advancing the integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis and promoting improved access to high quality care. Broad uptake of the CCBHC model solves a number of access and quality problems that exist in our current national landscape of services for persons with SMI and SED.

In FY 2018, SAMHSA implemented the CCBHC Expansion (CCBHC-E) grant program and awarded 52 grants to create new CCBHC expansions. In FY 2019, 12 new CCBHC-E grants were awarded, and eligibility was limited to the 24 states that participated in the FY 2016 Planning Grants for Certified Community Behavioral Health Clinics Grant program. In FY 2020, an additional 102 CCBHC-E grants were awarded by CMHS, but eligibility was not limited to the 24 FY 2016 planning states. An additional 64 CCBHC-E grants were funded by CARES Act funding appropriated through the Health Surveillance and Program Support COVID-19. In addition, SAMHSA will award a new cohort through the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 and the American Rescue Plan Act.
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The table below provides a demographic breakdown of the clients served by the CCBHCs.

Demographics	%
Race	
American Indian	4.4%
Asian	1.4%
Black	26.3%
Native Hawaiian/ Alaska Native	1.0%
White	75.0%
Ethnicity	
Hispanic	13.4%
Non-Hispanic	86.6%
Gender	
Male	47.0%
Female	52.3%
Transgender	0.4%
Other	0.3%
Age	
17 and under	22.0%
18 through 25	12.9%
26 through 45	37.4%
46 through 65	26.1%
66 and older	2.8%

The table below includes the amount of CCBHC-E funding awarded to community behavioral health clinics in each state for the grants initially awarded in FY 2018 and FY 2019, the grants awarded through the FY 2020 Budget, and FY 2020 CARES Act funding. The total awards

also include CARES Act funding that was appropriated to Health Surveillance and Program Support.

States	FY 2018 and FY 2019 Total Award	FY 2020 Budget Award	FY 2020 CARES Act Award
Alaska	-	2,000,000.00	4,000,000.00
Arkansas	-	3,784,113.00	4,000,000.00
California	-	5,995,620.00	8,000,000.00
Colorado	4,000,000.00	2,000,000.00	4,000,000.00
Connecticut	3,816,087.00	8,000,000.00	11,663,642.00
Florida	-	5,983,150.00	-
Georgia	-	2,000,000.00	-
Illinois	4,000,000.00	4,000,000.00	12,000,000.00
Indiana	7,487,309.00	5,754,223.00	11,049,390.00
Iowa	5,995,754.00	9,842,453.00	7,992,877.00
Kansas	-	1,999,817.00	-
Kentucky	8,000,000.00	8,000,000.00	4,000,000.00
Maryland	7,369,546.00	2,000,000.00	-
Massachusetts	13,815,812.00	19,836,454.00	11,907,664.00
Michigan	30,810,057.00	19,582,567.00	38,530,722.00
Minnesota	6,698,384.00	3,947,094.00	-
Missouri	10,705,359.00	5,986,083.00	7,849,834.00
Nebraska	-	3,999,607.00	-
Nevada	4,000,000.00	-	-
New Jersey	21,659,768.00	11,675,742.00	14,343,311.00
New York	25,175,329.00	37,035,028.00	54,609,663.00
North Carolina	3,122,602.00	4,886,998.00	3,957,711.00
Ohio	-	2,000,000.00	4,000,000.00
Oklahoma	14,974,106.00	5,822,801.00	8,000,000.00
Oregon	6,861,840.00	3,340,879.00	4,000,000.00
Pennsylvania	8,212,845.00	8,101,055.00	3,996,953.00
Rhode Island	2,000,000.00	3,695,402.00	4,000,000.00
Tennessee	-	-	8,000,000.00
Texas	21,830,701.00	14,578,015.00	11,784,318.00
Virginia	5,724,687.00	4,000,000.00	3,971,825.00
Washington	-	5,991,182.00	-
West Virginia	-	3,999,871.00	-
Wisconsin	-	-	4,000,000.00
Total	**216,260,186.00**	**219,838,154.00**	**249,657,910.00**

Since its inception, CCBHC-E grantees have served over 54,000 individuals. CCBHC-E grantees have increased the availability of critical services, improved staffing and training, reduced wait times, enhanced the integration of physical and behavioral health care, expanded addiction treatment capacity including Medication Assisted Treatment (MAT) for opioid use disorder. CCBHC-E grantees have improved the use of data, improved services to veterans and service members, and provided increased outreach and engagement with a variety of vulnerable populations.

In FY 2020, SAMHSA awarded a new cohort of 102 grants. SAMHSA also awarded 64 grants through the CARES Act. In FY 2021, SAMHSA will support 102 grant continuations, 22 new grants, and a Training and Technical Assistance Center. In addition, SAMHSA will award a new cohort through the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 and the American Rescue Plan Act.

Funding History

Fiscal Year	Amount
FY 2018	$100,000,000
FY 2019	$150,000,000
FY 2020	$200,000,000
FY 2021 Enacted	$250,000,000
FY 2022 Budget Request	$375,000,000

Budget Request

The FY 2022 budget request is $375.0 million, an increase of $125.0 million from the FY 2021 Enacted level to fund a new cohort of 158 grants and 22 continuation grants to continue the improvement of mental disorder treatment, services, and interventions for children and adults.

Outputs and Outcomes Table

Program: Certified Community Behavioral Health Clinic

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.4.10 Percentage of clients receiving services who report positive functioning at 6 months follow-up. (Outcome)	FY 2020: 56.1 Target: 58.9 (Target Not Met)	56.0	56.0	Maintain
3.4.11 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2019: 36.0 Target: 39.0 (Target Not Met)	36.0	36.0	Maintain
3.4.12 Percentage of clients receiving services who have a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2020: 64.9 Target: 60.6 (Target Exceeded)	60.6	60.6	Maintain
3.5.10 Number of individuals served by the program (Output)	FY 2020: 76,587.0 Target: 31,969.0 (Target Exceeded)	76,000.0	85,000.0	+9,000

SAMHSA/Mental Health
Certified Community Behavioral Health Clinics
Mechanism Table

(Dollars in thousands)

Program Activity	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Certified Community Behavioral Health Clinics						
Grants/Cooperative Agreements						
Continuations	12	$23,023	102	$195,709	23	$46,586
New/Competing	102	196,815	23	44,172	157	313,789
Subtotal	114	219,838	125	239,881	180	360,375
Contracts						
Continuations	---	6,751	---	7,706	---	14,625
New/Competing	---	---	---	3,000	---	---
Subtotal	---	6,751	---	10,706	---	14,625
Total, Certified Community Behavioral Health Clinics	**114**	**$226,589**	**125**	**$250,587**	**180**	**$375,000**
Enacted		**$200,000**		**$250,000**		
FY 2018 Carryover		**$1,048**				
FY 2019 Carryover		**$25,541**				
FY 2020 Carryover				**$587**		

Grant Awards Table

(Whole dollars)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	114	125	180
Average Awards	$1,928,405	$1,919,047	$2,003,255
Range of Awards	$886,998-$2,000,000	$886,998-$2,000,000	$1,000,000-$2,000,000

Community Mental Health Services Block Grant (MHBG)

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Community Mental Health Services Block Grant.....	$722,571	$757,571	$1,582,571	$825,000
Budget Authority (non-add).....	*701,532*	*736,532*	*1,561,532*	*825,000*
PHS Evaluation Funds (non-add).....	*21,039*	*21,039*	*21,039*	-

Authorizing Legislation……. Sections 1911 of the Public Health Service Act
FY 2022 Authorization $532,571,000
Allocation Method ..... Formula Grant
Eligible Entities ..... States, Territories, Freely Associated States, and District of Columbia

Program Description and Accomplishments

Serious mental illnesses are more common in the United States than is generally realized. According to the 2019 National Survey on Drug Use and Health (NSDUH)[42], 5.2% of adults aged 18 and older had a serious mental illness in 2019 (an estimated 11,131,000 individuals) and only 6,200,000 adults with SMI received services (47.7% received services in 2019).

Since 1992, the Community Mental Health Services Block Grant (MHBG) has distributed funds to 59 eligible states and territories and freely associated states through a formula based upon specified economic and demographic factors.[43] The MHBG distributes funds for a variety of services and for planning, administration, and educational activities. By statute, these services and activities must support community-based mental health services for children with serious emotional disturbances, and adults with serious mental illness. MHBG services include: outpatient treatment for persons with serious mental illnesses, such as schizophrenia and bipolar disorders; supported employment and supported housing; rehabilitation services; crisis stabilization and case management; peer specialist and consumer-directed services; wraparound services for children and families; jail diversion programs; and services for at-risk populations (e.g., individuals, who experience homelessness, those in rural and frontier areas, military families, and veterans). Through the administration of the MHBG, SAMHSA supports the implementation of practices demonstrated and proven effective in the Mental Health Programs of Regional and National Significance (PRNS) portfolio.

The MHBG continues to represent a significant "safety net" source of funding for mental health services for some of the most at-risk populations across the country. Together, SAMHSA's block grants support the provision of services and related support activities to more than eight million individuals with mental and substance use conditions in any given year. The MHBG's flexibility and stability have made it a vital support for public mental health systems. States rely on the MHBG for delivery of services and for

[42] Substance Abuse and Mental Health Services Administration. (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (HHS Publication No. PEP20-07-01, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[43] Territories include Guam, Puerto Rico, the Northern Mariana Islands, U.S. Virgin Islands and American Samoa. Freely Associated States, which have signed Compacts of Free Association with the United States, include the Republic of Palau, Federated States of Micronesia and Republic of the Marshall Islands. See http://www.doi.gov//oia/islands/index.cfm. Further information about the Block Grant program can be found on SAMHSA's Web site at http://www.samhsa.gov/grants/block-grants

an array of non-clinical coordination and support services that are not supported by Medicaid or other third-party insurance to strengthen their service.

The MHBG statute provides for a five percent administrative set-aside that allows SAMHSA to assist the states and territories in the development of their mental health systems through the support of technical assistance, data collection, and evaluation activities. States also use block grant funds, with other funding sources, to support training for staff and implementation of evidence-based practices and other promising practices for the treatment of mental disorders, improved business practices, use of health information technology, and integration of physical and behavioral health services.

SAMHSA's MHBG and Substance Abuse Prevention and Treatment Block Grant (SABG) applications align with changes in federal/state environments and statutes. SAMHSA offers states the opportunity to complete a combined application for mental health and substance abuse services, submit a biennial plan, and provide information regarding their efforts to respond to various changes in federal and state law.[44,45]

There are many individuals, both adolescent and adult, with co-occurring mental illness and drug/alcohol addiction. In recognition of this, SAMHSA strongly encourages coordination between MHBG programs and those supported by the SABG as well as other SAMHSA-funded efforts such as the systems of care for children and adolescents supported through the Children's Mental Health Initiative.

[44] State Plan for Comprehensive Community Mental Health Services for Certain Individuals (Sec. 1912 of Title XIX, Part B, Subpart I of the Public Health Service (PHS) Act (42 USC § 300x-2).
[45] State Plan (Sec. 1932 (b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x-32(b)).

According to the 2020 National Outcome Measures (NOMS) Report, the MHBG served 8,131,606 clients through the State Mental Health Systems. The table below provides 2019 demographics on the clients served.

Mental Health Block Grant Demographics	
Adults	5,841,784
Children	2,289,822
Female	52.9%
Male	47.1%
Age	
0-12	16%
13-17	12.2%
18-20	4.7%
20-24	5.7%
25-44	31.4%
45-64	24.5%
65-74	3.7%
75+	1.6%

The table below provides data on the FY 2020 evidence-based treatment services utilized by clients served by the MHBG.

Evidence-based Treatment Services Utilized	
Adults	
Supported Housing	2.3%
Supported Employment	1.9%
Assertive Community Treatment	1.8%
Family Psychoeducation	3.1%
Dual Diagnosis Treatment	9.5%
Illness Self-Management	19.1%
Medications Management	31.3%
Children	
Therapeutic Foster Care	1.7%
Multi-systemic Therapy	4.1%
Functional Family Therapy	5.8%

Most block grant recipients are currently reporting on NOMS for public mental health services within their state. State-level outcome data for mental health are currently reported by State Mental Health Authorities. The following outcomes for all people served by the publicly funded mental health system during 2019 show that:

- For the 57 states and territories that reported data in the Employment Domain, 21.7 percent of the mental health consumers were in competitive employment;

- For the 56 states and territories that reported data in the Housing Domain, 92 percent of the mental health consumers were living in private residences;

- For the 58 states and territories that reported data in the Access/Capacity Domain, state mental health agencies provided mental health services for approximately 24.81people per 1,000 population;

- For the 50 states and territories that reported data in the Retention Domain, only 7.8 percent of the patients returned to a state psychiatric hospital within 30 days of state hospital discharge; and

- For the 52 states and territories that reported data in the Perception of Care Domain, 75.4 percent of adult mental health consumers improved functioning as a direct result of the mental health services they received.

Beginning in September 2016, SAMHSA, in partnership with National Institute of Mental Health (NIMH) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), initiated a 3-year evaluation study of the First Episode Psychosis programs funded through the MHBG set-aside to ascertain the effectiveness of these programs. The study, which focused on services in 36 diverse programs, collected clinical outcome data and conducted fidelity assessments. The results indicate that these evidence based programs lead to statistically significant improvements in the health and well-being of individuals who participate in them, including reductions in hospitalization (-79%) and emergency room visits (-71%), criminal justice involvement (-41%), suicide attempts (-66%), and reductions in homelessness (-35%).

Mental Disorders Prevalence Data Collection, Analysis, and Dissemination

Section 505 of the Public Health Service Act (42 U.S.C. 290aa-4) requires SAMHSA, on an annual basis, to collect data on the prevalence of substance use and mental illness. To accomplish this, SAMHSA awarded a contract in FY 2018 to design a multi-component project that would provide local level psychiatric epidemiology information on incidence and prevalence of select mental disorders, substance use disorders, and services received for those disorders.

In FY 2019, SAMHSA awarded a new contract to pilot the Mental Disorders Prevalence Survey (MDPS) design and methodology on a small scale using ten catchment areas that are a mix of rural and urban areas with both household and non-household populations. This project will serve as a foundation for future, larger scale efforts to assess incidence and prevalence of such disorders on a national scale.

Crisis Services Set-Aside

Starting in FY 2021, states were required to set-aside five percent of their total allocation for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and

children with serious mental and emotional disturbances. The set-aside will fund some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.

A fully developed crisis response system is responsive any time and any place. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. SAMHSA recognizes that the development of fully accessible and responsive crises services involves complex problem solving with multiple entities and systems including a partnership between mental health and law enforcement. SAMHSA also recognizes that strategic crisis services implementation can result in better care and cost savings through the reduction in avoidable emergency department visits, psychiatric admissions, police engagement, arrests, incarcerations and 911 calls.

Set-aside for Evidence-based Programs that Address the Needs of Individuals with Early Serious Mental Illness

States are required to set aside ten percent of their MHBG funds to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders."[46] This totaled $68.5 million in FY 2020. SAMHSA is collaborating with the NIMH and states to implement this provision.

The majority of individuals with serious mental illness experience their first symptoms during adolescence or early adulthood, and there are often long delays between the initial onset of symptoms and receiving treatment. The consequences of delayed treatment can include loss of family and social supports, reduced educational achievement, incarceration, disruption of employment, substance use, increased hospitalizations, and reduced prospects for long-term recovery.

Through this funding, 50 states, DC and Puerto Rico implemented fully operating first-episode treatment programs and SAMHSA continues to monitor and ensure that the set-aside program is solely used to address first-episode psychosis.

[46] http://www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

The table below identifies activities, which have been implemented with the 10 percent set-aside.

State	FY 2021 10% Set Aside Allotment	Program Description
Alabama	$1,039,379	State uses the EASA and OnTrack USA. Services are delivered through a Coordinated Specialty Care Team that is reflective of the demographic mix of the community.
Alaska	$162,654	Use the OnTrAK model. The staffing structure highlights the realities of the Mat-Su Borough in size, scope, and incidence rate leading to the development of a task-based team approach focused on outcome.
American Samoa	$14,131	AS has adopted the Assertive Community Treatment (ACT) model for community mental health services for use with individuals with FEP.
Arkansas	$629,052	State ESMI/FEP program is contractually assigned to the Community Mental Health Centers. Evidenced-based treatment models are utilized for each client newly diagnosed with psychosis.
California	$9,419,007	State allocates MHBG funds to 57 local county subrecipients who administer their own Mental Health Plans that are unique to their particular geographic and population circumstances each year and utilize models, such as Portland Identification and Early Referral (PIER).
Colorado	$1,413,144	Providers have implemented CSC models with high fidelity.
Connecticut	$697,199	State implemented four programs based on two distinct CSC models (Potential and STEP).
District of Columbia	$170,233	The District's early intervention program (EIP), the Youth Blossom program at Community Connections, is utilizing CSC model offers early treatment to young adults (age 16-25) experiencing their first psychotic break.
Delaware	$167,577	A statewide program, Community Outreach, Referral and Early Intervention (CORE), has been implemented.
Florida	$4,776,058	The State of Florida currently has 7 Coordinated Specialty Care teams. Six of the seven utilize the NAVIGATE model and one utilizes the OnTrack model.

State	FY 2021 10% Set Aside Allotment	Program Description
Georgia	$2,300,633	State has now implemented ten (10) Coordinated Specialty Care teams around the state. All programs are based on the LIGHT-ETP model.
Guam	$46,645	State has begun providing services in the I Fine'na program, which is based on OnTrackNY, and offers Early Serious Mental Illness (ESMI) services through the OASIS Empowerment Center.
Hawaii	$362,111	State has implemented a program with three sites in Honolulu based on the OnTRACK model.
Idaho	$424,052	Four CSC programs have been implemented Idaho is implementing the STAR (Strength Through Active Recovery) program to provide FEP treatment based on the On-Track CSC treatment model.
Indiana	$1,288,471	State offers three programs based on the Prevention and Recovery Care (PARC) model and makes use of a "hub and spoke" design.
Iowa	$564,139	State has three functioning CSC programs based on the NAVIGATE model.
Kansas	$525,176	There are three teams in Kansas. The eligibility age was raised from 15 to 25-years-old to 15 to 36-years-old to increase access to women.
Kentucky	$934,076	Eight EASA CSC program sites are available throughout the state, with one in the installation phase. State is also using the MHBG to support data infrastructure to track outcomes.
Louisiana	$1,042,026	Six sites have been implemented. These programs are using the Navigate CSC model.
Maine	$282,072	State has implemented one program, Maine Medical Center/Portland Identification and Early Referral Program, based on the PIER Model in Portland. The state has also contracted with the PIER program to train staff at one other provider to provide FEP services.
Marshall Islands	$21,042	Use the set aside funding to develop first episode outreach practices and protocols for individuals experiencing FEP.

State	FY 2021 10% Set Aside Allotment	Program Description
Maryland	$1,400,957	The state has implemented four CSC programs, two in Baltimore, one in Gaithersburg and one in Catonsville.
Massachusetts	$1,440,213	Seven Community Clinics with comprehensive specialized FEP services are in operation, and 3 outpatient hospital sites.
Michigan	$2,111,464	The State has implemented six CSC programs using the NAVIGATE CSC model.
Federated States of Micronesia	$28,815	Funds are being used to train staff on the OnTrack CSC model in four locations. The state also has developed outreach and screening processes in schools and in the community in Majuro, Ebeye and Outer Islands.
Minnesota	$1,089,245	State has implemented three CSC programs using the Navigate model.
Missouri	$1,210,697	State has established ten sites spread throughout the state that provide Assertive Community Treatment for Transitional Age Youth (ACT-TAY) for individuals experiencing an early serious mental illness.
Montana	$220,246	The state has implemented the NAVIGATE model in one site.
Nebraska	$330,252	The state has implemented OnTrackUSA in two of the six behavioral health service regions of the state.
Nevada	$760,827	The state has implemented three CSC programs: in the Reno area and Las Vegas area using the Recovery After Initial Schizophrenic Episode (RAISE) TEAM approach and a third CSC program in Carson City that follows the NAVIGATE model.
New Hampshire	$253,468	State currently has one FEP program at the Greater Nashua Mental Health Center (GNMHC), utilizing the NAVIGATE model.
New Jersey	$1,970,795	State has implemented three CSC teams that provide CSC service in all 21 NJ counties.

State	FY 2021 10% Set Aside Allotment	Program Description
New Mexico	$437,403	State is expanding access to the NAVIGATE model for specialty coordinated care for individuals with FEP through the already implemented University of New Mexico EARLY program.
New York	$4,032,160	State is spending set-aside funds to expand its existing OnTrackNY program to two new sites, for 22 CSC sites statewide.
North Carolina	$2,092,398	North Carolina supports four CSC for FEP programs.
North Dakota	$124,874	State implemented CSC services in Fargo, which serves six counties in the state.
Northern Mariana Islands	$14,456	The Community Guidance Center implemented a psychoeducation group geared toward family education, which will help families and the community better identify FEP symptoms in their family or community leading to earlier treatment of the client.
Oklahoma	$791,316	State indicates they have expanded to 14 CSC and ESMI programs.
Oregon	$1,140,559	Oregon is integrating Coordinated Specialty Care teams in all counties using a standard model of care supported by the EASA Center for Excellence at Oregon Health & Science University and Portland State University.
Palau	$5,982	Supports one CSC team.
Pennsylvania	$2,359,765	State has 14 Coordinated Specialty Care Programs for First Episode Psychosis, serving 20 counties.
Puerto Rico	$915,984	Puerto Rico has implemented two Coordinated Specialty Care Programs using the OnTrack model.
Rhode Island	$267,129	Rhode Island will continue to use the entire set-aside amount to serve individual ages 16-25 experience a first episode of psychosis in the two CSC community health care centers.

State	FY 2021 10% Set Aside Allotment	Program Description
South Carolina	$1,082,125	State is funding four programs for individuals with an early serious mental illness, one of which uses the NAVIGATE model.
South Dakota	$155,104	State has implemented two CSC programs in Sioux Falls and Rapid City. They have been trained by OnTrackNY.
Tennessee	$1,374,292	State uses the MHBG funds to provide OnTrackTN in five sites across the state.
Texas	$6,489,575	State offers 24 CSC programs in rural and urban. These sites serve both indigent and Medicaid-eligible populations.
Utah	$649,072	State has 5 programs in total, all funded by MHBG. Four are FEP programs that follow the RAISE model and one is an ESMI program for Latinx youth (14-25).
Vermont	$123,198	State continues to partner with Vermont Corporative for Practice Improvement and Innovation to facilitate the initiative including targeted, research, implementation, workforce development, outreach and education.
Virginia	$1,802,793	Eight (8) Virginia community services boards (CSBs) operate CSC programs.
Washington	$1,672,613	State operates nine sites using the New Journeys model based on the NAVIGATE model.
West Virginia	$391,866	State has seven provider sites utilizing the FIRST CSC model ESMI services to fidelity.
Wisconsin	$1,240,805	State is continuing to fund the CSC model PROPS program operated by JMHC in Madison, which serves three rural counties north of Madison. In addition, the state is funding a CSC program in Milwaukee.
Wyoming	$91,246	The state has two providers providing CSC FEP programs: Southwest Counseling Service Yellowstone Behavioral Health Center.

Funding History

Fiscal Year	Amount
FY 2018	$722,571,000
FY 2019	$722,571,000
FY 2020	$722,571,000
FY 2021 Enacted	$757,571,000
FY 2022 Budget Request	$1,582,571,000

Budget Request

The FY 2022 budget request is $1.6 billion, an increase of $825.0 million from the FY 2021 Enacted level. With this funding, SAMHSA will continue to address the needs of individuals with SMI and SED and will continue to maintain the 10 percent set-aside for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The set-aside funds help reduce costs to society, as intervening early helps prevent deterioration of functioning in individuals experiencing a first episode of serious mental illness.

The Budget also set-asides $75 million, an increase of $40 million over FY 2021, of MHBG funds to support state efforts to build much needed crisis systems to address the needs of individuals in mental health crisis in a high quality, expeditious manner. In addition, this funding will support an ongoing partnership between mental health and law enforcement. The development of these services will promote 24/7 access to well-trained mental health professionals in the time of acute mental health crisis.

Outputs and Outcomes Table

Program: Mental Health Block Grant

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.3.11 Number of evidence based practices (EBPs) implemented (Output)	FY 2020: 5.0 per State Target: 5.0 per State (Target Met)	5.0 per State	5.0 per State	Maintain
2.3.14 Number of people served by the public mental health system (Output)	FY 2020: 8,131,606 Target: 7,808,416 (Target Exceeded)	7,808,416	8,131,606	+323,190
2.3.15 Rate of consumers (adults) reporting positively about outcomes (Outcome)	FY 2020: 75.4 % Target: 75.4 % (Target Met)	75.4 %	75.4 %	Maintain
2.3.16 Rate of family members (children/adolescents) reporting positively about outcomes (Outcome)	FY 2020: 71.9 % Target: 72 % (Target Not Met)	71 %	71 %	Maintain
2.3.19A: Supported Housing Supported Housing: Percentage of the population accessing selected evidence-based programs among people served by state mental health authorities (Outcome)	FY 2020: 3.1 % Target: 3.1 % (Target Met)	3.1 %	3.1 %	Maintain
2.3.19B Supported Employment: Percentage of the population accessing selected evidence-based programs among people served by state mental health authorities (Outcome)	FY 2021: 2.0 % Target: 2.0 % (Target Met)	2.0 %	2.0 %	Maintain
2.3.19C Assertive Community Treatment: Percentage of the population accessing selected evidence-based programs among people served by state mental health authorities (Output)	FY 2020: 1.9 % Target: 1.9 % (Target Met)	1.9 %	1.9 %	Maintain
2.3.19D Family Psychoeducation: Percent of the population accessing selected evidence-based programs among people served by state mental health authorities (Outcome)	FY 2020: 2.5 % Target: 2.4 % (Target Exceeded)	2.4 %	2.4 %	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.3.19E Dual Diagnosis Treatment: Percent of the population accessing selected evidence-based programs among people served by state mental health authorities. (Outcome) (Outcome)	FY 2020: 10.4 % Target: 10.4 % (Target Met)	10.4 %	10.4 %	Maintain
2.3.19F Illness Self-Management: Percent of the population accessing selected evidence-based programs among people served by state mental health authorities. (Outcome)	FY 2020: 18.9 % Target: 18.0 % (Target Exceeded)	18.0 %	18.0 %	Maintain
2.3.19G Medication Management: Percent of the population accessing selected evidence-based programs among people served by state mental health authorities. (Outcome)	FY 2020: 31.3 Target: 31.0 (Target Exceeded)	31.0	31.0	Maintain
2.3.19H Treatment Foster Care: Percent of the population accessing selected evidence-based programs among people served by state mental health authorities. (Outcome)	FY 2020: 0.7 % Target: 0.7 % (Target Met)	0.7 %	0.7 %	Maintain
2.3.19I Multi-Systemic Therapy: Percent of the population accessing selected evidence-based programs among people served by state mental health authorities. (Outcome)	FY 2020: 4.2 % Target: 4.2 % (Target Met)	4.2 %	4.2 %	Maintain
2.3.19J Functional Family Therapy: Percent of the population accessing selected evidence-based programs among people served by state mental health authorities. (Outcome)	FY 2020: 5.9 % Target: 5.9 % (Target Met)	5.9 %	5.9 %	Maintain
2.3.81 Percentage of service population receiving any evidence based practice (Outcome)	FY 2020: 12.2 % Target: 11.8 % (Target Exceeded)	11.8 %	11.8 %	Maintain

Substance Abuse and Mental Health Services Administration
FY 2022 Mental Health Block Grant Estimate Allotments
Appropriation $1,582,571,000, State-Territory Total $1,501,184,441
CFDA # 93.959

State/Territory	FY 2020 Final	FY 2021 Enacted[1]	FY 2022 President's Budget	FY 2022 +/- FY 2021
Alabama	$9,899,084	$10,393,794	$22,053,960	$11,660,166
Alaska	1,480,885	1,626,540	3,702,025	2,075,485
Arizona	18,493,829	19,762,210	37,417,906	17,655,696
Arkansas	5,986,777	6,290,522	13,314,177	7,023,655
California	91,832,541	94,190,067	197,169,806	102,979,739
Colorado	13,283,889	14,131,439	29,622,324	15,490,885
Connecticut	6,761,092	6,971,987	15,511,833	8,539,846
Delaware	1,582,328	1,675,774	3,181,073	1,505,299
District Of Columbia	1,603,015	1,702,334	3,665,552	1,963,218
Florida	45,278,203	47,760,577	103,127,587	55,367,010
Georgia	21,993,812	23,006,325	46,227,351	23,221,026
Hawaii	3,533,598	3,621,113	7,584,318	3,963,205
Idaho	3,957,780	4,240,521	8,197,068	3,956,547
Illinois	24,466,019	25,297,546	47,522,585	22,225,039
Indiana	12,129,344	12,884,705	30,094,890	17,210,185
Iowa	5,271,887	5,641,385	12,071,618	6,430,233
Kansas	4,988,410	5,251,758	11,127,703	5,875,945
Kentucky	8,895,473	9,340,762	19,751,221	10,410,459
Louisiana	9,780,411	10,420,263	19,740,178	9,319,915
Maine	2,699,523	2,820,718	5,983,783	3,163,065
Maryland	13,548,728	14,009,566	25,535,333	11,525,767
Massachusetts	13,983,098	14,402,129	32,286,556	17,884,427
Michigan	20,194,039	21,114,635	43,908,098	22,793,463
Minnesota	10,358,721	10,892,453	24,490,201	13,597,748
Mississippi	6,220,048	6,575,274	13,858,359	7,283,085
Missouri	11,522,294	12,106,967	25,809,500	13,702,533
Montana	2,054,853	2,202,462	5,485,391	3,282,929
Nebraska	3,069,216	3,302,524	7,062,657	3,760,133
Nevada	7,279,761	7,608,268	17,146,865	9,538,597
New Hampshire	2,404,349	2,534,678	5,054,093	2,519,415

Substance Abuse and Mental Health Services Administration
FY 2022 Mental Health Block Grant Estimate Allotments
Appropriation $1,582,571,000, State-Territory Total $1,501,184,441
CFDA # 93.959

State/Territory	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
New Jersey	19,362,783	19,707,954	41,575,650	21,867,696
New Mexico	4,070,758	4,374,034	9,286,056	4,912,022
New York	40,459,564	40,321,601	87,795,609	47,474,008
North Carolina	19,801,355	20,923,981	44,819,741	23,895,760
North Dakota	1,070,333	1,248,738	2,708,984	1,460,246
Ohio	21,215,342	22,426,204	47,475,037	25,048,833
Oklahoma	7,295,002	7,913,159	16,883,485	8,970,326
Oregon	10,607,443	11,405,593	24,017,515	12,611,922
Pennsylvania	22,533,122	23,597,645	51,073,462	27,475,817
Rhode Island	2,567,486	2,671,294	5,302,613	2,631,319
South Carolina	10,286,119	10,821,253	23,099,241	12,277,988
South Dakota	1,446,803	1,551,040	3,306,664	1,755,624
Tennessee	13,111,226	13,742,918	31,732,165	17,989,247
Texas	59,374,828	64,895,752	123,518,410	58,622,658
Utah	6,091,444	6,490,722	16,962,841	10,472,119
Vermont	1,175,538	1,231,981	2,611,361	1,379,380
Virginia	17,190,658	18,027,933	38,425,706	20,397,773
Washington	16,051,771	16,726,128	36,946,285	20,220,157
West Virginia	3,705,898	3,918,663	8,188,872	4,270,209
Wisconsin	11,793,459	12,408,047	23,247,560	10,839,513
Wyoming	812,359	912,460	1,985,406	1,072,946
American Samoa	134,614	141,308	295,658	154,350
Guam	437,419	466,446	991,602	525,156
Northern Marianas	136,598	144,556	304,993	160,437
Puerto Rico	8,760,573	9,159,843	19,108,582	9,948,739
Palau	56,014	59,820	127,380	67,560
Marshall Islands	194,820	210,419	452,973	242,554
Micronesia	272,334	288,152	607,751	319,599
Virgin Islands	280,363	297,421	628,828	331,407

1. The amuonts in FY 2021 exclude supplemental funding.

Substance Abuse Prevention

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Substance Abuse Prevention Appropriation

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Programs of Regional & National Sigificance	$206,469	$208,219	$216,667	$8,448
Total, Substance Abuse Prevention.....	**$206,469**	**$208,219**	**$216,667**	**$8,448**

The Substance Abuse Prevention FY 2022 Budget Request is $216.7 million, an increase of $8.4 million over the FY 2021 Enacted budget level.

Programs of Regional and National Significance (PRNS)
Substance Abuse Prevention Appropriation

(Dollars in Thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Capacity:				
Strategic Prevention Framework	$119,484	$119,484	$126,674	$7,190
Non-SPF Rx (non-add)	*109,484*	*109,484*	*111,674*	$2,190
Budget Authority (non-add)	*109,484*	*109,484*	*111,674*	$2,190
Strategic Prevention Framework Rx (non-add)	*10,000*	*10,000*	*15,000*	$5,000
Budget Authority (non-add)	*10,000*	*10,000*	*15,000*	$5,000
Federal Drug-Free Workplace	4,894	4,894	4,894	---
Minority AIDS	41,205	41,205	42,029	$824
Sober Truth on Preventing Underage Drinking Act (STOP Act)	9,000	10,000	10,000	---
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths	---	---	---	---
Tribal Behavioral Health Grants	20,000	20,750	21,165	$415
Subtotal, Capacity	**194,583**	**196,333**	**204,762**	**8,429**
Science and Service:				
Center for the Application of Prevention Technologies	7,493	7,493	7,493	---
SAP Minority Fellowship Program	321	321	340	$19
Science and Service Program Coordination	4,072	4,072	4,072	---
Subtotal, Science and Service	**11,886**	**11,886**	**11,905**	$19
Total, PRNS	**$206,469**	**$208,219**	**$216,667**	**$8,448**

Authorizing Legislation.....Section 516 of the PHS Act
FY 2022 Authorization.....$211,148,000
Allocation Method.....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities.....States, political subdivisions of States, Federally Recognized American Indian/Alaska Native tribe or tribal organizations, Indian Health Service-operated and contracted health facilities and programs, public or private nonprofit entities

Strategic Prevention Framework

(Dollars in thousands)

Program of Regional & National Sigificance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Strategic Prevention Framework	$119,484	$119,484	$126,674	$7,190
Strategic Prevention Framework Rx (non-add)	*$10,000*	*$10,000*	$15,000	$5,000

Authorizing Legislation.....Section 516 of the PHS Act
FY 2022 Authorization.....$211,148,000
Allocation Method.....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities.....States, Tribes, and Territories

Program Description and Accomplishments

Strategic Prevention Framework (SPF)
Drug and alcohol use are significant public health challenges. Youth and adolescents who use alcohol and drugs face an increased risk of poor school performance, criminal justice involvement, the development of a drug/alcohol addiction, risky sexual behavior, illnesses such as HIV and hepatitis, depression and anxiety, and injury and death. The immediate and long-term risks and negative outcomes associated with youth and adolescent drug and alcohol use underscore the need for effective prevention and treatment programs.

Youth and adolescents use a variety of substances. In 2019, an estimated 35.8 million Americans aged 12 or older used illicit drugs in the past 30 days. The illicit drug use estimate for 2019 was driven primarily by marijuana use and the misuse of prescription pain relievers, with 31.6 million individuals aged 12 or older who currently used marijuana (i.e., past 30 day use) and 2.8 million people aged 12 or older who reported current misuse of prescription pain relievers.

The 2019 National Survey on Drug Use and Health (NSDUH)[52] shows that underage alcohol use (i.e., people aged 12 to 20) and binge and heavy drinking use among young adults aged 18 to 25, have declined over time but remain a concern. In 2019, 18.5 percent of underage people reported current use of alcohol, 11.4 percent reported binge drinking, and 2.2 percent reported heavy alcohol use.

Among people aged 12 or older, past month binge alcohol was 23.9 percent in 2019. Among people aged 12 or older, the percentage who were past month heavy alcohol users was 5.8 percent (or 16.0 million people) in 2019.

[52] Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP 19-5068, NSDUH Series H-54). Rockville MD 20857 Retrieved from http://www.samhsa.gov/data.

The Strategic Prevention Framework – Partnerships for Success (SPF-PFS) program helps states, tribes, and communities address locally identified prevention priorities through a data-driven process. Common priorities include underage drinking among youth and young adults age 12 to 20, marijuana, or prescription drug misuse. In 2020 the SPF-PFS program supported a total of250 new and continuing grants to state, community and tribal organizations to address underage drinking among youth and young adults ages 9 to 20 and allow communities, at their discretion, to use funds to target up to two additional data driven substance misuse prevention priorities addressing ages 9 and above.

SPF-PFS is designed to ensure that prevention strategies and messages reach the populations most impacted by substance misuse. The program extends current established cross-agency and community-level partnerships by connecting substance misuse prevention programming to departments of social services and their community service providers. This includes working with populations disproportionately impacted by the consequences of substance use; i.e., children entering the foster care system, transition age youth, and individuals who support persons with substance use issues (e.g., women, families, parents, caregivers, and young adults).

In FY 2020, SAMHSA awarded 92 new grants to state, tribal, and community organizations for preventing the onset and reducing the progression of substance use and its related challenges while strengthening prevention capacity and infrastructure at the community and state levels. In FY 2021, SAMHSA will support the continuation of 92 grants and awarded 5 new SPF-PFS grants.

Strategic Prevention Framework for Prescription Drugs (SPF Rx)

From 1999 to 2017, drug-poisoning death rates more than tripled, from 6.1 per 100,000 to 21.7 per 100,000. In 2017, there were 70,237 deaths due to drug poisoning.[47] Also, from 1999 to 2017, the age-adjusted rate of drug-poisoning deaths increased from 8.2 per 100,000 to 29.1 per 100,000 for males, and from 3.9 per 100,000 to 14.4 per 100,000 for females. In 2019, drug overdose deaths increased 4.3% from 2018 with a total of 76,630 deaths.

The Strategic Prevention Framework for Prescription Drugs (SPF-Rx) assists grantees in developing capacity and expertise in the use of data from state run prescription drug monitoring programs (PDMP). Grantees have also raised awareness about the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program focuses on raising community awareness and bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients. SAMHSA tracks reductions in opioid overdoses and the incorporation of prescription drug monitoring data into needs assessments and strategic plans as indicators of program success. SAMHSA plans to maintain this level of support for SPF Rx through FY 2022.

Program Evaluation

Recipients of SPF-PFS grants measure the impact of their programs at the community-level. The goal of the SPF-PFS grant program is to support communities and tribes to identify and address their top substance misuse prevention priorities. In FY 2020, grantees in 234 communities reported improvements in one or more targeted national outcome measure (NOMs) indicators as a result of implementing more than 1,400 evidence-based interventions. Fifteen (15) states and

[47] https://www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality/

fourteen (14) tribal communities focused on alcohol use and at least one other substance, and many focused their prevention efforts on racial, ethnic, sexual, and gender subpopulations.

The Government Performance and Results Act (GPRA) requires reporting for the Strategic Prevention Framework for Prescription Drug (SPF-Rx) program for two measures. The number of funded states/tribes that incorporate Prescription Drug Monitoring Program (PDMP) data into their strategic plans, and the number of funded states/tribes reporting reductions in opioid overdoses.

Since the start of the SPF-Rx program, grantees and their sub-recipients have implemented a total of 508 interventions. Over 400 of these interventions remained active at the end of FY 2019, with 221 continuing from FY 2018. The most dramatic growth was in the first years of the program, as grantees added sub-recipients and they, in turn, developed their interventions. In FY 2019, 118 sub-recipients reported 377 active interventions. The 404 grantee- and sub-recipient-level interventions active in FY 2019 most often involved the CSAP Strategies of information dissemination (191 interventions or 47 percent) and environmental strategies (121 interventions or 30 percent).

Regarding interventions implemented, over a third of both grantees and their sub-recipients targeted the entire population in the jurisdictions they represent (i.e., the state, the county, the tribal community). The medical community in particular is often a focus for information and training. Of the 404 prevention interventions that were active in FY 2019, the three most common intervention service types were media campaigns, prescription drug safe storage and/or disposal, and training/educating environmental influencers.

The reach of the program interventions into their communities has been impressive. Without addressing duplicative counting of individuals receiving multiple interventions, the 358 active interventions in FY 2020 reached a total of 11.9 million individuals across the grantee and sub-recipient sites. This total is impacted by a small number of interventions that reached a large number of individuals, notably the media campaigns. Most interventions reached fewer than 8,000 individuals, many directed to specific health care professionals, such as prescribers, pharmacists and other direct influencers. In addition to the substantial media reach, almost 42,000 of the total individuals have been reached more directly through interventions such as trainings.

One important aspect of community-level interventions is partnership with community agencies and stakeholders to create and execute their interventions. Of the 124 sub-recipients and single-community grantees reporting in FY 2019, 89 percent reported partnering with at least one stakeholder organization, most often a substance use prevention organization (73.6 percent) and local law enforcement (72.7 percent).

One of the goals of the SPF-Rx program is to increase PDMP-related infrastructure and improve PDMP use. In grantee-level interviews conducted in the first and second years of the project, SPF-Rx project directors reported PDMP data availability as a common challenge. These issues have improved: In FY 2019, both grantees and sub-recipients reported that PDMP data became less of a challenge for them in terms of quality, analysis/reporting, and ease of use. Many of the sub-recipients, who as a group have the greatest challenges in accessing PDMP data, reported that their

access problems decreased; from 41 percent of sub-recipients reporting access problems in FY 2017 to 28 percent in FY 2019.

Funding History

Fiscal Year	Amount
FY 2018	$119,484,000
FY 2019	$119,484,000
FY 2020	$119,484,000
FY 2021 Enacted	$119,484,000
FY 2022 Budget Request	$126,674,000

Budget Request

The FY 2022 budget request is $126.7 million, an increase of $7.2 million over the FY 2021 Enacted budget. Funding for the SPF Rx program is increased by $5 million for a total of $15 million to support a new cohort of up to 26 grantees to be awarded in FY 2021, and 26 continuation and 12 new grants in FY 2022.

Outputs and Outcomes Table

Program: Partnerships for Success

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.3.79 Number of EBPs implemented by sub-recipient communities (Output)	FY 2020: 1,421 Target: 1,414 (Target Exceeded)	Discontinued	Discontinued	N/A
2.3.80 Number of sub-recipient communities that improved on one or more targeted NOMs indicators (Outcome)	FY 2020: 234 Target: 3215 (Target Not Met)	Discontinued	Discontinued	N/A
2.3.81 Increase in the percent of grantees that report at least 5% improvement in the past 30 day use of targeted substance in target population (Outcome)	FY 2021: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	Set Baseline	Maintain Baseline	N/A
2.3.82 Increase in percent of grantees that report improvement of perception of risk from targeted substance use in target population (Outcome)	FY 2021: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	Set Baseline	Maintain Baseline	N/A

Program: Strategic Prevention Framework Rx

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.3.12 Percent of funded states reporting reductions in opioid overdoses (Outcome)	FY 2020: 56 % Target: 62 % (Target Not Met)	62 %	62 %	Maintain
3.3.13 Percent of grantees that reported taking steps to enhance access to and use of PDMP data at the grantee level. (Outcome)	FY 2020: 73.70 Target: 88.2 (Target not met)	Discontinued	Discontinued	N/A

Federal Drug-Free Workplace

(Dollars in thousands)

Program of Regional & National Sigificance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Federal Drug-Free Workplace	$4,894	$4,894	$4,894	$---

Authorizing Legislation.....Section 516 of the PHS Act
FY 2022 Authorization.....$211,148,000
Allocation Method.....Inter-Agency Agreements/Contracts
Eligible Entities.....Federal Agencies, Regulated Entities (e.g., Department of Transportation, Nuclear Regulatory Commission), HHS- Certified Laboratories

Program Descriptions and Accomplishments

The use of illicit, prescription, and over-the counter drugs, including polysubstance use, is widespread and has a variety of negative consequences, particularly in the workplace. This program continues to examine emerging issues especially among young adults and high risk workplaces such as: increased legal/illegal opioid/synthetic opioid use and polysubstance use leading to injuries, overdoses, and death. Employers with successful drug-free workplace programs report decreases in absenteeism, accidents, downtime, turnover, and theft; increases in productivity; and overall improved morale. Additionally, they report better health status among many employees and family members and decreased use of medical benefits. Many organizations with drug-free workplace programs qualify for health care incentives, for example, decreased premium costs for certain kinds of insurance, such as Workers' Compensation.

The Federal Drug-Free Workplace Programs (DFWP) ensure employees in national security, public health, and public safety positions are tested for the use of illegal drugs and the misuse of prescription drugs and ensure the laboratories that perform this regulated drug testing are inspected and certified by HHS. Through this program, the federal government is able to avoid lost productivity and reduce absenteeism, injuries, and fatalities.

SAMHSA implements the Federal Drug-Free Workplace Programs, which consist of two principal activities mandated by Executive Order (E.O.) 12564 and Public Law (P.L.) 100-71. These include: 1) oversight of the Federal Drug-Free Workplace Programs, aimed at the elimination of the use of illegal drugs and the misuse of prescription drugs within Executive Branch agencies and the federally-regulated industries; and 2) oversight of the National Laboratory Certification Program (NLCP), which certifies laboratories to conduct forensic drug testing for federal agencies and federally-regulated industries. The private sector also uses the HHS-certified laboratories.

Since 1987, SAMHSA has funded the Drug-Free Workplace drug testing activities including the NLCP and the Drug Testing Advisory Board (DTAB). Activities continued in FY 2020 under the NLCP contract. The NLCP oversees the certification of the labs that perform drug testing under the Drug-Free Workplace Programs. Also, in FY 2019, SAMHSA issued mandatory guidelines for oral fluid, and in FY 2020 the proposed mandatory guidelines for hair were issued, in accordance with the DTAB recommendations, to allow oral fluid and to pursue the use of hair as

alternative specimens to urine. DTAB will continue to provide recommendations to the Assistant Secretary for Mental Health and Substance Use based on an ongoing review of the direction, scope, balance, and emphasis of SAMHSA's drug testing activities and the NLCP.

CSAP's Workplace Helpline supports the drug-free workplace program. The helpline is a toll-free telephone service (800-WORKPLACE) that answers questions from federal agencies, the public and private sectors about drug testing in the workplace.

Continued funding for the Federal Drug-Free Workplace Programs has ensured the testing of federal employees in national security, public health, and public safety positions for the use of illegal drugs, the misuse of prescription drugs, and the inspection certification of HHS-certified laboratories for the past four years.

The Drug Free Workplace Program (DFWP) helps individuals refrain from using illegal drugs and demonstrates that illegal drug use will not be tolerated in the federal workplace. The DFWP achieves this through policies and procedures including drug testing which allows for the drug testing of all executive branch agency employees. A key program aim is to eliminate illicit drug use in federal workplaces and oversee the NLCP, which certifies laboratories to conduct forensic drug testing for federal agencies and federally regulated industries.

The program publishes mandatory guidelines to establish the scientific and technical regulatory aspects of the program, which includes specifying the drugs to be tested for and setting laboratory certification standards through the NLCP. Another key responsibility of the program is the development and oversight of the federal Custody and Control Form (CCF), the standardized OMB-approved form for specimen collectors to document the collection and forensic chain of custody of specimens at the collection site, for certified laboratories to report results, and for Medical Review Officers (MROs) to document and report verified results. SAMHSA allows the use of the CCF as a paper or electronic form.

Additionally, the DFWP helps reduce health insurance costs, improves attendance and employee productivity, provides a safer workplace with reduced accidents and provides employee assistance programs (EAP) services to employees with substance use disorders.

The benefits of this program include:

- Implementation of *urine, oral fluid, and hair* drug testing programs with a federally supported performance testing program and a partial federally supported laboratory inspection program;

- Certification of laboratories across the nation to conduct federal and federally regulated drug tests which may include urine, oral fluid, and hair;

- Examining changes in drug testing methodologies, changes in law, and new and emerging issues related to marijuana (e.g., increased potency and use), cannabidiol (CBD) (e.g., increased availability due to the 2018 Farm Bill and possible risk of testing

positive for marijuana), opioids, synthetic drugs, polysubstance use/misuse, and hair/oral fluid drug testing;

- Continued use of subject matter experts and partnerships with other federal agencies to establish the scientific standards set out in the mandatory guidelines;
- Proposing hair as an alternative specimen, subject to the legal and scientific supportability of this matrix for use in federal workplace drug testing programs;
- Technical and scientific leadership for federal agencies on workplace drug testing; and
- Analysis of and guidance on emerging issues (e.g. opioids/synthetic opiates; polysubstance use; young adults, high-risk workplaces)

Funding History

Fiscal Year	Amount
FY 2018	$4,894,000
FY 2019	$4,894,000
FY 2020	$4,894,000
FY 2021 Enacted	$4,894,000
FY 2022 Budget Request	$4,894,000

Budget Request

The FY 2022 budget request is $4.9 million, level with the FY 2021 Enacted. Along with the implementation of the new oral fluid and hair drug testing programs, SAMHSA will continue oversight of the Executive Branch Agencies' Federal Drug-Free Workplace Programs. This includes review of Federal Drug-Free Workplace plans from those federal agencies that perform federal employee testing, random testing of those designated testing positions of national security, public health, and public safety, and testing for illegal drug use and the misuse of prescription drugs. SAMHSA will continue its oversight role for the inspection and certification of the HHS-certified laboratories.

Outputs and Outcomes Table

Program: Federal Drug-Free Workplace

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
6.0 Number of HHS Certified Labs (Output)	FY 2020: 24.0 certified labs Target: 26.0 certified labs (Target Not Met).	24.0 certified labs	28.0 certified labs	+2 Certified Labs

Minority AIDS

(Dollars in thousands)

Program of Regional & National Sigificance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Minority AIDS	$41,205	$41,205	$42,029	$824

Authorizing Legislation.....Section 516 of the PHS Act
FY 2022 Authorization.....$211,148,000
Allocation Method.....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities.....Local Government Entities, Community-based Organization, Minority Serving Institutions, and Institutions of Higher Education

Program Description and Accomplishments

The needs of people living with HIV and those who are at-risk for infection continue to evolve. Substance use disorder treatment services are vital to ending the HIV epidemic. Approximately 38,000 people become infected with HIV each year.[48] In addition, because HIV and viral hepatitis share common modes of transmission, one third of HIV infected individuals are also infected with hepatitis C.[49] The use of injection drugs is driving the increase in Hepatitis C cases.

The Minority AIDS program supports activities that build a strong foundation for delivering and sustaining high- quality and accessible substance misuse and HIV prevention services. The program aims to engage community-level domestic public and private non-profit entities, tribes, and tribal organizations in order to prevent and reduce the onset of substance misuse and transmission of HIV/AIDS among at-risk populations, including racial/ethnic minority youth and young adults, ages 13 to 24. SAMHSA works with college and university clinics/wellness centers and community-based providers that can provide comprehensive substance misuse and HIV prevention strategies. These strategies combine education and awareness programs, social marketing campaigns, and HIV and viral hepatitis testing services in non-traditional settings with substance misuse and HIV prevention programming for the population of focus. Because of the high rate of HIV/AIDS and hepatitis co-morbidity, this program includes viral hepatitis prevention and education training. The MAI program, along with many other HIV/AIDS programs across HHS, contributes to the goal to end the HIV epidemic in the United States.

SAMHSA has helped to prevent HIV and hepatitis infection acquired through substance use and misuse. SAMHSA's Minority AIDS and viral hepatitis prevention programs have included a focus on community-based organizations and minority serving institutions and a focus on the continuum of care.

In FY 2018, SAMHSA supported the continuation of 105 grants and 37 new grants. In FY 2019, SAMHSA supported the continuation of 142 grants and 6 new grants awards. In FY 2020,

[48] CDC: HIV in the United States at a Glance: https://www.cdc.gov/hiv/pdf/statistics/overview/cdc-hiv-us-ataglance.pdf
[49] U.S. Department of Health and Human Services: Secretary's Minority AIDS Initiative Fund: 2017: HIV BASICS: Staying in HIV Care: Other Related Health Issues: Hepatitis B & C: Hepatitis B Virus and Hepatitis C Virus Infection, https://www.hiv.gov/hiv-basics/staying-in-hiv-care/other-related-health-issues/hepatitis-b-and-c

SAMHSA supported the continuation of 93 grants and 84 new grants. In FY 2021, SAMHSA will support the continuation of 140 grants and 37 new grants.

Program Evaluation

Based on the latest data available, 24,162 persons received an HIV test in 2020 using grant funds, and of this number 8,917 people were tested for the first time. Grantees purchased 33,933 HIV test kits with grant funds and referred 100% of the people who tested positive for HIV to treatment. Participants averaged about 4 direct service encounters, with an average duration of 75 minutes per encounter. MAI grantees provided referrals to 4,180 participants for additional services, comprising 13,651 total referrals. 11,685 participants responded to surveys, with the findings summarized below:

- At least 6,952 participants received substance misuse prevention education services (59.5 percent of survey respondents).
- 57.8 percent of participants who reported binge drinking at baseline reported abstinence at follow-up.
- The percentage of participants rating tobacco use once to twice weekly as a great risk increased 38.2 percent from baseline to follow-up.
- The percentage of participants rating non-prescription opioid use once to twice weekly as a great risk increased 36.6 percent from baseline to follow-up.
- 88 percent of participants rated taking a prescription opioid without a prescription once to twice weekly as a great risk at follow-up, a 27.7 percent increase from baseline.
- 51.6 percent of participants rated binge drinking once to twice weekly a great risk at follow-up, a 28.9 percent increase from baseline.
- 74.2% of participants strongly agreed they would refuse if someone wanted to have sex without a condom at follow-up, with 23.3 percent reporting a higher level of agreement at follow-up compared to baseline.

Funding History

Fiscal Year	Amount
FY 2018	$41,205,000
FY 2019	$41,205,000
FY 2020	$41,205,000
FY 2021 Enacted	$41,205,000
FY 2022 Budget Request	$42,029,000

Budget Request

The FY 2022 budget request is $42.0 million, an increase of $824,000 above the FY 2021 Enacted budget. SAMHSA plans to support 163 continuations and 27 new grant awards.

Outputs and Outcomes Table

Program: Minority AIDS Initiative

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.3.56 Number of program participants exposed to substance abuse prevention education services (Output)	FY 2020: 6,952 Target: 8,345 (Target Not Met)	8,345	8,345	Maintain
2.3.85a Number of persons tested for HIV through the Minority AIDS Initiative prevention activities (Output)	FY 2020: 24,162 Target: 31,514 (Target Not Met)	31,514	31,514	Maintain
2.3.90 Percentage of program participants who reported reduced binge drinking at follow-up. (Outcome)	FY 2019: 57.8% Target: 64 % (Target Not Met)	64 %	64 %	Maintain

Sober Truth on Preventing Underage Drinking Act (STOP Act)

(Dollars in thousands)

Program of Regional & National Sigificance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Sober Truth on Preventing Underage Drinking Act	$9,000	$10,000	$10,000	$---

Authorizing Legislation.....Section 519B of the PHS Act
FY 2022 Authorization..... $7,000,000
Allocation Method.....Competitive Grants/Contracts
Eligible Entities.....Current and former Drug Free Communities grantees

Program Description and Accomplishments

Among Americans under age 21, underage drinking is one of our nation's significant public health challenges, and its associated problems have profound negative consequences not just for underage drinkers, but also for their families, their communities, and society as a whole. Alcohol continues to be the most widely used substance of misuse among America's youth, and a higher proportion use alcohol than use tobacco or other drugs. Annually, alcohol is a factor in the deaths of approximately 3,500 youths in the United States, shortening their lives by an average of 60 years. Every day an estimated 2,125 children ages 12 through 14 begin using alcohol. Among 12- to 20-year-olds, 18.8 percent reported using alcohol in the last month. These young people face a number of harmful potential consequences, including death or injury, impaired brain function, decreased academic performance, and increased risk of developing an alcohol use disorder later in life.[50]

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 (Public Law 114-255) was the nation's first comprehensive legislation on underage drinking. The STOP Act was reauthorized in 2016 as part of the 21st Century Cures Act (Public Law 114-255). The Act states, "A multi-faceted effort is needed to more successfully address the problem of underage drinking in the United States. A coordinated approach to prevention, intervention, treatment, enforcement, and research is key to making progress. This Act recognizes the need for a focused national effort, and addresses particulars of the federal portion of that effort, as well as federal support for state activities."

In keeping with the STOP Act's language calling for a multi-faceted, coordinated approach, the Interagency Coordinating Committee for the Prevention of Underage Drinking (ICCPUD) developed a Comprehensive Plan in 2006, with updates in 2018, and a pending update for 2021. The plan includes consensus recommendations from the federal agency members as well as for all

[50] U.S. Department of Health and Human Services. (December, 2020). *Report to Congress on the Prevention and Reduction of Underage Drinking,* Rockville, MD: Substance Abuse and Mental Health Services Administration Retrieved from www.stopalcoholabuse.gov. (National Survey on Drug Use and Health [NSDUH]; Center for Behavioral Health Statistics and Quality [CBHSQ], 2019c)

interested parties identified in the STOP Act, and established the following overarching goals and objectives:

1. Strengthen a national commitment to address the problem of underage drinking;
2. Reduce demand for, the availability of, and access to alcohol by persons under the age of 21;
3. Use research, evaluation, and scientific surveillance to improve the effectiveness of policies, programs, and practices designed to prevent and reduce underage drinking.

The STOP Act requires the HHS Secretary, in collaboration with other federal officials enumerated in the Act, to "formally establish and enhance the efforts of the ICCPUD that began operating in 2004." In 2006, SAMHSA assumed leadership as the HHS Secretary's designee.

The STOP Act calls for data and information on individual state performance and the enforcement of drinking laws, steps to reduce alcohol's availability to youth under the age of 21, research on underage drinking, and resources for local community efforts. The STOP Act also calls for four annual reports to Congress, which are developed under contract ($1 million/year): a report on the prevention and reduction of underage drinking, a report on state performance and best practices for the prevention and reduction of underage drinking, and a report series on state underage drinking prevention and enforcement activities.

A report on the evaluation of the adult oriented national media campaign to prevent underage drinking that includes the production, broadcasting, and effectiveness of the campaign – also known as "Talk They Hear You." The community-based coalition enhancement grant program provides up to $50,000 per year over four years to current or former grantees under the Drug-Free Communities Act of 1997 to prevent and reduce alcohol use among youth under the age of 21. The STOP Act grant program enables organizations to strengthen collaboration and coordination among stakeholders to achieve a reduction in underage drinking in their communities.

The national media campaign to prevent underage drinking, — "Talk They Hear You." (TTHY) responds to directives set forth in Section 2(d) of the STOP Act ($2 million/year), to produce and oversee an adult-oriented national media campaign to provide parents and caregivers of youth under the age of 21 with information and resources to discuss the issue of alcohol with their children. The ICCPUD will continue to guide the development process of the national media campaign, and subsequent evaluation, which is included as Chapter 5 of the Report to Congress annually.

In FY 2019, SAMHSA supported the continuation of 97 grants and 22 new grants. In FY 2020, SAMHSA supported the continuation of 39 grants and 95 new grants. In FY 2021, SAMHSA will fund 16 new grants and 117 continuing grants.

In FY 2020, STOP Act grant recipients began reporting GPRA data in SAMHSA's Performance Accountability and Reporting System (SPARS).

Program Evaluation

FY 2017 data showed that 58 percent of coalitions report at least 5 percent improvement in the 30-day use of alcohol in at least two grades, and 75% of coalitions reported improvement in youth perception of risk from alcohol in at least two grades.

Under ICCPUD's leadership, SAMHSA's Center for Substance Abuse Prevention developed the TTHY campaign in response to directives set forth in Section 2(d) of the STOP Act, requiring the HHS Secretary to fund and oversee a national adult-oriented media public service campaign and to report annually on the production, broadcasting, and evaluation of this campaign. ICCPUD has been instrumental in the overall development of TTHY, using input from experts and organizations representing a wide range of parties, including public health advocacy groups, the alcohol industry, ICCPUD member agencies, the U.S. Congress, and subject matter experts (SMEs). TTHY addresses two of the core goals laid out in ICCPUD's "Preventing & Reducing Underage Drinking 2018 Comprehensive Plan":

- Goal 1: Strengthen a national commitment to address the problem of underage drinking; and
- Goal 2: Reduce demand for, the availability of, and access to alcohol by persons under the age of 21.

To maintain its lasting message and keep it consistent and relevant over time, the TTHY campaign trademarked its logo in 2016, making it the official property of HHS. This trademark instills trust in the campaign, lends credibility to TTHY materials, and promotes consistency when organizations implement TTHY in their communities.

The "Talk They Hear You." (TTHY) earned media campaign[51] has yielded more than a $15-to-$1 return on investment for every dollar invested. Key strategies of the earned media campaign were to (1) secure prominent campaign coverage in several major media outlets and (2) leverage regional relationships in communities through town hall meetings and public health observances (e.g., SAMHSA's Prevention Day and National Prevention Week) to further educate parents and caregivers of children under 21 about why and how they should talk with their kids about the dangers of underage drinking and other substance use. The campaign also hosts community engagement meetings throughout the year to interact with local groups who are implementing the campaign locally and to learn specific details about their prevention efforts.

Since the campaign's inception, initial investment costs for development and implementation have been a little more than $1 million per year, totaling $12,5 million over a 12-year period. Earned media outreach efforts have generated an estimated $193.97 million in earned media placements on major networks and affiliates—with television, print, and radio PSAs having collectively garnered 14.9 billion impressions in all 50 states and in more than 300 cities. Distribution is augmented by community engagement, with groups such as the Community Anti-Drug Coalitions

[51] "Definition of earned media: Earned media, also referred to as media relations, word-of-mouth, public relations, or publicity, is an unpaid brand mention or recognition, such as a news article, published interview, or online review by a third party. In addition, earned media can also refer to a byline or article written by someone associated with the brand that is published by a third party." (Top Rank Marketing, n.d.)

of America and the National Prevention Network, which have direct access to parents and caregivers. With partner engagement and outreach included, the campaign has earned more than 39,270 donated labor hours from local community organizations since its inception, which equates to approximately 19 full-time employees and $885,539 in estimated salary. Disapproval of daily drinking and binge drinking post-intervention; and student perception of binge drinking being a health risk.

Supporting the development and justification of the TTHY campaign involves a complex interplay of formative, process, and outcomes evaluation efforts. Evaluation findings to date suggest that SAMHSA has met many markers for early success, including strongly resonating with intended TTHY audiences. The growing body of evidence presented in the Report to Congress for the Prevention and Reduction of Underage Drinking [52] supports that key campaign messages serve as important cues to action that increase both the plans and actions of parents to talk with their children about underage drinking and other substance use. There is further evidence to suggest that TTHY increases parents' confidence not only in talking with their children about underage drinking and other substance use but also in the behavioral efficacy of that action.

In meeting the requirements of the STOP Act, SAMHSA, under the leadership of ICCPUD, will continue to garner support for program efficacy over the next year and implement evaluation plans for the upcoming 2021–2022 campaign evaluation cycle, which includes the case study replication and "Parents' Night Out" field testing, will continue to establish links between TTHY exposure and the campaign's stated outcomes in quantifiable ways. Armed with data from this and future efforts, SAMHSA will persist in its work to estimate overall campaign impact as well as to ensure that the TTHY campaign evolves in ways that resonate with its primary target audiences and meet the needs of the U.S. population at large.

Funding History

Fiscal Year	**Amount**
FY 2018	$7,000,000
FY 2019	$8,000,000
FY 2020	$9,000,000
FY 2021 Enacted	$10,000,000
FY 2022 Budget Request	$10,000,000

[52] U.S. Department of Health and Human Services. (December, 2020). *Report to Congress on the Prevention and Reduction of Underage Drinking,* Rockville, MD: Substance Abuse and Mental Health Services Administration Retrieved from www.stopalcoholabuse.gov. (National Survey on Drug Use and Health [NSDUH]; Center for Behavioral Health Statistics and Quality [CBHSQ], 2019c)

Budget Request

The FY 2022 budget request is $10.0 million, level with the FY 2021 Enacted budget. SAMHSA will support 133 STOP Act grant continuations.

Outputs and Outcomes Table

Program: Sober Truth on Preventing Underage Drinking (STOP Act)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.3.01 Percent of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades (Outcome)	FY 2020: 62 % Target: 57.7 % (Target Exceeded)	57.7 %	57.7 %	Maintain
3.3.02 Percent of coalitions that report improvement in youth perception of risk from alcohol in at least two grades (Outcome)	FY 2017: 46 % Target: 75 % (Target Exceeded)	75 %	75 %	Maintain

Center for the Application of Prevention Technologies

(Dollars in thousands)

Program of Regional & National Sigificance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Center for the Application of Prevention Technologies.....	$7,493	$7,493	$7,493	$---

Authorizing Legislation.....Section 516 of the PHS Act
FY 2022 Authorization.....$211,148,000
Allocation Method..... Contracts
Eligible Entities.....Domestic and Public Entities

Program Description and Accomplishments

In 2019, SAMHSA funded the Prevention Technology Transfer Centers (PTTC) cooperative agreements. The PTTC Network is comprised of 10 Domestic Regional Centers, 1 National American Indian and Alaska Native PTTC, 1 National Hispanic and Latino PTTC, and Network Coordinating Office. Together the Network serves the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Islands of Guam, American Samoa, Palau, the Marshall Islands, Micronesia, and the Mariana Islands.

The purpose of the PTTC Network is to improve implementation and delivery of effective substance misuse prevention interventions and provide training and technical assistance services to the substance misuse prevention field. This is accomplished by developing and disseminating tools and strategies needed to improve the quality of substance misuse prevention efforts; providing intensive technical assistance and learning resources to prevention professionals in order to improve their understanding of prevention science, epidemiological data, and implementation of evidence-based and promising practices; and, developing tools and resources to engage the next generation of prevention professionals.

Program Evaluation

The two-year evaluation for this program began on September 30, 2019. To date, the PTTC has delivered over 1,760 events and provided training/technical assistance to over 70,400 participants. Current program accomplishments include the following:

The PTTC Network has developed many resources focusing on the prevention of vaping or tobacco use including over 15 webinars and several publications and newsletters.

Together, the PTTC Network created a free online cultural competency program in order to support providers to improve the quality of care provided to clients from diverse backgrounds. The goal of this e-learning program is to help behavioral health professionals increase their cultural and linguistic competency.

In response to COVID-19 pandemic, the PTTC Network developed several resources focused on "Bringing Prevention Virtual" to assist prevention professionals as they transition to delivering services and programming from face-to-face to virtual settings.

Among several events implemented and resources developed, the PTTC Network collaborates with the ATTC and the MHTTC to create a robust list of "Community Engagement Resources". Providing equitable mental health and substance use prevention, treatment, and recovery services means engaging with all communities to make sure all people feel welcome and supported.

Funding History

Fiscal Year	Amount
FY 2018	$7,493,000
FY 2019	$7,493,000
FY 2020	$7,493,000
FY 2021 Enacted	$7,493,000
FY 2022 Budget Request	$7,493,000

Budget Request

The FY 2022 budget request is $7.5 million, level with the FY 2021 Enacted level. Prevention T/TA services are being conducted by the PTTCs.

Outputs and Outcomes Table

Program: Center for the Application of Prevention Technologies (CAPT)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.4.14 Number of people trained (Output)	FY 2020: 70,400.0 Target: 70,400.0 (Baseline)	70,400.0	70,400.0	Maintain
1.4.15 Percentage expecting to use information from training to change their practice. (Outcome)	FY 2020: 69.0 Target: Maintain Baseline Target Exceeded)	Maintain Target	Maintain Target	Maintain

Science and Service Program Coordination

(Dollars in thousands)

Program of Regional & National Sigificance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Science and Service Program Coordination	$4,072	$4,072	$4,072	$---

Authorizing Legislation.....Section 516 of the PHS Act
FY 2022 Authorization.....$211,148,000
Allocation Method..... Contracts
Eligible Entities.....Domestic and Public Entities

Program Description and Accomplishments

SAMHSA has made preventing underage drinking a priority because of its potential impact on the health and well-being of young people and their communities. Over the past decade, there has been a steady decline of drinking by adolescents and young adults. Trend data report similar declines in underage binge and heavy drinking. In 2019, 139.7 million Americans aged 12 or older reported current use of alcohol, 65.8 million reported binge drinking and 16 million reported heavy drinking.[53] Alcohol continues to be the most widely used substance of abuse among American youth, and a higher proportion use alcohol than use tobacco, marijuana, or other drugs.[54]

The Science and Service Program Coordination program funds the provision of technical assistance and training to states, tribes, communities, and grantees around substance misuse prevention. Specifically, the program supports the Tribal Training and Technical Assistance Center (TTTAC) and the Underage Drinking Prevention Education Initiatives (UADPEI).

The TTTAC is an innovative training and technical assistance (TTA) project that helps tribal communities facilitate the development and implementation of comprehensive and collaborative community-based prevention plans to reduce violence, bullying, substance misuse, and suicide among American Indian/Alaska Native (AI/AN) youth, in support of the HHS Tribal Health and Well-Being Coordination. These plans mobilize tribal communities' existing social and educational resources to meet their goals.

The UADPEI efforts engage parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences. The UADPEI heavily promotes the adoption of evidence-based policies, programs, and practices by developing materials, resources, and other engagement tools to strengthen community-based prevention efforts on underage drinking and other substances. The initiative collaborates with other federal

[53] Substance Abuse and Mental Health Services Administration. (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/data
[54] U.S. Department of Health and Human Services (HHS), SAMHSA. (2018). Report to Congress on the Prevention and Reduction of Underage Drinking. Retrieved from https://www.stopalcoholabuse.gov/resources/reporttocongress/rtc2018.aspx

agencies on underage drinking prevention strategy implementation through ICCPUD and the StopAlcoholAbuse.gov website.

As part of its work to support SAMHSA and ICCPUD, the UADPEI develops new resources for prevention professionals that call out important trends from the NSDUH and emphasize new ways to approach underage and problem drinking prevention. These types of resources are audience specific and range from data visualizations and parent guides to the *College Drinking: Prevention Perspectives* (CD:PP) videos and discussion guides. CD:PP videos highlight evidence-based underage drinking prevention strategies at institutions of higher education, including historically black colleges and universities (HBCUs) while the discussion guides provide campus communities an opportunity to think critically about how these strategies can be adapted and modified to fit their own needs.

The UADPEI also engages families, youth, youth-serving organizations, and institutions of higher education in initiatives such as SAMHSA's *Communities Talk to Prevent Underage Drinking*.

In FY 2019, community-based organizations registered to host 1,200 events and activities in all 50 states, the District of Columbia, and three territories. Of the activities that took place,

- 7 in 10 activities (67%) included youth in planning and/or hosting and almost 300 included prevention messages related to marijuana, vaping and opioids, as well as mental health and wellness.

An estimated 77,000 people participated in activities, either in person or virtually. SAMHSA garnered 2.1 million social media impressions through the #CommunitiesTalk and reached an estimated 19.8 million people through traditional media promoting *Communities Talk*.

In FY 2020, SAMHSA modified the initiative to account for impacts on communities created by the COVID-19 pandemic. As a result, the 2021 cycle of Communities Talk places a higher emphasis on prevention activities that share important messages about underage drinking while accounting for social distancing guidelines, the limited capacity of prevention professionals and the new realities associated with underage and problem drinking. To do this, SAMHSA gathered insights from community- and state-level prevention professionals, including those that work at colleges and universities. Key changes to the initiative include additional support and resources for virtual activities (webinars, PSAs, interactive social media campaigns, etc.) and new messaging that creates a stronger link between overall wellness during the pandemic and substance use prevention. Since the initiative's launch in February, more than 500 organizations have registered their participation.

Program Evaluation

In 2019 the UADPEI reached its goal of 1,000 organizations hosting underage drinking prevention events. More than 150 institutions of higher education also participated in the 2019 *Communities Talk* cycle.

Tribal Training and Technical Assistance Contract (TTAC)

During FY 2020, GPRA data was collected from a total of 541 TTA participant questionnaires. The participant questionnaire results indicated an overall positive response to the TTA provided onsite and virtually. Respondents reported that the TTA improved their individual capacity and their organization's capacity to do prevention work. Overall, about 95 percent of participants reported TTA was useful and improved capacity for themselves and their organizations.

The total 541 TTA reported above also comprises the following FY 2020 activities. During FY 2020, the Tribal TTA Center team reported data on 9 Broad TTA events, 12 Focused TTA events, 31 Intensive TTA events, and 15 Opioids TTA events. The TTA Center collected GPRA measures on Onsite Broad TTA events serving a total of 123 participants representing 26 AI/AN communities over 10 days and 3 events. Six virtual Broad TTA events served a total of 244 participants. Onsite Focused TTA events served a total of 123 participants representing 73 AI/AN communities over 19 days and 6 events. Seven Focused virtual TTA events served a total of 56 participants. Intensive Virtual TA served 298 participants through 22 events and Intensive training served a total of 334 participants across 9 events. Onsite Opioids TTA events served a total of 309 participants representing 105 AI/AN communities over 15 days and 7 events. Eight Opioids virtual TTA events served a total of 397 participants.

Funding History

Fiscal Year	Amount
FY 2018	$4,072,000
FY 2019	$4,072,000
FY 2020	$4,072,000
FY 2021 Enacted	$4,072,000
FY 2022 Budget Request	$4,072,000

Budget Request

The FY 2022 budget request is $4.1 million, level with the FY 2021 Enacted budget. This funding will support SAMHSA's substance misuse prevention efforts and include a focus on preventing underage drinking and providing technical assistance and training to AI/AN communities.

Outputs and Outcomes Table

Program: Prevention - Science and Service Activities

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.3.100 Number of organizations or communities that demonstrate improved readiness to change their systems (Output)	FY 2020: 5.0 organizations Target: 5.0 organizations (Target Met)	5.0 organizations	5.0 organizations	Maintain

Tribal Behavioral Health Grants

(Dollars in thousands)

Program of Regional & National Sigificance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Tribal Behavioral Health Grants	$20,000	$20,750	$21,165	$415

Authorizing Legislation.....Section 516 of the PHS Act
FY 2022 Authorization.....$211,148,000
Allocation Method.....Grants/Contracts
Eligible Entities.....Tribes

Program Description and Accomplishments

Suicide is the second leading cause of death among American Indian/Alaska Native (AI/AN) youth ages eight to 24 years.[55] Further, AI/AN high school students report higher rates of suicidal behaviors than the general population of U.S. high school students.[56] These behaviors include serious thoughts of suicide, suicide plans, suicide attempts, and medical attention for a suicide attempt. However, the risk of suicide is not the same in all AI/AN youth demographic groups. For instance, AI/AN youth raised in urban settings have a smaller risk of having thoughts of suicide than AI/AN youth raised on tribal reservations (21 percent and 33 percent, respectively).[57]

Consistent with the goals of the Tribal Behavioral Health Agenda, the Tribal Behavioral Health Grant (TBHG) program addresses the high incidence of substance use and suicide among AI/AN populations. Starting in FY 2014, this program supports tribal entities with the highest rates of suicide by providing effective and promising strategies that address substance misuse, trauma, and suicide and by promoting the mental health of AI/AN young people.

These five-year grants help grantees develop and implement a plan that addresses suicide and substance misuse, thereby promoting mental health among tribal youth. In addition, SAMHSA's Tribal Training and Technical Assistance Center (http://www.samhsa.gov/tribal-ttac) provides training and education to AI/AN grantees and organizations serving AI/AN populations to support their ability to achieve their goals.

This initiative takes a comprehensive, culturally appropriate approach to help improve the lives of and opportunities for AI/AN youth. In addition to the Department of Health and Human Services, multiple agencies, including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing AI/AN youth.

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[55] Centers for Disease Control and Prevention. Fatal injury data, 2010. Web-based Injury Statistics Query and Reporting System. Available at www.cdc.gov/injury/wisqars/fatal.html. Accessed May 27, 2014.
[56] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Available at http://www.cdc.gov/healthyyouth/yrbs/index.htm. Accessed May 27, 2014.
[57] Freedenthal, S. & Stiffman, A. R. (2004). Suicidal Behavior in Urban American Indian Adolescents: A Comparison with Reservation Youth in a Southwestern State. Suicide and Life-Threatening Behavior, 34(2), 160-171.

Since FY 2016, SAMHSA expanded activities through the braided TBHG funding from the Substance Abuse Prevention appropriation and the Mental Health appropriation) to allow tribes the flexibility to implement community-based strategies to address trauma, prevent substance misuse, and promote mental health and resiliency among youth in tribal communities. SAMHSA currently funds 185 active tribal grantees through this program. SAMHSA's goal is to reduce substance use and the incidence of suicide attempts among AI/AN youth and to address behavioral health conditions that affect learning in the Bureau of Indian Education-funded schools.

Program Evaluation

The SAMHSA Native Connections (NC) Team provided training and technical assistance (TTA) to 92 NC grantees for support in achieving the goals of the grant and disseminating best practices and lessons learned. TTA focuses on evidence-based and culturally informed policies and practices, and promoting mental, emotional, and behavioral health. It helps grantees shape and implement effective strategies to reduce the impact of substance use and misuse and mental illness, and to foster culturally responsive models to reduce and respond to the impact of trauma on AI/AN communities through a public health approach. During FY 2020, the NC Team delivered 4,958 hours of virtual TTA to 92 grantees and developed and facilitated 13 live webinars. Ten individual podcasts featuring NC grantees were developed and accessed a total of 496 times throughout FY 2020. Three national prevention events were designed to engage grantees and communities: National Prevention Month (Digital Storytelling Festival), Native American Heritage Month (Native American Heritage Month Toolkit), and National Drug and Alcohol Facts Week (fact sheets and eblasts). Regional Learning Communities were organized and facilitated for five grantee regions: Alaska, California, Arizona-New Mexico, Great Lakes- Northern Plains, and Oklahoma-Kansas. Twenty-two learning communities took place in FY 2020. Six National Learning Communities also took place in FY 2020.

In FY 2020, grantees screened 46,887 individuals for mental health and suicide concerns; 466,861 individuals were contacted through program outreach efforts, and 3,887 organizations implemented specific mental health related practices and activities that aligned with program goals.

In FY 2019, SAMHSA supported 119 grant continuations, 26 new grants, and technical assistance activities. In FY 2020, SAMHSA supported 145 grant continuations, 40 new grants, and technical assistance activities. In FY 2021, SAMHSA plans to support 124 grant continuations, 29 new grants and technical activities.

Funding History

Fiscal Year	Amount
FY 2018	$15,000,000
FY 2019	$20,000,000
FY 2020	$20,000,000
FY 2021 Enacted	$20,750,000
FY 2022 Budget Request	$21,165,000

Budget Request

The FY 2022 budget request is $21.2 million, an increase of $415,000 above the FY 2021 Enacted budget. This request, along with $20.0 million in the Center of Mental Health Services will continue to support approximately 157 grants that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families.

As a braided activity, SAMHSA will track separately any amounts spent or awarded under Tribal Behavioral Health Grants through the distinct appropriations and ensure that funds are used for purposes consistent with legislative direction and intent of these appropriations.

Outputs and Outcomes Table

Program: Tribal Behavioral Health Grants

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.4.12 Percentage of youth age 10 - 24 who received mental health or related services after screening, referral or attempt (Output)	FY 2020: 47 Target: 42 (Target Exceeded)	47	47	Maintain
2.4.13 Number of programs/organizations that implemented specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2020: 3,076 Target: 6,880 (Target Not Met)	3,000	3,000	Maintain

Minority Fellowship Program

(Dollars in thousands)

Program of Regional & National Sigificance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Minority Fellowship Program	$321	$321	$340	$19

Authorizing Legislation.....Section 597 of the PHS Act
FY 2022 Authorization.....$12,669,000
Allocation Method.....Grants/Contracts
Eligible Entities.....Organizations that represent individuals obtaining post baccalaureate training (including for master's and doctoral degrees) for mental and substance use disorder treatment professionals in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling.

Program Description and Accomplishments

SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance use disorder treatment services for minority populations that are underserved. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, the program expanded to include marriage and family therapists and later added professional counselors. Professional guilds receive competitively awarded grants, and then competitively award the stipends to post-graduate students pursuing a degree in that professional field.

In FY 2019, SAMHSA funded seven continuation grants. SAMHSA supported the same level of effort in FY 2020. In FY 2020, SAMHSA supported 7 continuations and 1 new grant. SAMHSA will support 8 continuations in FY 2021.

Funding History

Fiscal Year	Amount
FY 2018	$71,000
FY 2019	$321,000
FY 2020	$321,000
FY 2021 Enacted	$321,000
FY 2022 Budget Request	$340,000

Budget Request

The FY 2022 budget request is $340,000, an increase of $19,000 over FY 2021 Enacted budget. Funding for this program will continue to support prevention related grants and support the provision of enhanced behavioral health services for racial and ethnic minority communities.

SAMHSA/Substance Abuse Prevention
PRNS Mechanism Table Summary

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final		FY 2021 Enacted		FY 2022 President's Budget	
	No	Amount	No	Amount	No	Amount
Grants						
Continuations	469	128,736	641	157,128	712	176,277
New/Competing	307	53,067	114	25,967	65	15,302
Supplements*	---	---	---	---	---	---
Subtotal	776	181,803	755	183,095	777	191,579
Contracts						
Continuations	10	23,677	12	21,135	13	19,393
New	1	989	3	3,989	2	5,695
Subtotal	11	24,666	15	25,124	15	25,088
Total, Substance Abuse Prevention PRNS	**787**	**$206,469**	**770**	**$208,219**	**792**	**$216,667**

SAMHSA/Substance Abuse Prevention
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final		FY 2021 Enacted		FY 2022 President's Budget	
	No	Amount	No	Amount	No	Amount
Capacity:						
Strategic Prevention Framework						
Grants						
Continuations	170	$82,105	230	$99,129	262	$111,155
New/Competing	87	28,939	32	12,186	13	$7,304
Supplements	---	---	---	---	---	---
Subtotal	257	111,044	262	111,315	275	118,459
Contracts						
Continuations	3	8,440	3	7,015	3	8,215
New	---	---	1	1,154	---	---
Subtotal	3	8,440	4	8,169	3	8,215
Total, Strategic Prevention Framework	**260**	**119,484**	**266**	**119,484**	**278**	**126,674**
Federal Drug-Free Workplace						
Contracts						
Continuations	2	4,888	5	4,892	4	1,277
New	---	6	---	2	1	3,617
Subtotal	2	4,894	5	4,894	5	4,894
Total, Federal Drug-Free Workplace	**2**	**4,894**	**5**	**4,894**	**5**	**4,894**
Minority AIDS						
Grants						
Continuations	94	22,482	147	31,784	163	34,656
New/Competing	84	16,641	37	7,392	27	5,393
Subtotal	178	39,123	184	39,176	190	40,049
Contracts						
Continuations	---	2,069	---	2,029	---	1,980
New	---	13	---	---	---	---
Subtotal	---	2,082	---	2,029	---	1,980
Total, Minority AIDS	**178**	**41,205**	**184**	**41,205**	**190**	**42,029**
Sober Truth on Preventing Underage Drinking Act						
Grants						
Continuations	39	1,833	117	5,772	133	6,577
New/Competing	95	4,758	16	800	---	43
Subtotal	134	6,591	133	6,572	133	6,620
Contracts						
Continuations	1	1,439	2	3,428	2	3,380
New	1	970	---	---	---	---
Subtotal	2	2,409	2	3,428	2	3,380
Total, Sober Truth on Preventing Underage Drinking Act	**136**	**9,000**	**135**	**10,000**	**135**	**10,000**

SAMHSA/Substance Abuse Prevention
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final		FY 2021 Enacted		FY 2022 President's Budget	
	No	Amount	No	Amount	No	Amount
Tribal Behavioral Health Grants						
Grants						
Continuations	145	14,983	124	12,625	132	16,093
New/Competing	40	2,489	29	5,590	25	2,562
Subtotal	185	17,472	153	18,214	157	18,654
Contracts						
Continuations	1	2,528	---	1,022	1	2,511
New/Competing	---	---	1	1,514	---	---
Subtotal	1	2,528	1	2,536	1	2,511
Total, Tribal Behavioral Health Grants	**186**	**20,000**	**154**	**20,750**	**158**	**21,165**
Subtotal, Capacity	**762**	**194,583**	**744**	**196,333**	**766**	**204,762**
Science and Service:						
Center for the Application of Prevention Technologies						
Grants						
Continuations	13	7,117	13	7,117	13	7,140
New/Competing	---	---	---	---	---	---
Subtotal	13	7,117	13	7,117	13	7,140
Contracts						
Continuations	---	376	---	376	---	353
New/Competing	---	---	---	---	---	---
Subtotal	---	376	---	376	---	353
Total, Center for the Application of Prevention Technol	**13**	**7,493**	**13**	**7,493**	**13**	**7,493**
SAP Minority Fellowship Program						
Grants						
Continuations	7	66	8	305	8	305
New/Competing	1	239	---	---	---	---
Supplements*	---	---	---	---	---	---
Subtotal	8	305	8	305	8	305
Contracts						
Continuations	---	16	---	16	---	16
New/Competing	---	---	---	**313**	---	**19**
Subtotal	---	16	---	16	---	35
Total, SAP Minority Fellowship Program	**8**	**321**	**8**	**321**	**8**	**340**

SAMHSA/Substance Abuse Prevention
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final		FY 2021 Enacted		FY 2022 President's Budget	
	No	Amount	No	Amount	No	Amount
Science & Service Program Coordination						
Grants						
Continuations	**1**	150	2	396,366	1	352,230
New/Competing	---	---	---	---	---	---
Subtotal	1	150	2	396	1	352
Contracts						
Continuations	3	3,922	2	2,357	3	1,661
New	---	---	1	1,319	1	2,059
Subtotal	3	3,922	3	3,676	4	3,720
Total, Science & Service Program Coordination	4	4,072	5	4,072	5	4,072
Subtotal, Science and Service	25	**11,886**	26	**11,886**	26	**11,905**
Total, Substance Abuse Prevention	787	**$206,469**	770	**$208,219**	792	**$216,667**

Grant Awards Table

(Whole dollars)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	787	770	792
Average Award	$234,282	$242,510	$246,562
Range of Awards	$50,000 - $2,300,000	$50,000 - $2,300,000	$50,000 - $2,300,001

Substance Abuse Treatment

Table of Contents

Substance Abuse Treatment Appropriation

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022 +/- FY 2021
Programs of Regional and National Significance.....	$479,677	$496,677	$650,864	$154,187
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*2,000*	---
State Opioid Response Grants.....	1,500,000	1,500,000	2,250,000	750,000
Set-Aside for Tribes (non-add)	*50,000*	*50,000*	*75,000*	*25,000*
Substance Abuse Prevention and Treatment Block Grant....	1,858,079	1,858,079	3,508,079	1,650,000
Budget Authority (non-add)	*1,778,879*	*1,778,879*	*3,428,879*	*1,650,000*
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	---
Total, Substance Abuse Treatment.....	**$3,837,756**	**$3,854,756**	**$6,408,943**	**$2,554,187**

The Substance Abuse Treatment FY 2022 Budget Request is $6.4 billion, an increase of $2.6 billion from the FY 2021 Enacted. The request includes $3.4 billion in Budget Authority and $79.2 million in Public Health Service (PHS) Evaluation funds.

Programs of Regional and National Significance (PRNS)
Substance Abuse Treatment Appropriation

(Dollars in thousands)

Programs of Regional and National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Capacity:				
Opioid Treatment Programs/Regulatory Activities	$8,724	$8,724	$13,086	$4,362
Screening, Brief Intervention and Referral to Treatment	30,000	30,000	30,560	560
Budget Authority (non-add)	*28,000*	*28,000*	*28,560*	*560*
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*2,000*	---
Targeted Capacity Expansion-General	100,192	102,192	147,916	45,724
Other Targeted Capacity Expansion	*11,192*	*11,192*	*11,416*	*224*
MAT for Prescription Drug and Opioid Addiction (non-add)	*89,000*	*91,000*	*136,500*	*45,500*
MAT for Prescription Drug and Opioid Addiction (Tribes)(non-add).	---	*11,000*	*16,500*	*5,500*
Pregnant and Postpartum Women	31,931	32,931	49,397	16,466
Recovery Community Services Program	2,434	2,434	5,151	2,717
Improving Access to Overdose Treatment	1,000	1,000	1,500	500
Building Communities of Recovery	8,000	10,000	20,000	10,000
Children and Families	29,605	29,605	30,197	592
Treatment Systems for Homeless	36,386	36,386	37,114	728
Minority AIDS	65,570	65,570	66,881	1,311
Criminal Justice Activities	89,000	89,000	124,380	35,380
Other Criminal Justice Activities (non-add)	*19,000*	*19,000*	*19,380*	*380*
Drug Court Activities(non-add)	*70,000*	*70,000*	*105,000*	*35,000*
Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths	12,000	12,000	18,000	6,000
Peer Support TA Center	1,000	1,000	1,500	500
Treatment, Recovery, and Workforce Support	4,000	6,000	9,000	3,000
Emergency Department Alternatives to Opioids	5,000	6,000	9,000	3,000
Opioid Response Grants	---	3,000	3,000	---
Comprehensive Opioid Recovery Centers	---	4,000	6,000	2,000
First Responder Training (CARA)	41,000	42,000	63,000	21,000
First Responder Training (non-add)	*18,000*	*18,000*	*27,000*	*9,000*
Rural Set-Aside (non-add)	*23,000*	*24,000*	*36,000*	*12,000*
Subtotal, Capacity	**465,842**	**481,842**	**635,682**	**153,840**
Science and Service:				
SAT Minority Fellowship Programs	4,789	5,789	6,136	347
Addiction Technology Transfer Centers	9,046	9,046	9,046	---
Subtotal, Science and Service	**13,835**	**14,835**	**15,182**	**347**
Total, PRNS	**$479,677**	**$496,677**	**$650,864**	**$154,187**

Opioid Treatment Programs/Regulatory Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Opioid Treatment Programs/Regulatory Activities.....	$8,724	$8,724	$13,086	$4,362

Authorizing Legislation.....Section 509 of the Public Health Service Act
FY 2022 Authorization..... $333,806,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Medical Association, American Osteopathic Association, American Psychiatric Association, American Dental Association Domestic Medical Schools, Physician Assistant Schools, and Schools of Nursing

Program Description and Accomplishments

The misuse of prescription opioid pain relievers and the use of illicit opioids, such as heroin and synthetic opioids, continues to be a major public health crisis. Communities continue to see growing overdose deaths[58], infectious diseases[59] and other injection drug use-related health concerns.

With increasing incidence of opioid abuse, there is a corresponding increase in admissions for treatment of opioid abuse.[60] Medication-assisted treatment (MAT) refers to the use of the Food and Drug Administration (FDA) approved pharmacotherapies (e.g. buprenorphine products, methadone, and naltrexone products) in combination with evidence-based psychosocial interventions for treatment of opioid use disorders. MAT is a safe and evidence-based strategy for decreasing the frequency and quantity of opioid use and reducing the risk of overdose and death. Approximately one million Americans need, but do not access, treatment for an opioid addiction.[61]

Opioid treatment programs (OTPs) are the only means of providing medication-assisted treatment (MAT) with methadone. Buprenorphine can be prescribed in an office setting by qualified health care providers who have received a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000) provision of the Controlled Substances Act. Most health care providers with a waiver to prescribe buprenorphine do not treat the maximum allowable number of patients.

[58] Centers for Disease Control and Prevention. Annual Surveillance Report of Drug-Related Risks and Outcomes, 2019. Retrieved from https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf.
[59] National Institute on Drug Abuse. Health Consequences of Drug Misuse, 2017. Retrieved from https://www.drugabuse.gov/publications/health-consequences-drug-misuse/hiv-hepatitis-other-infectious-diseases.
[60] Paulozzi LJ, Jones CM, Mack KA, Rudd RA. Vital signs: overdoses of prescription opioid pain relievers – United States, 1999-2008. MMWR Morb Mortal Wkly Rep. 2011;60(43): 1487-92.

In November 2016, the implementation of Section 303 of the Comprehensive Addiction and Recovery Act (CARA) enabled the Department of Health and Human Services (HHS) to announce that nurse practitioners (NPs) and physician assistants (PAs) could immediately begin taking the 24 hours of required training to prescribe buprenorphine for the treatment of opioid addiction. CARA expanded prescribing privileges to NPs and PAs for five years (until October 1, 2021). With the passage of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act in October 2018, the five-year limit on prescribing privileges for NPs and PAs was removed. Additionally, the SUPPORT Act expanded prescribing privileges to Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetists (CRNAs), and Certified Nurse Midwives (CNMs) until October 1, 2023.

SAMHSA is responsible for regulating and certifying 1,823 OTPs as of April 2021 to use opioid agonist treatment medications and processing DATA waivers for qualifying practitioners and physician assistants who wish to treat opioid use disorder with buprenorphine. SAMHSA reviews new and renewal applications for OTPs and oversees their accreditation process. OTPs are required to be accredited as a condition of certification. SAMHSA's OTP regulation plays a critical role in expanding access and maintaining quality. Accrediting organizations must be approved by SAMHSA to fulfill this function and this approval must be renewed every five years. SAMHSA monitors the accrediting bodies for quality assurance and improvement by making site visits to a percentage of programs that received accreditation review within that year; additionally, SAMHSA can conduct unannounced OTP site visits to investigate complaints and determine compliance with federal regulations in 42 CFR Part 8.

SAMHSA implements DATA 2000 in coordination with the Drug Enforcement Administration (DEA). This includes approving waivers for qualified practitioners to provide medication-assisted treatment in office-based settings.

In April 2021, SAMHSA released practice guidelines that allow for an alternative Notice of Intent (NOI) for those seeking to treat up to 30 patients: The customary NOI requires eligible providers to undertake required training activities prior to their application to prescribe Buprenorphine; the alternative type of NOI allows those providers who wish to treat up to 30 patients to forego the training requirement, as well as certification to counseling and other ancillary services (i.e., psychosocial services). Practitioners utilizing this training exemption are limited to treating no more than 30 patients at any one time (time spent practicing under this exemption will not qualify the practitioner for a higher patient limit). This exemption applies only to the prescription of Schedule III, IV, and V drugs or combinations of such drugs, covered under the CSA, such as buprenorphine.

As of February 1, 2021, a total of 95,804 professionals were certified to prescribe buprenorphine, as follows: [62] [63]

[61] Jones, C. M. (2013). Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers, United States, 2002-2004 and 2008-2010. Drug and Alcohol Dependence, 132(1-2):95-100.
[62] This is a non-duplicated count of active practitioners.

[63] Data provided by Center for Behavioral Health Statistics and Quality

- 50,748 physicians, 13,737 NPs, 3684 PAs, 113 CNMs, 58 CNSs, and 7 CRNAs were certified to treat up to 30 patients;
- 12,941 physicians, 6115 NPs, 1586 PAs, 36 CNMs, 19 CNSs, and 8 CRNA were certified to treat up to 100 patients; and
- 5259 physicians, 1199 NPs, and 304 PAs, and 1 CNS were certified to treat up to 275 patients.

Provider's Clinical Support System - Universities

SAMHSA supports the Providers' Clinical Support System- Universities (PCSS-U) grant program. This program provides education, training and clinical mentoring to students of healthcare professions seeking to treat opioid use disorder upon their graduation.

Program Evaluation

The PCSS-U program integration of formal education on opioid treatment for future providers while they are in school. This assures students are prepared to obtain a DATA 2000 Waiver allowing them to prescribe much needed medication to treat opioid use disorder, upon becoming licensed professionals.

In FY 2020, SAMHSA funded 29 continuation grants and 2 contracts.

In FY 2021, SAMHSA anticipates funding 1 continuation and 36 new grants, and 2 contracts.

Funding History

Fiscal Year	Amount
FY 2018	$8,724,000
FY 2019	$8,724,000
FY 2020	$8,724,000
FY 2021 Enacted	$8,724,000
FY 2022 Budget Request	$13,086,000

Budget Request

The FY 2022 Budget Request is $13.1 million, an increase of $4.4 million from the FY 2021 Enacted level. In FY 2022, SAMHSA will award approximately 36 continuation grants, 29 new grants and two contracts. SAMHSA will use the increase in funding to hold at least 300 additional events and provide training for an additional 8,000 participants.

Screening, Brief Intervention, and Referral to Treatment

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Screening, Brief Intervention and Referral to Treatment	$30,000	$30,000	$30,560	$560
Budget Authority (non-add)	*28,000*	*28,000*	*28,560*	*560*
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*2,000*	---

Authorizing Legislation.....Section 509 of the Public Health Service Act
FY 2022 Authorization..... $333,806,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Single State Authority and Health Departments in States, Territories, the District of Columbia, Federally Recognized American Indian/Alaska Native Tribes or Tribal Organizations, Domestic Public and Private Non-Profit Entities, and Public and Private Universities and Colleges

Program Description and Accomplishments

Among individuals age 12 or older, 30.5 million (11.2 percent) use illicit drugs, 66.6 million (47.4 percent of current alcohol users) binge drink, and 16.7 million (25.1 percent of current alcohol users) drink heavily.[64] This imposes a great cost on society by compromising individual health and potentially causing injury to others. The National Institute on Drug Abuse found that misuse of illicit drugs, tobacco and alcohol costs society $740 billion each year.[65] Of the individuals who need treatment for substance use disorder, only 12.2 percent receive treatment in a specialty treatment facility.[66] The vast majority of those meeting criteria for having a drug/alcohol addiction have not been diagnosed.

In 2003, SAMHSA started the Screening, Brief Intervention and Referral to Treatment (SBIRT) program, which is intended to help primary care physicians identify individuals who misuse substances and help them intervene early with education, brief treatment, or referral to specialty treatment. The program's goal is to increase the number of individuals who receive treatment and reduce the rate of substance misuse. Studies have long shown that this approach is effective in helping reduce harmful alcohol consumption.[67,68,69]

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[64] Center for Behavioral Health Statistics and Quality. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-0012020).Retrieved from https://www.samhsa.gov/data/report/2019-nsduh-annual-national-report

[65] National Institute on Drug Abuse (2017), Trends and Statistics, http://www.drugabuse.gov/related-topics/trends-statistics.

[66] Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health Retrieved from http://www.samhsa.gov/data/

[67] Bertholet, N., Daeppen, J.-B., Wietlisbach, V., Fleming, M., & Burnand, B. (2005). *Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis*. Archives of Internal Medicine 165, 986–995.

[68] Kahan, M., Wilson, L., & Becker, L. (1995). *Effectiveness of physician-based interventions with problem drinkers: A review*. Canadian Medical Association Journal*, 152,* 851–859.

[69] Wilk, A.I., Jensen, N.M., and Havighurst, T.C. (1997*). Meta-analysis of randomized control trails addressing brief interventions in heavy alcohol drinkers*. Journal of General Medicine, 12 (5), 274-283.

The SBIRT program seeks to increase the use of SBIRT in medical settings by promoting wide dissemination and adoption of the practice across the spectrum of primary care services. To achieve this, SAMHSA awards state implementation grants to encourage adoption of SBIRT by healthcare providers in each state. SAMHSA also supports the SBIRT Student Training grant programs.

The SBIRT program requires state grant recipients to implement the model in all primary care settings, as well as hospitals, trauma centers, federally qualified health centers, and other relevant health care settings. Recipients may use funds to screen for substance use and co-occurring mental illness and drug/alcohol addiction. They can support evidence-based client-centered interventions, such as Motivational Interviewing, brief treatment, and referral to specialty care for individuals exhibiting addiction symptoms.

The SBIRT training program helps train a wide range of medical providers to incorporate SBIRT as part of their ongoing practice. This includes physicians, nurses, counselors, social workers, health promotion advocates, health educators, and others. A SAMHSA-funded cross-site evaluation found that allied health professionals, rather than the physicians themselves, were more likely to implement SBIRT with their patients.[70] The SBIRT Student Training and Health Professionals Training grant programs support SBIRT training efforts for medical students, medical residents, nurses, social workers, psychologists, pharmacists, dentists, and physician assistants. These efforts aim to develop further the primary healthcare workforce in substance use disorder treatment and services.

Program Evaluation

In FY 2020, the program served over 133,115 clients. At six-month follow-up, the rate of change for the National Outcome Measures was as follows: 27.8 percent of clients reported that they were currently employed or attending school, 64.5 percent reporting that they had a permanent place to live in the community; 31.8 percent reported abstinence from substance use, a 387.7 percent increase from those reporting at intake; and 98.0 percent reported no past 30-day arrests, a 3.2 percent increase from those reporting at intake.

In FY 2020, SAMHSA funded 32 continuation grants.

In FY 2021, SBIRT anticipates funding 27 continuations and 10 new grants.

[70] RTI International (2009). *RTI International to Evaluate Comprehensive Substance Abuse Intervention Programs for SAMHSA.*

Funding History

Fiscal Year	Amount
FY 2018	$24,700,000
FY 2019	$27,854,000
FY 2020	$30,000,000
FY 2021 Enacted	$30,000,000
FY 2022 Budget Request	$30,560,000

Budget Request

The FY 2022 Budget Request is $30.6 million, an increase of $560,000 from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to award 37 continuation grants and one new grant.

Outputs and Outcomes Table

Program: Screening, Brief Intervention and Referral to Treatment

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.2.40 The number of clients served (Output)	FY 2020: 123,497 Target: 73,462 (Target Exceeded)	78,000	195,537	+117,537
1.2.41 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2020: 37.2 % Target: 35.2 % (Target Exceeded)	41 %	41 %	Maintain

Targeted Capacity Expansion-General

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022+/- FY 2021
Targeted Capacity Expansion-General	$100,192	$102,192	$147,916	$45,724
Other Targeted Capacity Expansion	*11,192*	*11,192*	*11,416*	*224*
MAT for Prescription Drug and Opioid Addiction (non-add)	*89,000*	*91,000*	*136,500*	*45,500*
MAT for Prescription Drug and Opioid Addiction (Tribes)(non-add)	*---*	*11,000*	*16,500*	*5,500*

Authorizing Legislation..... Sections 509 of the Public Health Service Act
FY 2022 Authorization..... $333,806,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities, States, Opioid Medication-Assisted SPF Rx Treatment Service Providers, Outpatient Substance Abuse Providers, Community Mental Health Centers, Federally Qualified Health Centers, SAMHSA Certified Opioid Treatment Programs, and Licensed Outpatient Substance Abuse Treatment Programs

Program Description and Accomplishments

Urgent, unmet, and emerging substance use disorder treatment and recovery support service capacity needs remain a critical issue for the nation. In an effort to assist communities in overcoming these barriers, SAMHSA initiated the Targeted Capacity Expansion (TCE) program. The program provides rapid, strategic, comprehensive, and integrated community-based responses to gaps in and capacity for substance use disorder treatment and recovery support services. Examples of such needs include limited or no access to medication-assisted treatment (MAT) for opioid use disorders; lack of resources needed to adopt and implement health information technology (HIT) in substance use disorder treatment settings; and short supply of trained and qualified peer recovery coaches to assist individuals in the recovery process.

Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT -PDOA)
The MAT-PDOA program addresses treatment needs of individuals who have an opioid use disorder (OUD) by expanding/enhancing treatment system capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based MAT and recovery support services.

MAT refers to the use of the Food and Drug Administration-approved pharmacotherapies (i.e., buprenorphine products, methadone, and naltrexone products) in combination with evidence-based psychosocial interventions for treatment of OUD. MAT is a safe and effective strategy for decreasing the frequency and quantity of opioid misuse and reducing the risk of overdose and death. Recovery support services include linking patients and families to social, legal, housing, and other supports to improve retention in MAT to increase the probability of positive outcomes.

Between 2016 and 2019, MAT use increased from 912,401 to 1,461,895.[71] In 2019, there was a significant decrease in prescription opioid misuse across all age groups. However, overdose deaths have been increasing. CDC preliminary data point to 90,000 overdose deaths for the 12 months ending last September – about 20,000 more than the same period the year before. Deaths involving synthetic opioids, likely driven by illicitly manufactured fentanyl (IMF), including fentanyl analogs, a main driver of the increase in overdose deaths. While prescription opioid overdoses are falling, other overdose categories continue to show troubling increases especially with the onset of Covid19 Synthetic opiates including fentanyl continue to drive tens of thousands of deaths in 2018. Despite these troubling statistics, significant gaps persist between treatment need and capacity.

The aim of the state MAT-PDOA continuation grants is to increase the number of individuals receiving services with pharmacotherapies approved by the Food and Drug Administration for the treatment of opioid use disorder (OUD); increase the number of individuals receiving integrated care; decrease the illicit opioid drug use at 6-month follow-up; and decrease prescription opioid use in a non-prescribed manner at 6-month follow-up.

The MAT-PDOA grants expand and enhance access to medication-assisted treatment (MAT) services for persons with an opioid use disorder (OUD) seeking or receiving MAT. The desired outcomes include: 1) an increase in the number of individuals with OUD receiving MAT, and 2) a decrease in illicit opioid drug use and prescription opioid misuse at six-month follow-up.

Program Evaluation
MAT-PDOA grants: In 2020, 8,150 clients were served through the MAT-PDOA grant program. At six-month follow-up, 66.3 percent of individuals served reported abstinence from alcohol or illegal drug use, an increase of 88.1 percent rate of change from intake.

In FY 2020, SAMHSA continued funding for 156 continuation grants and awarded five new grants.

In FY 2021, SAMHSA anticipates funding 30 continuation grants (on a 3-year grant cycle) and 135 new MAT-PDOA grants for 5 years.

Targeted Capacity Expansion-Peer to Peer (TCE-PTP)
Peer support is built on the premise that individuals in recovery from substance use disorders and addiction issues can be of great value through the sharing of their lived recovery experiences with those attempting to achieve and sustain recovery. Peer recovery support services, as an adjunct to clinical treatment, extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery from drug/alcohol addiction. Peer support and peer recovery support services have proven to reduce healthcare costs. Research studies indicate that recovery support service adjuncts provide significant benefits over and above treatment alone.

[71] https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretary-nsduh2019_presentation.pdf

There is a growing need to train and certify existing peer providers to address the increasing demand and diverse settings in which peer support specialists are employed. Since 2002, SAMHSA has awarded over 61 grants to community-based organizations that provide peer recovery support services to individuals in or seeking recovery from substance use addiction and to their families. The primary objective of these services is to help individuals and families in search of recovery to obtain much needed support, sustain clinical treatment gains, engage in healthy community living, and improve overall quality of life. This grant program incorporates a peer-to-peer model, capitalizing on the expertise of those individuals with similar lived experience.

The TCE-PTP program has reached over 16,000 individuals and their families. Significant strides have been made in helping program participants secure and maintain long-term recovery, cultivate employment and educational opportunities, enhance their sense of social connectedness, improve their housing stability, and decrease involvement with the criminal justice system.

Program Evaluation

Among the first of SAMHSA's grant awards for recovery initiatives, the TCE Peer-to-Peer program grants have supported individuals in achieving and sustaining recovery, and enhancing their education/employment opportunities, as well as their housing stability. As of FY 2020, four grants remained in the portfolio and all have been approved for FY 2021 continuations funded at $250,000 annually.

These programs represent Recovery Community Organizations (RCOs) that provide peer-to-peer services to individuals in need of recovery support services (RSS) while addressing their substance use disorder (SUD) issues. Peer recovery support takes the form of outreach and engagement in a variety of settings (e.g. hospital emergency departments, jails, institutions, homeless shelters, recovery homes, outpatient facilities, etc.), and peer recovery coaching to individuals can occur before, during, after, or in lieu of treatment, as well as peer navigator services (i.e. assisting individuals in recovery to obtain a driver's license, employment, housing, childcare, etc.). Grantees are engaged in some or all of these activities.

To date, this cohort of grantees has served 638 individuals (364 males and 269 females), which is 74.7 percent of the year to date program goal. In FY 2020, 362 clients were served. Of these clients, 204 were males and 156 were females and represented 55.5 percent White, 23.2 percent Black/African American, 19.3 percent selected none of the above, and the remaining individuals served were American Indian, Native Hawaiian or other Pacific Islander, multiracial or refused to answer this question.

From intake to discharge, clients reported an improved rate of change in all but one of SAMHSA's National Outcome Measures. At discharge, 100 percent of the participants had not been arrested in the past thirty days, a 1.6 percent increase from intake. Eighty seven percent reported no health, behavioral or social consequence as a result of alcohol or illegal drugs, a 96.4 percent increase from intake to discharge. Over 82 percent of participants abstained from alcohol or illegal drug use and 55 percent reported having a permanent place to live in the community, a 150 percent increase. Lastly, over 50 percent were currently employed or attending school, an increase of 18.5 percent from intake. Participants' social connectedness slightly decreased by 1.6 percent from intake to discharge although it remained high at 96.8 percent. This slight decrease is likely

attributed to the COVID-19 pandemic and its continued social isolation and quarantining throughout the country. It is important to note that at the six-month follow-up, 8.6 percent of participants reported injecting illegal drugs, which is a 13.3 percent decrease from intake.

Targeted Capacity Expansion – Special Projects

SAMHSA funded the TCE- Special Projects program beginning in FY 2019. The purpose of this program is to develop and implement targeted strategies for substance use disorder treatment provision to address a specific population or area of focus identified by the community. The purpose of the TCE program is to address an unmet need or underserved population; this program aims to enable a community to identify the specific need or population it wishes to address through the provision of evidence-based substance use disorder treatment and/or recovery support services.

In FY 2020, SAMHSA funded four continuation grants for TCE-PTP and 23 TCE-Special Projects.

In FY 2021, SAMHSA anticipates funding three new grants and 23 continuation grants for TCE Special Projects.

The output and outcome measures for TCE-PTP, and TCE - Special Projects are part of the Treatment - Other Capacity Outputs and Outcomes table shown on page 229.

Funding History

Fiscal Year	Amount
FY 2018	$95,192,000
FY 2019	$100,192,000
FY 2020	$100,192,000
FY 2021 Enacted	$102,192,000
FY 2022 Budget Request	$147,916,000

Budget Request

The FY 2022 Budget Request is $147.9 million, an increase of $45.7 million from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to support the TCE-Special Projects and MAT PDOA grants. Specifically, SAMHSA will fund 23 new and three continuation TCE-Special Projects grants. Also, SAMHSA plans to fund 107 new MAT-PDOA grants and 140 continuation grants, making MAT services accessible to 40 percent more individuals suffering from OUD.

Outputs and Outcomes Table

Program: Medication-Assisted Treatment for Prescription Drug and Opioid Addiction

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.3.01 Number of admissions for Medication Assisted Treatment (Output)	FY 2020: 2365 Target: 3158 (Target Not Met)	2500	3628	+1,128
1.3.02 Number of clients receiving integrated care (Output)	FY 2018: 1243 Target: 1301 (Target Not Met)	Discontinued	Discontinued	N/A
1.3.03 Illicit drug use at 6-month follow-up (Outcome)	FY 2020: 66 % Target: 57 % (Target Not Met)	67 %	68 %	+1 %

Pregnant and Postpartum Women

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Pregnant and Postpartum Women.....	$31,931	$32,931	$49,397	$16,466

Authorizing Legislation……. Section 508 of the Public Health Service Act
FY 2022 Authorization.....$ 29,931,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

Since 2003, the Pregnant and Postpartum Women program (PPW) has used a family-centered approach to provide comprehensive residential substance use disorder treatment, prevention, and recovery support services for pregnant and postpartum women, their minor children, and for other family members (e.g., fathers of the children). The family-centered approach includes partnering with others to leverage diverse funding streams, encouraging the use of evidence-based practices, supporting innovation, and developing workforce capacity to meet the needs of these families. The PPW program provides services not covered under most public and private insurance.

Based on an in-depth review of cross-site evaluation and performance data in FY 2014, SAMHSA built the current PPW program model on an evidence-based approach for serving pregnant and post-partum women in need of residential substance use disorder treatment. The PPW family-centered approach includes a variety of services and case management for women, children, and families. Services provided to women include: outreach; engagement; pre-treatment; screening and assessment; detoxification; substance misuse education; treatment; relapse-prevention; healthcare services, including mental health services; postpartum health care, including attention to depression, anxiety, and medication needs; parenting education and interventions; home management and life skills training, education, testing, and counseling; and treatment of hepatitis, HIV/AIDS, and other sexually transmitted diseases.

Services available to children include screening and developmental diagnostic assessments addressing social, emotional, cognitive, and physical well-being; and interventions related to mental, emotional, and behavioral wellness.

Services for families are family-focused programs that support family strengthening, including involvement with the child's other parent. The PPW program also supports tobacco use counseling and interventions, screening and assessment for Fetal Alcohol Syndrome Disorders, and a trauma-informed approach.

In FY 2020, SAMHSA funded four new and 39 residential treatment continuation grants and supplements for direct technical assistance.

In FY 2021, SAMHSA anticipates funding 43 continuation residential treatment grants and supplements for direct technical assistance.

Program Evaluation

In FY 2017, SAMHSA began a three-year PPW cross-site evaluation to examine the effectiveness of the PPW Pilot Program. The evaluation results will be used broadly to improve the collective understanding about effective components of the continuum of care for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including whether the PPW Pilot Program is an effective approach to increase access to the use of medication-assisted treatment.

The Pregnant and Postpartum Women Program has enhanced and expanded statewide capacity to offer comprehensive family-centered treatment, prevention and recovery services in residential and nonresidential treatment settings for pregnant and postpartum women, their minor children (age 17 and under), fathers of the children, partners of the women, and other family members of the women and children. The program has demonstrated benefits in the following: increasing access to medications for substance use disorders, mental disorders, and primary health conditions; integrating peer recovery approaches to engage and retain women in care; incorporating home visiting as part of the continuum of care, as a key strategy, to extend services to support recovery; and providing opportunities to increase access to care for diverse populations of women, particularly for those living in rural and remote locations in southern states.

In FY 2020, the PPW program served 1,296 women. Of the women served:

- 6.2 percent used methamphetamine,
- 5.6 percent used opioids,
- 18.4 percent used marijuana,
- 25.5 percent used alcohol,

Four hundred and seventy-eight completed a 6-month follow-up. Of these women:

34.1 percent at intake were abstinent from alcohol or illegal drug use. At 6-month follow-up 89.1 percent were abstinent of alcohol or illegal drug use. Between intake and 6-month follow-up there was a positive 161.3 percent rate of change in abstinence.

89.6 percent at intake had no past 30-day arrests. At 6-month follow up, 99.4 percent had no past 30-day arrests. Between intake and 6-month follow-up there was a positive 10.9 percent rate of change in no past 30-day arrest.

8.2 percent of the women at intake were either employed or attending school. At 6-month follow-up 20.5 were either employed or attending school. Between intake and 6-month follow-up there was a positive 151.3 percent rate of change in employment or school attendance.

18.4 percent had a permanent place to live in the community at intake. At 6-month follow-up, 28.9 percent of the women had a permanent place to live. Between intake and 6-month follow-up there was a positive 56.8 percent rate of change in permanent housing.

Pregnant and Postpartum Women Pilot

Section 501 of the Comprehensive Addiction and Recovery Act (CARA) increased accessibility and availability of services for pregnant women by expanding the authorized purposes of the PPW program to include the provision of outpatient and intensive outpatient services for pregnant women. Historically, the PPW program has only supported the provision of residential treatment services.

The PPW pilot provides grants to states to: 1) support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid disorders; 2) help state substance abuse agencies address the continuum of care, including services provided to women in nonresidential-based settings; and 3) promote a coordinated, effective and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery. An evaluation of this program is underway to determine the effectiveness of the pilot.

In FY 2020, SAMHSA funded five new and three pilot continuation grants.

In FY 2021, SAMHSA anticipates funding four new and five pilot continuation grants.

Program Evaluation

In FY 2020, the PPW Pilot program served 476 women.

- 18.8 percent used marijuana or hashish
- 16.3 percent used alcohol
- 10.8 percent used opioids
- 9.6 percent used methamphetamines
- 7.5 percent used cocaine/crack

Two hundred ninety-four women completed a 6-month follow-up in 2020. Of these women, 64.7 percent at intake were abstinent from alcohol or illegal drug use. At 6-month follow-up, 85.3 percent were abstinent of alcohol or illegal drug use. Between intake and 6-month follow-up, there was a positive 32 percent rate of change in abstinence.

Of these women, 93.9 percent at intake had no past 30-day arrests. At 6-month follow-up 98.6 percent, had no past 30-day arrests. Between intake and 6-month follow-up, there was a positive 5 percent rate of change in no past 30-day arrest.

At intake, 26.2 percent of the women were either employed or attending school. At 6-month follow-up 40.3 were either employed or attending school. Between intake and 6-month follow-up, there was a positive 53.8 percent rate of change in employment or school attendance.

Of these women, 39.9 percent at intake had a permanent place to live in the community. At 6-month follow-up, 54.7 percent of the women had a permanent place to live. Between intake and 6-month follow-up, there was a positive 37.3 percent rate of change in permanent housing.

Funding History

Fiscal Year	Amount
FY 2018	$29,931,000
FY 2019	$29,931,000
FY 2020	$31,931,000
FY 2021 Enacted	$32,931,000
FY 2022 Budget Request	$49,397,000

Budget Request

The FY 2022 Budget Request is $49.4 million, an increase of $16.5 million from the FY 2021 Enacted level. SAMHSA plans to use the increased funding to award nine pilot continuation grants, 3 new pilot grants, 24 PPW residential treatment continuation grants, and 45 new residential treatment grants to provide an array of services and supports to pregnant women and their families.

Outputs and Outcomes Table

Program: Pregnant and Postpartum Women Program

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.2.84 Number of admissions of women who are currently pregnant or have a child to substance abuse treatment programs (Output)	FY 2020: 1,672.0 Target: 800.0 (Target Exceeded)	1,700.0	2,658.0	+958
1.2.85 Percentage of PPW clients reporting no drug use in the past month at six month follow-up (Outcome)	FY 2020: 89.2 Target: 90.0 (Target Not Met but Improved)	90.0	90.0	Maintain
1.2.86 Percentage of PPW clients who reported substance misuse at intake, percent who report reduction in substance misuse at six month follow-up (Outcome)	FY 2020: 93.6 Target: 87.0 (Target Exceeded)	94.0	95.0	+1
1.2.87 Percentage of PPW clients who reported child/children not living with client at intake, percent who report child/children is living with client at six month follow-up (Outcome)	FY 2020: 53.9 Target: 47.0 (Target Exceeded)	55.0	55.0	Maintain
1.2.88 Number of women who are currently pregnant or have a child who receive SUD and related treatment services (Outcome) (Outcome)	FY 2020: 377.0 Target: 1,800.0 (Target Not Met but Improved)	380.0	380.0	Maintain

Recovery Community Services Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Recovery Community Services Program.....	$2,434	$2,434	$5,151	$2,717

Authorizing Legislation.....Section 509 of the Public Health Service Act
FY 2022 Authorization..... $333,806,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Family/Consumer Controlled Organizations, Domestic Public and Private Non-Profit Organizations in States, Territories, and Tribes, Recovery Community Organizations of Domestic Private Non-Profit Entities in States, Territories, and Tribal Organizations

Program Description and Accomplishments

In 2018, an estimated 20 million people in the United States, indicated that they have a substance use disorder and the 2018 NSDUH reports that among those who self-identified as ever having an alcohol or other drug problem, fully 87 percent reported having recovered or being in recovery in recovery from addiction to alcohol and other drugs.[72] As public education increases, there is broader acknowledgement of addiction as a treatable condition that can be successfully managed over the course of a lifetime with the appropriate resources. More people in recovery are now willing to be open about their own recovery and to share their experience to help others attempting to achieve recovery. Through the use of their lived experience, individuals in recovery can provide support and hope to those newly seeking recovery.

Since 1998, SAMHSA has recognized the value of supporting recovery through peers and other recovery supports and has provided funding through the Recovery Community Services Program (RCSP). RCSP was designed to assist recovery communities to strengthen their infrastructure and provide peer recovery support services to those in or seeking recovery from substance use disorders across the nation. The delivery of recovery support services (RSS) by people in recovery is known as peer recovery support services (PRSS). PRSS are a vital component in helping individuals and families address substance use disorders in the context of chronic disease management, especially when delivered by a Peer (often known as a Recovery Coach, Peer Specialist, or Peer Mentor). SAMHSA initiated the RCSP-SN to help build an infrastructure for PRSS programs to support the development and expansion of peer recovery services. These peer services are most frequently offered by Recovery Community Organizations (RCOs).

Though the RCSP was a services program from 2002-2010, it was evident that this approach needed to be taken system-wide to have a broader effect. Many states finally recognized the value of addiction peer recovery services; however, further efforts are still required to realize the potential of these services and supports at a system-wide level. The infusion of these services into state systems ensures the wide scale adoption of peer recovery support. By developing a workforce

[72] Substance Abuse and Mental Health Services Administration. (2019). 2018 National Survey on Drug Use and Health: Methodological summary and definitions. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

of trained and certified peers, and engaging recovery community organizations in the full continuum of treatment and recovery services, states have the ability to enhance their systems to ensure holistic approaches to care.

Recovery Community Services Program Statewide Network (RCSP-SN)

The RCSP-SN grant program supports a statewide approach to enhance the presence of people with lived experience in recovery from substance use addiction as key partners in state systems, as well as building a peer workforce. SAMHSA supports this state system development effort through the RCSP Statewide Network grant program. Since the inception of the RCSP, over 123 grants have been awarded to RCOs to expand PRSS locally and lay the groundwork for a national network of PRSS programs.

Activities include collaborating on local and state workforce development, developing linkages with other organizations that promote recovery throughout the state, and participating in policy, planning, and program development discussions at the state, community, and local levels. Involving recovery community leaders and key stakeholders in decision-making helps states to design peer services and PRSS programs that are authentic to the recovery experience, complementary to clinical practice, demonstrate strong recovery outcomes, and are sustainable over time. The statewide networks help to ensure the development of a trained, qualified, and effectively supervised peer workforce.

Workforce outcomes for the program include; expanding the extent of training provided, increasing the number of people trained, enhancing trainee satisfaction, and the effectiveness of positive information presented. Other key outcomes include: the number of RCOs that have been linked across the state; the number of state-sponsored events where participation of the statewide network occurred; the effects of linkages with behavioral health and other health systems; the outcomes of program activities on raising awareness about addiction peer recovery support; and the number of policy/program discussions which included addiction peer recovery support as a result of project efforts.

In addition to workforce development, the three current RCSP-SN grants enhance the presence of RCOs as key partners in treatment, recovery, and affiliated health systems. RCSP-SN grantees are engaged in regional and/or statewide infrastructure or capacity building activities where grantees seek to leverage resources, educate state legislatures and senior executive branch level leaders, and the public about the importance of recovery supports. A primary goal for these grants is to ensure that those in their respective jurisdictions regard the stakeholders in the recovery community as critical partners in state and local planning when discussing the funding of and planning for treatment and recovery support services. In addition to public health messaging, all grantees work to reduce stigma around SUDs by engaging family members, civic institutions, and the public at large. Recovery Month activities, held each September, are another way these programs enhance the voice of recovery through activities like recovery walks and rallies. These projects continue to emphasize the importance of sustainability through the diversification of revenue streams by RCOs working with their state Medicaid Plan Offices and local Managed Care Organizations interested in Recovery Support Services (RSS) to seek reimbursement for the delivery of peer-based recovery support services in statewide reform initiatives.

Program Evaluation
In FY 2020, RCSP-SN grantees held 296 events exceeding their programmatic goal, while providing a mix of services to over 2,975 participants who responded to post-event forms.

In FY 2020, SAMHSA funded six new RCSP grants and three RCSP-SN continuation grants.

In FY 2021, SAMHSA anticipates funding two new RCSP and six continuation RCSP grants.

The output and outcome measures for the Recovery Community Services Program are part of the Treatment - Other Capacity Outputs and Outcomes table shown on page 229.

Funding History

Fiscal Year	Amount
FY 2018	$2,434,000
FY 2019	$2,434,000
FY 2020	$2,434,000
FY 2021 Enacted	$2,434,000
FY 2022 Budget Request	$5,151,000

Budget Request

The FY 2022 Budget Request is $5.2 million, an increase of $2.7 million from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to award eight continuations and nine new RCSP grants. This will allow SAMHSA to continue the efforts of building addiction recovery networks throughout the nation and the collaboration among peer-run organizations.

Children and Families

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Children and Families.....	$29,605	$29,605	$30,197	$592

Authorizing Legislation.....Sections 509 and 514 of the Public Health Service Act
FY 2022 Authorization..... $333,806,000, $29,605,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Single State Agencies in States, Territories, District of Columbia, public and private non-profit entities, Federally Recognized American Indian/Alaska Native Tribes Tribal Organizations, and health facilities or programs operated by or in accordance with a contract or grant with the Indian Health Service

Program Description and Accomplishments

Substance use plays a significant role in the lives of many children and youth (ages 12 to 25) throughout the nation. In 2018, approximately 8 percent of adolescents between the ages of 12 and 17 and 24 percent of youth between the ages of 18 and 25 reported current illicit drug use. Less than two percent of adolescents between the ages of 12 and 17, and 10 percent of youth between the ages of 18 and 25 met the criteria for an alcohol use disorder. Many of these youth have co-occurring mental and substance use disorders. Most substance use begins during adolescence, making this developmental period a critical time for intervention. Approximately four percent of admissions to substance use treatment facilities were adolescents in 2017. Sixty-one percent of infants and 41 percent of older children involved in the child welfare system have at least one parent who is using alcohol or other drugs. Of children removed from their household and placed in foster care, nearly 35 percent can attribute the removal to instances where one or both parents had substance misuse or substance use disorders.

SAMHSA's Children and Families program makes appropriate treatment available to youth and their families/caregivers to reduce the impact of substance use disorders and/or co-occurring mental and substance use disorders on communities in the U.S.

Substance Use Disorder Treatment for Youth

The earlier youth start using substances, the greater their chances of continuing to use substances and developing substance use conditions later in life. Among adolescents aged 12 to 17 in 2019, 4.6 percent (or 1.1million people) needed substance use treatment in the past year. These estimates in 2019 were similar to the estimates in 2015 to 2017, but they were higher than the estimates in 2018. Among young adults aged 18 to 25 in 2019, 14.4 percent (or 4.8 million people) needed substance use treatment in the past year. This percentage in 2019 was lower than the percentages in most years from 2015 to 2018.

In 2019, adolescents aged 12 to 17 who had a SUD, 8.3 percent (or 93,000 people) received any substance use treatment and 0.3 percent (or 68,000 people) received substance use treatment at a specialty facility. These estimates were similar to the estimates in 2015 to 2018. In 2019, young adults aged 18 to 25 who had a SUD, 8.7 percent (or 415,000 people) received any substance use

treatment and 1.1 percent (or 357,000 people) received substance use treatment at a specialty facility. These estimates were similar to the estimates in 2015 to 2018.

Among the 397,000 adolescents aged 12 to 17 in 2019 who had a co-occurring SUD and an MDE in the past year (2019 DT 11.9), 66.3 percent (or 263,000 people) received either substance use treatment at a specialty facility or mental health services in the past year, 62.5 percent (or 249,000 people) received only mental health services, and 2.4 percent (or 10,000 people) received only substance use treatment at a specialty facility.[73]

SAMHSA's programs to treat youth with addiction and/or co-occurring substance use and mental disorders address gaps in service delivery by providing services for youth and their families and primary caregivers using effective evidence-based, family-centered practices. SAMHSA supports a youth treatment grant initiative at the state, territorial, and tribal levels. The populations of focus for the initiatives are adolescents (ages 12 to 17), transition-aged youth (ages 18 to 25), and their families and caregivers.

This initiative helps to further the use of, and access to, effective evidence-based family-centered treatment approaches for youth with alcohol/another drug addiction. It supports training across participating states and collaboration between local community-based providers and their state, tribal, or territorial infrastructure. The services provided include evidence-based assessment and treatment interventions appropriate for adolescents and transition age youths.

In FY 2018, SAMHSA developed a new grant program called Enhancement and Expansion of Treatment and Recovery Services for Adolescents, Transitional Aged Youth, and their Families (Youth and Family TREE). Its purpose is to enhance and expand comprehensive treatment, early intervention, and recovery support services for adolescents (ages 12-18), transitional aged youth (ages 16-25), and their families/primary caregivers with SUD and/or co-occurring substance use and mental disorders. Eligibility includes public and private non-profit entities. Youth and Family TREE is focused on: increasing the unduplicated number of individuals served with evidence-based services and practices; increasing abstinence from the use of opioids, alcohol, marijuana, and other substances; increasing access, engagement, and retention in treatment, including medication assisted treatment; improving parenting skills and family functioning; improving mental health; and increasing access to health services for underserved populations, specifically federally recognized American Indian/Alaskan Native tribes and tribal organizations.

[73] Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Program Evaluation

State Youth Treatment Implementation (SYT-I)
In FY 2020, the SYT-I program provided substance use disorder treatment, recovery, and family support services to 800 program participants. Program data collected at 6-month follow-up showed a positive change in risky behaviors while identifying behaviors that require additional support. For example, having unprotected sexual contact with an individual who is or was HIV positive or had AIDS (0 occurrences), had unprotected sexual contact with injected drug user (0 occurrences), injection drug use: injected illegal drugs (1.3 percent). Areas of continued struggle are evident in data in unprotected sexual contact (55.6 percent) and unprotected sexual contact with an individual high on some substance (25 percent). Favorable trends at discharge reveals positive effects and gains in program participants overall functioning. Significant improvements in abstinence (77.6 percent), crime and criminal justice: had no past 30 day arrest (100 percent), employment and education: were currently employed or attending school (88.2 percent), health/behavior /social consequences (93.6 percent), social connect connectedness(76.1 percent) and stability in housing (71.2 percent).

Services for Adolescents, Transitional Aged Youth, and their Families (YFTREE)
In FY 2020, the YFTREE program provided substance use disorder treatment, recovery and family support services to 1,790 program participants. Program data collected at six-months follow-up and discharge demonstrate program participants reduced risky behaviors associated with substance use and have experienced improved functioning in many areas of their life. Outcome data from risky behavior categories at 6 months follow-up revealed decrease in injection drug use (1.0 percent), unprotected sexual contact (2.9 percent), unprotected sex with an individual who was HIV positive or has AIDS (0 percent), unprotected sexual contact with injection drug user (1.0 percent), unprotected sexual contact with an individual high or on some substance (15.8 percent). The data collected at discharge highlights successful outcomes in abstinence (83.2 percent), decreased recent involvement in the criminal justice system (6.1 percent), improved employment and education advancements (76.8 percent), health/behavior/social consequences (87.5 percent), increased social connectedness (76.6 percent) and stability in housing (63.6 percent).

Risky behavior categories and reduction outcomes at 6 months: Injection drug use (1.0 percent), unprotected sexual contact (2.9 percent), unprotected sex with an individual who was HIV positive or has AIDS (0 percent), unprotected sexual contact with injection drug user (1.0 percent), unprotected sexual contact with an individual high or on some substance (15.8 percent). The data collected at discharge determined successful outcomes in abstinence (3.2 percent).

National Center on Substance Abuse and Child Welfare
SAMHSA and the Administration for Children and Families (ACF) collaborate to support the National Center on Substance Abuse and Child Welfare (NCSACW). NCSACW provides training and technical assistance (TA) to improve collaborative practices among agencies and organizations that serve families affected by substance use disorders and involvement with child welfare services.

From September 2017 to September 2020, NCSACW responded to 2,021 training and technical (TTA) requests from a wide range of disciplines and from all 50 states. It facilitated 73 events (including site visits, conference presentations, webinars and virtual training) attended by 12,964 people. As a result of the public health pandemic, NCSACW responded to significant shifts in TA delivery by adopting virtual strategies, while pivoting from in-person to fully virtual events.

The NCSACW website increases availability of policy and practice resources, products, and TTA services. From September 2017 to September 2020, the NCSACW website accumulated 272,147 website visits with an average of 380 user visits per day. Since 2007, the NCSACW has provided three web-based tutorials on serving families affected by substance use disorders for specific audiences: substance use disorder treatment, child welfare, and court professionals.

From 2007 through September 2020, there were 85,053 tutorial registrations for these courses. The tutorials were updated with new content in 2020.

The NCSACW provides a child welfare training toolkit entitled Helping Child Welfare Workers Support Families with Substance Use, Mental, and Co-Occurring Disorders Training Package to educate child welfare professionals about substance use and mental disorders among families involved in the child welfare. The toolkit was updated in 2019 to highlight new research and best practices as well as provide special modules on working with families affected by opioid and methamphetamine use disorders and infants with prenatal substance exposure and their families. The toolkit has been downloaded 6,134 times since its re-release in 2019.

The NCSACW's activities have assisted professionals throughout the nation to improve cross-system collaboration and meet child welfare requirements for timely child permanency decisions. The NCSACW continues to provide training and technical assistance to tribes, state agencies, and communities to develop collaborative approaches to the treatment of pregnant women with opioid use disorders and their infants and families. Since August 2016, NCSACW has disseminated SAMHSA's publication, *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical and Service Providers,* to child welfare, substance use treatment, dependency court, and medical professionals. The publication has been disseminated in TTA or downloaded 5,190 times since its 2016 release through September 2020.

Specific to infants with prenatal substance exposure, the NCSACW has provided in-depth TA on addressing the needs of pregnant and parenting women with opioid and other substance use disorders and their infants and families to the thirteen states. From September 2016 to March 2020, the NCSACW has responded to 5 TA requests on Plans of Safe Care, the provisions related to prenatal substance exposure in the Child Abuse and Prevention Treatment Act (CAPTA), and infants with prenatal substance exposure.

The NCSACW has facilitated multiple state and regional meetings, including a tri-regional convening in regions 4, 6 and 7 in 2018, a regional convening in region 9 in 2019 and a regional training meeting for region 8 in 2019. NCSACW also planned and implemented two policy academies (2017 and 2020). These helped more than 200 individuals for 23 cross-systems teams enhance capacity to meet the multiple and complex needs of pregnant and parenting women with opioid and other SUDs, their affected infants, and family members. These convenings focused on changes to the Child Abuse Prevention and Treatment Act (CAPTA) as a result of the Comprehensive Addiction and Recovery Act (CARA), regarding identification, notification and monitoring of plans of safe care for infants affected by substance use, withdrawal symptoms or fetal alcohol spectrum disorders.

In FY 2020, SAMHSA funded 35 Youth and Family TREE continuation grants, 11 continuing State Youth Treatment Implementation grants and 1 contract.

In FY 2021, SAMHSA anticipates funding 17 new Youth and Family Tree (YFTREE) grants and 35 continuation grants.

The output and outcome measures for Children and Families are part of the Treatment - Other Capacity Outputs and Outcomes table shown on page 229.

Funding History

Fiscal Year	Amount
FY 2018	$29,605,000
FY 2019	$29,605,000
FY 2020	$29,605,000
FY 2021 Enacted	$29,605,000
FY 2022 Budget Request	$30,197,000

Budget Request

The FY 2022 Budget Request is $30.2 million, an increase of $592,000 from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to award two new and 52 continuation Youth and Family Tree grants. These grants will continue to support states and tribes who have not previously received funds under this initiative, and to address the gaps in substance use disorder treatment by providing services for youth, their families, and caregivers.

Treatment Systems for Homeless

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Treatment Systems for Homeless.....	$36,386	$36,386	$37,114	$728

Authorizing Legislation.....Section 506 of the Public Health Service Act
FY 2022 Authorization..... $41,304,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States, Domestic Public and Community Organizations, Private Nonprofit Entities, and Community-based Public or Nonprofit Entities

Program Description and Accomplishments

SAMHSA's Treatment Systems for Homeless portfolio supports services for those with alcohol/other drug addiction and who are experiencing homelessness, including youth, veterans, and families.

The number of individuals experiencing chronic homelessness declined by 20 percent, or nearly 24,000 people, between 2007 and 2019.[74] On a single night in January 2019, 567,715 people were experiencing homelessness in the United States. Of these individuals, 105,583 were experiencing chronic homelessness, 116,179 had severe mental illness, 88,873 were affected by chronic substance use, and 37,085 were veterans.[75]

Many factors contribute to the problem of homelessness, including lack of affordable housing, foreclosures, rising housing costs, job loss, underemployment, mental illness, and drug/alcohol addiction. The progress made to date in reducing homelessness points to improvement in services, as well as the effectiveness of collaboration across all levels, from the federal government to state governments and community systems. The U.S. Interagency Council on Homelessness, in which HHS participates, has set aggressive goals to prevent and end homelessness. These goals include ending homelessness among veterans, people with disabilities, families with children, unaccompanied youth, and all other individuals. The services and support offered through SAMHSA's Treatment Systems for Homeless programs are crucial to achieving these goals.

SAMHSA manages the following Treatment Systems for Homelessness grant programs:

Grants for the Benefit of Homeless Individuals (GBHI)
The GBHI program supports the development and/or expansion of local implementation of a community infrastructure that integrates treatment and recovery support services for substance use

[74] The U.S Department of Housing and Urban Development, Office of Community Planning and Development (2020). The 2019 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. Retrieved from https://files.hudexchange.info/resources/documents/2019-AHAR-Part-1.pdf
[75] U.S. Department of Housing and Urban Development (HUD) 2019 Continuum of Care (CoC) Homeless Assistance Programs Homeless Populations and Subpopulations Report – Retrieve from https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2019.pdf

disorders or co-occurring mental and substance use disorders, permanent housing, and other critical services for individuals (including youth) and families experiencing homelessness.

Program Evaluation

Based on FY 2020 data for the GBHI program, 54.9 percent of clients reported abstinence from substance use at a six-month follow-up, while approximately 29.1 percent of clients reported being employed or engaged in productive activities, and 34.8 percent of clients reported having a permanent place to live in the community.[76]

In FY 2020, SAMHSA funded 13 new GBHI grants and 72 continuation grants, and supplement for direct technical assistance.

In FY 2021, SAMHSA anticipates funding 85 continuations grants and supplements for direct technical assistance.

Funding History

Fiscal Year	Amount
FY 2018	$36,386,000
FY 2019	$36,386,000
FY 2020	$36,386,000
FY 2021 Enacted	$36,386,000
FY 2022 Budget Request	$37,114,000

Budget Request

The FY 2022 Budget Request is $37.1 million, an increase of $728,000 from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to support grants to reduce homelessness for nearly 5,000 people. SAMHSA intends to fund 20 new and 68 GBHI continuation grants with grant supplements for direct technical assistance.

[76] SPARS. (2020). Retrieved from www.samhsa-gpra.samhsa.gov.

Outputs and Outcomes Table

Program: Treatment System for Homelessness (GBHI)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
3.4.23 The number of clients served (Output)	FY 2020: 3634 Target: 3521 (Target Exceeded)	3521	3758	+237
3.4.24 Percentage of homeless clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2020: 30.3 % Target: 20 % (Target Exceeded)	34.4 %	34.4 %	Maintain
3.4.25 Percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2020: 34.4 % Target: 70 % (Target Not Met but Improved)	31.1 %	36.1 %	+5 %

Minority AIDS

(Dollars in Thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Minority AIDS.....	$65,570	$65,570	$66,881	$1,311

Authorizing Legislation……. Section 509 of the Public Health Service Act
FY 2022 Authorization..... $333,806,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

SAMHSA's Minority AIDS Initiative (MAI) funded programs are making a significant contribution in addressing HIV and hepatitis infection by facilitating the development and expansion of culturally competent and effective community-based treatment systems for substance use and co-occurring mental disorder treatment within racial and ethnic minority communities. The purpose of the Targeted Capacity Expansion-HIV program is to increase engagement in care for racial and ethnic minority individuals with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (COD) who are at risk for HIV or HIV positive that receive HIV services/treatment. Populations of focus for the TCE-HIV programs include African American, Hispanic/Latina, and other racial/ethnic minority women ages 18 years and older; black young men who have sex with men (YMSM) (ages 18-29); other high-risk populations such as Latino YMSM and men who have sex with men (MSM) (ages 30 years and older); and gay, bisexual, and transgender individuals who have a SUD or COD, are HIV positive or at risk for HIV/AIDS and hepatitis. The MAI program, along with many other HIV/AIDS programs across HHS, supports and contributes to the primary goal to end the HIV epidemic in the United States.

Program Evaluation

FY 2020, the TCE-HIV program served 18,230 clients. Significant steps have been taken to increase abstinence, employment and educational opportunities, social connectedness and housing stability. In FY 2020, the percentage of clients who reported that they did not use alcohol or illegal drugs within the past 30 days increased by 74.2 percent between intake to 6-month follow-up. Between intake and six-month follow-up, the percentage of clients who reported no arrests within the past 30 days increased by 2.7 percent. In addition, the percentage of clients who were employed or attending school increased by 15.3 percent between intake to 6-month follow-up. Those clients who reported being socially connected increased by 3.0 percent from intake to 6-month follow-up. The percentage of clients who reported housing stability increased by 14.2 percent between intake and 6-month follow-up[77].

[77] SAMHSA. (2020, November). CSAT GPRA Modernization Act Discretionary Services Tools. Retrieved from https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services

In FY 2020, SAMHSA funded 121 TCE-HIV continuation grants and supplements for direct technical assistance.

In FY 2021, SAMHSA anticipates funding 121 TCE-HIV grant continuations and supplements for direct technical assistance.

Funding History

Fiscal Year	Amount
FY 2018	$64,534,000
FY 2019	$65,570,000
FY 2020	$65,570,000
FY 2021 Enacted	$65,570,000
FY 2022 Budget Request	$66,881,000

Budget Request

The FY 2022 Budget Request is $66.9 million, an increase of $1.3 million from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to award 64 new grants and 62 continuation grants.

Criminal Justice Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Criminal Justice Activities	$89,000	$89,000	$124,380	$35,380
Other Criminal Justice Activities (non-add)	*19,000*	*19,000*	*19,380*	*380*
Drug Court Activities (non-add)	*70,000*	*70,000*	*105,000*	*35,000*

Authorizing Legislation.....Section 509 of the Public Health Service Act
FY 2022 Authorization..... $333,806,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities, Operational Individual Misdemeanor and Felony Adult Criminal Courts, Municipal Courts, Tribal, State, Local Government Proxies, Government with Direct Involvement with Adult Criminal Courts, Tribal Organizations and Individual Adult Tribal Healing to Wellness Courts, and Public or private universities and colleges and Community- and faith-based organizations.

Program Description and Accomplishments

SAMHSA's Criminal Justice portfolio includes several grant programs that focus on diversion, alternatives to incarceration, drug courts, and re-entry from incarceration for adolescents and adults with drug/alcohol addiction and/or co-occurring drug/alcohol addiction and mental illness.

Referral source for substance use disorder treatment
The criminal justice system was the major source of referrals to substance use disorder treatment, with probation or parole referrals representing the largest proportion of criminal justice system referrals to treatment.[78]

Most probation or parole referrals to treatment were men between the ages of 18 and 44. The most common substances reported by these referrals were alcohol, marijuana, and methamphetamine.[79]

[78] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set (TEDS): 2005-2015. National Admissions to Substance Abuse Treatment Services. BHSIS Series S-91, HHS Publication No. (SMA) 17-5037. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.
[79] SAMHSA. (2015). *Criminal and Juvenile Justice*. Retrieved from http://www.samhsa.gov/criminal-juvenile-justice

Drug Courts

According to a 2017 Bureau of Justice Statistics (BJS) Special Report, approximately 14 percent of state and federal prisoners, and 26 percent of jail inmates reported experiences that met the threshold for serious psychological distress (SPD) in the 30 days prior to a survey that was conducted between February 2011 and May 2012.[80] More than half (58 percent) of state prisoners and two-thirds (63 percent) of sentenced jail inmates met the criteria for drug dependence or abuse, according to data collected 2007-2009.[81] An estimated 42 percent of state prisoners and 49 percent of jail inmates met the criteria for both a mental illness and drug/alcohol addiction.[82] According to BJS, there were 10.6 million jail admissions in 2016.[83] At mid-year 2016, city and county jails held over 740,000 individuals.[84] Although the corrections system faced a decline in its prison population for the third consecutive year, more than 1.5 million Americans were incarcerated in 2016.[85] In 2016, the rate of imprisonment for adult Americans was 450 per 100,000 U.S. residents.[86]

Drug Court Purpose

Drug courts are designed to combine the sanctioning power of courts with effective treatment services for a range of populations with circumstances, such as alcohol and/or other drug use, child abuse/neglect, criminal behavior, or people with mental illness. Drug courts represent the coordinated efforts of the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities to intervene and break the cycle of substance misuse, addiction, and crime. Stakeholders work together to give individual clients the opportunity to improve their lives, including recovery from substance drug/alcohol addiction, and develop the capacity and skills to become fully functioning parents, employees, and citizens.

Drug Court Services

SAMHSA's ATDC programs support a variety of services including direct treatment services for diverse populations, wraparound and recovery support services such as recovery housing and peer recovery support services designed to improve access and retention, drug testing for illicit substances, educational support, relapse prevention and long-term management, and HIV and viral hepatitis B and C testing conducted in accordance with state and local requirements.

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[80] Bronson, J., & Berzofsky, M., (2017). Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12. Washington, D.C.: Bureau of Justice Statistics. Available: https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

[81] Bronson, J., Stroop, J., Zimmer, S. & Berzofshi, M., (2017). Drug Us, Dependence, and Abuse AmongState prisoners and jail Inmates, 2007-2009. Washington, D.C.: Bureau of Justice Statistics. Available: https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf

[82] James, D. J., & Glaze, L. E. (2006). *Highlights mental health problems of prison and jail inmates.* Retrieved from https://www.bjs.gov/index.cfm?ty=pbdetail&iid=789

[83] Zeng, Z. (2018). *Jail Inmates in 2016*. Washington, D.C.: Bureau of Justice Statistics. Available: https://www.bjs.gov/content/pub/pdf/ji16.pdf

[84] Ibid.

[85] Carson, E. A. (2018). *Prisoners in 2016.* Washington, D.C.: Bureau of Justice Statistics. Available: https://www.bjs.gov/content/pub/pdf/p16.pdf

[86] Ibid.

Medication-Assisted Treatment

SAMHSA's grant programs are encouraged to use part of their annual award to provide medication-assisted treatment (MAT) and are required to ensure that drug courts funded by SAMHSA-funded drug courts cannot deny the use of Food and Drug Administration (FDA)-approved medications for opioid addiction to drug court clients. Drug court judges, however, retain judicial discretion in cases where specified conditions for pharmacotherapy provisions were not met. Drug courts funded in FY 2020 are required to provide MAT services.

Evidence-based Services

These grant programs use existing evidence from numerous studies to support current programs and new proposals. There have been more than 125 evaluation and research studies of the effectiveness of drug courts in addition to Government Accountability Office reports. SAMHSA requires evidence-based practices from federal inventories to be used. SAMHSA also has regular communications with the National Association of Drug Court Professionals to obtain and incorporate the latest findings and field expertise.

Program Evaluation

Performance data show that these grant programs are effective in improving the lives of drug court participants. Based on FY 2020 SAMHSA data, 5,936 clients received services through SAMHSA's Adult Treatment Drug Court Programs. Of these clients at six-month follow-up, 84.2 percent reported that they did not use alcohol or illegal drugs within the past 30 days, an increase of 30.7 percent. Additionally, there was an 8.7 percent increase from intake that had no involvement with the criminal justice system, a 28.3 percent increase of adult clients that were either employed or attending school, and a 34.2 percent increase in clients who had a permanent place to live in the community.

Criminal Justice Drug Court and Reentry funded programs expand and enhance substance use disorder (SUD) treatment services to adults involved in the Criminal Justice system. They provide recovery support services, screening, assessment, case management, and program coordination to defendants/offenders to facilitate successful reentry to their communities. The desired outcome is to break the cycle of criminal behavior, alcohol and/or drug use, and incarceration or other penalties, and encourage stable work and home environments.

Family Treatment Drug Courts

The purpose of the Family Treatment Drug Court (FTDC) program is to expand substance use disorder (SUD) treatment services in existing family treatment drug courts, which use the family treatment drug court model in order to provide alcohol and drug treatment (including recovery support services, screening, assessment, case management, and program coordination) to parents with a SUD and/or co-occurring SUD and mental disorders, who have had a dependency petition filed against them or are at risk of such filing. FTDCs are expected to provide a coordinated, multi-system approach designed to combine the sanctioning power of treatment drug courts with effective treatment services promoting successful family preservation and reunification. FTDCs assist participants in reducing the rates of substance misuse, the severity of SUDs and co-occurring disorders, and decreasing out of home placements for children through family reunification and preservation. This should also decrease the number of parents or guardians whose parental rights have been or will be terminated.

Program Evaluation
Based on FY 2020 data, 1,241 clients received services through SAMHSA's Family Drug Court programs. Of these clients at six-month follow-up, 80.7 percent reported that they did not use alcohol or illegal drugs within the past 30 days, an increase of 34.6 percent. Additionally, there was a 4.8 percent increase from intake that had no involvement with the criminal justice system, a 40.9 percent increase of adult clients that were either employed or attending school, and 6.4 percent increase in clients who had a permanent place to live in the community.

In FY 2020, SAMHSA funded 15 new drug court (ATDC) grants, three new FTDC grants, and four Tribes/Tribal organizations, 155 drug court (ATDC/FTDC) grant continuations, and one contract.

In FY 2021, SAMHSA anticipates funding two new and 179 continuation ATDC and FTDC grants.

Reentry
Across the country, more than 600,000 Americans are released from prisons and jails every year, and more than 4.5 million are serving a community supervision sentence.[87] For these individuals, transitioning back to their communities following incarceration can be a challenge for a number of reasons. Often, when individuals are released, they face several critical barriers to successful reentry that they will need to overcome. Some have substance use issues, others have no place to live, and a criminal record makes it difficult for many to find a job.[88] For most, it is only a matter of time before they return to prison. According to the Bureau of Justice Statistics, 68 percent of state prisoners are rearrested within three years of their release.[89]

Other Criminal Justice /Offender Reentry Program
In addition to the drug court portfolio, SAMHSA supports the Offender Reentry Program (ORP) grants, as well as other criminal justice activities, such as a regional and national criminal justice technical support contract. Studies show that only about 10 percent of individuals involved with the criminal justice system who are in need of substance use disorder treatment receive it as part of their justice system supervision. Approximately one-half of the institutional treatment provided is educational programming.[90] During the past decade, awareness of the need for a continuum of care of services for adult offenders has grown as states and local communities have struggled with the increasing number of these individuals returning to the community after release from correctional confinement. ORP grants provide screening, assessment, comprehensive treatment, and recovery support services for diverse populations reentering the community from incarceration. ORP grant services include screening, comprehensive individual assessment for

[87] Danielle Kaeble and Lauren Glaze, Correctional Populations in the United States, 2015, Bulletin, Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, December 2016, NCJ 250374, https://www.bjs.gov/ content/pub/pdf/cpus15.pdf
[88] Blair Ames, "NIJ-Funded Research Examines What Works for Successful Reentry," NIJ Journal 281, November 2019, https:// nij.ojp.gov/topics/articles/nij-funded-researchexamines-what-works-successful-reentry.
[89] Mariel Alper, Matthew R. Durose, and Joshua Markman, 2018 Update on Prisoner Recidivism: A 9-Year Follow-up Period (2005-2014), Special Report, Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, May 2018, NCJ 250975, https://www.bjs.gov/content/pub/ pdf/18upr9yfup0514.pdf.
[90] Taxman FS, Perdoni ML, Harrison LD. (2007). Drug treatment services for adult offenders: The state of the state. Journal of Substance Abuse Treatment 32(3), 239-254.

substance use and/or co-occurring mental disorders, program and case management, and alcohol and other drug treatment. Other supported services include wraparound and recovery support services such as recovery housing and peer recovery support designed to improve access and retention, drug testing for illicit substances, educational support, relapse prevention and long-term management, and HIV and viral hepatitis B and C testing conducted in accordance with state and local requirements. SAMHSA's ORP grants are encouraged to use part of their annual award to provide medication-assisted treatment with FDA-approved medications.

Program Evaluation

Performance data show that these grant programs are effective in improving the lives of Offender Reentry Program court participants.

Based on FY 2020 data, 1,734 clients received services through SAMHSA's Offender Re-entry Programs. Of these clients at six-month follow-up, 75.3 percent reported that they did not use alcohol or illegal drugs within the past 30 days, an increase of 125.4 percent. Additionally, there was a 21.2 percent increase from intake that had no involvement with the criminal justice system, a 144 percent increase of adult clients that were either employed or attending school, and 125 percent increase in clients who had a permanent place to live in the community.

In FY 2020, SAMHSA funded 10 new ORP grants and 23 ORP grant continuations, and one contract.

In FY 2021, SAMHSA anticipates funding 33 ORP continuation grants and one contract.

Funding History

Fiscal Year	Amount
FY 2018	$89,000,000
FY 2019	$89,000,000
FY 2020	$89,000,000
FY 2021 Enacted	$89,000,000
FY 2022 Budget Request	$124,380,000

Budget Request

The FY 2022 Budget Request is $124.4 million, an increase of $35.4 million from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to support 94 new and 166 drug court continuation grants, and 33 continuation ORP grants, and one contract. SAMHSA estimates that an additional 3,287 clients will be served per year with the additional funding.

Outputs and Outcomes Table

Program: Criminal Justice – Drug Courts

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.2.72 Percentage of adult clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2020: 58.4 % Target: 66.1 % (Target Not Met)	60.1 %	62 %	+1.9 %
1.2.73 Percentage of adult clients receiving services who had a permanent place to live in the community (Outcome)	FY 2020: 45.2 % Target: 47.3 % (Target Not Met)	47.3 %	47.3 %	Maintain
1.2.74 Percentage of adult clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2020: 95.6 % Target: 85 % (Target Exceeded)	96 %	96 %	Maintain
1.2.76 Percentage of adult clients receiving services who had no past month substance use (Outcome)	FY 2020: 83.9 % Target: 87.3 % (Target Not Met)	87.3 %	89 %	+1.7 %
1.2.79 Number of adult clients served (Output)	FY 2020: 6,973 Target: 5,700 (Target Exceeded)	6,960	10,247	+3,287

Outputs and Outcomes Table

Program: Criminal Justice – Ex-Offender Re-Entry Program

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.2.80 Number of clients served (Outcome)	FY 2020: 1,580 Target: 1,300 (Target Exceeded)	1,661	1,661	Maintain
1.2.81 Percentage of clients who had no past month substance use (Outcome)	FY 2020: 76.4 % Target: 70 % (Target Exceeded)	77.4 %	78.4 %	+1 %
1.2.84 Percentage of clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2020: 94.5 % Target: 93 % (Target Exceeded)	95 %	95 %	Maintain

Outputs and Outcomes Table

Program: Treatment – Other Capacity

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.2.25 Percentage of adults receiving services who had no past month substance use (Outcome)	FY 2020: 63.3 % Target: 63.3 % (Baseline)	63 %	63 %	Maintain
1.2.26 Number of clients served (Output)	FY 2020: 1,357 Target: 1,357 (Baseline)	1,357	1,357	Maintain
1.2.27 Percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2020: 48.3 % Target: 48.3 % (Baseline)	48 %	48 %	Maintain
1.2.28 Percentage of adults receiving services who had a permanent place to live in the community (Outcome)	FY 2020: 54 % Target: 54 % (Target Met)	54 %	54 %	Maintain
1.2.29 The percentage of adults receiving services who had no involvement with the criminal justice system (Outcome)	FY 2020: 98 % Target: 98 % (Baseline)	98 %	98 %	Maintain

Building Communities of Recovery (BCOR)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Building Communities of Recovery.....	$8,000	$10,000	$20,000	$10,000

Authorizing Legislation..Section 302 of the Comprehensive Addiction and Recovery Act of 2016
FY 2022 Authorization..... $5,000,000
Allocation Method .....Grants/Contracts
Eligible Entities. Recovery Community Organizations (RCOs) that are domestic private nonprofit entities in states, territories, or tribes that are led and governed by representatives of local communities of recovery. Only organizations controlled and managed by members of the addiction recovery community are eligible to apply

Program Description and Accomplishments

Peer services play a vital role in assisting individuals in achieving recovery from substance use disorders. Recovery Community Organizations (RCOs) are central to the delivery of those services. In FY 2017, SAMHSA funded the first new cohort of grants through the Comprehensive Addiction Recovery Act (CARA) Building Communities of Recovery (BCOR) program. The purpose of this program is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery support from drug/alcohol addiction. These grants are intended to support the development, enhancement, expansion, and delivery of recovery support services (RSS) as well as promotion of and education about recovery. Programs are designed to be overseen by individuals in recovery from SUDs who reflect the community served.

BCOR grants support linkages between recovery networks and a variety of other organizations, systems, and communities. These include primary care, specifically hospital emergency departments, other recovery networks such as recovery community centers, the child welfare system, the criminal justice system, recovery housing services, and education/employment systems. Grantees also work to reduce negative attitudes, discrimination, prejudice, and stigma around addiction and recovery. These grants aim to mobilize resources within and outside of the recovery community and increase the prevalence and quality of long-term recovery support from substance use and addiction. The programs support the development, enhancement, expansion, and delivery of recovery support services (RSS) as well as the promotion of, and education about, recovery. They are managed and implemented primarily by individuals with lived experience and who are in recovery from substance use disorders and addiction and who reflect the community being served. Grantees are using funds to 1) build connections and linkages between recovery networks, between RCOs, and other Recovery Support Services (RSS); 2) reduce the stigma associated with addiction and recovery; and 3) conduct public education and outreach on issues relating to addiction and recovery.

Program Evaluation

In FY 2020 and FY 2021, BCOR participants began collecting data for recovery support services. In FY 2020, a total of 1,280 clients were served for an intake coverage rate of 88 percent.

In FY 2021, a total of 1,568 clients were served for an intake coverage rate of 80 percent. Also, in FY 2021, BCOR grant recipients have provided peer-related services events to approximately 3,000 program participants with a participant coverage rate of 100 percent. 855 events were held with a coverage rate of 271 percent. At post event survey, 100 percent of all program participants reported that the trainings were beneficial and relevant to their careers.

At six-month follow-up participants have demonstrated a 74 percent improvement in obtaining education/employment, 16 percent remained abstinent and 16.3 percent with no past 30-day criminal justice involvement. Participants reported a 3.6 percent rate of change in social connectedness, and a 35 percent positive rate of change in housing stability was reflected. In an effort to enhance program success and performance, as well as ensure long-term sustainability, the majority, 98 percent, of BCOR grantees have an external program evaluator.

In FY 2020, SAMHSA funded 13 new grants and 23 continuation grants and supplements for direct technical assistance.

FY 2021 SAMHSA anticipates funding 31 new grants and 18 continuations.

Funding History

Fiscal Year	Amount
FY 2018	$5,000,000
FY 2019	$6,000,000
FY 2020	$8,000,000
FY 2021 Enacted	$10,000,000
FY 2022 Budget Request	$20,000,000

Budget Request

The FY 2022 Budget Request is $20.0 million, an increase of $10.0 million from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to support 31 new grants and 19 continuation grants for the Building Communities of Recovery program to develop, expand, and enhance recovery support services. Building Communities of Recovery supports linkages between recovery networks and a variety of organizations, including primary care, other recovery networks, the child welfare system, the criminal justice system, housing services, and education/employment systems. This increase in funding will support further mobilization of resources within and outside the recovery community to increase the prevalence and quality of long-term recovery support from drug and alcohol addiction.

Outputs and Outcomes Table

Program: Building Communities for Recovery

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.2.80 Number of clients receiving recovery services (Output)	FY 2020: 453.0 Target: 300.0 (Target Exceeded)	1,175.0	2,275.0	+1,110.0
1.2.81 Clients who report not having stable housing at baseline who report having stable housing at six-month follow-up (Outcome)	FY 2020: 37.7 Target: 27.0 (Target Exceeded)	47.4	50.0	+2.6
1.2.82 Percent of clients who report not being employed (full-time or part-time) or in school at baseline who report having employment or being in school at follow-up (Outcome)	FY 2020: 54.6 Target: 36.0 (Target Exceeded)	64.5	67.0	+2.5

Minority Fellowship Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Minority Fellowship Program	$4,789	$5,789	$6,136	$347

Authorizing Legislation.....Section 597 of the Public Health Service Act
FY 2022 Authorization..... $6,136,000
Allocation Method .....Grants/Contracts
Eligible Entities..... Organizations that represent individuals obtaining post-baccalaureate training (including for master's and doctoral degrees) for mental and substance use disorder treatment professionals, including in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling

Program Description and Accomplishments

SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The mental health and substance use needs of racial and ethnic minority communities in the United States have been historically underserved due to a variety of factors. These include a limited number of post-baccalaureate (including master's and doctoral level) trained professionals in psychiatry, psychology, nursing, social work, marriage and family therapy, mental health counseling, and substance use and addictions counseling who are equipped with the skills and cultural competencies needed to deliver effective services. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, the program expanded to include marriage and family therapists and later added professional counselors specializing in addiction. In FY 2018, an additional program was created to address specialized training in addiction psychiatry, psychology, and addiction medicine. Professional guilds receive competitively awarded grants, and then competitively award the stipends to graduate and post-graduate students pursuing a degree in corresponding professional fields.

This program is jointly administered by the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS) at SAMHSA. CSAT also funded one additional grant to support the program that specializes in fellowships for addiction psychiatry, psychology, and addiction medicine.

Combined, these programs will support fellowships for hundreds of students as well as support additional training through webinars on culturally appropriate services to thousands of students.

In FY 2020, SAMHSA funded eight continuation grants, one new grant and one contract.

In FY 2021, SAMHSA anticipates funding nine continuation grants and one contract.

Funding History	
Fiscal Year	**Amount**
FY 2018	$4,789,000
FY 2019	$4,789,000
FY 2020	$4,789,000
FY 2021 Enacted	$5,789,000
FY 2022 Budget Request	$6,136,000

Budget Request

The FY 2022 Budget Request is $6.1 million, an increase of $347,000 from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to support nine continuation grants, eight new grants and one technical assistance contract.

Addiction Technology Transfer Centers

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Addiction Technology Transfer Centers.....	$9,046	$9,046	$9,046	$---

Authorizing Legislation.....Section 509 of the Public Health Service Act
FY 2022 Authorization..... $333,806,000
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

The estimated cost of drug use in the United States - including illegal drugs, alcohol, and tobacco - is more than $740 billion a year and growing.[91] Substance misuse in the U.S. costs society in increased healthcare costs, crime, and lost productivity. Recently, the nation's attention has been on the increase misuse of opioids. CDC preliminary data point to 90,000 overdose deaths for the 12 months ending last September – about 20,000 more than the same period the year before. Opioids, particularly synthetic opioids such as fentanyl, are a main driver in the increase in overdose deaths. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare that likely was exacerbated by the ongoing COVID-19 pandemic. The country will be dealing with the repercussions of the pandemic's effect on substance use disorder for years to come. In the midst of these ongoing challenges, there is a critical need is to recruit, train, and support treatment providers in the use of evidence-based practices.

The purpose of the Technology Transfer Centers is to develop and strengthen the specialized behavioral healthcare and primary healthcare workforce that provides prevention, treatment and recovery support services for substance use disorder (SUD) and mental illness. The program's mission is to help people and organizations to incorporate effective evidence based practices into substance use disorder and mental health prevention, treatment and recovery services. Together the Network serves the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the Pacific Islands of Guam, American Samoa, Palau, the Marshall Islands, Micronesia, and the Mariana Islands.

After over 26 years of conducting training workshops, translating research into bite-size pieces for curricula or stand-alone products, and creating opportunities for performance feedback to enhance skill development, the Addiction Technology Transfer Centers (ATTCs) are improving and updating their programs to offer novel training and technical assistance (TA) options that include multiple learning components in new delivery formats focused on changing practices. In response to the COVID-19 pandemic, the ATTC program has developed and implemented many alternative ways to deliver training and technical assistance. A robust virtual platform has been used to support healthcare professionals with telehealth strategies and many adaptations of evidence-based

[91] (NIDA, Trends and Statistics. Published online, updated Feb. 2020)

interventions for the virtual settings. The ATTC centers will continue the response to the differential impact of the pandemic by addressing the needs of the providers and continuing to develop resources to help to address the needs of all communities.

In 2017, SAMHSA funded a new five-year cycle of the ATTC program (2017-2022) which is comprised of ten regional centers (one in each HHS Region), one coordinating center, and two national focus-area centers: the National American Indian and Alaska Native ATTC and the National Hispanic and Latino ATTC. SAMHSA recently completed the continuation application for these 13 centers (FY 2020) which are entering their fourth year of their current program cycle.

To date, under the current cycle (2017-2022), the 13 ATTCs combined have delivered over 4,400 training and technical assistance (TA) events for over 12,000 healthcare professionals and paraprofessionals who deliver services for patients with substance use disorders. Participant satisfaction rates were consistently high, with over 90 percent of attendees reporting that they were satisfied with their training or TA events.

Program Evaluation
In FY 2019, SAMHSA funded a two-year grant to evaluate the ATTC program. The ATTC evaluation started on September 30, 2019 and it will be completed by September 29, 2021. To date the evaluation team has completed, transcribed, and reviewed semi-structured interviews and began work on the analysis.

In FY 2020, SAMHSA funded 12 continuation grants. The ATTC program continued with its mission of helping people and organizations to incorporate effective practices into substance use disorder treatment and recovery services. Together the 13 centers coordinated several webinars and learning collaborative series, developed several products and online trainings to address the opioid and COVID-19 crisis and provided consultation to professional and paraprofessional throughout the US and its territories.

In FY 2021, SAMHSA anticipates funding 12 continuation grants in the ATTC program (year 5 of the current cycle) and the network will continue to focus on delivering training and technical assistance for providers who are serving patients with substance use disorders by improving their capacity and understanding of evidence based practices, especially practices that are effective in combating the opioid crisis.

Building on a rich history, the ATTC Network continuously strives to improve the quality of addictions treatment and recovery services by facilitating alliances among front line counselors, treatment and recovery services agency administrators, faith-based organizations, policy makers, the health and mental health communities, consumers and other stakeholders. By connecting these providers to the latest research and information through activities such as skills training, academic education, online and distance education, conferences, workshops, and publications, the ATTC Network continues to respond to the emerging needs of the field.

Funding History	
Fiscal Year	**Amount**
FY 2018	$9,046,000
FY 2019	$9,046,000
FY 2020	$9,046,000
FY 2021 Enacted	$9,046,000
FY 2022 Budget Request	$9,046,000

Budget Request

The FY 2022 Budget Request is $9.0 million, level with the FY 2021 Enacted level. SAMHSA plans to fund 11 new grants and one continuation grant. Funding will allow the ATTC grantees to disseminate evidence-based, promising practices to addiction treatment and recovery professionals, public health and mental health personnel, institutional and community corrections professionals, and other related disciplines.

Improving Access to Overdose Treatment

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Improving Access to Overdose Treatment	$1,000	$1,000	$1,500	$500

Authorizing Legislation..Section 302 of the Comprehensive Addiction and Recovery Act of 2016
FY 2022 Authorization..... $12,000,000
Allocation Method .....Grants/Contracts
Eligible Entities.....Primary care, child welfare system, criminal justice system

Program Description and Accomplishments

CDC preliminary data point to 90,000 overdose deaths for the 12 months ending last September – about 20,000 more than the same period the year before.

As part of SAMHSA's response, the Opioid Overdose Prevention Toolkit was developed to help reduce the number of opioid-related overdose deaths and adverse events. SAMHSA's Improving Access to Overdose Treatment (ODTx) grant program utilizes this toolkit and other resources to help grantees train and support health care providers and pharmacists on the prescribing of FDA approved drugs or devices for the emergency treatment of known or suspected opioid overdose.

In addition, the ODTx program addresses the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder (including prescription opioids as well as illicit drugs such as heroin).

Program Evaluation

In FY 2020, 29 programs or best practices were developed for prescribing or co-prescribing FDA-approved opioid-overdose reversal drugs or devices. These best practices were used to train 2,274 pharmacists and health care providers. Additionally, grant funding provided 768 naloxone (or other FDA-approved) kits.

In FY 2020, SAMHSA funded five continuation grants.

In FY 2021, SAMHSA anticipates funding five continuation grants.

Funding History

Fiscal Year	Amount
FY 2018	$1,000,000
FY 2019	$1,000,000
FY 2020	$1,000,000
FY 2021 Enacted	$1,000,000
FY 2022 Budget Request	$1,500,000

Budget Request

The FY 2022 Budget Request is $1.5 million, an increase of $500,000 from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to support five continuation grants and two new grants to continue increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder. With this additional funding, we anticipate an increase of 1,270 individuals trained.

Outputs and Outcomes Table

Program: Improving Access to Overdose Treatment (ODTx)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
5.2.0 Number of programs or best practices developed for prescribing or co-prescribing FDA-approved opioid-overdose reversal drugs or devices. (Output)	FY 2020: 29.0 Target: 35.0 (Target Not Met)	Discontinued	Discontinued	N/A
5.2.1 Number trained on prescribing FDA-approved opioid-overdose reversal drugs or devices for emergency treatment of known or suspected opioid overdose. (Output)	FY 2020: 2,274.0 Target: 2,141.0 (Target Exceeded)	2,141.0	3,411.0	+1,270.0

First Responder Training for Opioid Overdose Reversal Drugs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
First Responder Training (CARA).....	$41,000	$42,000	$63,000	$21,000
First Responder Training (non-add)	*18,000*	*18,000*	*27,000*	*9,000*
Rural Set-Aside (non-add)	*23,000*	*24,000*	*36,000*	*12,000*

Authorizing Legislation..... Section 546 of the PHS Act
FY 2022 Authorization .....$ 36,000,000
Allocation Method…….....Competitive Grants
Eligible entities……States, local government entities, federally recognized American Indian/Alaska Native tribe or tribal organizations

Program Description and Accomplishments

SAMHSA's First Responders – Comprehensive Addiction and Recovery Act (FR-CARA) program is an important part of the US government's response to the opioid crisis. The FR-CARA program trains and equips firefighters, law enforcement officers, paramedics, emergency medical technicians, and other legally organized and recognized volunteer organizations in a position to respond to adverse opioid-related incidents. This program also establishes processes, protocols, and mechanisms for referral to appropriate treatment and recovery communities. FR-CARA's broader eligibility and rural-set asides ensure that much needed services reach rural and tribal areas.

Training, technical assistance, and evaluation activities are also being supported to assist grantees, determine best practices, and assess program outcomes. SAMHSA has awarded 69 state, rural and tribal organizations over the past 3 years. Approximately 52 percent of the funds went to rural entities hit particularly hard by the opioid crisis.

Program Evaluation

To date, grantees report having trained 206,509 first responders and community members on the use of naloxone or other FDA approved drugs or devices, and how to respond to overdose emergencies. The program has equipped these communities with 187,243 FDA-approved overdose reversal kits since the start of the program. Of these, 70,218 kits have been administered to treat suspected overdose cases, resulting in more than 24,965 confirmed overdose reversals.

Rural Emergency Medical Services Training Grant

SAMHSA recognizes the great need for emergency services in rural areas and the critical role EMS personnel serve across the country. In FY 2020 SAMHSA funded the Rural Emergency Medical Services Training Grant (EMS Training). The purpose of this one-year grant program is to recruit and train emergency medical services (EMS) personnel in rural areas. SAMHSA funded 27 grantees to ensure that EMS personnel are trained on mental and substance use disorders and care for people with such disorders in emergency situations.

In FY 2020, SAMHSA funded 59 continuation grants. In addition, SAMHSA funded six new FR-CARA grants and 27 new grants for the Rural Emergency Medical Services Training Grant program.

In FY 2021, SAMHSA anticipates funding 20 new and 49 continuation FR-CARA grants, 27 new grants for the Rural Emergency Medical Services Training Grant program.

Funding History

Fiscal Year	Amount
FY 2018	$41,000,000
FY 2019	$41,000,000
FY 2020	$41,000,000
FY 2021 Enacted	$42,000,000
FY 2022 Budget Request	$63,000,000

Budget Request

The FY 2022 Budget Request is $63.0 million, an increase of $21.0 million from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to award 46 continuation grants and 60 new grants. In addition, SAMHSA plans to fund 27 new Rural Emergency Medical Services Training Grants.

Outputs and Outcomes Table

Program: First Responder Training-CARA

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
5.0.1 Number of FDA-approved overdose reversing medication kits distributed. (Output)	FY 2020: 91,911.0 Target: 73,845.0 (Target Exceeded)	91,911.0	71,831.0	+79,920.0
5.1.1 Number of first responders trained how to administer FDA-approved overdose reversing medication kits (Output)	FY 2020: 44,155.0 Target: 16,759.0 (Target Exceeded)	44,155.0	82,495.0	+38,340.0

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022+/- FY 2021
Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths.....	$12,000	$12,000	$18,000	$6,000

Authorizing Legislation..... Section 516 and Section 546 of the PHS Act
FY 2022 Authorization.....$ 211,148,000, $ 36,000,000
Allocation Method .....Competitive Grants, Contracts
Eligible Entities...States, local government entities, federally recognized American Indian/Alaska Native tribe or tribal organizations

Program Description and Accomplishments

Opioid overdose remains a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids (including synthetics such as fentanyl).[92] Opioids include illegal drugs such as heroin, as well as prescription medications used to treat pain. These prescription medications include morphine, codeine, methadone, oxycodone (OxyContin, Percodan, Percocet), hydrocodone (Vicodin, Lortab, Norco), fentanyl (Duragesic, Fentora), hydromorphone (Dilaudid, Exalgo), and buprenorphine (Subutex, Suboxone). Opioids bind to specific receptors in the brain, spinal cord, and gastrointestinal tract and reduce the body's perception of pain. As opioids reduce pain, they induce a slight sense of euphoria, which can lead to overuse. While national data showed that overall numbers of overdose deaths and opioid involved deaths were beginning to decrease, an estimated 90,000 drug overdose deaths occurred in the United States in the 12 months ending in September 2020, the highest number of overdose deaths ever recorded in a 12-month period, according to recent provisional data from CDC. Provisional CDC data also indicate that 37 of 38 states reporting synthetic opioid data reported increases in overdose deaths tied to synthetic opioid use.[93] Fentanyl has been a significant driver of this increase.

SAMHSA supports 12 grants to 12 states for the Grants to Prevent Prescription Drug and Opioid Overdose-related Deaths program, which helps states identify communities of high need and provide education, training, and resources necessary to meet their specific needs. The grant funds can be used for purchasing overdose reversing drugs, equipping first responders with them, providing training on their use, developing other overdose-related death prevention strategies, and providing materials to assemble and disseminate overdose kits. These grantees are also required to develop a dissemination plan and a training course tailored to meet the needs of first responders in their communities. The course uses SAMHSA's Opioid Overdose Prevention Toolkit as a guide

[92] National Institute on Drug Use (NIDA). America's Addiction to Opioids: Heroin and Prescription Drug Abuse. (2014) Available from URL: http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2015/americas-addiction-to-opioids-heroin-prescription-drug-abuse#_ftnref4

[93] Centers for Disease Control (CDC). Overdose Deaths Accelerating During COVID-19. (2020) Available from URL: https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html#:~:text=37%20of%20the%2038%20U.S.,in%20synthetic%20opioid%2Dinvolved%20deaths.

and includes a comprehensive prevention program that will focus on prevention, treatment, and recovery services in order to decrease the likelihood of drug overdose recurrence.

Program Evaluation

In FY 2020, grantees reported that they held 9,982 trainings and grantees trained 26,445 on naloxone administration or on other opioid-overdose related topics. This number greatly exceeded the 2020 target of 2,000 people trained. Grantees holding virtual trainings during the pandemic has increased capacity to reach a broader and harder to reach audiences. SAMHSA estimates that this number of people will also be served in each of FY 2021 and FY 2022. Throughout FY 2020, grantees have acquired and distributed 52,750 Naloxone or other FDA-approved kits, which surpasses our previous target of 44,348. Due to the kits purchased and trainings held, grantees have successfully conducted 4,629 opioid overdose reversals.

In FY 2020, SAMHSA funded 12 continuation awards.

In FY 2021, SAMHSA anticipates funding 13 new grants.

Funding History

Fiscal Year	Amount
FY 2018	$12,000,000
FY 2019	$12,000,000
FY 2020	$12,000,000
FY 2021 Enacted	$12,000,000
FY 2022 Budget Request	$18,000,000

Budget Request

The FY 2022 Budget Request is $18.0 million, an increase of $6.0 million from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to support seven new and 13 continuation grants across seven states to reduce the number of opioid overdose-related deaths. This will also help states purchase overdose reversing drugs, equip first responders in high-risk communities, support education on the use of naloxone and other overdose-related death prevention strategies, provide the necessary materials to assemble overdose kits, and cover expenses incurred from dissemination efforts. SAMHSA estimates the increase in funding will result in an estimated increase of 2,695 overdose reversals, 7,662 more Naloxone kits distributed, and 4,166 more persons trained to administer Naloxone or other FDA approved drug or device.

Outputs and Outcomes Table

Program: PDO/Naloxone

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
5.0 Number of Naloxone (or other FDA-approved) kits distributed (Output)	FY 2020: 52,750.0 Target: 45,088.0 (Target Exceeded)	45,088.0	52,750.0	+7,662.0
5.1 Number of lay persons trained how to administer Naloxone (or other FDA approved drug or device). (Output)	FY 2020: 26,445.0 Target: 22,279.0 (Target Exceeded)	22,279.0	26,445.0	+4,166.0

Peer Support Technical Assistance Center

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Peer Support TA Center.....	$1,000	$1,000	$1,500	$500

Authorizing Legislation...Section 7152 of the SUPPORT for Patients and Communities Act (Sec. 547A of the PHS Act)
FY 2022 Authorization..... $1,000,000
Allocation Method ..... Competitive Grants
Eligible Entities..... Recovery Community Organizations

Program Description and Accomplishments

The purpose of this new program, which is authorized by section 7152 of the SUPPORT for Patients and Communities Act (P.L. 115-271), is to provide funding for the creation of a National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support, or the Center. The Center provides technical assistance and support to recovery community organizations and peer support networks. The technical assistance is related to training, translation and interpretation services, data collection, capacity building, and evaluation and improvement of the effectiveness of such services provided by recovery community organizations.

In FY 2020, SAMHSA funded one new grant.

In FY 2021, SAMHSA anticipates funding one continuation grant.

Funding History

Fiscal Year	Amount
FY 2018	---
FY 2019	---
FY 2020	$1,000,000
FY 2021 Enacted	$1,000,000
FY 2022 Budget Request	$1,500,000

Budget Request

The FY 2022 Budget Request is $1.5 million, an increase of $500,000 from the FY 2021 Enacted level. SAMHSA continues to support the existing grantee in this program and increase the funding available for the grantee.

Outputs and Outcomes Table

Program: Peer Support Technical Assistance Center

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.1.0 Number of people train for the support of the recovery community organizations and peer support networks (Output)	FY 2020: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	Maintain Baseline	Maintain Target*	N/A
1.2.0 Number trained on technical assistance, translation and interpretation services, data collection, capacity building, and evaluation and improvement of the effectiveness of such services provided by recovery community organizations (Output)	FY 2020: Result Expected Dec 31, 2021 Target: 1,500.0 (Pending)	1,500.0	3,000.0	+1,500.0

*Note: the target for FY22 has been maintained, may be increased 1-2% based on FY21 actuals. The difference between FY20 and FY22, reflect the increase in funding between FY21 and FY22.

Emergency Department Alternatives to Opioids

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Emergency Department Alternatives to Opioids.....	$5,000	$6,000	$9,000	$3,000

Authorizing Legislation..... Section 7091 of the SUPPORT for Patients and Communities Act
FY 2022 Authorization..... $5,000,000
Allocation Method ..... Competitive Grants
Eligible Entities..... Hospitals and Emergency Departments

Program Description and Accomplishments

The purpose of this new program, which is authorized by section 7091 of the SUPPORT for Patients and Communities Act (P.L. 115-271) is to provide funding to hospitals and emergency departments, including freestanding emergency departments, to develop, implement, enhance, or study alternative pain management protocols and treatments that limit the use and prescribing of opioids in emergency departments. In addition, these funds will be used to target common painful conditions, train providers and other hospital personnel, and provide alternatives to opioids for patients with painful conditions.

In FY 2020, SAMHSA funded 10 new grants.

In FY 2021, SAMHSA anticipates funding 10 continuation grants and two new grants.

Funding History

Fiscal Year	Amount
FY 2018	---
FY 2019	---
FY 2020	$5,000,000
FY 2021 Enacted	$6,000,000
FY 2022 Budget Request	$9,000,000

Budget Request

The FY 2022 Budget Request is $9.0 million, an increase of $3.0 million from the FY 2021 Enacted level**.** SAMHSA plans to use the increase in funds to award six new and 12 continuation grants.

Outputs and Outcomes Table

Program: Emergency Department Alternative to Opioids

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.60.1 Number of providers trained on non-opioids therapies. (Output)	FY 2020: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	Maintain Baseline	Maintain Baseline*	Maintain
1.60.2 Number of patients who received non-opioid therapies. (Output)	FY 2020: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	Maintain Baseline	Maintain Baseline*	Maintain

*Note: the target for FY22 has been maintained, may be increased 1-2% based on FY21 actuals. The difference between FY20 and FY22, reflect the increase in funding between FY21 and FY22.

Treatment, Recovery, and Workforce Support

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Treatment, Recovery, and Workforce Support.....	$4,000	$6,000	$9,000	$3,000

Authorizing Legislation..... Section 7183 of the SUPPORT for Patients and Communities Act
FY 2022 Authorization..... $6,000,000
Allocation Method ..... Competitive Grants
Eligible Entities.....SSAs, Tribes and Tribal Organizations, Entities that offer treatment or other services following a drug overdose (e.g., emergency departments)

Program Description and Accomplishments

The purpose of this new program, which is authorized by section 7183 of the SUPPORT for Patients and Communities Act, is to implement evidence-based programs to support individuals in substance use disorder treatment and recovery to live independently and participate in the workforce. To achieve this objective, recipients must coordinate, as applicable, with Indian tribes or tribal organizations, state and local workforce development boards, lead state agencies responsible for a workforce investment activity, and state agencies responsible for carrying out substance use disorder prevention and treatment programs. The program launched in September 2020 with eight grant recipients, three grants in February 2021 and one additional grant will be awarded in 2021 for a total of twelve grants awarded.

In FY 2020, SAMHSA funded eight new awards.

In FY 2021, SAMHSA anticipates funding four new and eight continuation grants.

Funding History

Fiscal Year	Amount
FY 2018	---
FY 2019	---
FY 2020	$4,000,000
FY 2021 Enacted	$6,000,000
FY 2022 Budget Request	$9,000,000

Budget Request

The FY 2022 Budget Request is $9.0 million, an increase of $3.0 million from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to award six new and 12 continuation grants.

Outputs and Outcomes Table

Program: Treatment, Recovery, and Workforce Support

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.21.1 Number of people participate in the workforce (Output)	FY 2020: Result Expected Dec 31, 2021 (Pending)	Set Baseline	Maintain Target*	N/A
1.21.2 Number of people received treatment and recovery to live independently (Output)	FY 2019: Result Expected Dec 31, 2021 (Pending)	Set Baseline	Maintain Target*	N/A

*Note: the target for FY22 has been maintained, may be increased 1-2% based on FY21 actuals. The difference between FY20 and FY22, reflect the increase in funding between FY21 and FY22.

Comprehensive Opioid Recovery Centers

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Comprehensive Opioid Recovery Centers.....	$---	$4,000	$6,000	$2,000

Authorizing Legislation..... …Section 7121 of the SUPPORT Act (Section 552 of the PHS Act)
FY 2022 Authorization..... $4,000,000
Allocation Method ..... Competitive Grants
Eligible Entities. Public and private nonprofit entities (that provide treatment for individuals with substance use disorders).

Program Description and Accomplishments

For individuals with opioid use disorders, there is an increasing need for access to coordinated, comprehensive care services, including long-term care and support services that utilize the full range of FDA-approved medications and evidence-based treatments.

This program provides grants to nonprofit substance use disorder treatment organizations to operate of comprehensive centers which provide a full spectrum of treatment and recovery support services for opioid use disorders. The funding represents the first year of a four-year project period. Grantees are required to provide outreach and the full continuum of treatment services including MAT; counseling; treatment for mental disorders; testing for infectious diseases, residential rehabilitation, and intensive outpatient programs; recovery housing; peer recovery support services; job training, job placement assistance, and continuing education; and family support services such as child care, family counseling, and parenting interventions. Grantees must utilize third party and other revenue to the extent possible. Grantees are required to report client-level data, including demographic characteristics, substance use, diagnosis, services received, types of MAT received, length of stay in treatment, employment status, criminal justice involvement, and housing.

In FY 2020, SAMHSA funded two new grants.

In FY 2021, SAMHSA anticipates funding two new and two continuation grants.

Funding History

Fiscal Year	Amount
FY 2018	---
FY 2019	---
FY 2020	---
FY 2021 Enacted	$4,000,000
FY 2022 Budget Request	$6,000,000

Budget Request

The FY 2022 Budget Request is $6.0 million, an increase of $2.0 million from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to support four continuations and two new grants. These funds will also provide critical comprehensive care services, including long-term care and support services utilizing the full range of FDA-approved medications and evidence-based treatments and will cover the costs of critical linkage and system development not currently covered by other sources of funding. These funds will extend the reach of MAT treatment and recovery support services to address the opioid epidemic across systems and regional locations, reducing scattered, uncoordinated treatment efforts, and expanding access to care for people with special needs and/or in rural areas.

Outputs and Outcomes Table

Program: Comprehensive Opioid Recovery Centers

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.1.1 Number of clients served with MAT (Output)	FY 2020: Result Expected Dec 31, 2021 (Pending)	Set Baseline	Maintain Target*	N/A
1.2.1 Percentage of adults receiving services who had no past month substance use at 6-month follow-up (Output)	FY 2021: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	Set Baseline	Maintain Target*	N/A
1.3.1 Percentage of adults receiving services who were currently employed or engaged in productive activities at 6-month follow-up (Outcome)	FY 2021: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	Set Baseline	Maintain Baseline*	N/A
1.4.1 Number of adults receiving recovery housing and community based and peer recovery support services at 6-month follow-up (Output)	FY 2021: Result Expected Dec 31, 2022 Target: Set Baseline (Pending)	Set Baseline	Maintain Target*	N/A

*Note: the target for FY22 has been maintained, may be increased 1-2% based on FY21 actuals. The difference between FY20 and FY22, reflect the increase in funding between FY21 and FY22.

Opioid Response Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
Opioids Response Grants.....	$---	$3,000	$3,000	$---

Authorizing Legislation.....Section 509 of the Public Health Service Act
FY 2022 Authorization..... $333,806,000
Allocation Method ..... Competitive Grants
Eligible Entities……Limited to Single State Agencies (SSAs), Existing USDA Cooperative Extension Grantees, and U.S. Territories, Tribes and tribal organizations are eligible to apply to set-aside funds described below.

The Opioid Response Grants program is included in the State Opioid Response (SOR) narrative section on page 266.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table Summary

(Dollars in thousands)

Program Activity	FY 2020 Final		FY 2021 Enacted		FY 2022 Budget Request	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Grants/Cooperative Agreements:						
Continuations	825	$391,978	703	$324,914	786	$363,835
New/Competing	132	54,566	308	139,944	577	254,396
Supplements	---	6,989	---	5,387	---	2,254
Subtotal	957	453,532	1,011	470,245	1,363	620,485
Contracts:						
Continuations	6	25,847	3	23,157	4	28,960
New/Competing	---	298	1	3,274	---	1,419
Subtotal	6	26,145	4	26,432	4	30,379
Total, Substance Abuse Treatment	**963**	**$479,677**	**1,015**	**$496,677**	**1,367**	**$650,864**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final		FY 2021 Enacted		FY 2022 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Capacity:						
Opioid Treatment Programs/Regulatory Activities						
Grants						
Continuations	29	$6,007	1	$2,000	36	$5,400
New/Competing	---	---	36	5,400	29	6,093
Supplements*	---	1,364	---	---	---	---
Subtotal	29	7,371	37	7,400	65	11,493
Contracts						
Continuations	2	1,327	2	1,257	2	1,569
New/Competing	---	26	---	67	---	24
Subtotal	2	1,353	2	1,324	2	1,593
Total, Opioid Treatment Programs/Regulatory Activities	**31**	**8,724**	**39**	**8,724**	**67**	**13,086**
Screening, Brief Intervention and Referral to Treatment						
Grants						
Continuations	32	27,721	27	17,562	37	27,502
New/Competing	---	---	10	9,950	1	1,400
Supplements*	---	200	---	200	---	200
Subtotal	32	27,921	37	27,712	38	29,102
Contracts						
Continuations	---	1,511	---	1,484	---	1,391
New/Competing	---	568	---	804	---	67
Subtotal	---	2,079	---	2,288	---	1,458
Total, Screening, Brief Intervention and Referral to Treatment	**32**	**30,000**	**37**	**30,000**	**38**	**30,560**
Targeted Capacity Expansion						
Grants						
Continuations	183	91,818	53	24,621	143	76,227
New/Competing	5	3,142	138	72,458	130	64,533
Supplements*	---	100	---	---	---	---
Subtotal	188	95,060	191	97,079	273	140,760
Contracts						
Continuations	---	5,199	---	5,207	---	6,968
New/Competing	---	-67	---	-95	---	188
Supplements*	---	---	---	---	---	---
Subtotal	---	5,132	---	5,113	---	7,156
Total, Targeted Capacity Expansion	**188**	**100,192**	**191**	**102,192**	**273**	**147,916**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final		FY 2021 Enacted		FY 2022 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Pregnant and Postpartum Women						
Grants						
Continuations	42	22,872	48	26,515	33	20,303
New/Competing	9	6,500	4	3,600	48	26,197
Supplements*	---	1,050	---	975	---	500
Subtotal	51	30,422	52	31,090	81	47,000
Contracts						
Continuations	---	1,656	---	1,677	---	2,327
New/Competing	---	-147	---	164	---	69
Supplements*	---	---	---	---	---	---
Subtotal	---	1,509	---	1,841	---	2,397
Total, Pregnant and Postpartum Women	**51**	**31,931**	**52**	**32,931**	**81**	**49,397**
Recovery Community Services Program						
Grants						
Continuations	3	450	6	1,788	8	2,399
New/Competing	6	1,782	2	600	9	2,573
Supplements **	---	75	---	---	---	---
Subtotal	9	2,307	8	2,388	17	4,973
Contracts						
Continuations	---	127	---	124	---	172
New/Competing	---	---	---	-79	---	6
Subtotal	---	127	---	46	---	178
Total, Recovery Community Services Program	9	**2,434**	**8**	**2,434**	**17**	**5,151**
Children and Families						
Grants						
Continuations	46	26,263	35	18,454	52	27,766
New/Competing	---	68	17	9,265	2	936
Supplements *	---	275	---	---	---	---
Subtotal	46	26,605	52	27,719	54	28,703
Contracts						
Continuations	1	3,000	---	1,512	---	1,423
New/Competing	---	---	---	373	---	72
Subtotal	1	3,000	---	1,886	---	1,494
Total, Children and Families	**47**	**29,605**	**52**	**29,605**	**54**	**30,197**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final		FY 2021 Enacted		FY 2022 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Treatment Systems for Homeless						
Grants						
Continuations	72	28,353	85	33,807	68	26,799
New/Competing	13	5,422	---	---	20	7,859
Supplements *	---	720	---	720	---	550
Subtotal	85	34,495	85	34,527	88	35,208
Contracts						
Continuations	---	1,891	---	1,859	---	1,827
New/Competing	---	---	---	---	---	79
Subtotal	---	1,891	---	1,859	---	1,906
Total, Treatment Systems for Homeless	**85**	**36,386**	**85**	**36,386**	**88**	**37,114**
Minority AIDS						
Grants						
Continuations	121	59,681	121	59,837	62	30,645
New/Competing	---	32	---	---	64	32,027
Supplements *	---	2,375	---	2,375	---	900
Subtotal	121	62,088	121	62,212	126	63,572
Contracts						
Continuations	---	3,408	---	3,350	---	3,151
New/Competing	---	74	---	9	---	158
Subtotal	---	3,482	---	3,358	---	3,309
Total, Minority AIDS	**121**	**65,570**	**121**	**65,570**	**126**	**66,881**
Criminal Justice Activities						
Grants						
Continuations	178	67,711	212	81,978	199	76,776
New/Competing	32	15,109	2	799	94	40,000
Supplements *	---	---	---	---	---	---
Subtotal	210	82,820	214	82,778	293	116,776
Contracts						
Continuations	2	6,180	---	4,544	1	7,313
New/Competing	---	---	1	1,679	---	291
Subtotal	2	6,180	1	6,222	1	7,604
Total, Criminal Justice Activities	212	**89,000**	**215**	**89,000**	**294**	**124,380**
Improving Access to Overdose Treatment						
Grants						
Continuations	5	915	5	913	5	917
New/Competing	---	---	---	---	2	405
Supplements *	---	104	---	104	---	104
Subtotal	5	1,019	5	1,017	7	1,427
Contracts						
Continuations	---	52	---	51	---	73
New/Competing	---	-71	---	-68	---	---
Subtotal	---	-19	---	-17	---	73
Total, Improving Access to Overdose Treatment	**5**	**1,000**	**5**	**1,000**	**7**	**1,500**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final		FY 2021 Enacted		FY 2022 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Building Communities of Recovery						
Grants						
Continuations	23	4,439	19	3,485	44	8,685
New/Competing	14	2,725	30	6,013	52	10,360
Supplements *	---	425	---	---	---	---
Subtotal	37	7,589	49	9,498	96	19,044
Contracts						
Continuations	---	411	---	502	---	942
New/Competing	---	---	---	---	---	13
Subtotal	---	411	---	502	---	956
Total,Building Communities of Recovery	**37**	**8,000**	**49**	**10,000**	**96**	**20,000**
Grants to Prevent Prescription Drug/Opioid Overdoes-Related Deaths						
Grants						
Continuations	12	11,253	---	591	13	11,898
New/Competing	---	---	13	11,050	7	6,102
Supplements *	---	300	---	---	---	---
Subtotal	12	11,553	13	11,641	20	18,000
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	447	---	359	---	---
Subtotal	---	447	---	359	---	---
Total, Grants to Prevent Prescription Drug/Opioid Overdoes-Related Deaths	12	**12,000**	**13**	**12,000**	**20**	**18,000**
First Responder Training (CARA)						
Grants						
Continuations	59	31,557	49	28,606	46	24,947
New/Competing	33	9,816	47	13,394	87	38,053
Subtotal	92	41,372	96	42,000	133	63,000
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	-372	---	---	---	---
Subtotal	---	-372	---	---	---	---
Total, First Responder Training (CARA)	92	**41,000**	**96**	**42,000**	**133**	**63,000**

SAMHSA/Substance Abuse Treatment

PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Peer Support TA Center						
Grants						
Continuations	---	---	1	950	1	950
New/Competing	1	950	---	---	---	---
Subtotal	1	950	1	950	1	950
Contracts						
Continuations	---	26	---	49	---	71
New/Competing	---	24	---	1	---	480
Subtotal	---	50	---	50	---	550
Total, Peer Support TA Centers	1	**1,000**	**1**	**1,000**	**1**	**1,500**
Treatment, Recovery, and Workforce Support						
Grants						
Continuations	---	---	8	3,989	12	5,881
New/Competing	8	3,951	4	1,862	6	3,000
Subtotal	8	3,951	12	5,851	18	8,881
Contracts						
Continuations	---	103	---	149	---	204
New/Competing	---	-54	---	---	---	-85
Subtotal	---	49	---	149	---	119
Total, Treatment, Recovery, and Workforce Support	8	**4,000**	**12**	**6,000**	**18**	**9,000**
Emergency Department Alternatives to Opioids						
Grants						
Continuations	---	---	10	4,759	12	5,713
New/Competing	10	4,771	2	1,000	6	3,083
Subtotal	10	4,771	12	5,759	18	8,796
Contracts						
Continuations	---	129	---	149	---	204
New/Competing	---	100	---	92	---	---
Subtotal	---	229	---	241	---	204
Total, Emergency Department Alternatives to Opioids	**10**	**5,000**	**12**	**6,000**	**18**	**9,000**

SAMHSA/Substance Abuse Treatment

PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Opioid Response Grants						
Grants						
Continuations	---	---	---	---	1	2,788
New/Competing	---	---	1	2,852	---	---
Subtotal	---	---	1	2,852	1	2,788
Contracts						
Continuations	---	---	---	148	---	212
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	148	---	212
Total, Opioid Response Grants	**---**	**---**	**1**	**3,000**	**1**	**3,000**
Comprehensive Opioid Recovery Centers						
Grants						
Continuations	---	---	2	1,699	4	3,399
New/Competing	---	---	2	1,700	2	2,300
Subtotal	---	---	4	3,399	6	5,699
Contracts						
Continuations	---	---	---	215	---	283
New/Competing	---	---	---	386	---	18
Subtotal	---	---	---	601	---	301
Total, Comprehensive Opioid Recovery Centers	**---**	**---**	**4**	**4,000**	**6**	**6,000**
Total, Capacity	**941**	**465,842**	**993**	**481,842**	**1,337**	**635,682**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Science and Service	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 President's Budget No.	FY 2022 President's Budget Amount
Addiction Technology Transfer Centers						
Grants						
Continuations	12	8,898	12	9,019	1	500
New/Competing	---	---	---	---	11	8,093
Subtotal	12	8,898	12	9,019	12	8,593
Contracts						
Continuations	---	471	---	445	---	426
New/Competing	---	-323	---	-419	---	26
Subtotal	---	148	---	27	---	453
Total, Addiction Technology Transfer Centers	**12**	**9,046**	**12**	**9,046**	**12**	**9,046**
SAT Minority Fellowship Program						
Grants						
Continuations	8	4,042	9	4,340	9	4,340
New/Competing	1	298	---	---	8	1,379
Supplements *	---	---	0	1,012	---	---
Subtotal	9	4,340	9	5,353	17	5,719
Contracts						
Continuations	1	357	1	436	1	404
New/Competing	---	92	---	---	---	13
Subtotal	1	449	1	436	1	417
Total, Minority Fellowship Program (MF)	**10**	**4,789**	**10**	**5,789**	**18**	**6,136**
Subtotal, Science and Service:	**22**	**13,835**	**22**	**14,835**	**30**	**15,182**
Total, Substance Abuse Treatment PRNS	**963**	**$479,677**	**1,015**	**$496,677**	**1,367**	**$650,864**

***** Excluding Supplements number count to avoid duplication.

Grant Awards Table

(Whole Dollars)

`	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request
Number of Awards	957	1,011	1,363
Average Award	$473,910.03	$465,128.69	$455,099.50
Range of Awards	$300,000-$600,000	$300,000-$600,000	$300,000-$600,000

State Opioid Response Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022+/- FY 2021
State Opioid Response Grants.....	$1,500,000	$1,500,000	$2,250,000	$750,000
Set-Aside for Tribes (non-add)	*50,000*	*50,000*	*75,000*	*25,000*

Authorizing Legislation.....Section 509 of the Public Health Service Act
FY 2022 Authorization.....$2,250,000,000
Allocation Method ..... Competitive Grants
Eligible Entities……Limited to Single State Agencies (SSAs), Existing USDA Cooperative Extension Grantees, and U.S. Territories, Tribes and tribal organizations are eligible to apply to set-aside funds described below.

Program Description & Accomplishments

The State Opioid Response Grants (SOR) program was established by Congress in 2018 in order to address the public health crisis caused by escalating opioid misuse and addiction across the nation. According to CDC provisional data, 90,000 overdose deaths for the 12 months ending last September – about 20,000 more than the same period the year before. The SOR program provides resources to states, territories, and tribes to continue and enhance the development of comprehensive strategies focused upon preventing, intervening, and promoting recovery from issues related to opioid misuse.

This program aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs). In FY 2018, SAMHSA started awarding grants to 57 states and territories via formula. The program includes a 15 percent set-aside for the 10 states with the highest mortality rate related to drug overdose deaths.

The SOR program requires grantees to: use epidemiological data to demonstrate the critical gaps in availability of treatment for OUDs in geographic, demographic, and service level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly and adequately address the gaps in their systems of care; deliver evidence-based treatment interventions that include medication(s) FDA-approved specifically for the treatment of OUD, and psychosocial interventions; report progress toward increasing availability of medication-assisted treatment for OUD and reducing opioid-related overdose deaths.

The program supplements activities pertaining to opioids currently undertaken by the state agency and support a comprehensive response to the opioid epidemic. The program identifies gaps and resources, while building upon existing substance use prevention and treatment activities as well as community-based recovery support services. Grantees are required to describe how they will expand access to treatment and recovery support services. Grantees are required to describe how they will advance substance misuse prevention in coordination with other federal efforts.

Grantees must use funding to supplement and not supplant existing opioid prevention, treatment, and recovery activities in their state. Grantees are required to describe how they will improve retention in care, using a chronic care model or other innovative model that has been shown to improve retention in care.

In addition to the grant program, SAMHSA supports a robust technical assistance and training effort to enhance education across the country to address the opioid crisis. This effort began with a $12 million investment in FY 2018 with STR funds and continued in FY 2019. SAMHSA has identified local teams of experts on the ground in every state. These teams are comprised of clinicians, preventionists, and recovery specialists to provide training and education not just to practitioners but also to individuals and families. Providing this training ensures that local response to the opioid and substance use crisis is tailored to local needs.

In FY 2020, SAMHSA funded a new cohort of SOR grants. In addition to addressing the opioid crisis, the program was expanded to support evidence-based prevention, treatment and recovery support services to address stimulant misuse and use disorders, including cocaine and methamphetamine misuse. In FY 2020, SAMHSA also continued to support SOR technical assistance and training efforts.

Tribal Opioid Response Grants

The Tribal Opioid Response Grants (TOR) program addresses the public health crisis caused by escalating opioid misuse and addiction across tribal communities. The program aims to address the opioid crisis in tribal communities by increasing access to culturally appropriate and evidence-based treatment, including medication-assisted treatment (MAT) using one of the three FDA-approved medications for the treatment of opioid use disorder (OUD). The intent of this program is to reduce unmet treatment need and opioid overdose related deaths through the provision of prevention, treatment and/or recovery activities for OUD and stimulant misuse including methamphetamine and cocaine. According to the Centers for Disease Control and Prevention, American Indians and Alaska Natives (AI/AN) have had the highest drug overdose death rates in 2015 and the largest percentage increase in the number of deaths over time from 1999-2015 among all racial and ethnic groups. During that time, deaths rose more than 500 percent.

American Indian/Alaska Native communities experience high rates of physical, emotional, and historical trauma and significant socioeconomic disparities, which may contribute to higher rates of drug abuse in the tribal communities[94]. The TOR program addresses the gaps in prevention, treatment, and recovery identified by the tribes and develop strategies to purchase and disseminate naloxone and provide training on its use to first responders and other tribal members.

Program Evaluation

The SOR Evaluation Report to Congress is currently under development. As of April 2, 2021, grantees reported data on 157,333 people into the SPARS system.[95] Since the SOR program began, approximately 646,854 patients have received treatment services, including 240,571 who have received medication-assisted treatment (MAT). Of that number, 107,905 received methadone, 117,352 received buprenorphine, and 15,314 received naltrexone.[96]

Rural Opioids Technical Assistance (ROTA) Grants

SAMHSA is collaborating with the United States Department of Agriculture (USDA) through the Rural Opioid Technical Assistance (ROTA) program. The USDA provides Cooperative Extension Services programs to improve the quality of people's lives by providing research-based knowledge to strengthen the social, economic and environmental well-being of families, rural communities, and agriculture enterprises. Extension experts focus on issues which affect rural communities. The USDA has identified opioid misuse in rural America to be one of the areas of focus of these programs. SAMHSA's ROTA grants build upon these Cooperative Extension Services programs by expanding their reach. From 2018 to 2020 SAMHSA has funded three cohorts of ROTA grantees. Together, they have implemented over 2,300 events and served over 60,400 community members, including providers, in rural areas. In FY 2020, SAMHSA funded 16 grantees that will remain active until 2022 to continue to develop and disseminate training and technical assistance for rural communities on addressing opioid issues affecting these communities. Training and technical assistance can also be geared toward addressing stimulant issues in these communities.

In FY 2020, SAMHSA funded 57 new SOR grants, and 92 new TOR grants, and technical assistance and training grants.

In FY 2021, additional funds from the Opioid Response Grants PRNS were appropriated for supplemental grants to states whose award from the State Opioid Response formula grant declined by more than 40 percent in fiscal year 2021 in comparison to fiscal year 2019.

In FY 2021, SAMHSA anticipates funding 57 SOR and 40 TOR continuation grants and continues to support technical assistance and training grants.

Funding History

Fiscal Year	Amount
FY 2018	$1,000,000,000
FY 2019	$1,500,000,000
FY 2020	$1,500,000,000
FY 2021 Enacted	$1,500,000,000
FY 2022 Budget Request	$2,250,000,000

[94] Whitesell NR, Beals J, Crow CB, Mitchell CM, Novins DK. Epidemiology and etiology of substance use among American Indians and Alaska Natives: risk, protection, and implications for prevention. Am J Drug Alcohol Abuse 2012;38:376–82.

[95] Data reported is based on GPRA data generated in SPARS on April 2, 2021 for clients who received services during both SOR and SOR20 grants.

[96] Data is based on the FY18 SOR cohort year 1 and year 2 Performance Progress Report collected from September 30, 2018 to September 29, 2020.

Budget Request

The FY 2022 Budget Request is $2.3 billion, an increase of $750.0 million from the FY 2021 Enacted level. The FY 2022 budget includes $75 million for TOR, a $25.0 million increase for tribes. SAMHSA plans to fund new grants to continue to support states and territories, including a 15 percent set-aside for the 10 states with the highest mortality rates related to drug overdose deaths. The allowable uses of this program will continue to include state efforts to address stimulants, including methamphetamine, and cocaine. Stimulants are an increasing source of concern and are responsible for more deaths than opioids in a growing number of states, even as opioid overdose deaths are continuing to increase. The additional funding will enhance states' ability to address stimulants, as well as other issues related to the opioid epidemic that have been compounded due to COVID-19.

In FY 2022, SAMHSA will continue to fund supplemental grants to states whose award from the State Opioid Response formula grant declined by more than 40 percent in fiscal year 2021 in comparison to fiscal year 2019.

Outputs and Outcomes Table

Program: State Opioid Response Grants

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.2.70 Number of admissions for OUD treatment (Output)	FY 2020: 90,487.0 Target: 20,959.0 (Target Exceeded)	90,487.0	99,536.0	+9,049.0
1.2.71 number of clients receiving recovery services (Output)	FY 2020: 38,147.0 Target: 10,213.0 (Target Exceeded)	38,147.0	38,147.0	Maintain
1.2.73 Illicit drug use at 6 months follow-up (Output)	FY 2020: 70.0 Target: 41.3 (Target Exceeded)	70.0	70.0	Maintain

Substance Abuse Prevention and Treatment Block Grant

(Dollars in thousands

Program	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022 +/- FY 2021
Substance Abuse Prevention and Treatment Block Grant...	$1,858,079	$1,858,079	$3,508,079	$1,650,000
Budget Authority (non-add)	*1,778,879*	*1,778,879*	*3,428,879*	*1,650,000*
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	---

Authorizing Legislation.....Section 1935 of the Public Health Service Act
FY 2022 Authorization.....$3,508,079,000
Allocation Method ..... Formula Grants
Eligible Entities.....States, Territories, Freely Associated States, District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota

Program Description and Accomplishments

The Substance Abuse Prevention and Treatment Block Grant (SABG) program distributes funds to 60 eligible states, territories and freely associated states[97], the District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota (referred to collectively as states) to plan, carry out, and evaluate substance use disorder prevention and treatment, and recovery support services for individuals, families, and communities impacted by substance misuse. The SABG's overall goal is to support and expand substance use disorder (SUD) prevention and treatment services while providing maximum flexibility to grantees.

The SABG is critically important because it provides the states and their respective SABG sub-recipients, including, but not limited to, administrative service organizations, county and municipal governments, and prevention and treatment providers, the flexibility to respond to local and/or regional emergent issues impacting health, public health, and public safety through a consistent federal funding stream. SABG accounts for approximately 15 percent of total state substance abuse agency funding[98] and on average 68 percent of total state SUD prevention and public health funding. Individuals and families without health coverage or whose health insurance benefit will not cover certain services (e.g., recovery support) rely on services funded by the SABG. Block grant funds are being leveraged by states, along with other funding sources, to support training for staff and implementation of evidence-based practices for the prevention of substance misuse and the treatment of drug/alcohol addiction, improved business practices such as facilitating enrollment in appropriate health coverage and use of health information technology and integration

[97] Territories include Guam, Puerto Rico, the Northern Mariana Islands, U.S. Virgin Islands and American Samoa. Freely Associated States, which have signed Compacts of Free Association with the United States, include the Republic of Palau, Federated States of Micronesia and Republic of the Marshall Islands. . U.S. Department of Interior. Office of Insular Affairs. (n.d.). Islands We Serve. Retrieved from http://www.doi.gov//oia/islands/index.cfm

[98] Web Block Grant Application System (WebBGAS) FY 2020 SABG State Agency Reported Expenditures by Target Activity Within Source of Funds, State/Jurisdiction Selection: All States/Jurisdictions.

of physical and behavioral health.[99] SAMHSA encourages states to use block grant resources to support and not supplant services that are covered through commercial and public insurer plans.

SAMHSA block grant funds are directed toward four purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
- Fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;
- Fund primary prevention for individuals not identified as needing treatment (which may include universal programs that are targeted to the general public or a whole population group that has not been identified on the basis of individual risk, selective activities that are targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average, and indicated prevention activities that are targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels); and
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral disorder treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.

SAMHSA also encourages the states to use their block grants to:

- Strengthen current activities that facilitate and allow the pursuit of recovery through personal choice, regarding issues that matter most to people in their lives, that enhance their health, wellness, and quality of life, and provide increased support for many pathways of recovery, including recovery check-ups, mutual aide, peer based recovery, peer coaching, services supporting recovery residences, recovery community centers, and recovery supports in educational settings; encourage providers to assess performance based on outcomes that demonstrate client successes; and
- Expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services.

Funding Allocations and Requirements

The authorizing statute and implementing regulation governing the SABG includes a number of prescriptive performance and expenditure requirements as well as explicit expenditure

[99] Substance Abuse and Mental Health Services Administration. Case Studies of Three Policy Areas and Early State Innovators: 2014 State Profiles of Mental Health and Substance Use Disorder Agencies. HHS Publication No. SMA-15-4418. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

prohibitions. The states and jurisdictions have the flexibility to plan, carry out, and evaluate substance use disorder treatment and recovery support services that reflect comments received from individuals, families and communities during the development of their respective biennial plans and the results of such plans are reflected in their respective annual reports. The statute and regulation prioritize two populations to be served with SABG funds: (1) substance using pregnant women and women with dependent children; and (2) persons who inject drugs. Although the statute and regulation prioritize such individuals, the states and jurisdictions have the flexibility to prioritize other underserved populations as determined by anecdotal and empirical data. For example, most states and jurisdictions prioritize substance use disorder treatment and recovery support services for adolescents and transitional age youth. Some states and jurisdictions are also developing peer-to-peer recovery support services to facilitate individuals' entry to substance use disorder treatment services and to promote and support individuals in early recovery. States and jurisdictions frequently partner with other executive branch departments, e.g., education, human services, justice and public health, to coordinate services for individuals and families impacted by substance misuse.

Formula: SABG funds are distributed[100] through a formula grant that provides funding based on specified economic and demographic factors and is administered by SAMHSA's Centers for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP). Of the amounts appropriated for the SABG program, 95 percent are distributed to states through a formula included in the authorizing legislation. The formula calculates states shares based on three components derived from state-level data: the size of the population needing services, the cost of services, and the state's fiscal capacity.[101] The SABG also includes "hold harmless" provisions that limit fluctuations in allotments as the total block grant appropriation changes from year to year.

Maintenance of Effort: The authorizing legislation and implementation regulation for the SABG requires states to maintain its expenditures for certain SUD prevention and treatment activities at a level that is no less than the state's average expenditures for the previous two years.

Funding Set-Asides and Other Requirements: The authorizing legislation and implementing regulation for the SABG includes specific funding set-asides, including 20 percent for primary prevention (see below), and five percent for early intervention service for HIV for designated states.[102] The statute also includes performance requirements for the treatment of substance-using pregnant women and women with dependent children, and provides states with the flexibility to expend a combination of federal and non-federal funds for women's services. There are also requirements and a potential penalty reduction of the block grant allotment if the state fails to enact and enforce laws prohibiting the sale or distribution of tobacco products to individuals under the age of 18.

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[100] Block Grants and Formula Grants: A Guide for Allocation Calculations; 2007 Department of Health and Human Services, SAMHSA.

[101] Substance Abuse and Mental Health Services Administration. (2017). Block Grant Laws and Regulations. Retrieved April 6, 2020 from http://www.samhsa.gov/grants/block-grants/laws-regulations.

[102] Substance Abuse and Mental Health Services Administration. (2017). Block Grant Laws and Regulations. Retrieved April 6, 2020 from http://www.samhsa.gov/grants/block-grants/laws-regulations.

The FY 2022 Budget includes a new 10 percent set-aside for recovery support services (see below).

Coordination of Efforts: SAMHSA emphasizes that block grant recipients should coordinate and partner with government agencies, nonprofit organizations, consumers and families and providers to support integrated and coordinated services and programs.

Performance and Evaluation

SAMHSA is undertaking a series of agency-wide efforts designed to develop a set of common performance, quality, and cost measures to demonstrate the impact of SAMHSA's programs. Ultimately, SAMHSA and its state partners will collaborate to develop a streamlined behavioral health data system that complements other existing systems (e.g., Medicaid administrative and billing data systems, state mental health and SUD treatment data systems), ensures consistency in the use of measures, and provides a more complete perspective of the delivery of mental and substance use disorder treatment services.

An independent evaluation of the SABG demonstrated how states leveraged the statutory requirements to expand existing or establish new treatment capacity in underserved areas of states and territories and to improve coordination of services with other state systems.[103] SAMHSA data show that on average, the SABG has been successful in expanding treatment capacity by annually supporting approximately two million[104] admissions to treatment programs receiving public funding. Outcome data for the Block Grant program show positive results as reported through Behavioral Health Services Information System/Treatment Episode Data Set (TEDS) administered by SAMHSA's Center for Behavioral Health Statistics and Quality. In the FY 2020 SABG Annual Report, which reflects State Fiscal Year (SFY) 2019 data, at discharge, clients demonstrated above average abstinence rates from both illegal drug (54 percent) and alcohol (78 percent) use.

State substance abuse authorities reported in the FY 2020 SABG Annual Report the following outcomes for services[105] provided during SFY 2019, the most recent year for which data is available:

- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Palau, Puerto Rico, Red Lake, and Virgin Islands that reported data concerning abstinence from alcohol use, 50 of the 60 jurisdictions identified improvements in client abstinence;
- Similarly, for the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Palau, Puerto Rico, Red Lake, and Virgin Islands that reported data concerning the abstinence from drug use, 42 of 60 jurisdictions identified improvements in client abstinence;

[103] Center for Substance Abuse Treatment and Center for Substance Abuse Prevention. Independent Evaluation of the Substance Abuse Prevention and Treatment Block Grant Program: Final Evaluation Report. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

[104] Web Block Grant Application System (WebBGAS) FY 2015 - 2019 SABG Treatment Utilization Matrix Admissions & Persons Served, State/Jurisdiction Selection: All States/Jurisdictions.

[105] Services include services from Short-term residential, Long-term residential, Outpatient, and Intensive outpatient only.

- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Palau, Puerto Rico, Red Lake, and Virgin Islands that reported employments data, 51 of 60 jurisdictions identified improvements in client employment;
- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Palau, and Puerto Rico that reported criminal justice data, 50 of 58 jurisdictions reported an increase in clients with no arrests based on data reported to TEDS;[106]
- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia Northern Marianas, Palau, Puerto Rico, Red Lake, and Virgin Islands that reported housing data, 53 of 60 jurisdictions identified improvements in stable housing for clients based on data reported to TEDS; and
- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Puerto Rico, and Red Lake that reported recovery support data, 58 states out of 60 jurisdictions identified improvements in client engagement in recovery support programs.

In FY 2020, states expended:

- $681,310,520 for primary prevention activities;
- $3,517,692 for tuberculosis services;
- $44,302,915 for early intervention services for HIV; and
- $384,188,055 for state-level administration.

All states admitted 61,664,415 total clients, specifically: [107]

- 282,211 persons to detoxification services;
- 675,559 persons to rehabilitation/residential services;
- 50,359,565 persons to ambulatory services; and
- 10,347,080 persons to opioid replacement therapy.

[106] The States of Oregon and Washington did not provide data.
[107] WebBGAS FY 2020 SABG Behavioral Health Report – Table 10 Treatment Utilization Matrix Admissions & Persons Served by Level of Care. The State of Kentucky did not provide data.

FY 2020 SABG Demographics[108,109]	
Total Persons Served (Adults and Children)	1,709,397
Female	41.9%
Male	58.1%
Race	
White	64.5%
Blacks or African Americans	17.9%
American Indian/Alaska Natives	3.6%
Asians	0.7%
Native Hawaiian/Other Pacific Islanders	0.5%
Unknown	10.7%
Multi-Racial	2.2%
Ethnicity	
Not Hispanic or Latino	86.3%
Hispanic or Latino	13.7%
Age	
17 and Under	4.9%
18 - 24	11.6%
25 - 44	55.7%
45 - 64	25.9%
65 and Over	1.9%

20 Percent Primary Prevention Set-Aside

SAMHSA is responsible for managing the 20 percent primary prevention set-aside of the SABG. The 20 percent set-aside requires SABG grantees to spend at least 20 percent of their SABG expenditures to develop and implement a comprehensive substance misuse prevention program, which includes a broad array of prevention strategies directed at individuals not identified to be in need of treatment.[110] The prevention set-aside is one of SAMHSA's main vehicles for supporting SAMHSA's initiatives aimed at preventing substance misuse and mental illness. The 20 percent set-aside is focused only on substance misuse prevention. States use these funds to develop infrastructure and capacity and to fund programs specific to primary substance misuse prevention. Some states rely solely on the 20 percent set-aside to fund their prevention systems while others use the funds to target gaps and enhance existing program efforts.

States are encouraged to make prevention a top priority, taking advantage of recent science, best practices in community coordination, proven planning processes, and the findings articulated by

[108] Source: FY 2020 SABG Report – Table 10 - Treatment Utilization Matrix has been used to reflect official total number of persons served. Kentucky did not supply data. Historically, Table 10 has been used to reflect official numbers of persons served. Furthermore, the table does not break out persons served by age or gender. The total reflects adults and children served.

[109] Source: FY 2020 SABG Report - Table 11 – Unduplicated Count of Persons Served for Alcohol and Other Drug Use. Kentucky did not supply data. Table 11 is the only table that collects gender and age data. Hence, gender and age percentages are calculated based on data from Table 11.

[110] Substance Abuse and Mental Health Services Administration (2015). *Substance Abuse Prevention and Treatment Block Grant.* Retrieved from http://www.samhsa.gov/grants/block-grants/sabg

the Institute of Medicine report, *Preventing Mental, Emotional, and Behavioral Disorders among Young People.*[111] SAMHSA regularly works with states to improve their accountability systems for prevention and to establish necessary reporting capacities.

10 Percent Recovery Support Services Set-Aside

The 2022 budget includes a new 10 percent set-aside for non-clinical recovery support services. The 10 percent set-aside will require SABG grantees to spend at least 10 percent of their SABG expenditures for recovery community organizations or peer recovery support services. Recovery support systems partner people in recovery from mental and substance use disorders, as well as their family members, with recovery services. These services may include recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries. These programs utilize individual, community, and system-level approaches to increase the four dimensions of recovery as defined by SAMHSA: health (access to quality health and SUD treatment); home (housing with needed supports); purpose (education, employment, and other pursuits); and community (peer, family and other social supports)[112] States will use these funds to develop local recovery community support institutions, provide system navigation resources and supports, and to collaborate and coordinate with local private, public, non-profit, and faith community response efforts. This new set-aside will build upon the more than two decades of practice based research that began when SAMHSA awarded the first Recovery Community Services Program (1998) discretionary grants and to expand access to long-term recovery services, a necessary component to extend the continuum of care. This set-aside will help increase access to recovery support services across the country and complement the existing efforts to respond to the ongoing opioid crisis that has accelerated during the COVID-19 pandemic.

Synar Program Overview

The Synar program is the set of actions put in place by states, with the support of the federal government, to implement the requirements of the Synar Amendment. The Synar Amendment requires states to ensure tobacco is not sold to individuals under the federal legal age of sale.[113] The Amendment was developed in the context of a growing body of evidence about the health problems related to tobacco use by youth, as well as evidence about the ease with which youth could purchase tobacco products through retail sources. The Synar program is a critical component of the success of youth tobacco use prevention efforts. SAMHSA is charged with overseeing states' implementation of the Synar requirements and provides consultation to states to ensure compliance with the Synar requirements.

While the national weighted retailer violation rate declined steadily from 40.1 percent in the program's baseline year in FY 1997 through FY 2011, the rate increased from an all-time low of 8.5 percent in FY 2011 to 9.6 percent in FY 2018. Although the rate has declined in each year since FY 2015, it has not returned to the historic low of FY 2011. One of the greatest predictors

[111] "Front Matter." *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington, DC: The National Academies Press, 2009. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK32775/.

[112] Substance Abuse and Mental Health Services Administration FFY 2020-2021 Block Grant Application. Retrieved from https://www.samhsa.gov/sites/default/files/grants/ffy_2020-2021_block_grant_application_and_plan.pdf

[113] Substance Abuse and Mental Health Services Administration (2015). *Synar Program.* Retrieved from http://www.samhsa.gov/synar

of a state's retailer violation rate is the amount and reach of their enforcement efforts. As states have faced budget shortfalls, some have scaled back their enforcement programs and this may be contributing to the higher rates of tobacco sales to youth. Also, under the Synar program, SAMHSA encourages states to include in their inspections the types of tobacco products most often used by youth in their states. As states have expanded the types of tobacco products included in their Synar inspections, some states are reporting that retailers are sometimes more likely to sell non-cigarette tobacco products, including smokeless tobacco, to youth. These factors are likely contributing to the overall increase in the national weighted retailer violation rate since FY 2011. SAMHSA is addressing this increase by providing consultation to states, as well as examining Synar data in order to provide states with guidance on best practices including enforcement, merchant education, and community mobilization.

Technical Assistance

In addition to the states' and jurisdictions' plans and reports, the authorizing legislation provides SAMHSA with significant resources to support technical assistance to the SABG grantees and their respective sub-recipients, i.e., community- and faith-based organizations approved by the states and jurisdictions to provide substance use disorder treatment and recovery support services. SAMHSA's Knowledge Application Program (KAP) (https://www.samhsa.gov/kap) produces the Technical Assistance Publication Series that provide practical guidance and information related to the delivery of substance use disorder treatment services and related public health services to individuals and families. The KAP also produces the Treatment Improvement Protocol Series, a growing library of best practice guidelines, which are produced by a consensus-development process based on the experience and knowledge of clinical, research, and administrative experts.

Program Evaluation

The SABG provides for the planning and development of a comprehensive statewide system of care and services that emphasizes the importance of the provision of a broad continuum of services and supports encompassing prevention, treatment, and recovery across the population age range.

Among the critical populations identified as priorities for outreach and intervention are pregnant and postpartum women, persons who inject drugs, persons at risk for HIV, justice-involved populations, people with co-occurring mental disorders, and persons experiencing homeless.

The SABG:

- Contributes to positive effects on the health and lives of individuals with substance use disorders as evidenced by demonstrated positive client outcomes in all six treatment domains;
- Acts as a major impetus for improving state prevention and treatment systems' infrastructure and capacity thereby increasing availability of services, development and implementation of evidence-based practices, development and collection of specific outcome measures, and development and maintenance of state data management systems;
- Aids states in leveraging requirements, resources, and federal guidance can be leveraged to sustain and improve state systems further emphasizing the importance of the SABG in the development of the same; and

- Contributes to the development and maintenance of successful state collaborations with other agencies and stakeholders concerned with preventing and treating substance use disorders.

Funding History

Fiscal Year	Amount
FY 2018	$1,858,079,000
FY 2019	$1,858,079,000
FY 2020	$1,858,079,000
FY 2021 Enacted	$1,858,079,000
FY 2022 Budget Request	$3,508,079,000

Budget Request

The FY 2022 Budget Request level is $3.5 billion, an increase of $1.7 billion from the FY 2021 Enacted level. SAMHSA plans to use the increase in funds to continue serving as a source of safety-net funding, including providing assistance to states in addressing and evaluating activities to prevent, treat, and provide recovery support services for individuals, families, and communities that are adversely impacted by substance use disorders (SUDs), and related conditions such as opioid use disorder. The need and demand for treatment and recovery support services for SUDs continues to grow, as exacerbated by the coronavirus pandemic. SAMHSA will continue to assist states and jurisdictions in planning for, expanding, enhancing, and building capacity in their service systems to address these burgeoning needs.

The budget includes a new ten percent set aside within the SABG for recovery support services. This set-aside will significantly expand the continuum of care for substance use disorder, both upstream and downstream. States will use this funding to support the development of local recovery community support institutions (i.e. recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries); develop strategies and provide educational campaigns, trainings, and events to reduce addiction/recovery-related stigma and discrimination at the local level; provide addiction treatment and recovery resources, and support system navigation needs; provide accessible peer recovery support services that are diverse and inclusive of all pathways to recovery delivered in person or using technology; collaborate and coordinate with local private and non-profit clinical health care providers and the faith community, in addition to city, county, state, and federal public health and criminal justice response efforts. Recent studies indicate the critical impact and important contribution of recovery support services in assisting individuals in gaining and maintaining critical improvements in functioning and well-being across a variety of life domains. It is anticipated that the implementation of recovery support

services in all 50 states, territories, and eligible tribes will significantly strengthen and enhance the entire prevention, treatment, and recovery supports continuum of services.[114]

[114] March 25, 2021 issue of Alcohol Research, Volume 41, Issue 1.

Outputs and Outcomes Table

Program: Prevention Set-Aside

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.3.63 Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17) (Outcome)	FY 2020: 41.1 % Target: 37.3 % (Target Exceeded)	41.1 %	41.1 %	Maintain
2.3.65 Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 12-17) (Outcome)	FY 2020: 51.8 % Target: 53 % (Target Not Met)	67.5 %	67.5 %	Maintain
2.3.67 Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 12-17) (Outcome)	FY 2020: 50 % Target: 43 % (Target Exceeded)	63 %	63 %	Maintain
2.3.68 Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 18+) (Outcome)	FY 2020: 19.6 % Target: 25 % (Target Not Met)	43 %	43 %	Maintain

Outputs and Outcomes Tables

Program: Treatment Activities

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
1.2.43 Number of admissions to substance abuse treatment programs receiving public funding (Output)	FY 2020: 1,948,531 Target: 1,880,000 (Target Exceeded)	2,065,199	2,271,192	+206,520
1.2.48 Percentage of clients reporting no drug use in the past month at discharge (Outcome)	FY 2020: 53.6 % Target: 74 % (Target Not Met)	55.7 %	54.7 %	-1 %
1.2.49 Percentage of clients reporting no alcohol use in the past month at discharge (Outcome)	FY 2020: 78.4 % Target: 78 % (Target Exceeded)	77.3 %	77.9 %	+0.6 %
1.2.50 Percentage of clients reporting being employed/in school at discharge (Outcome)	FY 2020: 35.4 % Target: 40 % (Target Not Met but Improved)	36 %	36 %	Maintain
1.2.51 Percentage of clients reporting no involvement with the Criminal Justice System (Outcome)	FY 2020: 93.2 % Target: 92 % (Target Exceeded)	95.5 %	95.5 %	Maintain
1.2.85 Percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2020: 88.4 % Target: 92 % (Target Not Met but Improved)	89 %	89 %	Maintain

Substance Abuse and Mental Health Services Administration
FY 2021 Substance Abuse Prevention and Treatment Block Grant Final Allotment
Appropriation Amount $3,508,079,000, State-Territory Total $3,327,669,730
CFDA # 93.959

State/Territory	FY 2020 Final	FY 2021 Enacted[1]	FY 2022 President's Budget	FY 2022 +/- FY 2021
Alabama	$23,090,733	$23,091,681	$44,441,997	$21,350,316
Alaska	5,889,392	5,889,634	13,155,296	7,265,662
Arizona	40,428,835	40,591,646	84,907,396	44,315,750
Arkansas	13,525,228	13,525,784	25,736,964	12,211,180
California	254,428,502	254,438,953	461,097,985	206,659,032
Colorado	28,916,325	28,917,513	65,040,308	36,122,795
Connecticut	18,213,209	18,213,957	37,316,441	19,102,484
Delaware	6,968,173	6,968,459	13,155,296	6,186,837
District Of Columbia	6,968,173	6,968,459	13,155,296	6,186,837
Florida	111,385,315	111,389,890	211,449,950	100,060,060
Georgia	57,155,304	57,157,652	101,749,094	44,591,442
Hawaii	8,582,682	8,583,035	15,101,219	6,518,184
Idaho	8,536,299	8,536,650	16,248,082	7,711,432
Illinois	67,649,432	67,652,211	106,653,108	39,000,897
Indiana	32,247,828	32,249,153	66,537,770	34,288,617
Iowa	13,094,055	13,094,593	25,138,925	12,044,332
Kansas	11,900,305	11,900,794	23,645,562	11,744,768
Kentucky	20,379,475	20,380,312	38,263,658	17,883,346
Louisiana	25,027,783	25,028,811	40,866,880	15,838,069
Maine	6,968,173	6,968,459	13,155,296	6,186,837
Maryland	34,081,826	34,083,226	56,664,856	22,581,630
Massachusetts	39,847,237	39,848,874	80,007,593	40,158,719
Michigan	56,055,882	56,058,184	95,527,406	39,469,222
Minnesota	24,103,340	24,104,330	48,456,340	24,352,010
Mississippi	13,804,308	13,804,875	25,522,882	11,718,007
Missouri	26,549,909	26,550,999	52,296,110	25,745,111
Montana	6,968,173	6,968,459	13,155,296	6,186,837
Nebraska	7,641,653	7,641,967	15,240,998	7,599,031
Nevada	17,004,311	17,005,009	36,290,415	19,285,406

Substance Abuse and Mental Health Services Administration
FY 2021 Substance Abuse Prevention and Treatment Block Grant Final Allotment
Appropriation Amount $3,508,079,000, State-Territory Total $3,327,669,730
CFDA # 93.959

State/Territory	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
New Hampshire	6,968,173	6,968,459	13,155,296	6,186,837
New Jersey	48,066,790	48,068,764	93,453,090	45,384,326
New Mexico	9,565,630	9,566,023	18,680,978	9,114,955
New York	111,836,103	111,840,696	193,522,391	81,681,695
North Carolina	44,994,339	44,996,187	93,502,793	48,506,606
North Dakota	6,533,901	6,534,169	13,155,296	6,621,127
Ohio	64,539,223	64,541,874	98,502,099	33,960,225
Oklahoma	17,150,267	17,150,971	33,994,397	16,843,426
Oregon	20,579,458	20,580,303	47,429,091	26,848,788
Pennsylvania	59,103,394	59,105,822	107,006,582	47,900,760
Rhode Island	7,598,886	7,599,198	13,287,318	5,688,120
South Carolina	23,719,055	23,720,029	46,753,828	23,033,799
South Dakota	6,042,037	6,042,285	13,155,296	7,113,011
Tennessee	31,979,975	31,981,289	64,189,070	32,207,781
Texas	144,716,491	144,722,435	290,288,425	145,565,990
Utah	16,589,477	16,590,158	45,425,206	28,835,048
Vermont	6,460,223	6,460,488	13,155,296	6,694,808
Virginia	41,982,172	41,983,896	85,184,035	43,200,139
Washington	37,786,705	37,788,257	76,240,247	38,451,990
West Virginia	8,433,135	8,433,481	14,634,927	6,201,446
Wisconsin	27,199,453	27,200,570	48,711,037	21,510,467
Wyoming	4,197,785	4,197,957	13,155,296	8,957,339
Red Lake Indians	594,059	594,083	1,194,271	600,188
American Samoa	346,037	346,584	655,384	308,800
Guam	1,124,417	1,144,043	2,198,081	1,054,038
Northern Marianas	351,136	354,549	676,077	321,528
Puerto Rico	22,519,704	22,466,159	42,357,918	19,891,759
Palau	143,987	146,718	282,363	135,645
Marshall Islands	500,800	516,092	1,004,102	488,010
Micronesia	700,055	706,745	1,347,200	640,455
Virgin Islands	720,695	729,480	1,393,921	664,441

1. The amuonts in FY 2021 exclude supplemental funding.

SAMHSA
Health Surveillance and Program Support
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Health Surveillance and Program Support Appropriation

(Dollars in thousands)

Program Name	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Health Surveillance and Program Support	$126,258	$126,258	$130,913	$4,655
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*30,428*	---
Data Request/Publications User Fees	1,500	1,500	1,500	---
Public Awareness and Support	13,000	13,000	13,260	260
Performance and Quality Information Systems	10,000	10,000	10,200	200
Behavioral Health Workforce Data and Development	1,000	1,000	1,000	---
PHS Evaluation Funds (non-add)	*1,000*	*1,000*	*1,000*	---
Drug Abuse Warning Network	10,000	10,000	15,000	5,000
PHS Evaluation Funds (non-add)	---	---	---	---
Total, Health Surveillance and Program Support	**$161,758**	**$161,758**	**$171,873**	**$10,115**

The Health Surveillance and Program Support Budget Request is $171.9 million, an increase of $10.1 million from the FY 2021 Enacted budget.

Health Surveillance

(Dollars in thousands)

Program Name	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Health Surveillance	$47,258	$47,258	$47,595	$337
Budget Authority (non-add)	*16,830*	*16,830*	*17,167*	*337*
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*30,428*	---

Authorizing Legislation.....Sections 501 and 505 of the Public Health Service Act
FY 2022 Authorization..... Permanent
Allocation Method ..... Federal/Intramural, Contracts, Grants, Other
Eligible Entities.....Not Applicable

Program Description and Accomplishments

The Health Surveillance funding primarily supports the activities of the Center for Behavioral Health Statistics and Quality (CBHSQ). The detailed funding for each activity along with a detailed narrative description of each project follows.

Health Surveillance

Resources by Activity/Program

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Health Surveillance				
Population Data Collection, Analyis, and Dissemination	$16,320	$13,287	$6,925	-$6,362
National Survey on Drug Use and Health (NSDUH)	*14,595*	*11,237*	*6,925*	*-4,312*
Treatment Services Data Collection, Analysis, and Dissemination	13,741	8,313	9,493	1,179
Behavioral Health Services Information System (BHSIS)	*13,741*	*8,313*	*9,493*	*1,179*
Behavioral Health Data Dissemination	1,707	1,332	2,174	843
Substance Abuse and Mental Health Data Archive (SAMHDA)	*1,707*	*1,332*	*2,174*	*843*
Performance Measurement/Systems	*2,458*	*4,069*	*2,474*	*-1,595*
SAMHSA Performance Accountability Reports System (SPARS)	---	*1,605*	---	*-1,605*
WebBGAS	*466*	*476*	*487*	*10*
Program Evaluations	750	---	---	---
TTC Evaluation	*750*	---	---	---
Drug Abuse Warning Network	*2,545*	*2,997*	---	*-2,997*
PHS Evaluation (non add)	---	*452*	---	*-452*
Support	9,737	17,260	26,529	9,269
Operations	*9,737*	*17,260*	*26,529*	*9,269*
Total Health Surveillance	**$47,258**	**$47,258**	**$47,595**	**$337**

Overview

The Center for Behavioral Health Statistics and Quality (CBHSQ) is the government's lead agency for behavioral health statistics. Authorized by Section 505 of the Public Health Service Act, which was reauthorized and amended by Section 6004 of the 21st Century Cures Act, CBHSQ performs activities that: (1) coordinate SAMHSA's integrated data strategy, including collecting data each year; (2) provide statistical and analytical support for SAMHSA's activities; (3) manage a core set of performance metrics to evaluate activities supported by SAMHSA; (4) coordinate with the Assistant Secretary, the Assistant Secretary for Planning and Evaluation, National Mental Health and Substance Use Policy Lab, and SAMHSA's Chief Medical Officer, as appropriate, to improve the quality of data collection services and evaluations of SAMHSA activities.

for Health Surveillance (HS), the Drug Abuse Warning Network (DAWN), and Performance and Quality Information Systems (PQIS) within the Health Surveillance and Program Support appropriation (HSPS) funding sources and the Substance Abuse Treatment appropriation from Block Grant Set Aside (BGSA) funding sources. Programs are often funded from several sources. (a table detailing all Funding Sources follows the PQIS section). Under Health Surveillance, CBHSQ work includes Population Data Collection, Analysis, and Dissemination; Treatment Services Data Collection, Analysis, and Dissemination; and Behavioral Health Data Dissemination. Under PQIS, CBHSQ activities include Performance Measurement/Systems, Behavioral Health Data Dissemination, and Evidence-Based Programs/Practices.

The FY 2022 budget request is $178.9 million, which is $55.0 million higher than the FY 2021 Enacted, and includes $73.8 million from Health Surveillance and Program Support (HSPS) Appropriation and $105.1 million from the Substance Abuse Treatment (SAT) Appropriation.

Population Data Collection, Analysis, and Dissemination

National Survey on Drug Use and Health: Section 505 of the Public Health Service Act (42 USC 290aa-4) requires SAMHSA to annually collect prevalence data on substance use and mental illness. To accomplish this data collection, SAMHSA administers the National Survey on Drug Use and Health (NSDUH). NSDUH is an annual collection of behavioral health data on approximately 67,500 persons aged 12 or older of the U.S. civilian, non-institutionalized population. NSDUH is the nation's primary source of statistical information on the use of illicit drugs, alcohol, and tobacco, certain mental health issues, co-occurring drug/alcohol addiction and mental illness, and treatment for mental and substance use disorders. NSDUH data provide estimates at the national, state, and sub-state level and among demographic, socioeconomic or geographic subgroups, as well as trend estimates over time. State-specific NSDUH data provide states the opportunity to focus on their leading public health challenges. Each year, three simultaneous NSDUH activities are ongoing: planning for future surveys, collecting data on over 67,500 persons in the current year survey, and analysis and dissemination of data from previous collections. In 2018, SAMHSA began a NSDUH redesign to ensure the survey is clinically up to date, through alignment of questions with the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), along with several other updates. In an effort to expedite these critical revisions, the DSM-5 Substance Use Disorder module was added to NSDUH in 2020 and data will be available in 2021, four years ahead of the previously planned 2025 redesign target date.

Based on the 2019 NSDUH survey data, among the 20.4 million people aged 12 or older with a past year substance use disorder (SUD), 71.1 percent had a past year alcohol use disorder and 40.7 percent had a past year illicit drug use disorder. In addition, among adults aged 18 or older, the percentage who had any mental illness (AMI) in the past year increased from 17.7 percent in 2008 to 20.6 percent in 2019. From 2008 to 2019, serious mental illness among people aged 18 and older (SMI) increased from 3.7 percent to 5.2 percent.

In December 2013, the Senate Appropriations Committee encouraged SAMHSA to consider fully incorporating Puerto Rico and the U.S. Territories into the redesign of the NSDUH (https://www.congress.gov/113/crpt/srpt71/CRPT-113srpt71.pdf)
SAMHSA recognizes the importance of expanding data collection to include Puerto Rico and the US Territories. In 2022, NSDUH plans to add Puerto Rico to the data collection and explore expanding NSDUH to the US Territories in phases for the following years.

SAMHSA is continuously improving the quality of the NSDUH questionnaire, to ensure collection of the highest quality data and to address emerging and critical data needs related to mental health and substance use behaviors. In 2019, SAMHSA included medication-assisted treatment (MAT), perceived recovery, and Kratom questions in the survey. In 2020, questions about vaping, including vaping nicotine or tobacco, were added. In addition, questions on synthetic marijuana,

synthetic stimulants, marijuana withdrawal symptoms, prescription tranquilizer misuse, withdrawal symptoms, and craving for all substances were added. These additions reflect the DSM-5 diagnostic criteria for substance use disorders. In 2020, the NSDUH questionnaire added items to assess the impact of the COVID-19 pandemic on mental health and substance use. COVID-19 questions were added to assess changes in substance use frequency due to COVID-19, the use of telehealth for treatment, and suicidal ideation and behavior related to COVID-19 among both youth and adults. In 2021, vaping questions will be expanded to include marijuana and other flavorings, and questions on prescription and non-prescription fentanyl use will be expanded.

NSDUH data collection was discontinued in March 2020 due to the COVID-19 pandemic. When data collection resumed in July 2020, SAMHSA responded quickly by implementing a new web survey mode, in order to reach areas where face-to-face interviews were not deemed safe.

The 2020 NSDUH data collection covers two of the four calendar-year quarters (together with a small number of cases in July). In October 2020 (quarter 4), multi-mode NSDUH data collection was instituted, by combining web-based interviewing for the entire sample with in-person interviewing in areas safe for field data collection.

Data Dissemination:

SAMHSA is committed to facilitating broader data use and dissemination. NSDUH data are released in three different formats: person-level analytic files, interactive online tools, and products. Person-level data are optimal for complex analyses and are released in two different versions: public use- and restricted-use files. Public-use files are available at SAMHSA's web pages, while restricted-use files are accessible through Federal Statistical Research Data Centers (FSRDCs). The public can readily access NSDUH data via SAMHSA's interactive online tools, specifically designed for customized analyses of substance use and mental health indicators, without needing to download any data. In addition, SAMHSA disseminates annual reports, data visualizations, slide decks, data tables and other types of reports—products created using NSDUH data. In FY 2020, over 149,000 NSDUH files were downloaded from SAMHDA and the SAMHSA Data webpage, and NSDUH webpages received over 650,000 page views. In FY 2020, the SAMHSA Data Web page received over 1.4 million page views overall, with over 67% of the traffic consisting of new visitors to the website. There were over 260,000 files total downloaded in FY 2020.

Treatment Services Data Collection, Analysis, and Dissemination

Section 505 of the Public Health Service Act (42.U.S.C. 290aa-4) requires SAMHSA to collect data on mental health and substance use disorder treatment services. For this purpose, CBHSQ developed the Behavioral Health Services Information System (BHSIS). Data collected through BHSIS provides information to the public on treatment services through the Behavioral Health Treatment Services Locator, which is part of the National Treatment Referral Service. The Locator provides accurate, timely, and regularly updated information on mental health and substance use disorder treatment facilities across the country.

BHSIS includes multiple data collection programs and information resources. The data collections comprise: (1) the National Mental Health Services Survey (N-MHSS), which provides information

on all public and private specialty mental health disorder treatment facilities in the United States; in 2020, the overall response rate was 90 percent; (2) the National Survey of Substance Abuse Treatment Services (N-SSATS), which provides information on all public and private substance use disorder treatment facilities in the United States; in 2020, the overall response rate was 91 percent; (3) the Treatment Episode Data Set (TEDS), which provides demographic, clinical, and substance use characteristics on publicly funded admissions and discharges from substance use disorder treatment facilities; (4) the Mental Health Treatment Episode Data Set (MH-TEDS) and the Mental Health Client Level Data (MH-CLD), which provide demographic characteristics and outcomes of individuals served by state mental health agencies (SMHAs) for mental health treatment; and (5) the Uniform Reporting System (URS), which provides a set of standardized data tables submitted annually by states and territories as part of their Mental Health Block Grant annual implementation reports. In 2021, SAMHSA is combining the two surveys, N-SSATS and N-MHSS, into the National Substance Use and Mental Health Services Survey (N-SUMHSS), in order to reduce respondent burden and duplication of effort for facilities that provide both substance use and mental health treatment services and thus respond to both surveys. This streamlining of the two surveys will also improve overall quality of the data, which serve as the principal data source for the SAMHSA Behavioral Health Treatment Locator. SAMHSA is initiating data collection on the combined survey in April 2021.

In FY 2020, the Behavioral Treatment Locator homepage received more than 4 million page views, while the locator map had over 950,000 page views from individuals, families, community groups, and organizations, in order to identify appropriate treatment services.

In FY 2020, the data webpage received over 1.4 million page views. Through this webpage the public downloaded more than 41,000 BHSIS publications, including 7,498 downloads of TEDS publications, 9,886 downloads of N-MHSS publications, 12,211 of N-SSATS publications, and 7,456 URS tables. In FY 2020, SAMHSA awarded a new BHSIS contract that includes the newly combined annual N-SSATS and N-MHSS, the N-SUMHSS, and TEDS, MH-CLD, MH-TEDS, URS, and the Behavioral Health Treatment Locator.

Behavioral Health Data Dissemination

The Substance Abuse and Mental Health Data Archive (SAMHDA) makes public-use data files, available in a variety of formats, that anyone can download and use their software to analyze and explore the data. Through SAMHDA, CBHSQ provides access to a data visualization tool and to public- and restricted-use data through a web-based analytic tool. The analytic tool was launched in April 2017 and allows researchers to generate tables based on these data through an online interface.

Historically, CBHSQ has managed two separate websites/interfaces for data dissemination to the public. There is a data webpage, which makes reports, survey information, and supporting documentation available. This site currently resides at https://www.samhsa.gov/data/. There is also a data archive, the Substance Abuse and Mental Health Data Archive (SAMHDA), which makes public-use files and analytic tools available. This site currently resides at https://datafiles.samhsa.gov/. While SAMHDA's target population is researchers, the analytic tools available for access can be useful to various public audiences. SAMHSA removed

overlapping functions and combined the SAMHDA and data webpage into a single contract in FY 2020. This migration provided cost savings, eliminated duplicate work, allows for easier, more efficient access to all SAMHSA data in one place, and promotes the goal of expanding dissemination of data relevant to behavioral health. SAMHSA has also been conducting user testing and through the implementation of user centric design, is launching a refresh of SAMHDA in FY 2021, which will allow for easier access to a wider audience and will promote increased use and access to behavioral health data.

In a united effort to support broader use of restricted-use NSDUH data, SAMHSA collaborates with other federal agencies. Researchers apply for, and obtain access to, restricted-use NSDUH data via Federal Statistical Research Data Centers (FSRDCs). SAMHSA promotes data use by aiding researchers in navigating resources, accessing relevant substance use and mental health indicators, and completing important public health investigations, while also protecting privacy and minimizing disclosure risk.

Buprenorphine Waiver Notification (BWNS) Beginning in August 2020, CBHSQ assumed data management of the inventory of practitioners permitted to provide medication-assisted treatment to individuals with Opioid Use conditions. SAMHSA implements DATA 2000 in coordination with the Drug Enforcement Administration (DEA), including approving waivers for qualified practitioners to provide medication-assisted treatment in office-based settings. As of March 2021, there were over 98,000 practitioners with an active waiver to prescribe buprenorphine to patients with opioid use disorder (OUD). Among these practitioners, 71% can treat up to 30 patients, 22% can treat up to 100 patients, and 7% can treat up to 275 patients. Almost three quarters of practitioners with waivers are physicians (72%), while advanced practice registered nurses (APRNs) and physician assistants (PAs) comprise 22% and 6%, respectively, of waivered practitioners.

Funding History

Fiscal Year	Amount
FY 2018	$47,258,000
FY 2019	$47,258,000
FY 2020	$47,258,000
FY 2021 Enacted budget	$47,258,000
FY 2022 Budget Request	$47,595,000

Budget Request

The FY 2022 budget request is $47.6 million, which is an increase of $337,000 from the FY 2021 Enacted level. SAMHSA intends to provide support to states for the development of data infrastructure efforts, including an emphasis on using data to improve health equity. In addition, these funds will support exploring the expansion of NSDUH to include data from Puerto Rico and the other territories, and the continuation of the BHSIS and SAMHDA contracts.

Mechanism Table

Health Surveillance

(Dollars in thousands)

Program Activity	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 Budget Request No.	FY 2022 Budget Request Amount
Health Surveillance						
Grants						
Continuations	1	$750	---	$---	---	$---
New/Competing	---	---	---	---	---	---
Subtotal	1	750	---	---	---	---
Contracts						
Continuations	---	$39,327	22	$45,653	---	$47,595
New/Competing	1	7,181	---	1,605	---	---
Subtotal	1	46,508	22	47,258	---	47,595
Total, Health Surveillance	**2**	**47,258**	**22**	**47,258**	**---**	**47,595**

Outputs and Outcomes Table

Program: National Survey on Drug Use and Health Measures

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
2.3.19L Percentage of adults with Serious Mental Illness (SMI) receiving mental health services (Outcome)	FY 2019: 65.5 % Target: 68.0 % (Target Not Met but Improved)	75.0 %	76.0 %	+1 %
2.3.19M Percentage of people who meet criteria for needing substance use treatment who receive treatment from a specialty substance use disorder treatment provider (Outcome)	FY 2018: 11.1 % Target: 11.5 % (Target Not Met)	11.1 %	11.1 %	Maintain
2.3.19N Past year prescription pain reliever misuse (age 12 and older) (Outcome)	FY 2018: 2,000,000.0 Target: 9,500,000.0 (Target Exceeded)	2,000,000.0	2,000,000.0	Maintain
2.3.19O Percent of youth ages 12-17 who experienced major depressive episodes with severe impairment in the past year receiving treatment for depression. (Outcome)	FY 2019: 49.7 % Target: 48.5 % (Target Exceeded)	55.0 %	56.0 %	+1 %

Drug Abuse Warning Network (DAWN)

(Dollars in thousands)

Program Name	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Drug Abuse Warning Network	$10,000	$10,000	$15,000	$5,000
PHS Evaluation Funds (non-add)	---	---	---	---

Authorizing Legislation……. Section 505 of the Public Health Service Act
FY 2022 Authorization..... $15,000,000
Allocation Method .....Contracts
Eligible Entities.....Not Applicable

Program Description and Accomplishments

SAMHSA re-established DAWN in 2018 as a nationwide public health surveillance system to monitor emergency department (ED) visits related to recent substance use, including those related to opioids. Authorized by the 21st Century Cures Act, DAWN provides necessary information such as patient demographic details and substances used in order to respond effectively to the opioid and addiction crises in the United States and to better inform public health, clinicians, policymakers, and other stakeholders to respond to emerging substance use trends. There are several important improvements for the new DAWN, including timeliness of data, data available at more frequent intervals, and data abstracted from a wider range of geographic area types—urban, suburban and rural. Having data available more quickly means that DAWN can serve as a true "early warning" system and inform local public health response efforts.

DAWN data are abstracted from hospital emergency department records. Hospital participation is optional. SAMHSA currently is at 98% in achieving targeted hospital participation and anticipates being at 100% by the middle of CY 2021. By using data abstracted directly from ED records, DAWN captures detailed information about the substances involved in ED visits, and serves as an early warning system for the emergence of new and novel psychoactive substances. It monitors the geographic, temporal and demographic characteristics of drug-related ED visits. Unlike other public health surveillance systems, DAWN captures both ED visits that are directly caused by drugs, such as overdoses, and those in which drugs are a contributing factor but not the direct cause of the ED visit, such as a motor vehicle crash involving a driver who had combined medications with alcohol. These criteria encompass all types of drug-related events, from substance use and misuse to substance-related suicide attempts. In CY 2021, DAWN surveillance of ED visits was expanded to include those visits to due to alcohol use by individuals 21 years and older. Complete implementation of this critical data abstraction expansion should be completed by Q3 of FY2021. The detailed information captured by DAWN is used to assess health hazards associated with specific substances and monitor the impact of drug use and misuse on the Nation's health care system. As of February 2021, the DAWN surveillance system has reviewed more than 1,823,000 ED records from 51 participating hospitals (24 urban, 11 suburban and 16 rural) and abstracted over 114,000 DAWN cases (5.3% of total ED records reviewed). Preliminary analysis demonstrates that the most common substances associated with DAWN cases are illicit substances (53,430 cases, 47%) and Central Nervous System (CNS) agents (9,329 cases, 17%); among illicit

drugs, stimulants were the most commonly associated with DAWN cases, with the majority involving methamphetamine.

Funding History

Fiscal Year	Amount
FY 2018	$10,000,000
FY 2019	$10,000,000
FY 2020	$10,000,000
FY 2021 Enacted budget	$10,000,000
FY 2022 Budget Request	$15,000,000

Budget Request

The FY 2022 budget request is $15.0 million, an increase of $5.0 million over the FY 2021 Enacted level. SAMHSA will be able to improve and enhance the DAWN data abstraction system including increasing the participating hospitals, leveraging advanced technologies in EHR data review and retrieval, and support the continued abstraction of alcohol-related ED visits.

Mechanism Table
Drug Abuse Warning Network

(Dollars in thousands)

Program Activity	FY 2020 Final		FY 2021 Enacted		FY 2022 Budget Request	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Drug Abuse Warning Network						
Contracts						
Continuations	1	$10,000	1	$10,000	1	$15,000
New/Competing	---	---	---	---	---	---
Subtotal	1	10,000	1	10,000	1	15,000
Total, Drug Abuse Warning Network	**1**	**10,000**	**1**	**10,000**	**1**	**15,000**

Performance and Quality Information Systems

(Dollars in thousands)

Program Name	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Performance and Quality Information Systems	$10,000	$10,000	$10,200	$200

Authorizing Legislation..... Sections 501, 505, 509, 516, 520A, and 543A of the PHS Act
FY 2022 Authorization..... Indefinite
Allocation Method ..... Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

The Performance and Quality Information Systems (PQIS) funding primarily supports the activities of the Center for Behavioral Health Statistics and Quality (CBHSQ). The detailed narrative description of each project follows.

Performance and Quality Information Systems
Resources by Activity/Program

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Request	FY 2022 +/- FY 2021
Performance and Quality Information Systems				
Performance Measurement and Performance Systems	$6,022	$6,898	$7,338	$439
SAMHSA Performance Accountability Reports System (SPARS)	*6,022*	*6,898*	*7,338*	*439*
Evidence-Based Programs/Practices	1,745	1,789	2,110	321
Evidence Based Resource Center	*1,745*	*1,789*	*2,110*	*321*
Behavioral Health Data Dissemination	101	---	---	---
DAWN	1,530	690	---	-690
DAWN	*1,530*	*690*	---	*-690*
Support	602	623	752	129
Operations	*602*	*623*	*752*	*129*
Total Performance and Quality Information Systems	**$10,000**	**$10,000**	**$10,200**	**$200**

Performance Measurement and Performance Systems

SAMHSA collects data on key output and outcome measures to monitor and manage discretionary grant performance, improve the quality of treatment services, and inform the public and stakeholders on the impact of financial investments. SAMHSA collects these data in the SAMHSA Performance Accountability and Reporting System (SPARS).

Data collected and analyzed through SPARS allow SAMHSA to monitor the progress of discretionary grants, support data-informed decision-making for funding, and provide an understanding of the quality of services delivered through the programs. SAMHSA continues to implement the 21st Century Cures Act through continuously evaluating and improving the performance of SAMHSA programs, including updates to modernize the SPARS data collection system. Recent advances to automated reporting and scheduled reminders encourage greater access to data and assist in achieving real-time outcome reporting.

In addition, the CBHSQ Office of Evaluation provides support to the three program centers, CMHS, CSAT, and CSAP, and the Office of Tribal Affairs and Policy's (OTAP) grantees and project officers, by initiating enhancements to the SPARS system. These enhancements improve the end-user experience by enabling easier access to reports, as well as greater data visualization options for examination of demographic data on both adult and youth participants for a single year or for multiple years of funding.

The SPARS team provides technical support, grantee and staff training, and help-desk assistance to ensure SAMHSA effectively manages its grant portfolio and provides timely, accurate information to policy makers and stakeholders.

Program Evaluation

The CBHSQ Office of Evaluation (OE) is responsible for providing centralized planning and management of program evaluation activity across SAMHSA, including the evaluation reports for Projects for Assistance in Transition from Homelessness (PATH), Garret Lee Smith, and the state Pilot for Pregnant and Postpartum Women (PPW-PLT). In partnership with the program centers, OE provides oversight and management of agency quality improvement and performance management activities and advances agency goals and objectives relating to performance measurements and quality improvement. In FY 2020, the OE team collaborated with CBHSQ's Office of Program Analysis and Coordination (OPAC) and CMHS staff to acquire the PATH Data Exchange (PDX) from prior private contractor management of the system. OPAC manages PDX now, and OE provides evaluation expertise and support to grantees and CMHS staff. OE activities include development of evaluation language for funding announcements, to ensure a clear statement of evaluation objectives, development and implementation of standard measures for evaluating program performance and improvement of services. OE identifies and maintains performance indicators to monitor each SAMHSA program, and develops periodic evaluation reports for use in agency planning, program change, and reporting to departmental and external organizations. In FY 2020, OE developed Program Profiles for grant programs administered by SAMHSA. These documents offer internal and external audiences an overview of the goal of each program, as well as a summary of the demographic and program outcome data associated with each grant program. OE works collaboratively with the National Mental Health and Substance Use Policy Laboratory and the Office of the Chief Medical Officer to provide support for SAMHSA evaluation activities.

Evidence-Based Practice Resource Center (EBPRC)

Section 7002 of the 21st Century Cures Act directs SAMHSA to promote access to reliable and valid information on evidence-based programs and practices and share information on the strength of evidence associated with such programs and practices related to mental illness and drug/alcohol addiction. To fulfill this charge, SAMHSA has developed the Evidence-Based Practices Resource Center (EBPRC), which provides information on evidence-based programs and practices to states, local communities, non-profit entities, and other stakeholders.

The EBPRC, which is managed by the National Mental Health and Substance Use Policy Laboratory (NMHSUPL), provides communities, clinicians, policy-makers and others in the field with the information and tools that they need to incorporate evidence-based practices in their communities or clinical settings. As part of this effort, SAMHSA develops and disseminates resources, such as new or updated Treatment Improvement Protocols, guidance documents, clinical practice policies, toolkits, systematic reviews, data reports and other actionable materials that incorporate the latest scientific evidence on mental health and substance use and address priority areas where more information or guidance is needed to help the field move forward. This approach enables SAMHSA to quickly develop and disseminate expert consensus on the latest prevention, treatment, and recovery sciences. The EBPRC currently includes 149 resources. SAMHSA expects to add at least 15 more resources over the next two years to the EBPRC, including five SAMHSA-developed Guidebooks each year.

SAMHSA convenes bimonthly committee meetings with staff from across the agency to review potential new resources on different topics related to mental illness and substance use for inclusion in EBPRC. The EBPRC enables SAMHSA to collaborate with experts in the field, to rapidly translate science into action. The EBPRC provides communities and practitioners with tools to facilitate comprehensive needs assessment, matches interventions to those needs, supports implementation, and incorporates continuous quality improvement into its prevention, treatment, and recovery efforts. This strategy, coupled with SAMHSA's regional and locally based training and technical assistance efforts, ensures that communities and practitioners are equipped to bring about the improvements in mental health and substance use prevention, treatment, and recovery that our Nation requires. The EBPRC website has recently been updated with new content and improvements to its functionality, which will enable a broad audience to easily access needed materials.

Behavioral Health Quality Measures

Behavioral health quality activities are housed within CBHSQ. The Center provides oversight of the agency's quality improvement efforts, including the identification of gaps in behavioral health quality measurement and the adoption and implementation of behavioral health quality measures. This work includes partnerships with the Center for Medicare & Medicaid Services (CMS) and the Assistant Secretary for Planning and Evaluation (ASPE), among other federal partners, in quality measures work. CBHSQ serves as the SAMHSA lead to the National Quality Forum (NQF), as well as participates as a federal advisor for other agencies conducting measure development work, including CMS and ASPE. CBHSQ also participates in the Measures Application Partnership, a group convened to guide HHS on measures adoption.

CBHSQ staff provides internal collaborations across SAMHSA, advising on quality measure issues and identifying key next steps. CBHSQ staff regularly consult with other federal agencies, the NQF, and other key stakeholders regarding behavioral health quality indicators, including barriers to and facilitators of data collection, tracking, and reporting. SAMHSA continues its behavioral health quality measure activities through ongoing identification of behavioral health measurement gaps and the capacity to address such gaps.

Funding History

Fiscal Year	Amount
FY 2018	$10,000,000
FY 2019	$10,000,000
FY 2020	$10,000,000
FY 2021 Enacted budget	$10,000,000
FY 2022 Budget Request	$10,200,000

Budget Request

The FY 2022 budget request is $10.2 million, an increase of $200,000 over the FY 2021 Enacted level. SAMHSA will use these funds for modernization efforts and continuation of the SPARS and EBPRC contracts.

Mechanism Table

Performance and Quality Information Systems

(Dollars in thousands)

Program Activity	FY 2020 Final		FY 2021 Enacted		FY 2022 Budget Request	
	No.	Amount	No.	Amount	No.	Amount
Performance and Quality Information Systems						
Contracts						
Continuations	2	$9,899	1	$3,102	2	$10,200
New/Competing	---	101	1	6,898	---	---
Subtotal	2	10,000	2	10,000	2	10,200
Total, Performance and Quality Information Systems	**2**	**10,000**	**2**	**10,000**	**2**	**10,200**

The following table provides a detailed description of all funding sources supporting CBHSQ activities.

Center for Behavioral Health Statistics and Quality
Breakout by Activity/Program (all sources)

(Dollars in thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Substance Abuse Treatment Appropriation				
Substance Abuse Block Grant Set Aside				
Population Data Collection, Analysis, and Dissemination	$43,493	$45,410	$52,824	$7,414
PHS Evaluation (non add)	*43,493*	*45,410*	*52,824*	*7,414*
Treatment Services Data Collection, Analysis, and Dissemination	7,724	6,841	*47,701*	40,861
PHS Evaluation (non add)	*7,724*	*6,841*	*21,698*	*14,857*
Behavioral Health Data Dissemination	381	357	357	---
PHS Evaluation (non add)	*381*	*357*	*357*	---
Support	3,998	2,996	4,202	1,206
PHS Evaluation (non add)	*3,998*	*2,996*	*4,202*	*1,206*
Total Substance Abuse Block Grant Set Aside	**55,596**	**55,603**	**105,084**	**49,481**
Total Substance Abuse Treatment PHS Evaluation	*55,596*	*55,603*	*79,081*	*23,478*
Health Surveillance and Program Support Appropriation				
Health Surveillance				
Population Data Collection, Analysis, and Dissemination	16,320	13,287	6,925	-6,362
PHS Evaluation (non add)	*14,595*	*11,237*	*6,925*	*-4,312*
Treatment Services Data Collection, Analysis, and Dissemination	13,741	8,313	9,493	1,179
PHS Evaluation (non add)	*7,788*	*8,313*	*9,493*	*1,179*
Behavioral Health Data Dissemination	1,707	1,332	2,174	843
PHS Evaluation (non add)	*1,707*	*1,332*	*2,174*	*843*
Performance Measurement/Systems	2,458	4,069	2,474	-1,595
PHS Evaluation (non add)	*2,159*	*3,763*	*2,162*	*-1,601*
Program Evaluations	750	---	---	---
PHS Evaluation (non add)	*750*	---	---	---
Drug Abuse Warning Network	2,545	2,997	---	-2,997
PHS Evaluation (non add)	---	*452*	---	*-452*
Support	9,737	17,260	26,529	9,269
PHS Evaluation (non add)	*3,428*	*5,331*	*9,674*	*4,343*
Total Health Surveillance	**47,258**	**47,258**	**47,595**	**337**
Drug Abuse Warning Network	10,000	10,000	15,000	5,000
PHS Evaluation (non add)	---	---	---	---
Total Drug Abuse Warning Network	**10,000**	**10,000**	**15,000**	**5,000**
Performance and Quality Information Systems				
Performance Measurement/Systems	6,022	6,898	7,338	439
Evidence-Based Programs/Practices	1,745	1,789	2,110	321
Behavioral Health Data Dissemination	101	---	---	---
DAWN	1,530	690	---	-690
Support	602	623	752	129
Total Performance and Quality Information Systems	**10,000**	**10,000**	**10,200**	**200**
Behavioral Health Workforce Data and Development				
Behavioral Health Workforce Data Development	1,000	1,000	1,000	---
PHS Evaluation (non add)	*1,000*	*1,000*	*1,000*	---
Total Behavioral Health Workforce Data and Development	1,000	1,000	1,000	---
Total Health Surveillance and Program Support	**68,258**	**68,258**	**73,795**	**5,537**
Total Health Surveillance and Program Support PHS Evaluation	*31,428*	*31,428*	*31,428*	---
Total Center for Behavioral Health Statistics and Quality	**$123,854**	**$123,861**	**$178,879**	**$55,018**

Program Support

(Dollars in thousands)

Program Name	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Program Support	$79,000	$79,000	$83,318	$4,318

Authorizing Legislation.....Section 501 of the Public Health Service Act
FY 2022 Authorization..... $83,318,000
Allocation Method .....Direct Federal/Intramural, Contracts, Grants, Other
Eligible Entities.....Not Applicable

Program Description and Accomplishments

The Program Support budget supports the majority of SAMHSA staff who plan, direct, and administer SAMHSA's programs, as well as business operations and processes, information technology, and overhead expenses, such as rent, utilities, and miscellaneous charges. In addition, this budget supports the Unified Financial Management System, which covers administrative activities such as human resources, information technology, and the centralized services provided by HHS and the Program Support Center.

SAMHSA supported 452 Full Time Equivalents (FTEs) in FY 2020. SAMHSA is in the process of adding additional FTEs in to support staffing for areas such as the Office of the Chief Medical Officer and Cures implementation. Staff positions that are not covered through the Health Surveillance and Program Support appropriation are funded with Substance Abuse Prevention and Treatment and Mental Health Block Grant set-asides for activities associated with technical assistance, data collection, and evaluation.

SAMHSA applies an estimated internal administrative charge for overhead expenses to all programs, projects, and activities.

Funding History

Fiscal Year	Amount
FY 2018	$79,000,000
FY 2019	$79,000,000
FY 2020	$79,000,000
FY 2021 Enacted budget	$79,000,000
FY 2022 Budget Request	$83,318,000

Budget Request

The FY 2022 budget request is $83.3 million, an increase of $4.3 million with the FY 2021 Enacted level. This investment in program support will increase available staff to administer and manage SAMHSA's diverse array of programs. This increase for personnel costs would be the first increase in four years. An investment in SAMHSA's staff will ensure that the agency can efficiently and effectively respond to the evolving and growing opioid crisis, as well as provide the significant resources, technical assistance, and leadership within the mental health and behavioral health public health sphere. This level of funding will also continue to cover overhead costs associated with 5600 Fishers Lane, including rent, the Federal Acquisition Service loan repayment program, and security charges.

Mechanism Table

Program Support

(Dollars in thousands)

Program Activity	FY 2020 Final		FY 2021 Enacted		FY 2022 Budget Request	
	No.	Amount	No.	Amount	No.	Amount
Program Support						
Grants						
Continuations	10	$2,359	21	$2,787	1	$800
New/Competing	1	800	---	---	8	1,987
Subtotal	11	3,159	21	2,787	9	2,787
Contracts						
Continuations	---	73,677	---	76,213	---	80,531
New/Competing	---	2,164	---	---	---	---
Subtotal	---	75,841	---	76,213	---	80,531
Total, Program Support	**11**	**79,000**	**21**	**79,000**	**9**	**83,318**

Public Awareness and Support

(Dollars in thousands)

Program Name	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Public Awareness and Support.....	$13,000	$13,000	$13,260	$260

Authorizing Legislation……. Sections 501, 509, 516, and 520A of the Public Health Service Act
FY 2022 Authorization.....Indefinite
Allocation Method .....Contracts
Eligible Entities.....Not Applicable

Program Description and Accomplishments

Part of SAMHSA's mission is to raise the public's understanding of mental and substance use disorders, serve as an expert on mental and substance use disorders, lead public health efforts to advance the health of the nation, and inform and equip the healthcare workforce. SAMHSA's Office of Communications (OC) staff ensure that the vital information, publications, and training materials produced through SAMHSA's Centers and Offices are available to the healthcare workforce, people in treatment and recovery, people in crisis or in areas affected by disasters, SAMHSA grantees, and the public. OC staff communicate information on mental and substance use disorders and products through various channels. These channels include print, radio, and television media; social media platforms; the SAMHSA.gov website; the SAMHSA Store, the subscription-based e-blast system; and the inquiries received through the National Helpline. In addition, the OC staff manage SAMHSA events to interact with stakeholders, media organizations, and the public and assist in the development and execution of materials, products, and campaigns.

The OC media team evaluates and acts upon media inquiries; develops and issues press releases, news bulletins, and media advisories; and provides in-house media support to the Centers and Offices. The team builds relationships with representatives of the media; identifies and seeks corrections to inaccuracies about SAMHSA in media products, when necessary; works to add SAMHSA's life-saving resources to journalistic and entertainment products; supports broad HHS and administration communications priorities; and collaborates with other departmental OpDivs. The media team collaborates with SAMHSA staff when a disaster occurs to quickly disseminate press releases and social media featuring SAMHSA's Disaster Distress Helpline and links to relevant SAMHSA resources.

OC manages SAMHSA's social media presence on Facebook, Twitter, LinkedIn, Instagram and YouTube. In addition to print and traditional media, social media messaging is now incorporated in communications plans and is employed daily to communicate messages about mental and substance use disorders and resources. OC has staff who specialize in monitoring social media conversations, writing social media messages, participating in twitter chats, and writing and posting blogs on SAMHSA.gov.

OC is responsible for managing the SAMHSA.gov website via the Web Management and Support contract. The contract provides enterprise-wide content and technical support for SAMHSA.gov and other related public-facing websites. Key activities include website operations and

maintenance updates, development and enhancements, and Section 508 remediation. On a daily basis OC staff add, update, and manage content for the SAMHSA website, in addition to technical maintenance and enhancements as needed.

OC also manages the Public Engagement Platform (PEP) contract and the Contact Center contract. The PEP is a large-scale information dissemination program. PEP provides the public and other stakeholders with one-stop, quick access to mental and substance use disorder prevention, treatment, and recovery information, materials, and services. It operates a customer-oriented order fulfillment/distribution center, which includes an online store (store.SAMHSA.gov) and warehouse, the SAMHSA listserv and subscriber database system, and mobile applications.

The Contact Center contract supports the National Helpline (1-800-662-HELP) and the 1-877-SAMHSA-7 line. The National Helpline provides free, confidential treatment referral and information services in English and Spanish for individuals and families facing mental illness and/or substance use disorders. It is operational 365 days-a-year, 24/7. The 1-877-SAMHSA-7 line is the single point of entry for SAMHSA's information services and is operated Monday through Friday, 8:00 am to 8:00 pm (except for federal holidays).

OC manages the SAMHSA Public Awareness and Support Activities contract that enables the agency to develop and disseminate public service announcements (PSAs) for television and radio. Topics, audiences, and formats range but all phases from creative concepts to storyboards as well as focus group testing are included. As an example, in the past there have been PSAs targeted to providers on the use of naltrexone for opioid use disorder, PSAs targeted to the public on the danger of methamphetamine, and PSAs targeted to pregnant women on the dangers of substance use. This contract also enables SAMHSA to conduct national campaigns.

Funding History

Fiscal Year	Amount
FY 2018	$10,000,000
FY 2019	$10,000,000
FY 2020	$13,000,000
FY 2021 Enacted budget	$13,000,000
FY 2022 Budget Request	$13,260,000

Budget Request

The FY 2022 budget request is $13.3 million, an increase of $260,000 from the FY 2021 Enacted level. SAMHSA intends to fund 6 contracts that will allow SAMHSA to manage media relationships, maintain its web and social media presence, manage critical helplines, deliver publications and resources, produce and deliver PSAs, and conduct national campaigns

Mechanism Table
Public Awareness and Support

(Dollars in thousands)

Program Activity	FY 2020 Final No.	FY 2020 Final Amount	FY 2021 Enacted No.	FY 2021 Enacted Amount	FY 2022 Budget Request No.	FY 2022 Budget Request Amount
Public Awareness and Support						
Contracts						
Continuations	6	$13,000	3	$6,729	5	$9,804
New/Competing	---	---	3	6,271	1	3,456
Subtotal	6	13,000	6	13,000	6	13,260
Total, Public Awareness and Support	**6**	**13,000**	**6**	**13,000**	**6**	**13,260**

Outputs and Outcomes Table

Program: Public Awareness and Support

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
4.4.12 The number of individuals referred for behavioral health treatment resources. (Output)	FY 2020: 784,638 Target: 667,783 (Target Exceeded)	784,638	784,638	Maintain
4.4.13 The total number of interactions through phone inquiries, e-blasts, dissemination of SAMHSA publications, and total website hits (Output)	FY 2020: 55,238,274 Target: 45,000,000 (Target Exceeded)	55,238,274	55,238,274	Maintain

Drug Control Program

Substance Abuse and Mental Health Services Administration

(Dollars in millions)

Resource Summary

	Budget Authority (in millions)				
	FY 2020		FY 2021		FY 2022
	Final	Supplemental Funding	Enacted	Supplemental Funding	Budget Request
Drug Resources by Decision Unit and Function					
Programs of Regional and National Significance					
Substance Abuse Prevention	$206.47	-	$208.22	-	$216.67
Substance Abuse Treatment	$479.68	-	$496.68	$30.00	$650.86
Total Programs of Regional and National Significance	**$686.15**	-	**$704.90**	**$30.00**	**$867.53**
State Opioid Response Grants	**$1,500.00**	-	**$1,500.00**	-	**$2,250.00**
Substance Abuse Prevention and Treatment Block Grant					
Prevention	$371.62	-	$371.62	$630.00	$701.62
Treatment	$1,486.46	-	$1,486.46	$2,520.00	$2,806.46
Total, Substance Abuse Prevention and Treatment Block Grant	**$1,858.08**	-	**$1,858.08**	**$3,150.00**	**$3,508.08**
Health Surveillance and Program Support					
Prevention	$22.81	-	$22.46	-	$24.13
Treatment	$91.24	-	$89.84	-	$96.53
Total, Health Surveillance and Program Support	**$114.05**	-	**$112.30**	-	**$120.66**
Total Drug Resources by Unit and Function	**$4,158.27**	-	**$4,175.27**	**$3,180.00**	**$6,746.27**
Drug Resources Personnel Summary					
Total FTEs	428	-	336	-	426
Drug Resources as a Percent of Budget					
Total Agency Budget	$5,884.00		$6,017.01	$3,180.00	$9,734.01
Drug Resources Percentage	70.7%		69.4%	100.0%	69.3%

1 The Substance Abuse Prevention and Treatment Block Grant is split 20% to the Prevention function and 80% to the Treatment function.

2 The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health and Substance Abuse as follows: The Drug Abuse Warning Network is allocated fully to substance abuse. Program Support, Health Surveillance and PQIS are split the same proportion as drug control to the overall SAMHSA budget as defined by the substance abuse portions divided by the mental health and substance abuse portions combined. Public Awareness and Support, Behavioral Health Workforce Data and Development and Data Request, and Publication User Fees are allocated 50% to drug control activities. The drug control total for HSPS after these calculations is allocated between Prevention (20%) and Treatment (80%).

Drug Budget Split between Prevention and Treatment

(Dollars in millions)

Substance Abuse Prevention	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Programs of Regional and National Significance (PRNS)			
Strategic Prevention Framework	$119.48	$119.48	$126.67
Strategic Prevention Framework Rx (non-add)	*10.00*	*10.00*	*15.00*
Budget Authority (non-add)	*10.00*	*10.00*	*15.00*
PHS Evaluation Funds (non-add)	-	-	-
Federal Drug-Free Workplace	4.89	4.89	4.89
Minority AIDS	41.21	41.21	42.03
Sober Truth on Preventing Underage Drinking	9.00	10.00	10.00
Center for the Application of Prevention Technologies	7.49	7.49	7.49
Science and Service Program Coordination	4.07	4.07	4.07
Tribal Behavioral Health Grants	20.00	20.75	21.17
SAP Minority Fellowship Program	0.32	0.32	0.34
Total, Substance Abuse Prevention PRNS	**206.47**	**208.22**	**216.67**
Substance Abuse Prevention and Treatment Block Grant1	371.62	371.62	701.62
PHS Evaluation Funds (non-add)	*15.84*	*15.84*	*15.84*
Total, Substance Abuse Prevention and Treatment Block Grant	**371.62**	**371.62**	**701.62**
Health Surveillance and Program Support 2			
Health Surveillance and Program Support	17.85	17.52	18.14
Health Surveillance	6.68	6.56	6.60
Budget Authority (non-add)	*2.38*	*2.34*	*2.38*
PHS Evaluation Funds (non-add)	*4.30*	*4.22*	*4.22*
Program Support	11.17	10.96	11.55
Public Awareness and Support	1.30	1.30	1.33
Performance and Quality Information Systems	1.41	1.39	1.41
Behavioral Health Workforce Data and Development	0.10	0.10	0.10
PHS Evaluation Funds (non-add)	*0.10*	*0.10*	*0.10*
Drug Abuse Warning Network	2.00	2.00	3.00
PHS Evaluation Funds (non-add)	-	-	-
Data Request/Publication User Fees	0.15	0.15	0.15
Total, Health Surveillance and Program Support	**22.81**	**22.46**	**24.13**
Total, Substance Abuse Prevention	**600.90**	**602.29**	**942.41**

[1] The Substance Abuse Prevention and Treatment Block Grant is split 20% to the Prevention function and 80% to the Treatment function.

[2] The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health and Substance Abuse as follows: The Drug Abuse Warning Network is allocated fully to substance abuse. Program Support, Health Surveillance and PQIS are split the same proportion as drug control to the overall SAMHSA budget as defined by the substance abuse portions divided by the mental health and substance abuse portions combined. Public Awareness and Support, Behavioral Health Workforce Data and Development, and Publication User Fees are allocated 50% to drug control activities. The drug control total for HSPS after these calculations is allocated between Prevention (20%) and Treatment (80%).

Drug Budget Split between Prevention and Treatment (continued)

(Dollars in millions)

Substance Abuse Treatment	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Programs of Regional and National Significance (PRNS)			
Opioid Treatment Programs/Regulatory Activities	$8.72	$8.72	$13.09
Screening, Brief Intervention and Referral to Treatment	30.00	30.00	30.56
Targeted Capacity Expansion	100.19	102.19	147.92
Pregnant and Postpartum Women	31.93	32.93	49.40
Improving Access to Overdose Treatment	1.00	1.00	1.50
Recovery Community Services Program	2.43	2.43	5.15
Children and Family Programs	29.61	29.61	30.20
Treatment Systems for Homeless	36.39	36.39	37.11
Minority AIDS	65.57	65.57	66.88
SAT Minority Fellowship Program	4.79	5.79	6.14
Criminal Justice Activities	89.00	89.00	124.38
Addiction Technology Transfer Centers	9.05	9.05	9.05
Building Communities of Recovery	8.00	10.00	20.00
Peer Support TA Center	1.00	1.00	1.50
Treatment, Recovery, and Workforce Support	4.00	6.00	9.00
Emergency Department Alternatives to Opioids	5.00	6.00	9.00
Opioid Response Grants	0.00	3.00	3.00
Comprehensive Opioid Recovery Centers	0.00	4.00	6.00
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths	12.00	12.00	18.00
First Responder Training	41.00	42.00	63.00
Total, Substance Abuse Treatment PRNS	479.68	496.68	650.86
State Opioid Response Grants	1,500.00	1,500.00	2,250.00
Substance Abuse Prevention and Treatment Block Grant1	**1,486.46**	**1,486.46**	**2,806.46**
PHS Evaluation Funds (non-add)	*63.36*	*63.36*	*63.36*
Total, Substance Abuse Prevention and Treatment Block Grant	**1,486.46**	**1,486.46**	**2,806.46**
Health Surveillance and Program Support2			
Health Surveillance and Program Support	71.39	70.09	72.57
Health Surveillance	26.72	26.23	26.38
Budget Authority (non-add)	*9.52*	*9.34*	*9.52*
PHS Evaluation Funds (non-add)	*17.20*	*16.89*	*16.87*
Program Support	44.67	43.85	46.18
Public Awareness and Support	5.20	5.20	5.30
Performance and Quality Information Systems	5.65	5.55	5.65
Behavioral Health Workforce Data and Development	0.40	0.40	0.40
PHS Evaluation Funds (non-add)	*0.40*	*0.40*	*0.40*
Drug Abuse Warning Network	8.00	8.00	12.00
PHS Evaluation Funds (non-add)	-	-	-
Data Request/Publication User Fees	0.60	0.60	0.60
Total, Health Surveillance and Program Support	**91.24**	**89.84**	**96.53**
Total, Substance Abuse Treatment	**3,557.38**	**3,572.98**	**5,803.85**

[1] The Substance Abuse Prevention and Treatment Block Grant is split 20% to the Prevention function and 80% to the Treatment function.

[2] The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health and Substance Abuse as follows: The Drug Abuse Warning Network is allocated fully to substance abuse. Program Support, Health Surveillance and PQIS are split the same proportion as drug control to the overall SAMHSA budget as defined by the substance abuse portions divided by the mental health and substance abuse portions combined. Public Awareness and Support, Behavioral Health Workforce Data and Development, and Publication User Fees are allocated 50% to drug control activities. The drug control total for HSPS after these calculations is allocated between Prevention (20%) and Treatment (80%).

The FY 2022 Budget Request is $6.7 billion, an increase of $2.7 billion from FY 2021 Enacted level.

The budget directs resources to activities that have demonstrated improved health outcomes and that increase service capacity. SAMHSA has three major drug-related portfolios, and attendant decision units: Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support.

Each decision unit is discussed below:

Substance Abuse Prevention

Programs of Regional and National Significance

Strategic Prevention Framework
FY 2022 Budget Request: $126.7 million, an increase of $7.2 million from the FY 2021 Enacted Level

SAMHSA's Strategic Prevention Framework (SPF) grant programs support activities to help grantees build a solid foundation for delivering and sustaining effective substance abuse prevention services and reducing substance abuse problems. The Strategic Prevention Framework – Partnerships for Success program addresses underage drinking among youth and young adults age 12 to 20 and allows states to prioritize state-identified top data driven substance abuse target areas.

Strategic Prevention Framework for Prescription Drugs

Due to alarming trends related to prescription drug misuse and overdoses involving opioids, SAMHSA is prioritizing efforts to address prescription drug misuse. SAMHSA implemented the Strategic Prevention Framework for Prescription Drugs to raise awareness about the dangers of sharing medications and to work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program focuses on raising community awareness and bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients. SAMHSA tracks reductions in opioid overdoses and the incorporation of prescription drug monitoring data into needs assessments and strategic plans as indicators of program success.

Federal Drug-Free Workplace
FY 2022 Budget Request: $4.9 million, the same with the FY 2021 Enacted level

SAMHSA's activities related to the Federal Drug-Free Workplace support two principal activities mandated by Executive Order (E.O.) 12564 and Public Law (P.L.) 100-71. This includes: 1) oversight of the Federal Drug-Free Workplace, aimed at the elimination of illicit drug use within Executive Branch agencies and the federally-regulated industries; and 2) oversight of the National Laboratory Certification Program (NLCP), which certifies laboratories to conduct forensic drug testing for federal agencies, federally-regulated industries; the private sector also uses the HHS-Certified Laboratories.

SAMHSA will continue oversight of the Executive Branch Agencies' Federal Drug-Free Workplace Programs. This includes review of Federal Drug-Free Workplace plans from those federal agencies that perform federal employee testing, random testing of those designated testing positions of national security, public health, and public safety, and testing for illegal drug use and the misuse of prescription drugs. SAMHSA will continue its oversight role for the inspection and certification of the HHS-certified laboratories.

Sober Truth on Preventing Underage Drinking
FY 2022 Budget Request: $10.0 million, the same with the FY 2021 Enacted level

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 (Public Law 109 - 422) was the nation's first comprehensive legislation on underage drinking. One of the primary components of the STOP Act is the community-based coalition enhancement grant program, which provides up to $50,000 per year over four years to current or former grantees under the Drug Free Communities Act of 1997 to prevent and reduce alcohol use among youth under the age of 21. The STOP Act grant program enables organizations to strengthen collaboration and coordination among stakeholders to achieve a reduction in underage drinking in their communities. The STOP Act was reauthorized in the 21st Century Cures Act.

Centers for the Application of Prevention Technologies
FY 2022 Budget Request: $7.5 million, the same with the FY 2021 Enacted level

In 2019, Center for the Application of Prevention Technologies (CAPT) changed how it delivered services and began providing science-based training and technical assistance through Prevention Technology Transfer Centers (PTTC) cooperative agreements. SAMHSA leadership established the PTTC the previous year to expand and improve implementation and delivery of effective substance abuse prevention interventions and provide training and technical assistance services to the substance abuse prevention field. The PTTC does this by developing and disseminating tools and strategies needed to improve the quality of substance abuse prevention efforts; providing intensive technical assistance and learning resources to prevention professionals in order to improve their understanding of prevention science, epidemiological data, and implementation of evidence-based and promising practices; and, developing tools and resources to engage the next generation of prevention professionals.

Science and Service Program Coordination
FY 2022 Budget Request: $4.1 million, the same with the FY 2021 Enacted level

The Science and Service Program Coordination program funds the provision of technical assistance and training to states, tribes, communities, and grantees around substance abuse prevention. Specifically, the program supports the Tribal Training and Technical Assistance Center and the Underage Drinking Prevention Education Initiatives (UADPEI).

This funding will support SAMHSA's substance abuse prevention efforts and include a focus on preventing underage drinking and providing technical assistance and training to American Indians/Alaska Native communities.

Tribal Behavioral Health Grants
FY 2022 Budget Request: $21.2 million, an increase of $0.4 million from the FY 2021 Enacted level

SAMHSA's Tribal Behavioral Health Grants (TBHG) program addresses the high incidence of substance abuse and suicide among AI/AN populations. Starting in FY 2014, this program supports tribal entities with the highest rates of suicide by providing effective and promising strategies that address substance abuse, trauma, and suicide and by promoting the mental health of AI/AN young people.

This request, along with $21.2 million in the Center of Mental Health Services will continue to support grants that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families.

Performance

Prevention: Selected Measures of Performance Program SPF: Partnerships for Success	FY 2020 Target	FY 2020 Achieved
» Increase the number of sub-recipient communities that improved one or more targeted NOMs indicators	315	234
» Increase the number of EBPs implemented by sub-recipient communities	1,414	1,421
SPF: Rx	**FY 2020 Target**	**FY 2020 Achieved**
» Increase the percent of funded states reporting reductions in opioid overdoses	62%	56%
STOP Act	**FY 2020 Target**	**FY 2020 Achieved**
» Increase the percent of coalitions that report at least a 5 percent improvement in the past 30-day use of alcohol in at least 2 grades	58%	62%
» Increase the percent of coalitions that report improvement in youth perception of risk from alcohol in at least two grades	75%	46%
Tribal Behavioral Health Grants	**FY 2020 Target**	**FY 2020 Achieved**
» Increase the number of programs/organizations that implemented specific mental health-related practices/activities as a result of the grant	6,880	3,076

Substance Abuse Treatment

Substance Abuse Prevention and Treatment Block Grant FY 2022 Budget Request: $3.5 billion, an increase of $1.65 billion from the FY 2021 Enacted level.

SABG serves as a source of safety net funding, including assistance to states in addressing the opioid epidemic, and will continue to support certain services (e.g., recovery support services) not covered by commercial insurance and non-clinical activities and services that address the critical needs of state substance abuse prevention and treatment service systems.

Funding will aid in having a positive effect on the health and lives of individuals with substance use disorders as evidenced by demonstrated positive client outcomes in all six treatment domains; greater provide as a major impetus for improving state prevention and treatment systems' infrastructure and capacity thereby increasing availability of services, development and implementation of evidence-based practices, development and collection of specific outcome measures, and development and maintenance of state data management systems; strengthen the requirements, resources, and federal guidance that can be leveraged to sustain and improve state

systems and emphasize the importance of the SABG in the development of the same; and further contribute to the development and maintenance of successful state collaborations with other agencies and stakeholders concerned with preventing and treating substance use disorders.

Performance

SAMHSA is undertaking a series of agency-wide efforts designed to develop a set of common performance, quality, and cost measures to demonstrate the impact of SAMHSA's programs. Ultimately, SAMHSA and its state partners will collaborate to develop a streamlined behavioral health data system that complements other existing systems (e.g., Medicaid administrative and billing data systems, and state mental health and substance abuse treatment data systems), ensures consistency in the use of measures, and provides a more complete perspective of the delivery of mental illness and substance abuse treatment services.

An independent evaluation of the SABG demonstrated how states leveraged the statutory requirements to expand existing or establish new treatment capacity in underserved areas of states and territories and to improve coordination of services with other state systems.[115] SAMHSA data show that on average, the SABG has been successful in expanding treatment capacity by annually supporting approximately two million[116] admissions to treatment programs receiving public funding. Outcome data for the Block Grant program show positive results as reported through Behavioral Health Services Information System/Treatment Episode Data Set (TEDS) administered by SAMHSA's Center for Behavioral Health Statistics and Quality. In FY 2019, at discharge, clients demonstrated above average abstinence rates from both illegal drug (56 percent) and alcohol (77 percent) use. State substance abuse authorities reported in the FY 2020 SABG Annual Report the following outcomes for services[117] provided during FY 2019, the most recent year for which data is available:

- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Palau, Puerto Rico, Red Lake, and Virgin Islands that reported data concerning abstinence from alcohol use, 50 of the 60 identified improvements in client abstinence;
- Similarly, for the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Palau, Puerto Rico, Red Lake, and Virgin Islands that reported data concerning the abstinence from drug use, 42 of 60 identified improvements in client abstinence;
- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Palau, Puerto Rico, Red Lake, and Virgin Islands that reported employments data, 53 of 60 identified improvements in client employment;

[115] Substance Abuse and Mental health Administration. Retrieved from https://www.samhsa.gov/sites/default/files/grants/sapt-bg-evaluation-final-report.pdf.

[116] Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 01 May 2018.

[117] Services include services from Short-term residential, Long-term residential, Outpatient, and Intensive outpatient only.

- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Palau, and Puerto Rico that reported criminal justice data, 50 of 58 reported an increase in clients with no arrests based on data reported to TEDS;
- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia Northern Marianas, Palau, Puerto Rico, Red Lake, and Virgin Islands that reported housing data, 53 of 60 identified improvements in stable housing for clients based on data reported to TEDS; and
- For the 50 states, American Samoa, the District of Columbia, Guam, Marshall Islands, Micronesia, Northern Marianas, Puerto Rico, and Red Lake that reported recovery support data, 58 states out of 60 identified improvements in client engagement in recovery support programs.

Substance Abuse Prevention and Treatment Block Grant: Selected Measures of Performance		
Prevention Set-Aside	**FY 2020 Target**	**FY 2020 Achieved**
» Increase the percent of states showing a decrease in state level estimates of percent of survey respondents to report 30 day use of other illicit drugs (age 12 – 17)	43%	50%
» Increase the percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 18+)	25%	20%
Treatment Activities	**FY 2020 Target**	**FY 2020 Achieved**
» Percentage of clients reporting no drug use in the past month at discharge.	74%	54%
» Increase the percentage of clients reporting being employed/in school at discharge.	40%	35%
» Increase the percentage of clients reporting no involvement with the criminal justice system.	92%	93%
» Increase the percentage of clients receiving services who had a permanent place to live in the community.	92%	88%

State Opioid Response
FY 2022 Budget Request: $2.25 billion, an increase of $750 million from FY 2021 Enacted level

Substance Abuse and Mental Health Services Administration established the State Opioid Response Grants (SOR) program in FY 2018. This program aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment needs, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs). Funding is awarded grants to states and territories via formula. The program also includes a 15 percent set-aside for the 10 states with the highest mortality rates related to drug overdose deaths. The program also includes a $75 million set-aside for tribes. Given the varying nature of substance misuse across the United States, the budget continues to allow the use of State Opioid Response grants to include methamphetamine and other stimulants, giving states and tribes flexibility to address their unique community needs. States and communities across the country are dealing with rising rates of stimulant use and its negative health, social, and economic consequences.

Programs of Regional and National Significance

Targeted Capacity Expansion
The FY 2022 Budget Request: $148 million, an increase of $45.7 million from the FY 2021 Enacted level

The Targeted Capacity Expansion (TCE) program provides rapid, strategic, comprehensive, and integrated community-based responses to gaps in and capacity for SUD treatment and recovery support services. Examples of such needs include limited or no access to medication-assisted treatment (MAT) for opioid use disorders; lack of resources needed to adopt and implement health information technologies (HIT) in SUD treatment settings; and short supply of trained and qualified peer recovery coaches to assist individuals in the recovery process. This will continue support for TCE-PTP and TCE-Special Projects

Opioid Treatment Programs/Regulatory Activities
FY 2022 Budget Request: $13.1 million, an increase of $4.4 million from the FY 2021 Enacted level
As part of its regulatory responsibility, SAMHSA certifies Opioid Treatment Programs that use methadone, buprenorphine, or buprenorphine/naloxone to treat patients with opioid dependence. SAMHSA carries out this responsibility by enforcing regulations established by an accreditation-based system. This is accomplished in coordination with the Drug Enforcement Administration, states, territories, and the District of Columbia. SAMHSA also funds the Opioid Treatment Programs Medical Education and Supporting Services project aimed at preparing Opioid Treatment Programs to achieve accreditation and providing technical assistance and clinical training to enhance program clinical activities. Additionally, SAMHSA funds grants and contracts that support the regulatory oversight and monitoring activities of Opioid Treatment Programs.

This request supports the Secretary's five-prong strategy to address the opioid crisis priorities. In this program, this is through regulatory activities, ongoing training, certification, and technical assistance to provider groups and communities impacted by the opioid crisis.

Treatment Systems for Homeless
FY 2022 Budget Request: $37.1 million, an increase of $0.73 million from the FY 2021 Enacted level

SAMHSA's Treatment Systems for Homeless portfolio supports services for those with substance use disorders and who are experiencing homelessness, including veterans, and those experiencing chronic homelessness. This funding is to support grants to reduce homelessness for nearly 4,000 people.

Pregnant and Postpartum Women
FY 2022 Budget Request: $49.4 million, an increase of $16.5 million from the FY 2021 Enacted level

The Pregnant and Postpartum Women supports grants for residential treatment and the Pregnant and Postpartum Women Pilot, authorized in the Comprehensive Addiction and Recovery Act (CARA), helps state substance abuse agencies address the continuum of care, including services provided to women in nonresidential-based settings and promote a coordinated, effective and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery. An evaluation of this program is underway to determine the effectiveness of the pilot. In FY 2018, SAMHSA funded new state PPW pilot grants and continuation state PPW pilot grants for program implementation, supplement for direct technical assistance, and continuation evaluation contract to provide an array of services and supports to pregnant women and their children.

Building Communities of Recovery
FY 2022 Budget Request: $20.0 million, an increase of $10.0 million from FY 2021 Enacted level

The Building Communities of Recovery program mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery support from drug/alcohol addiction. These grants are intended to support the development, enhancement, expansion, and delivery of recovery support services (RSS) as well as promotion of and education about recovery. Programs are designed to be overseen by people in recovery from SUDs who reflect the community served. Grants support linkages between recovery networks and a variety of other organizations, systems, and communities, including primary care, other recovery networks, child welfare system, criminal justice system, housing services and employment systems. Grantees will also work to reduce negative attitude, discrimination, and prejudice around addiction and addiction recovery. These funds will support continuation grants for the Building Communities of Recovery program to develop, expand, and enhance recovery support services.

Criminal Justice Activities
FY 2022 Budget Request: $124.4 million, an increase of $35.4 million from the FY 2021 Enacted level

SAMHSA's Criminal Justice portfolio includes several grant programs that focus on diversion, alternatives to incarceration, drug courts, and re-entry from incarceration for adolescents and adults with substance use disorders and/or co-occurring substance use and mental disorders. This includes Treatment Drug Courts and the Offender Re-Entry Programs.

Drug Court Activities

SAMHSA's Adult Drug Court programs support a variety of services including direct treatment services for diverse populations, wraparound/recovery support services designed to improve access and retention, drug testing for illicit substances, education support, relapse prevention and long-term management, pharmacotherapy), and HIV testing conducted in accordance with state and local requirements. The program seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use, and outcomes among the racial and ethnic minority populations served.

Ex-Offender Re-Entry Program

In addition to the drug court portfolio, SAMHSA supports Offender Reentry Program (ORP) grants, as well as other criminal justice activities, such as evaluation and behavioral health contracts. These grants will provide screening, assessment, comprehensive treatment, and recovery support services for diverse populations reentering the community from incarceration. Other supported services include wraparound and recovery support services such as recovery housing and peer recovery support designed to improve access and retention, drug testing for illicit substances, educational support, relapse prevention and long-term management, and HIV and viral hepatitis B and C testing conducted in accordance with state and local requirements.
SAMHSA budget request continues to support grants and contracts of the program.

First Responder Training
FY 2022 Budget Request: $63.0 million, an increase of $21.0 million from the FY 2021 Enacted level

First Responder Training supports efforts to help first responders and members of other key community sectors to administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose. Grantees train and provide resources to first responders and members of other key community sectors at the state, tribal, and local governmental levels on carrying and administering a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose. Grantees also establish processes, protocols, and mechanisms for referral to appropriate treatment and recovery communities. Training, technical assistance, and evaluation activities are also being supported to assist grantees, determine best practices, and assess program outcomes.

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths
FY 2022 Budget Request: $18.0 million, an increase of $6.0 million from the FY 2021 Enacted level

Opioid overdose is a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids (including synthetics), such as fentanyl). SAMHSA's Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths program seeks to help states identify communities of high need, and provide education, training, and resources necessary to tailor the overdose kits to meet their specific needs. Grantees can use the funds to purchase naloxone, equip first responders with naloxone and other overdose death prevention strategies, support education on these strategies, provide materials to assemble and disseminate overdose kits.

This funding will provide grants to states to reduce the number of opioid overdose-related deaths. Funding will help states purchase overdose reversing drugs, equip first responders in high-risk communities, support education on the use of naloxone and other overdose-related death prevention strategies, provide the necessary materials to assemble overdose kits, and cover expenses incurred from dissemination efforts.

Other PRNS Treatment Programs
FY 2022 Budget Request: $45.9 million, an increase of $3.8 million from the FY 2021 Enacted level

The budget request includes resources for several Treatment Capacity programs including: Recovery Community Services Program; Children and Families; Improving Access to Overdose Treatment; and Addiction Technology Transfer Centers. The funding will enhance overall drug treatment quality by incentivizing treatment and service providers to achieve specific performance targets. Examples of grant awards could include supplements for treatment and service providers who are able to connect higher proportions of detoxified patients with continuing recovery-oriented treatment; or for outpatient providers who are able to successfully retain greater proportions of patients in active treatment participation for longer periods.

Peer Support Technical Assistance Center
FY 2022 Budget Request: $1.5 million, an increase of $0.5 million from the FY 2021 Enacted level

The program is authorized by section 7152 of the SUPPORT for Patients and Communities Act (P.L. 115-271), is to provide funding for the creation of a National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support, or the Center. The Center provides technical assistance and support to recovery community organizations and peer support networks. The technical assistance is related to training, translation and interpretation services, data collection, capacity building, and evaluation and improvement of the effectiveness of such services provided by recovery community organizations.

Treatment, Recovery, and Workforce Support
FY 2022 Budget Request: $9.0 million, an increase of $3.0 million from the FY 2021 Enacted level

The program is authorized by section 7081 of the SUPPORT for Patients and Communities Act, is to support the implementation of voluntary programs for care and treatment of individuals after a drug overdose, as appropriate, which may include utilizing recovery coaches, establishing policies and procedures that address the provision overdose reversal medication and FDA-approved medications to treat substance use disorders, and establishing integrated models of care for individuals who have experienced a non-fatal drug overdose. SAMHSA is directed, in consultation with the Secretary of Labor, to award competitive grants to entities to carry out evidence- based programs to support individuals in substance use disorder treatment and recovery to live independently and participate in the workforce.

Emergency Department Alternatives to Opioids
FY 2022 Budget Request: $9.0 million, an increase of $3.0 million from the FY 2021 Enacted level

The program is authorized by section 7091 of the SUPPORT for Patients and Communities Act (P.L. 115-271) is to provide funding to hospitals and emergency departments, including freestanding emergency departments, to develop, implement, enhance, or study alternative pain management protocols and treatments that limit the use and prescribing of opioids in emergency departments. In addition, these funds will be used to target common painful conditions, train providers and other hospital personnel, and provide alternatives to opioids for patients with painful conditions.

Performance

Treatment: Selected Measures of Performance		
Criminal Justice	**FY 2020 Target**	**FY 2020 Achieved**
» Drug Courts: Increase the percentage of adult clients receiving services who had no past month substance use	87%	84%
» Offender Reentry: Increase the percentage of adult clients receiving services who had no past month substance use	70%	76%

Health Surveillance and Program Support Appropriation

The FY 2022 Budget Request is $120.7 million, an increase of $8.4 million from the FY 2021 Enacted level. The budget request represents the Substance Abuse portion of the Health Surveillance and Program Support appropriation and supports staffing and activities to administer SAMHSA programs as described below.

Health Surveillance and Program Support
FY 2022 Budget Request: $90.7 million, an increase of $3.1 million from the FY 2021 Enacted level

Health Surveillance and Program Support (HSPS) provides funding for personnel costs, building and facilities, equipment, supplies, administrative costs, and associated overhead to support SAMHSA programmatic activities, as well as provide funding for SAMHSA national data collection and survey systems, funding to support the Center for Disease Control and Prevention's National Health Information Survey, and the data archive. This request represents the total funding available for these activities first divided between Mental Health and Substance Abuse using the same percentages splits that exist between the Mental Health and Substance Abuse (Prevention and Treatment) appropriation amounts. The Drug Control portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

SAMHSA intends to continue funding the continuation of the NSDUH, BHSIS, SAMHDA, and EBPRC contracts and payroll Program Support funding will continue to cover overhead costs associated with 5600 Fishers Lane, including rent, the Federal Acquisition Service loan repayment program, and security charges.

Public Awareness and Support
FY 2022 Budget Request: $6.6 million, an increase of $0.1 million from FY 2021 Enacted level

Public Awareness and Support provides funding to support the unified communications approach to increase awareness of behavioral health, mental disorders and substance abuse issues. This represents the total funding available for these activities first divided evenly between Mental Health and Substance Abuse. The Drug Control portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively. The funding for Public Awareness and Support will support contracts that will allow SAMHSA to manage media relationships, maintain its web and social media presence, manage critical helplines, and deliver publications and resources.

Performance and Quality Information Systems
FY 2022 Budget Request: $7.1 million, an increase of $0.1 million from the FY 2021 Enacted level

Performance and Quality Information Systems provides funding to support SAMHSA's Performance Accountability and Reporting System (SPARs) related activities, as well as provide support for the National Registry of Evidence-based Programs and Practices that will reduce the backlog of interventions accepted but not reviewed under the previous contract. SPARS will provide a common data and reporting system for all SAMHSA discretionary grantees and allow programmatic technical assistance (TA) on use of the data to enhance grantee performance monitoring and improve quality of service delivery. This request represents the total funding available for these activities first split into Mental Health and Substance Abuse using the same percentages splits as between the Mental Health and Substance Abuse (Prevention and Treatment)

appropriation amounts. The Drug Control portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

SAMHSA will use these funds to continue its performance management, quality improvement, and activities. This funding will ensure that SAMHSA continues a strong focus on developing and implementing evidence-based practices and programs and continues its emphasis on performance management for quality improvement and program monitoring.

Drug Abuse Warning Network
FY 2022 Budget Request: $15.0 million, an increase of $5.0 million from the FY 2021 Enacted level

DAWN is a nationwide public health surveillance system that will improve emergency department monitoring of substance use crises, including those related to opioids. Authorized by the 21st Century Cures Act, this program is necessary to respond effectively to the opioid and addiction crisis in the United States and to better inform public health, clinicians, policymakers, and other stakeholders to respond to emerging substance use trends. This request represents the total funding available for these activities. The Drug Abuse Warning Network is allocated fully to substance abuse. This funding will continue to support contract to fund the expansion of additional hospitals for FY 2021 to inform stimulant abuse prevention and response strategies. DAWN's expansion to additional hospitals will allow for SAMHSA DAWN data-based estimates to be more generalizable and more representative across the country and will also allow SAMHSA to produce more accurate and complete assessment of geographic patterns (e.g. substance use disparities in urban, suburban and rural areas) and temporal trends (e.g. emerging or new substance misuse or abuse) in substance use related ED visits in the United States.

Behavioral Health Workforce Data and Development
FY 2022 Budget Request: $0.5 million, the same as of the FY 2021 Enacted level

The purpose of this program is to provide comprehensive data and analysis on individuals who comprise the prevention and treatment fields to address mental and substance use disorders. The goal of the program is to provide valid data on the existing practitioners and usable information to SAMHSA on which to make policy and planning decisions.

Data Request and Publication User Fees
FY 2022 Budget Request: $0.75 million, the same from the FY 2021 Enacted level

SAMHSA will collect and retain fees for extraordinary data and publications requests. This represents the total funding estimated for these activities first divided evenly between Mental Health and Substance Abuse. The Drug Control portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

Performance

Health Surveillance and Program Support: Selected Measures of Performance		
Public Awareness and Support	**FY 2020 Target**	**FY 2020 Achieved**
» Increase the number of individuals referred for behavioral health treatment resources.	667,783	784,638
» Increase the total number of interactions through phone inquiries, e-blasts, dissemination of SAMHSA publications, and total website hits.	45,000,000	55,238,274

Supplementary Tables

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Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Summary Direct Budget Authority
(Dollars in Thousands)

Object Class - Direct Budget Authority[1,2]	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$48,082	$48,563	$49,048
Other than full-time permanent (11.3)	2,061	2,081	2,102
Other personnel compensation (11.5)	1,260	1,273	1,286
Military personnel (11.7)	3,401	3,503	3,609
Special personnel services payments (11.8)	18	19	19
Subtotal personnel compensation:	54,823	55,439	56,063
Civilian benefits (12.1)	15,961	16,137	16,478
Military benefits (12.2)	1,792	1,846	1,901
Subtotal Pay Costs:	72,575	73,422	74,442
Travel and transportation of persons (21.0)	222	225	229
Transportation of things (22.0)	8	8	8
Rental payments to GSA (23.1)	5,653	5,744	5,853
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	312	317	323
Printing and reproduction (24.0)	488	496	506
Other Contractual Services:			
Advisory and assistance services (25.1)	35,557	35,821	36,502
Other services (25.2)	94,712	94,459	92,336
Purchase of Goods & Svcs. from Govt. Accts (25.3)	33,156	33,391	34,025
Operation and maintenance of facilities (25.4)	58	59	60
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	924	939	957
Subtotal Other Contractual Services:	164,407	164,669	163,880
Supplies and materials (26.0)	147	150	153
Equipment (31.0)	118	109	111
Grants, subsidies, and contributions (41.0)	5,504,898	5,624,702	9,341,339
Interest and dividends (43.0)	---	---	---
Subtotal Non-Pay Costs	5,676,254	5,796,420	9,512,402
Total Direct Obligations	$5,748,829	$5,869,841	$9,586,844

[1] Does not include PHS Evaluation Funds.

[2] Does not include Prevention and Public Health Funds.

Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Mental Health
(Dollars in Thousands)

Object Class - Direct Budget Authority[1,2]	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$1,396	$1,410	$1,424
Other than full-time permanent (11.3)	27	27	27
Other personnel compensation (11.5)	18	18	18
Military personnel (11.7)	---	---	---
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	1,441	1,455	1,470
Civilian benefits (12.1)	456	460	470
Military benefits (12.2)	---	---	---
Subtotal Pay Costs:	1,896	1,915	1,940
Travel and transportation of persons (21.0)	66	67	69
Transportation of things (22.0)			
Rental payments to GSA (23.1)	150	152	155
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	265	269	274
Printing and reproduction (24.0)	248	252	257
Other Contractual Services:		$---	$---
Advisory and assistance services (25.1)	17,157	17,432	17,763
Other services (25.2)	24,754	25,150	25,628
Purchase of Goods & Svcs. from Govt. Accts (25.3)	13,982	14,206	14,476
Operation and maintenance of facilities (25.4)	40	41	41
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	72	73	75
Subtotal Other Contractual Services:	56,006	56,902	57,983
Supplies and materials (26.0)	33	34	34
Equipment (31.0)	84	85	87
Grants, subsidies, and contributions (41.0)	1,586,226	1,699,558	2,842,690
Interest and dividends (43.0)	---	---	---
Subtotal Non-Pay Costs	1,643,078	1,757,320	2,901,549
Total Direct Obligations	$1,644,974	$1,759,236	$2,903,489

[1] Does not include PHS Evaluation Funds.
[2] Does not include ACA or PPHF

Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Substance Abuse Prevention
(Dollars in Thousands)

Object Class - Direct Budget Authority[1]	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$---	$---	$---
Other than full-time permanent (11.3)	---	---	---
Other personnel compensation (11.5)	---	---	---
Military personnel (11.7)	---	---	---
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	---	---	---
Civilian benefits (12.1)	---	---	---
Military benefits (12.2)	---	---	---
Subtotal Pay Costs:	---	---	---
Travel and transportation of persons (21.0)	---	---	---
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)	---	---	---
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---
Printing and reproduction (24.0)	156	159	162
Other Contractual Services:			
Advisory and assistance services (25.1)	5,162	5,244	5,344
Other services (25.2)	14,474	14,705	14,985
Purchase of Goods & Svcs. from Govt. Accts (25.3)	4,501	4,573	4,660
Operation and maintenance of facilities (25.4)	---	---	---
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	---	---	---
Subtotal Other Contractual Services:	24,136	24,522	24,988
Supplies and materials (26.0)	2	2	2
Equipment (31.0)	---	---	---
Grants, subsidies, and contributions (41.0)	182,174	183,536	191,515
Interest and dividends (43.0)	---	---	---
Subtotal Non-Pay Costs	206,469	208,219	216,667
Total Direct Obligations	$206,469	$208,219	$216,667

[1] Does not include PHS Evaluation Funds.

Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Substance Abuse Treatment
(Dollars in Thousands)

Object Class - Direct Budget Authority[1]	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$3,182	$3,214	$3,246
Other than full-time permanent (11.3)	85	86	87
Other personnel compensation (11.5)	55	55	56
Military personnel (11.7)	---	---	---
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	3,323	3,356	3,389
Civilian benefits (12.1)	1,037	1,064	1,086
Military benefits (12.2)	---	---	---
Subtotal Pay Costs:	4,359	4,419	4,475
Travel and transportation of persons (21.0)	5	5	6
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)	138	140	143
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	2	2	2
Printing and reproduction (24.0)	83	85	86
Other Contractual Services:			
Advisory and assistance services (25.1)	11,692	11,879	12,105
Other services (25.2)	13,455	13,670	13,930
Purchase of Goods & Svcs. from Govt. Accts (25.3)	10,957	11,133	11,344
Operation and maintenance of facilities (25.4)	18	19	19
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	251	255	259
Subtotal Other Contractual Services:	36,373	36,955	37,658
Supplies and materials (26.0)	-	-	-
Equipment (31.0)	---	---	---
Grants, subsidies, and contributions (41.0)	3,715,595	3,731,950	6,285,374
Interest and dividends (43.0)	---	---	---
Subtotal Non-Pay Costs	3,752,197	3,769,137	6,323,267
Total Direct Obligations	$3,756,556	$3,773,556	$6,327,743

[1] Does not include PHS Evaluation Funds.

Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Health Surveillance and Program Support
(Dollars in Thousands)

Object Class - Direct Budget Authority[1]	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$43,503	$43,938	$44,377
Other than full-time permanent (11.3)	1,949	1,969	1,988
Other personnel compensation (11.5)	1,188	1,200	1,211
Military personnel (11.7)	3,401	3,503	3,609
Special personnel services payments (11.8)	18	19	19
Subtotal personnel compensation:	50,060	50,628	51,205
Civilian benefits (12.1)	14,468	14,613	14,922
Military benefits (12.2)	1,792	1,846	1,901
Subtotal Pay Costs:	66,320	67,087	68,027
Travel and transportation of persons (21.0)	150	152	155
Transportation of things (22.0)	7	8	8
Rental payments to GSA (23.1)	5,365	5,451	5,555
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	46	46	47
Printing and reproduction (24.0)			
Other Contractual Services:			
Advisory and assistance services (25.1)	1,246	1,266	1,290
Other services (25.2)	42,028	40,933	37,793
Purchase of Goods & Svcs. from Govt. Accts (25.3)	3,425	3,479	3,546
Operation and maintenance of facilities (25.4)	---	---	---
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	602	611	623
Subtotal Other Contractual Services:	47,301	46,289	43,251
Supplies and materials (26.0)	112	114	116
Equipment (31.0)	24	24	25
Grants, subsidies, and contributions (41.0)	9,505	9,657	21,761
Interest and dividends (43.0)	---	---	---
Subtotal Non-Pay Costs	62,511	61,743	70,918
Total Direct Obligations	$128,830	$128,830	$138,945

[1] Does not include PHS Evaluation Funds.

Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Prevention and Public Health Funds
(Dollars in Thousands)

Object Class - Direct Budget Authority[1]	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$---	$---	$---
Other than full-time permanent (11.3)	---	---	---
Other personnel compensation (11.5)	---	---	---
Military personnel (11.7)	---	---	---
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	---	---	---
Civilian benefits (12.1)	---	---	---
Military benefits (12.2)	---	---	---
Subtotal Pay Costs:	---	---	---
Travel and transportation of persons (21.0)	---	---	---
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)			---
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)		---	---
Printing and reproduction (24.0)	---	---	---
Other Contractual Services:			
Advisory and assistance services (25.1)	300	305	311
Other services (25.2)	---	---	---
Purchase of Goods & Svcs. from Govt. Accts (25.3)	291	296	301
Operation and maintenance of facilities (25.4)	---	---	---
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	---	---	---
Subtotal Other Contractual Services:	591	601	612
Supplies and materials (26.0)	---	---	---
Equipment (31.0)	11	11	11
Grants, subsidies, and contributions (41.0)	11,398	11,388	11,377
Interest and dividends (43.0)	---	---	---
Subtotal Non-Pay Costs	12,000	12,000	12,000
Total Direct Obligations	$12,000	$12,000	$12,000

[1] Does not include PHS Evaluation Funds.

Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Summary PHS Evaluation Funds

(Dollars in Thousands)

Object Class - PHS Evaluation Funds	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel Compensation:			
Full Time Permanent (11.1)	$11,940	$8,040	$12,179
Other than Full-Time Permanent (11.3)	641	470	654
Other Personnel Compensation (11.5)	234	186	239
Military Personnel Compensation (11.7)	345	356	448
Special personnel services payments (11.8)	---	---	---
Subtotal Personnel Compensation:	**13,160**	**9,052**	**13,520**
Civilian Personnel Benefits (12.1)	3,966	1,571	4,061
Military Personnel Benefits (12.2)	221	161	234
Subtotal Pay Costs:	**17,346**	**10,785**	**17,815**
Travel (21.0)	31	32	32
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)	---	---	---
Communications, Utilities and Misc. Charges (23.3)	---	---	---
Printing and Reproduction (24.0)	634	645	646
Other Contractual Services:	---	---	---
Advisory and assistance services (25.1)	---	---	---
Other services (25.2)	82,241	89,875	83,939
Purchase of Goods & Svcs. from Govt. Accts (25.3)	2,344	2,382	1,694
Operation and maintenance of equipment (25.7)	10	10	10
Subtotal Other Contractual Services:	**84,595**	**92,268**	**85,643**
Supplies and Materials (26.0)	23	24	24
Equipment (31.0)	6	6	6
Grants, Subsidies, and Contributions (41.0)	31,030	29,908	29,502
Subtotal Non-Pay Costs	**116,320**	**122,882**	**115,852**
Total PHS Evaluation Funds	**$133,667**	**$133,667**	**$133,667**

Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Mental Health
(Dollars in Thousands)

Object Class - PHS Evaluation	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$1,611	$1,627	$1,643
Other than full-time permanent (11.3)	---	---	---
Other personnel compensation (11.5)	24	24	25
Military personnel (11.7)	107	110	114
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	**1,742**	**1,762**	**1,782**
Civilian benefits (12.1)	549	554	560
Military benefits (12.2)	62	63	65
Subtotal Pay Costs:	**2,352**	**2,379**	**2,406**
Travel and transportation of persons (21.0)	1	1	1
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---
Printing and reproduction (24.0)	---	---	---
Other Contractual Services:	---	---	---
Advisory and assistance services (25.1)	---	---	---
Other services (25.2)	8,373	8,507	8,669
Purchase of Goods & Svcs. from Govt. Accts (25.3)	49	50	51
Operation and maintenance of equipment (25.7)			
Subtotal Other Contractual Services:	**8,422**	**8,557**	**8,719**
Supplies and materials (26.0)			
Equipment (31.0)	---	---	---
Grants, subsidies, and contributions (41.0)	10,264	10,102	9,912
Subtotal Non-Pay Costs	**18,687**	**18,660**	**18,632**
Total PHS Evaluation Funds	**$21,039**	**$21,039**	**$21,039**

Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Substance Abuse Treatment
(Dollars in Thousands)

Object Class - PHS Evaluation	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$3,029	$3,059	$3,090
Other than full-time permanent (11.3)	96	97	98
Other personnel compensation (11.5)	62	63	63
Military personnel (11.7)	175	180	186
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	**3,362**	**3,399**	**3,437**
Civilian benefits (12.1)	967	992	1,002
Military benefits (12.2)	95	98	101
Subtotal Pay Costs:	**4,424**	**4,489**	**4,540**
Travel and transportation of persons (21.0)	10	10	10
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---
Printing and reproduction (24.0)	419	426	427
Other Contractual Services:		---	---
Advisory and assistance services (25.1)	---	---	---
Other services (25.2)	60,296	61,260	61,441
Purchase of Goods & Svcs. from Govt. Accts (25.3)	263	268	268
Operation and maintenance of equipment (25.7)	---	---	---
Subtotal Other Contractual Services:	**60,559**	**61,528**	**61,710**
Supplies and materials (26.0)	---	---	---
Equipment (31.0)	---	---	---
Grants, subsidies, and contributions (41.0)	15,787	14,746	14,513
Subtotal Non-Pay Costs	**76,776**	**76,710**	**76,660**
Total PHS Evaluation Funds	**$81,200**	**$81,200**	**$81,200**

Budget Authority by Object Class
Substance Abuse and Mental Health Services Administration
Health Surveillance and Program Support
(Dollars in Thousands)

Object Class - PHS Evaluation	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$7,300	$3,354	$7,447
Other than full-time permanent (11.3)	545	374	556
Other personnel compensation (11.5)	148	100	151
Military personnel (11.7)	63	65	148
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	**8,056**	**3,892**	**8,302**
Civilian benefits (12.1)	2,450	25	2,499
Military benefits (12.2)	64	---	68
Subtotal Pay Costs:	**10,570**	**3,917**	**10,869**
Travel and transportation of persons (21.0)	20	21	21
Transportation of things (22.0)			
Rental payments to GSA (23.1)	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---
Printing and reproduction (24.0)	215	218	219
Other Contractual Services:			
Advisory and assistance services (25.1)	---	---	---
Other services (25.2)	13,572	20,108	13,830
Purchase of Goods & Svcs. from Govt. Accts (25.3)	2,032	2,065	1,375
Operation and maintenance of equipment (25.7)	10	10	10
Subtotal Other Contractual Services:	**15,614**	**22,183**	**15,215**
Supplies and materials (26.0)	23	23	23
Equipment (31.0)	6	6	6
Grants, subsidies, and contributions (41.0)	4,980	5,060	5,075
Subtotal Non-Pay Costs	**20,859**	**27,511**	**20,559**
Total Reimbursable Obligations	**$31,428**	**$31,428**	**$31,428**

Salaries and Expenses Tables
Substance Abuse and Mental Health Services Administration
(Dollars in Thousands)

Object Class - Direct Budget Authority[1,2]	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$48,082	$48,563	$49,048
Other than full-time permanent (11.3)	2,061	2,081	2,102
Other personnel compensation (11.5)	1,260	1,273	1,286
Military personnel (11.7)	3,401	3,503	3,609
Special personnel services payments (11.8)	18	19	19
Subtotal personnel compensation	54,823	55,439	56,063
Civilian benefits (12.1)	15,961	16,137	16,478
Military benefits (12.2)	1,792	1,846	1,901
Subtotal Pay Costs:	72,575	73,422	74,442
Travel (21.0)	222	225	229
Transportation of things (22.0)	8	8	8
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	312	317	323
Printing and reproduction (24.0)	488	496	506
Other Contractual Services:			
Advisory and assistance services (25.1)	35,557	35,821	36,502
Other services (25.2)	94,712	94,459	92,336
Purchase of Goods & Svcs. from Govt. Accts (25.3)	33,156	33,391	34,025
Operation and maintenance of facilities (25.4)	58	59	60
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	924	939	957
Subtotal Other Contractual Services:	164,407	164,669	163,880
Supplies and materials (26.0)	147	150	153
Subtotal Non-Pay Costs	165,585	165,865	165,099
Total Salary and Expenses	238,160	239,287	239,541
Rental Payments to GSA (23.1)	5,653	5,744	5,853
Grand Total, Salaries & Expenses and Rent	$243,813	$245,030	$245,393
Direct FTE	396	429	499

[1] Does not include PHS Evaluation Funds.
[2] Does not include Prevention and Public Health Funds.

Salaries and Expenses Tables
Substance Abuse and Mental Health Services Administration
(Dollars in Thousands)

Object Class - PHS Evaluation	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$11,940	$8,040	$12,179
Other than full-time permanent (11.3)	641	470	654
Other personnel compensation (11.5)	234	186	239
Military personnel (11.7)	345	356	448
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation	**13,160**	**9,052**	**13,520**
Civilian benefits (12.1)	3,966	1,571	4,061
Military benefits (12.2)	221	161	234
Subtotal Pay Costs:	**17,346**	**10,785**	**17,815**
Travel (21.0)	31	32	32
Transportation of things (22.0)	---	---	---
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---
Printing and reproduction (24.0)	634	645	646
Other Contractual Services:			
Advisory and assistance services (25.1)	---	---	---
Other services (25.2)	82,241	89,875	83,939
Purch. Goods & Svcs. Govt. Accts (25.3)	2,344	2,382	1,694
Operation and maintenance of facilities (25.4)	10	10	10
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	23	24	24
Subtotal Other Contractual Services:	**84,618**	**92,291**	**85,667**
Supplies and materials (26.0)	23	24	24
Subtotal Non-Pay Costs	**85,307**	**92,991**	**86,368**
Total Salary and Expenses	**102,653**	**103,777**	**104,183**
Rental Payments to GSA (23.1)	---	---	---
Grand Total, Salaries & Expenses and Rent	**$102,653**	**$103,777**	**$104,183**
Reimbursable FTE	56	55	116

Detail of Full Time Equivalents (FTE)
Substance Abuse and Mental Health Services Administration

	FY 2020 Actual Civilian	FY 2020 Actual Military	FY 2020 Actual Total	FY 2021 Est. Civilian	FY 2021 Est. Military	FY 2021 Est. Total	FY 2022 Est. Civilian	FY 2022 Est. Military	FY 2022 Est. Total
Health Surveillance and Program Support.....									
Direct:.....	357	28	385	377	26	403	419	30	449
Reimbursable:.....	1	2	3	40	2	42	40	4	44
Total:.....	358	30	388	417	28	445	459	34	493
Mental Health Services.....									
Direct:.....	--	--	--	--	--	--	14	--	14
Reimbursable:.....	14	1	15	2	1	3	22	2	24
Total:.....	14	1	15	2	1	3	36	2	38
Substance Abuse Prevention.....									
Direct:.....	--	--	--	--	--	--	--	--	--
Reimbursable:.....	21	1	22	--	--	--	21	1	22
Total:.....	21	1	22	--	--	--	21	1	22
Substance Abuse Treatment.....									
Direct:.....	11	--	11	25	1	26	34	2	36
Reimbursable:.....	15	1	16	9	1	10	25	1	26
Total:.....	26	1	27	34	2	36	59	3	62
SAMHSA FTE Total.....	**419**	**33**	**452**	**453**	**31**	**484**	**575**	**40**	**615**

Detail of Positions
Substance Abuse and Mental Health Services Administration

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Executive Level IV	1	1	1
Subtotal	1	1	1
Total - Exec Level Salaries	**$170,800**	**$170,800**	**$170,800**
SES	6	10	20
Subtotal	6	10	20
Total, SES salaries	**$1,235,149**	**$2,058,582**	**$4,117,164**
GM/GS-15/EE	49	54	64
GM/GS-14	91	96	122
GM/GS-13	163	164	205
GS-12	45	54	54
GS-11	18	28	27
GS-10	--	--	1
GS-09	12	16	27
GS-08	12	8	18
GS-07	18	21	22
GS-06	2	11	11
GS-05	3	3	3
GS-04	--	--	--
GS-03	--	--	--
GS-02	--	--	--
GS-01	--	--	--
Subtotal	413	455	554
Total, GS salaries	**$55,732,857**	**$61,861,110**	**$75,885,907**
CC-08/09	--	1	1
CC-07	--	--	--
CC-06	15	16	18
CC-05	5	5	9
CC-04	9	9	9
CC-03	3	2	3
CC-02	--	--	--
CC-01	--	--	--
Subtotal	32	33	40
Total, CC salaries	**$4,420,492**	**$4,661,202**	**$5,777,065**
Total Positions[1]	**452**	**499**	**615**
Average ES level	ES	ES	ES
Average ES salary	$170,800	$170,800	$170,800
Average SES level	SES	SES	SES
Average SES salary	$205,858	$205,858	$205,858
Average GS grade	13.6	13.6	13.6
Average GS salary	$134,946	$135,958	$136,978
Average CC level	5	5	5
Average CC salaries	$138,140	$141,249	$144,427

[1] This figure accounts for the staff needed to ensure the full functioning of the 21st Century Cures Act Mental Health and Substance Use Policy Laboratory. It also represents the staffing needed to administer the $1.2 billion in discretionary funding. It differs from the reported figure in MAX, which does not include these elements.

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

HHS/Substance Abuse and Mental Health Services Administration

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

We have to offer PCAs because our salaries are not competitive with the private sector.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	FY 2020 (Final)	**FY 2021[118] (Enacted)**	**FY 2022 (Budget Request)**
3a) Number of Physicians Receiving PCAs	1	1	1
3b) Number of Physicians with One-Year PCA Agreements			
3c) Number of Physicians with Multi-Year PCA Agreements	1	1	1
4a) Average Annual PCA Physician Pay (without PCA payment)	157,709	157,709	157,709
4b) Average Annual PCA Payment	16,000	16,000	16,000

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)* We have to offer PCAs because our salaries are not competitive with the private sector (e.g., we might offer 75% of a physician's salary on the outside). In addition, physicians of interest to SAMHSA often have income from consulting as well. The PCA is the only way to raise the government income so as to make the offer acceptable.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

[118] FY 2021 data will be approved during the FY 2022 Budget cycle

Significant Items

Joint Explanatory Statement

1. **Mental Health Awareness Training:** *SAMHSA is directed to continue to include as eligible grantees local law enforcement agencies, fire departments, and emergency medical units with a special emphasis on training for crisis de-escalation techniques. SAMHSA is also encouraged to allow training for veterans and armed services personnel and their family members. (Page 75 JES)*

   Actions Taken or to be taken
   SAMHSA included eligible grantees as directed. The Funding Opportunity Announcement (FOA) included as eligible grantees: local law enforcement agencies, fire departments, and emergency medical units with a special emphasis on training for crisis de-escalation techniques. In addition, the allowable activities in the FOA include training for veterans, service members, and their family members. In FY 2020, SAMHSA funded the continuation of 156 Mental Health Awareness Training grants to entities including local law enforcement, fire departments, and emergency medical units.

2. **Medication-Assisted Treatment for Prescription Drug and Opioid Addiction:** *Within the amount, the agreement includes $11,000,000 for grants to Indian Tribes, Tribal Organizations, or consortia. The agreement directs SAMHSA to ensure grants allow the use of medication-assisted treatment and other clinically appropriate services to achieve and maintain abstinence from all opioids, including programs that offer low-barrier or same day treatment options. (Page 80 JES)*

   Actions Taken or to be taken
   SAMHSA is requiring that for CSAT's services programs, grants support the delivery of medication-assisted treatment and other clinically appropriate services to achieve and maintain abstinence. The MAT-PDOA program's focus is on funding organizations and tribes/tribal organizations within states identified as having the highest rates of primary treatment admissions for heroin and opioids per capita and includes those states with the most dramatic increases for heroin and opioids.

3. **Treatment for Hepatitis:** *The agreement encourages SAMHSA to work with CDC to develop a plan to increase hepatitis A and B vaccinations among those populations targeted through SAMHSA's overdose prevention and substance use treatment programs. SAMHSA is further encouraged to promote awareness about the importance of hepatitis A and B vaccination among medical and health professionals, communities at high risk, and the general public. The agreement requests an update on these efforts in the fiscal year 2022 Congressional Justification. (Page 81 JES)*

   Actions Taken or to be taken
   SAMHSA has worked to decrease the prevalence of viral hepatitis and increase awareness about the importance of hepatitis vaccination. SAMHSA has worked with several partners including CDC in developing the Office of Infectious Disease Policy- Viral Hepatitis National Strategic Plan. SAMHSA has continued to work to increase vaccination through our grants and technical assistance. Also, through the Minority Aids Initiative SAMHSA grant funding can be used for hepatitis screening and testing, and hepatitis vaccination. SAMHSA will continue these efforts and strive to increase awareness and the importance of hepatitis vaccinations but has yet to develop a formal plan with CDC as SAMHSA already participates regularly in the Federal Viral Hepatitis Implementation Workgroup (VHIG), Viral Hepatitis Affinity Group and frequently amplifies CDC messaging

around these issues. SAMHSA recently published a health advisory based on TIP 53, Addressing Viral Hepatitis in People with Substance Use Disorders promoting education, screening, treatment and vaccination. It offers guidance to providers and administrators in substance use disorder treatment programs on screening for, and treating clients with, hepatitis A, hepatitis B, and hepatitis C infections. SAMHSA published this advisory which was widely disseminated, and references CDC data and guidance.

4. **Treatment, Recovery, and Workforce Support:** *The agreement includes an increase to implement section 7183 of the SUPPORT Act (P.L. 115-271). SAMHSA is directed to, in consultation with the Secretary of Labor, award competitive grants to entities to carry out evidence-based programs to support individuals in substance use disorder treatment and recovery to live independently and participate in the workforce. (Page 81 JES)*

   Actions Taken or to be taken
   SAMHSA launched the Treatment, Recovery, and Support Workforce Support Initiative. (Workforce Support) in FY 2020. As of FY 2021, twelve grants will have been awarded and continued funding is requested for FY 2022.

5. **Pregnant and Postpartum Women:** *The agreement encourages SAMHSA to prioritize States that support best-practice collaborative models for the treatment and support of pregnant women with opioid use disorders. SAMHSA is also encouraged to fund an additional cohort of States under the pilot program authorized by the Comprehensive Addiction and Recovery Act (P.L. 114-198). (Page 81 JES)*

   Actions Taken or to be taken
   SAMHSA continues to prioritize states that support best-practice collaborative models for the treatment, as well as, provide support to pregnant women with opioid use disorder. In FY 2021, SAMHSA awarded nine PPW pilot grants and SAMHSA plans to fund three new PPW-PLT programs in FY 2022.

House Appropriations Committee, Labor/HHS/Education Subcommittee (H. Rept. 116-450)

1. **Criminal and Juvenile Justice Programs:** *The Committee strongly encourages SAMHSA's Criminal Justice Activities to prioritize funding for centers that provide assistance to those with severe mental health needs who are at risk of recidivism. These mental health centers can provide, but are not limited to, the following services: crisis care, residential treatment, outpatient mental health and primary care services, and community re-entry supports. The Committee strongly encourages SAMHSA to prioritize applications from areas with high rates of uninsured individuals, poverty, and substance use disorders. (Page 147 H. Rept.)*

   Actions Taken or to be taken
   CSAT continues to fund its Drug Court grants and its Offender Reentry programs. These programs are designed to serve individuals with substance use disorders (SUDs) as their primary diagnosis. These grants may also serve individuals with co-occurring SUDs and mental disorders. However, CMHS's criminal justice portfolio focuses on individuals with mental disorders and co-occurring SUDs as a primary population of focus. In FY 2018, CMHS awarded Law Enforcement Behavioral Health Partnerships for Early Diversion (Short Title: Early Diversion) grants. Early Diversion

participants are individuals with Serious Mental Illness (SMI) or a Co-occurring Disorder (COD). The program is intended to divert participants from arrest and booking, thereby keeping them out of the criminal justice system. Many participants are homeless and repeat offenders without insurance or a source of income. In FY 2021, SAMHSA proposes to place a greater emphasis on those with SMI who are at greater risk of becoming involved in the criminal justice system.

2. **Now is the Time:** *The Committee encourages SAMHSA to sustain and strengthen its Project AWARE grant and other programs that support school-based and campus-based services aimed at preventing and treating mental health challenges experienced by younger Americans. The Committee is concerned that some States were notified that they would not be receiving already approved funding due to a new requirement and urges SAMHSA to not change requirements mid-award cycle. In addition, the Committee supports the Healthy Transitions program, which provides grants to states and tribes to improve access to mental disorder treatment and related support services for young people aged 16 to 25 who either have, or at risk of developing a serious mental health condition. (Page 148 H. Rept.)*

   Actions Taken or to be taken
   SAMHSA believes that America's schools should be safe and secure settings where children can focus on learning and develop their full potential and helping them stay on a positive trajectory that supports academic success. Project AWARE supports several strategies for addressing mental health in schools; supports for mental wellness in education settings, building awareness of mental health issues, and early intervention with coordinated supports. The program also includes a focus on the specific needs affecting rural and tribal communities, which struggle with access to mental health services in schools and access to qualified health professionals to provide such services. In addition, SAMHSA funds three other programs with an emphasis on school mental health: Mental Health Awareness Training grants that provide training to teachers and other school staff, Resiliency in Communities After Stress and Trauma (ReCAST) grants and provides technical assistance to develop school-based mental health models. Healthy Transition grantees (states and federally recognized tribes) also help youth and young adults between the ages of 16 and 25, who have serious emotional disturbance or serious mental illness, by providing outreach, youth engagement, referrals to treatment, coordination of care, and evidence informed treatment using culturally appropriate practices.

3. **Suicide Prevention:** *The Committee urges SAMHSA to develop and disseminate programs to provide specialized training and resources on identifying and responding to people at risk of suicide for families and friends of at-risk individuals. The Committee includes an increase of $5,000,000 for the implementation the Zero Suicide model, a comprehensive, multi-setting approach to suicide prevention in health care systems. The Committee includes an increase of $2,000,000 and recognizes the importance of the Suicide Lifeline to provide rapid access at any time of the day or night to crisis intervention, and when needed, emergency response. The Committee is concerned by recent data from CDC and the National Survey on Drug Use and Health indicating a significant rise in youth suicide reported over the last decade. The Committee encourages that SAMHSA, in consultation with the U.S. Department of Education, to develop a standard for providing all school-based teachers and nurses with suicide prevention training to treat mental health challenges experienced by younger Americans. In House Report 116–62, the Committee urged SAMHSA to provide specific training programs for Suicide Lifeline counselors to increase competency in serving LGBTQ youth through the utilization of existing specialized resources. The Committee also urged SAMHSA to*

consider the diversion of calls to specialty partners who are best situated to serve the LGBTQ community. As the Lifeline continues to anticipate higher call volume, both due to mental health stresses caused by COVID–19 and the potential transition to a three digit code, it is now more important than ever that SAMHSA work to implement LGBTQ competency training for counselors and an Integrated Voice Response option for LGBTQ youth callers. (Page 148-149 H. Rept.)

Actions Taken or to be taken

In FY 2020, SAMHSA developed and disseminated programs to provide specialized training and resources on identifying and responding to people at risk for suicide for families and friends of at risk individuals. This included a Psychoeducational Toolkit for Families with a Loved One Who is Suicidal, as well as specialized resources for LGBTQ youth. In FY 2020, SAMHSA will assure specific training is provided to the National Suicide Prevention Lifeline counselors to increase competency in serving LGBTQ youth. SAMHSA will also review options for the diversion of calls to specialty LGBTQ providers.

4. **Mental Health Block Grant:** *The Committee continues the ten percent set-aside within the Mental Health Block Grant total for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The Committee expects SAMHSA to continue its collaboration with the National Institute of Mental Health to encourage States to use this block grant funding to support programs that demonstrate strong evidence of effectiveness. Furthermore, the Committee directs a new five percent set-aside of the total for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. The Committee directs SAMHSA to use the set-aside to fund, at the discretion of eligible States and Territories, some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time. (Page 149-150 H. Rept.)*

   Actions Taken or to be taken

   Through the ten percent set-aside, SAMHSA continues to assist states in implementing and sustaining evidence-based practice models to address early serious mental illness including first episode psychosis. SAMHSA continues to collaborate with the National Institute of Mental Health (NIMH) to identify and support the implementation and sustainability of evidence-based programs that support early serious mental illness, including first episode psychosis. The 2021 Budget includes a five percent set aside for evidence-based crisis care programs that provide persons in a psychiatric crisis a set of core services including statewide call centers, 24/7 mobile crisis teams, and crisis stabilization or residential beds that help mitigate the crisis. SAMHSA will continue to work with states to develop state-wide call center and evidence-based crisis intervention treatment services that address the needs of persons with acute psychiatric crisis, including those with acute suicide ideation.

5. **Health Care Disparities:** *The Committee believes that addressing health care disparities experienced by racial and ethnic minorities should be a priority in programs funded by federal agencies, including programs funded in whole or part by the Community Mental Health Services Block Grant authorized under 42 U.S.C. 300x–1. The Committee directs SAMHSA to require, in the reporting mandated of states receiving the Mental Health Block Grant under 42 U.S.C. 300x–1, that State Mental Health Agencies report on services provided to individuals from racial and ethnic*

minorities, including the extent to which those services are provided to individuals from racial and ethnic minorities and the outcomes experienced by individuals from racial and ethnic minorities as a result of those services being provided. SAMHSA shall direct that impact and outcomes be reported for racial and ethnic minority adults with serious mental illness and racial and ethnic minority children with serious emotional disturbance in reports of data submitted relating to systems of care, diversions from hospitalization and criminal justice system involvement, treatment for first episode psychosis, reductions in suicide and treatment for suicidal ideation, response through crisis services, and treatment of homeless individuals and individuals residing in rural communities. State Mental Health Agencies shall also report on outreach to, and the hiring of, racial and ethnic minority providers of mental health services. (Page 150 H. Rept.)

Actions Taken or to be taken

Currently, SAMHSA Mental Health Block Grant grantees are collecting and reporting data on racial, ethnic, age, and sex demographics; criminal justice involvement; and homelessness. SAMHSA will explore the remaining items for future data collections.

6. **Child Victims of Disaster:** *The Committee recognizes the ongoing threat to mental health posed to our nation's children and families as a result of increasing frequency and intensity of natural and manmade technological disasters. Children who experience traumatic stress may struggle with a wide range of childhood developmental capabilities, including social and educational functioning, and are at higher risk of later adverse physical, mental, and behavioral health outcomes if not recognized and addressed at an early stage. For this reason, the Committee strongly encourages that funding for the National Child Traumatic Stress Network be used to address child trauma as a result of natural and technological manmade disasters. (Page 150 H. Rept.)*

   Actions Taken or to be taken

   SAMHSA believes that child traumatic stress is a pervasive and potentially life changing experience that affects tens of thousands of children each year and is a serious public health challenge. There is strong evidence that the negative impact of child trauma may lead to early childhood mental health, chronic medical, and social development issues - if not recognized and addressed early in life. The National Child Traumatic Stress Initiative (NCTSI) aims to improve and create access to evidenced-based behavioral health services and interventions for children and adolescents exposed to traumatic events. In addition to funding grants for the three NCTSI Categories in FY 2019 and FY 2020, SAMHSA funded supplemental NCTSI grants to improve the mental health services of unaccompanied migrant children. In FY 2021, SAMHSA proposes to continue supporting children, youth and families who may experience traumatic stress due to natural or technological manmade disasters. SAMHSA also proposes to fund additional supplemental grants to: (a) broaden the reach of trauma treatment and services for this population in areas not currently covered; and (b) offer mental health service provider training for direct-care providers serving this population.

7. **Certified Community Behavioral Health Clinics:** *The Committee is pleased that the Certified Community Behavioral Health Clinics (CCBHC) program is expanding access to mental health and addiction treatment services and significantly reducing hospital emergency room utilization while assisting local law enforcement agencies nationwide....The Committee directs SAMHSA to prioritize resources to entities within States that are part of section 223(a) of the Protecting Access to Medicare Act of 2014 (P.L. 113–93) demonstration and to entities within States that were awarded planning grants. (Page 151 H. Rept.)*

Actions Taken or to be taken
In FY 2020, SAMHSA released a new Funding Opportunity Announcement that prioritized entities within states that are part of the Protecting Access to Medicare Act of 2014 demonstration and to entities within states that were awarded planning grants.

8. **State Opioid Response Grants:** *The Committee is concerned longstanding guidance to the Department to avoid a significant cliff between States with similar mortality rates was overlooked in the award of fiscal year 2020 funds. For future awards, the Committee directs the Assistant Secretary to award funds to address funding cliffs between States with similar mortality rates. (Page 152 H. Rept.)*

Actions Taken or to be taken
SAMHSA will review the formula and its impact on states with similar mortality rates.

9. **Criminal Justice Activities:** *The Committee continues to direct SAMHSA to ensure that all funding appropriated for Drug Treatment Courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. The Committee directs SAMHSA to ensure that all drug treatment court grant recipients work directly with the corresponding State substance abuse agency in the planning, implementation, and evaluation of the grant. The Committee further directs SAMHSA to expand training and technical assistance to drug treatment court grant recipients to ensure evidence-based practices are fully implemented. (Page 153 H. Rept.)*

Actions Taken or to be taken
SAMHSA will continue to ensure that all funding appropriated for Drug Treatment Courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. Future SAMHSA drug court FOAs will direct all Drug Treatment Court grant recipients to work directly with the corresponding state substance abuse agency in the planning, implementation, and evaluation of the grant. SAMHSA currently provides training and technical assistance to drug treatment courts across the nation through the GAINS Center for Behavioral and Justice Transformation Center contract. SAMHSA will ensure that the GAINS Center provide SAMHSA grant recipients training and technical assistance to ensure evidence-based practices are fully implemented.

10. **Emphasis on Comprehensive Services:** *In recent fiscal years, the Committee has provided historic resources to combat the opioid epidemic, with a particular focus on expanding access to treatment, and treating and preventing comorbidities that can be associated with injection drug use. At the Committee's urging, the Department has rightfully prioritized efforts that increase access to treatment and recovery services. For all programs not focused exclusively on prevention of substance abuse, the Committee directs the Department to continue its emphasis on evidence-based medical interventions, and to ensure that all such interventions, including programs that focus on harm reduction, provide referral to treatment and recovery services. (Page 153 H. Rept.)*

Actions Taken or to be taken
SAMHSA continues to emphasize evidence-based medical interventions that promoted referral to treatment and recovery services. For example, SAMHSA's criminal justice portfolio includes drug court grants that focus on diversion and alternatives to incarceration for adolescents and adults with drug/alcohol addiction and/or co-occurring drug/alcohol addiction and mental illness. The Offender Reentry Program (ORP) grants provide screening, assessment, comprehensive treatment, and recovery

support services for diverse populations reentering the community from incarceration. Grantees are encouraged to use grant funds to provide medication-assisted treatment with FDA-approved medications. In July 2019, SAMHSA published an Evidence-based Practice Guidebook focused on medication-assisted treatment (MAT) implementation in criminal justice settings.

SAMHSA's Improving Access to Overdose Treatment (CARA) grant program increases access to treatment, reduces unmet treatment need, and reduces opioid overdose related deaths. Grantees utilize SAMHSA's Opioid Overdose Prevention Toolkit as a guide and includes a comprehensive prevention program that focuses on prevention, treatment, and recovery services to decrease the likelihood of drug overdose recurrence. SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SABG) funds priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time. The SABG 20 percent primary prevention set-aside requires that grantees spend at least 20 percent of their SABG expenditures to develop and implement a comprehensive substance misuse prevention program. It is imperative that our addiction crisis response evolve from an acute short-term individual-focused treatment response to a broader community recovery response. Addiction is a chronic illness, and recovery often is a life-long process where external community and social determinants of health play a vital role in its sustainability. The budget request includes a new 10% set aside within the SABG for recovery support services in order to significantly expand the continuum of care both upstream and downstream. This new set-aside will: support the development of local recovery community support institutions (i.e. recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries); develop strategies and educational campaigns, trainings, and events to reduce addiction/recovery-related stigma and discrimination at the local level; provide addiction treatment and recovery resources and support system navigation; make accessible peer recovery support services that support diverse populations and are inclusive of all pathways to recovery; and collaborate and coordinate with local private and non-profit clinical health care providers, the faith community, city, county, state, and federal public health agencies, and criminal justice response efforts.

Additionally, SAMHSA, along with other HHS agencies, has developed guidance for grantees regarding use of grant funds to support syringe services programs, testing kits for HIV, navigation services to ensure linkage to HIV and viral hepatitis prevention, testing, treatment and care services, including antiretroviral therapy for HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother to child transmission and partner services; substance use disorder treatment, and medical and mental health care.

11. **Grants to Prevent Prescription Drug/Opioid Overdose and First Responder Training:** *The Committee notes strong concerns about the increasing number of unintentional overdose deaths attributable to prescription and nonprescription opioids. SAMHSA is urged to take steps to encourage and support the use of Substance Abuse and Prevention Block Grant funds for opioid safety education and training, including initiatives that improve access for licensed healthcare professionals, including paramedics, to emergency devices used to rapidly reverse the effects of opioid overdoses. Such initiatives should incorporate robust evidence-based intervention training and facilitate linkage to treatment and recovery services. (Page 153 H. Rept.)*

Actions Taken or to be taken

SAMHSA ensures that SABG recipients are addressing the opioid crisis by monitoring recipient's adherence to their respective SABG application. The application explicitly states that "states continue to make primary substance use disorder prevention a priority. To respond to the primary prevention set-aside requirement of the SABG, states should keep in mind that the backbone of a prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance

use and its associated consequences. The system must also be able to use this data to identify areas of greatest need, and to identify, implement, and evaluate evidence-based programs, practices and policies that have the ability to reduce substance use and improve health and well-being in all communities." Also, written in the application, "state authorities are strategic in leveraging scarce resources to fund prevention services." SAMHSA works with state authorities to ensure that they comport with changes in quality reporting. States are required to utilize the National Behavioral Health Quality Framework (NBHQF) as a mechanism for to examine, prioritize, and report on approaches to prevention, treatment, and recovery processes through the SABG as well as discretionary and formula grantees. As a result, SAMHSA SABG funded recipients are able to utilize substance prevention block grant dollars for opioid safety education and training, including initiatives that improve access for licensed healthcare professionals, including paramedics, to emergency devices used to rapidly reverse the effects of opioid overdoses. In addition, to this tool, SAMHSA has been working with states and state representative organizations to identify and implement a core set of measures, which includes approved quality measures to assess outcomes and quality in programming. This effort guides and aligns the measurement requirements of Medicaid and Medicare. Also, SAMHSA continues to encourage SABG recipients to incorporate evidence-based intervention training and facilitate linkage to treatment and recovery services.

The PTTC Network delivers training and technical assistance on practices that have proven effective in transferring knowledge and skills, tailored to the local needs of specific technical assistance recipients. A primary goal of the PTTC Network is to help prevention organizations make effective changes that produce measurable changes in outcomes. In addition, CSAP Project Officers during their monitoring calls (monthly for newer grantees) and quarterly, remind, as well as, continue to encourage grantees to be sure to incorporate evidence-based intervention training and to facilitate linkage to treatment and recovery services. SAMHSA's Grants to Prevent Prescription Drug and Opioid Overdose-related Deaths program helps states identify communities of high need and provide education, training, and resources necessary to meet their specific needs. Grant funds may be used for purchasing overdose reversing drugs, equipping first responders with them, providing training on their use, developing other overdose-related death prevention strategies, and providing materials to assemble and disseminate overdose kits. A growing evidence base suggests that overdose reversal drugs are a cost-effective method to reducing opioid overdose deaths. Grantees are also required to develop a dissemination plan and a training course tailored to meet the needs of first responders in their communities. The course uses SAMHSA's Opioid Overdose Prevention Toolkit as a guide and includes a comprehensive prevention program that will focus on prevention, treatment, and recovery services in order to decrease the likelihood of drug overdose recurrence. SAMHSA also funds First Responder Training grants and Improving Access to Overdose Treatment grants, which also increase access to treatment, reduce unmet need, and reduce opioid overdose related deaths through the use of evidence-based training.

12. **Screening, Brief Intervention, and Referral to Treatment:** *The Committee directs $2,000,000 for implementing grants to pediatric health care providers in accordance with the specifications outlined in Section 9016 of P.L. 114–255, Sober Truth in Preventing Underage Drinking Reauthorization. Training grants should focus on screening for underage drinking, opioid use, and other drug use, and be managed by CSAT within the existing SBIRT program. (Page 154 H. Rept.)*

Actions Taken or to be taken

The SBIRT program in CSAT is currently accepting applications for FY 2021. This program is to implement screening, brief intervention, and referral to treatment services for children, adolescents, and/or adults in primary care and community health settings with a focus on screening for underage

drinking, opioid use, and other substance use. SAMHSA plans to award 10 new grants to support this program.

13. **Targeted Capacity Expansion:** *The Committee includes an increase of $2,000,000 for grants to Indian tribes, tribal organizations, or consortia. The Center for Substance Abuse Treatment is directed to include as an allowable use medication-assisted treatment and other clinically appropriate services to achieve and maintain abstinence from all opioids and heroin and prioritize treatment regimens that are less susceptible to diversion for illicit purposes. (Page 154 H. Rept.)*

Actions Taken or to be taken
SAMHSA supports the use of Medication Assisted Treatment (MAT) to assist individuals who have an opioid use disorder. In fact, within SAMHSA service funding opportunity announcements, SAMHSA stipulates that a grantee can not deny any appropriate and eligible client access to their program because of their use of Food and Drug Administration approved medications (e.g., methadone, injectable naltrexone, non-injectable naltrexone, disulfiram, acamprosate calcium, buprenorphine, etc.) that were appropriately authorized through prescription of a licensed prescriber. Additionally, MAT must be permitted to be continued for as long as the prescriber determines that the medication is clinically beneficial.

14. **Pregnant and Postpartum Women:** *The Committee recognizes SAMHSA for its work managing the Pregnant and Postpartum Women program which utilizes a family-centered approach to provide comprehensive residential substance use disorder treatment services for pregnant and postpartum women, their minor children and for other family members. A provision in the Comprehensive Addiction and Recovery Act (CARA) authorized SAMHSA to allocate a portion of these resources for a pilot program to State alcohol and drug agencies to support outpatient, intensive outpatient and related services in a family-centered approach. The Committee encourages SAMHSA to fund an additional cohort of States above and beyond those pilots already funded. (Page 154 H. Rept.)*

Actions Taken or to be taken
SAMHSA continues to prioritize states that support best-practice collaborative models for the treatment, as well as, provide support to pregnant women with opioid use disorder. In FY 2021, SAMHSA awarded nine PPW pilot grants and SAMHSA plans to fund three new PPW-PLT programs in FY 2022.

15. **Family Support Services for Addiction:** *As many resources have been disbursed to state and local agencies, the Committee urges SAMHSA, in accordance with the Public Health Service Act, to ensure these family community organizations also have access to these funds to develop, expand, and enhance their services for families of those struggling with substance use disorder. (Page 154-155 H. Rept.)*

Actions Taken or to be taken
Many of SAMHSA's FOAs are open to domestic public and private non-profit entities, which would include family community organizations. SAMHSA has two programs that provide funding to community-based organizations- 1) Enhancement and Expansion of Treatment Recovery Services for Adolescents, Transitional Aged Youth, and Their Families and 2) Pregnant and Postpartum Women's (PPW) Residential Program. Both programs focus on advancing service delivery from a family-centered perspective to ensure the inclusiveness of comprehensive substance use disorder treatment services for the primary populations and their family members. Additionally, SAMHSA

provides funding to states, territories, and tribes, which support multiple community-based organizations in delivering family-centered substance use disorder treatment services through two programs-1) Cooperative Agreements for Adolescents and Transitional-Aged Youth Treatment Implementation and 2) state Pilot Grant Program for Treatment for PPW (outpatient program). One of the main goals of these two programs is to build long-term sustainable capacity. In the future, SAMHSA will continue to provide support in encouraging the participation of family community organizations in SAMHSA's funded programs, including through technical support provided by SAMHSA's existing Addiction Technology Transfer Centers.

OPDIV Specific Requirements

PPHF

GLS - Youth Suicide Prevention - States (PPHF)	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Grants	11,397,473.00	11,409,087.00	11,434,674.00
PHS Eval Tap	300,000.00	300,000.00	300,000.00
CCB Tap	302,527.00	290,913.00	265,326.00
Total	**12,000,000.00**	**12,000,000.00**	**12,000,000.00**

The Garrett Lee Smith (GLS) Memorial Act (Public Law 108-35) authorizes SAMHSA to award grants to states tribes and manage this grant program through a competitive process. This grant funded is the major federal support for youth suicide prevention efforts in the United States. The GLS Youth Suicide Youth Suicide Prevention State and Tribal grant program develops and implements youth suicide prevention and early intervention strategies involving public-private collaborations among youth serving institutions. In FY 2019, the GLS Youth Suicide Prevention State and Tribal grant program was funded at $12 million from the Prevention and Public Health Fund (PPHF) and $22 million from SAMHSA's base budget. In FY 2020 and FY 2021, SAMHSA also funded the GLS Youth Suicide Prevention State and Tribal grant program at $12 million from the PPHF and $22 million from SAMHSA's base budget. In FY2022, SAMHA is also requesting $12 million from the PPHF

SAMHSA's evaluation of national youth suicide prevention efforts (age 10 to 24) have shown that counties implementing SAMHSA funded GLS youth suicide prevention activities have lower rates of youth suicide deaths than matched counties not implementing such activities. This impact is maintained for two years and the impact appears directly related to years of continued funding. Approximately 50 percent of the counties in America have received at least one year of funding since the program started in 2005. Since 2005 over 1.6 million individuals participated in over 39,000 training events or educational seminars provided by grantees. In FY 2019, 195,000 youth were screened for suicide risk, 30,362 youth were referred to services, and 76.3 percent received services. Grantees' efforts are reducing the likelihood of at-risk youth falling through the gaps in the system through the provision of proactive follow up after Emergency Room and Inpatient discharge.