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

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Updated September 5, 2008

Abstract. This report describes SAMHSA's history, organization, authority, and programs, and analyzes the issues that may be considered if the 110th Congress takes up the agency's reauthorization. The Appendices include a list of relevant websites, the National Outcome Measures, and a table that shows authority and appropriations for SAMHSA's various programs since 2004.

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

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Summary

SAMHSA is the federal agency that provides federal funds for community-based substance abuse and mental health services. SAMHSA awards discretionary funds to substance abuse and mental health programs through its authorities in Title V of the Public Health Service (PHS) Act. In addition, SAMHSA provides formula-based Substance Abuse Prevention and Treatment (SAPT) block grants and Mental Health (MH) block grants through its authorities in Title XIX of the PHS Act. SAMHSA has had level funding at approximately $3 billion since it was last reauthorized in 2000. Most of SAMHSA's authorities expired at the end of FY2003.

The 2000 reauthorization (P.L. 106-310) focused on improving mental health and substance abuse services for children and adolescents, implementing proposals to give states more flexibility in the use of block grant funds with accountability based on performance, and consolidating discretionary grant authorities to give the Secretary of the Department of Health and Human Services (HHS) more flexibility to respond to those who require mental health and substance abuse services. The legislation provided a waiver from the requirements of the Narcotic Addict Treatment Act of 1974 to permit qualified physicians to dispense schedule III, IV, or V narcotic drugs or combinations of such drugs approved by Food and Drug Administration (FDA) for the treatment of heroin addiction, and provided a comprehensive strategy to combat methamphetamine use.

SAMHSA has had three new authorizations since 2000. The Sober Truth on Preventing Underage Drinking Act of 2005 (P.L. 109-422) requires SAMHSA to collaborate with other federal agencies to prevent alcohol use by minors. The Garrett Lee Smith Memorial Act of 2004 (P.L. 108-355) enables SAMHSA to support youth suicide prevention activities in states and on college campuses. The No Child Left Behind Act of 2002 (P.L. 107-110) requires SAMHSA to consult with the Secretary of the Department of Education on the soliciting and awarding of grants through this program.

As SAMHSA reauthorization is considered, issues that may be of interest include accountability for the block grants, flexibility for SAMHSA to issue grants using its general authority, the Access To Recovery Program, and SAMHSA's role in disaster response. In addition, there have been some criticisms of the formula used to distribute SAMHSA's block grants.

This report describes SAMHSA's history, organization, authority, and programs, and analyzes the issues that may be considered if the 110th Congress takes up the agency's reauthorization. The **Appendixes** include a list of relevant websites, the National Outcome Measures, and a table that shows authority and appropriations for SAMHSA's various programs since 2004.

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Background and History

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency, located within the Department of Health and Human Services (HHS), that funds mental health and substance abuse treatment and prevention services. SAMHSA provides federal support for these services by administering two block grants (one for substance abuse prevention and treatment services, the other for mental health services), two other formula grants, and discretionary grants to local communities, states, and private entities to address the public health issues of substance abuse and mental illness. SAMHSA funds a wide range of activities including strategic planning, education and training, prevention programs, early intervention, and treatment services. SAMHSA's Substance Abuse Prevention and Treatment (SAPT) block grant provides an average of 42% of the expenses of the state agency responsible for substance abuse. By comparison, SAMHSA's Community Mental Health Services (CMHS) block grant funds only an average of 2-3% of the expenses for the state mental health agency.[1] The difference reflects the historical role federal and state governments have played in funding services in these two areas.

In 1946 Congress established the National Institute of Mental Health (NIMH), in growing recognition of the extraordinary burden that disorders of brain and behavior place on national health resources. Congress, after determining that a strong program of research and research training would contribute most directly to improving mental health and to treating mental illness, alcoholism, and drug abuse, established NIMH as one of the original components of the National Institutes of Health (NIH). In addition to research, the new institute's mission included programs for educating and training clinical personnel and for providing leadership to enhance the quality of treatment services.

In the early 1970s, increasing awareness of the public health problems of alcohol abuse and alcoholism led to the founding of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) from what had been NIMH's alcohol division; a similar event occurred in the field of drug abuse with the founding of the National Institute on Drug Abuse (NIDA). In 1974, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) was created as the parent agency for the three research agencies, NIMH, NIAAA and NIDA, and to provide federal funding to states for substance abuse and mental health treatment services.

In 1992, the ADAMHA Reorganization Act (P.L. 102-321) moved the three research institutes—NIMH, NIDA and NIAAA—to NIH. ADAMHA was renamed SAMHSA to reflect its focus on funding community-based services. SAMHSA is authorized under Title V of the Public Health Service (PHS) Act, as amended. The SAPT and CMHS block grants are authorized under the PHS Act Title XIX Part B. In 2000, most of SAMHSA's authorities were reauthorized through FY2003.[2]

This report describes SAMHSA's history, organization, authority, and programs, and analyzes the issues that may be considered if the 110th Congress takes up the agency's reauthorization. This report will be updated as necessary.

[1] SAMHSA, Office of Legislative Affairs, May 7, 2007.

[2] P.L. 106-310.

Organization and Funding

In FY2008, SAMHSA employed 534 full-time employees and had a budget of nearly $3.4 billion. SAMHSA is composed of three centers of operation, as described below. Each center has a director who reports to SAMHSA's Administrator. Each center has general authority to fund states and communities to address priority substance abuse and mental health needs. This authority, called Programs of Regional and National Significance (PRNS), authorizes SAMHSA to fund projects that (1) translate promising new research findings to community-based prevention and treatment services; (2) provide training and technical assistance; and (3) target resources to increase service capacity where it is most needed. SAMHSA determines its funding priorities in consultation with states and other stakeholders. For a list of specific programs authorities within each of SAMHSA's centers, see **Appendix A**.

Center for Mental Health Services (CMHS)

CMHS supports mental health services provided by the states and local governments through its mental health block grant and discretionary grant programs. CMHS is authorized to prevent mental illness and promote mental health by providing funds to evaluate, improve and implement effective treatment practices, address violence among children, provide technical assistance to state and local mental health agencies, and collect data.

Center for Substance Abuse Treatment (CSAT)

CSAT administers the SAPT block grant and other programs of regional and national significance. CSAT is authorized to develop, evaluate and implement effective treatment programs; and enable improvement of service quality and access.

Center for Substance Abuse Prevention (CSAP)

CSAP supports programs of regional and national significance for substance abuse prevention. CSAP is authorized to prevent substance abuse through public education, training, technical assistance, and data collection. This center also provides states with grants to support their strategic planning activities and maintains a registry of evidence-based practices for substance abuse prevention.

SAMHSA's budget has been fairly level since the agency was reauthorized in 2000. As shown in **Table 1**, the dollar amounts have been fairly constant since FY2002.

Table 1. SAMHSA Funding, FY2000-FY2008

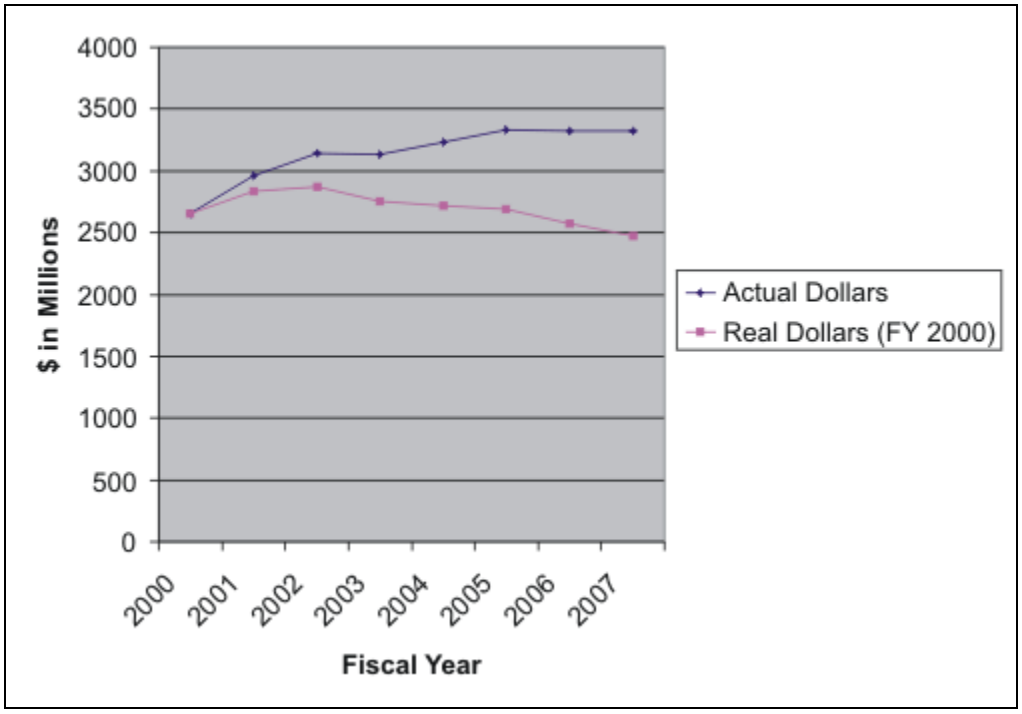
(dollars in millions)

	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08
CMHS	631	782	832	856	862	901	883	883	911
CSAP	479	175	198	197	198	198	192	192	194
CSAT	1,814	1,921	2,016	2,071	2,198	2,197	2,156	2,157	2,159
Total	**2,651**	**2,966**	**3,141**	**3,137**	**3,233**	**3,334**	**3,322**	**3,326**	**3,356**

Source: SAMHSA budget justifications.

If SAMHSA's appropriation levels are adjusted for inflation, there has been a net decrease in funding available for substance abuse and mental health services. For example, SAMHSA's FY2000 budget of $2.651 billion is equivalent to $3.417 billion for FY2007. Actual FY2007 appropriation was only $3.326 billion. This is illustrated in **Figure 1**, which shows a downward trend in the real dollar value of SAMHSA's total appropriations between FY2000 and FY2007. **Appendix B** includes the authorization and appropriation levels for major SAMHSA programs.

Figure 1. SAMHSA Funding FY2000-FY2007



Source: Prepared by CRS using SAMHSA budget justifications.

Priorities Matrix

In April 2006, SAMHSA published a matrix[3] that listed the mental health and substance abuse issues addressed by the agency, along with the cross-cutting principles SAMHSA applies to each issue area (See **Appendix C**).

SAMHSA has identified a number of priority areas; typically these are policy issues that cut across the work of its three centers. The priority issue areas include individual health concerns like co-occuring mental health and substance abuse disorders, suicide, behavioral health issues for individuals with hepatitis and HIV/AIDS; societal issues like homelessness, and criminal justice; and systems-level issues like treatment capacity and workforce development. In addition, SAMHSA has identified principles to guide program, policy and resource allocation within the agency. These principles include use of evidence-based practices, evaluation, collaboration, cultural competence, stigma reduction, and cost-effectiveness. The matrix illustrates, for example, that SAMHSA aims to address the issue of co-occurring disorders using each of the cross-cutting principles including evidence-based practices, surveillance, and collaboration.

SAMHSA does not formally require its grantees to apply each of these cross-cutting principles to their work. Instead, SAMHSA requires grantees to submit data using the indicators identified through the National Outcome Measures, as described later in this report. There is no crosswalk between the National Outcome Measures and the cross-cutting principles in this matrix.

Reauthorization Issues in 2000

SAMHSA was last authorized in 2000, as part of the Children's Health Act.[4] At the time of that reauthorization, most of the agency's programs were extended for three years, through FY2003, and the block grant funding formula was not modified. A discussion of issues surrounding the block grant formula, which has not changed since 1992, is presented later in this report.

The 2000 reauthorization focused on improving mental health and substance abuse services for children and adolescents, implementing proposals to give states more flexibility in the use of block grant funds, and replacing some existing categorical grant programs with general authority to give the Secretary of HHS more flexibility to respond to those who require mental health and substance abuse services.

Provisions in the 2000 reauthorization that related to children and adolescents authorized programs to address emergency response, treatment services, and other comprehensive community-based services for youth at risk due to violence, substance abuse, or mental illness. Other provisions addressed the issue of homeless individuals with substance abuse and/or mental illness. Additionally, SAMHSA was required to issue regulations on use of restraint and seclusion within residential non-medical facilities.[5] These facilities were required to report deaths occurring as a result of use of restraint (restricting the movement of a person's limbs, head or body by the use of mechanical or physical devices for the purpose of preventing injury to self or others) and

[3] SAMHSA, *Matrix of Priorities*, April 2006 at http://www.samhsa.gov/Matrix/ Matrix_Brochure_2006.pdf.

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

[5] 42 CFR 483 Subpart G (2003).

seclusion (isolation and containment of residents who pose an imminent threat of physical harm to themselves or others) to the Secretary of HHS within 24 hours of the death. Finally, provisions relating to methamphetamine abuse included criminal penalties, enhanced law enforcement, and programs for abuse prevention and treatment.

The 2000 reauthorization legislation also included two additional titles.[6] The first title permitted qualified physicians to treat heroin addicts in the doctor's offices using drugs approved by the Food and Drug Administration (FDA), and the second title provided a comprehensive strategy to combat methamphetamine abuse.

As part of the 2000 reauthorization, SAMHSA was required to produce two reports to Congress. The first report was on the efforts of the agency and the states to provide coordinated services to individuals who have co-occuring substance abuse and mental health problems. In this report, which was produced in 2002, SAMHSA summarized the prevention and treatment practices for people with co-occurring disorders, and provided a plan for improving services for these people.[7] The second report discusses the flexibility and performance of its block grants and accountability measures. This report, which SAMHSA delivered in 2005, detailed the flexibility given to states, defined the common performance measures to be used for state accountability, outlined an implementation strategy, and discussed possible obstacles to implementing the performance measures.[8] A discussion of the performance measures is included in this report under the section on current reauthorization issues.

Authorizations Since FY2000

There have been few modifications of SAMHSA's authority since the 2000 reauthorization. The three major laws passed since then that involve SAMHSA are described below.

The Sober Truth on Preventing Underage Drinking Act of 2005[9]

SAMHSA is required to participate in the Interagency Coordinating Committee on the Prevention of Underage Drinking. The committee is intended to guide policy and program development across the federal government, with respect to underage drinking. SAMHSA has been providing leadership for this committee.[10]

[6] P.L. 106-310, Titles XXXV - XXXVI.

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

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

[9] P.L. 109-422.

[10] For a discussion of SAMHSA's role in the prevention of underage drinking, see CRS Report RS22636, *Alcohol Use Among Youth*, by Andrew Sommers and Ramya Sundararaman.

The Garrett Lee Smith Memorial Act of 2004[11]

This act authorizes SAMHSA to support the planning, implementation, and evaluation of organized activities involving statewide youth suicide early intervention and prevention strategies; to provide grants to institutions of higher education to reduce student mental and behavioral health problems; to support a national suicide prevention hotline; and to fund a national technical assistance center for suicide prevention.

The No Child Left Behind Act of 2002[12]

This act requires SAMHSA to provide consultation to the Secretary of Education in awarding grants to local educational agencies for reducing alcohol abuse in secondary schools.

Current Reauthorization Issues

As SAMHSA reauthorization is considered, issues that may be of interest include accountability for SAMHSA grants, the consequences of increased flexibility for SAMHSA to issue grants using general authority (PRNS), the Access To Recovery Program, and SAMHSA's role in disaster response.

Accountability for SAMHSA Grants

In order to increase accountability, SAMHSA has identified 10 domains as National Outcome Measures (NOMs) in collaboration with the states. The indicators for these domains (see **Appendix D**) are intended to measure the effectiveness of SAMHSA's mental health and substance abuse grants in enabling individuals in need to attain and sustain recovery; build resilience; and work, learn, and participate fully in their communities. SAMHSA's 2006 annual report indicates that between 43 and 47 states report on the different mental health outcomes, and between 27 and 38 states report on the different substance abuse outcomes.[13]

Flexible Use of Funds

Most of SAMHSA's substance abuse funding is provided under general authority (PRNS), rather than being directed toward specific substances of abuse, whether for prevention or treatment. This gives the agency, in consultation with states, the flexibility to determine the specific problem the funds will be used to address, such as unique or emerging substance abuse issues in a particular state. This practice may also make it easier to provide coordinated care for those in need of multiple substance abuse treatment services. On the other hand, SAMHSA's use its block grant funding and PRNS authority to provide grants makes it difficult for Congress to determine how much funding is used to address specific issues of interest. For example, while there was a line

[11] P.L. 108-355.

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

[13] SAMHSA, *A Message from the Administrator*, 2007, at http://www.nationaloutcomemeasures.samhsa.gov/welcome.asp. The 2006 SAMHSA report highlighting the compiled results of the data submitted by the states is at http://www.nationaloutcomemeasures.samhsa.gov/./PDF/overview2006.pdf.

item in SAMHSA's FY2006 budget providing $3.9 million to address methamphetamine abuse, no funding was provided specifically for methamphetamine treatment. However, states used some of their block grant funds, Access To Recovery funds and other grant funds for methamphetamine treatment. For a list of SAMHSA authorizations and their funding levels, see **Appendix B**.

Access To Recovery (ATR)

The Access to Recovery (ATR)[14] program is an initiative, proposed by President Bush in FY2003, which provides vouchers to clients for the purchase of substance abuse clinical treatment and recovery support services. The program has been funded at about $98 million per year since FY2004. ATR is different from other grant programs funded by SAMHSA in that the state uses program funds to evaluate the consumer and provide a voucher for the consumer to obtain treatment services from an approved provider of his or her choice. The first ATR grants were funded through CSAT in FY2004. SAMHSA expects to evaluate the program with FY2007 funds, by which time all 15 grantees will have been funded for more than two years. The evaluation is expected to take three years to complete.

Disaster Response

SAMHSA played a significant role in providing mental health and substance abuse services after Hurricanes Katrina and Rita. However, experts believe that the current evidence base for effective treatment and prevention strategies targeting disaster survivors is weak. One approach to addressing this concern might be requiring a collaborative effort on this issue by SAMHSA and the National Institute of Mental Health (NIMH).[15]

Collaboration with Other Federal Agencies

SAMHSA works closely with the three behavioral health research institutes at NIH (NIDA, NIMH and NIAAA) to enable promising research findings to be translated into services. While SAMHSA has expertise in and funds programs in the fields of substance abuse and mental health, other federal agencies have expertise on and access to populations that are affected by these problems. The Departments of Education and Justice serve youth, with substance abuse and mental health problems, who are also the focus of many SAMHSA programs. The Centers for Disease Control and Prevention's (CDC) Injury Prevention and Control Program works on prevention and surveillance in the fields of violence, suicide and mental health. The Indian Health Service (IHS) serves a population that has significant substance abuse problems, along with issues of access to mental health care. However, there are few statutory requirements by which these agencies are required to work closely with SAMHSA. Improved collaboration between these agencies may be required in order to improve the quality and cost-effectiveness of services provided by the federal government.

[14] Program details available at http://atr.samhsa.gov.

[15] For a detailed description of the services provided by SAMHSA and analysis of issues, see CRS Report RL33738, *Gulf Coast Hurricanes: Addressing Survivors' Mental Health and Substance Abuse Treatment Needs*, by Ramya Sundararaman, Sarah A. Lister, and Erin D. Williams.

Focus on Prevention and Early Intervention

The 1999 Surgeon General's Report on Mental Health and the 2002 President's New Freedom Commission Report framed mental health as a public health issue. The reports advised applying a public health approach, which would emphasize prevention and early intervention, rather than focusing on individuals who have become severely ill and expensive to treat. The Commission recommended a wholesale transformation of the nation's approach to mental health care involving consumers and providers, policymakers at all levels of government, and both the public and private sectors. SAMHSA has funded states to develop plans to reduce system fragmentation and increase services and support available to people living with mental illness.

Block Grants Formula

History

The Alcohol, Drug, and Mental Health Services (ADMS) block grant was one of seven block grants established by the Omnibus Budget Reconciliation Act of 1981 (OBRA).[16] This block grant consolidated several existing categorical grants for substance abuse and community mental health services in order to provide state and local governments with more flexibility and control over funding to enhance their ability to meet localized needs, to end duplication of effort in delivering services, and to enable better coordination. OBRA authorized ADMS block grant funds for FY1982 through FY1984 in proportion to the historical funding patterns of the original categorical grants. Due to the resulting inequities among states in per capita funding for substance abuse and mental health services, OBRA directed HHS to conduct a study that would produce a formula, considering population and state fiscal capacity, to more equitably distribute funds among states.

The 1984 ADAMHA Amendments renewed the block grants for three years with a "minor equity adjustment" that would hold harmless states that would have otherwise received decreased funding under the new calculation.[17] Funds above the FY1984 hold-harmless level[18] were to be allocated using a formula based equally on state population and relative per capita income. The Amendments also required a non governmental entity to provide recommendations on the formula proposed by HHS. The resulting recommendations, from the Institute for Health and Aging (IHA),[19] included phasing out the hold-harmless provisions, allocating funds based on populations at risk, and incorporating a state fiscal capacity measure.

The 1988 Anti-Drug Abuse Act[20] revised the formula, based on the IHA recommendations, to phase out the hold-harmless provision, use total taxable resources as the measure of state fiscal

[16] P.L. 97-35.

[17] P.L. 98-509.

[18] This hold-harmless provision assured that each state's block grant funding would not be less than the amount it received in FY1984. Currently, the hold-harmless provision is set at the level received by the state in FY1998 for the mental health block grant, and the previous fiscal year for the substance abuse block grant. If there is a decrease in appropriation for the substance abuse block grant, states can get a proportionate decrease in their block grant amount. There is no similar provision for the mental health block grant.

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

[20] P.L. 100-690, Comprehensive Alcohol Abuse, Drug Abuse and Mental Health Amendments Act.

capacity, and incorporate weighted age cohorts as a measure of population at risk. The high-risk age cohorts, determined using an IHA study, were 25-64 years for alcohol abuse, 18-24 years for other drug abuse, and 25-44 for selected mental disorders. Later studies indicated that inequities in the block grants persisted even after the recommendations were implemented.[21]

The 1992 ADAMHA Reorganization Act split the ADMS block grant into two separate block grants, one for mental health services (CMHS block grant) and another for substance abuse services (SAPT block grant). The formula for the two block grants was adjusted to reflect the differences in the population in need of mental health and substance abuse services.[22]

Current Formula

The formula for calculating the grant amounts, which is in Sec. 1918 and Sec. 1933 of the PHS Act, takes into account three measures: (1) the population in need of services, (2) costs of services in the state, and (3) fiscal capacity of the state. The first factor is intended to be a proxy for the extent of need for services in a state. Adjustments were made to the weights assigned to each age-cohort in this factor to address the inequities caused by the original weights used. The second factor, which is the cost of services, is derived from the 1990 report of Health and Economics Research, Inc., and ranges from 0.9 to 1.1.[23] The third factor, which is the fiscal capacity of the state, is intended to adjust for differences in state capacity to pay for these services. This factor uses the three-year mean of the total taxable revenue of the state.

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

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

where

G_i = grant amount for the i^{th} state
A = total funds appropriated for distribution among the states
X_i = score for the i^{th} state

There is a hold-harmless provision (no less than previous year's amount) as well as a state minimum provision ($50,000 + 30.65% of the percentage increase in the total block grant amount).

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

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

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

Issues Regarding Current Formula

A number of issues has been raised regarding the current formula. First, the formula does not consider variations in numbers of uninsured individuals across the states, and other federal funding (e.g., Medicare and Medicaid) that a state may also receive for mental health and substance abuse services. Second, experts recommend using data from major national epidemiological datasets to determine the population in need of services. These datasets are from the National Comorbidity Survey-Replication[24] for mental health needs, and the National Survey on Drug Use and Health (NSDUH)[25] for substance abuse needs. Third, research indicates that the currently used cost-of-services measure does not adequately represent interstate wage variations in occupations related to substance abuse and mental health.[26]

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

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

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

Appendix A. Program Descriptions for Authorized SAMHSA Sections

Section PHS Act (42 U.S.C. Citation)	Title	Program Description
Center for Substance Abuse Treatment (CSAT)		
Sec. 509 (290bb-2)	Priority Substance Abuse Treatment Needs of Regional and National Significance	General authority to provide grants and fund activities intended to increase knowledge on best practices, provide training and technical assistance, and increase capacity of states and local entities to provide for necessary substance abuse treatment services.
Sec. 508 (290bb-1)	Residential Treatment Programs for Pregnant and Postpartum Women	Grants to expand the availability of comprehensive, high quality residential treatment services for pregnant and postpartum women who suffer from alcohol and other drug use problems, and for their minor children impacted by perinatal and environmental effects of maternal substance use and abuse.
Sec. 514 (290bb-7)	Substance Abuse Treatment Services for Children and Adolescents	Grants, contracts or cooperative agreement for providing substance abuse treatment services, early intervention, programs to prevent the use of methamphetamine and inhalants, and for creating centers of excellence to assist States and local jurisdictions in providing appropriate care for adolescents who are involved with the juvenile justice system and have a serious emotional disturbance.
Sec. 514A (290bb-8)	Early Intervention Services For Children and Adolescents	Grants to provide early intervention substance abuse services for children and adolescents. (Not funded)
Sec. 514(d) (290bb-9(d))	Methamphetamine and Amphetamine Treatment Initiative	To expand methamphetamine treatment services in areas with high prevalence of methamphetamine abuse. (Not funded)
Sec. 1935 (a) (200x-35)	Substance Abuse Prevention and Treatment Performance Partnership Block Grants	Provides funding to States by formula to plan, carry out, and evaluate activities to prevent and treat substance abuse.
Center for Substance Abuse Prevention (CSAP)		
Sec. 516 (290bb-22)	Priority of Substance Abuse Prevention and Needs of Regional and National Significance	General authority to provide grants and fund activities intended to increase knowledge on best practices, provide training and technical assistance, and increase capacity of states and local entities to provide for necessary substance abuse prevention efforts.
Sec. 519 (290-bb25)	Services for Children of Substance Abusers	Grants to provide evaluations, treatment and referrals to children of substance abusers. (Not funded)
Sec. 519A (290bb-25a)	Grants for Strengthening Families	Grants to provide early intervention and substance abuse prevention services for individuals of hig-risk families and their communities. (Not funded)
Sec. 519B (290bb-25b)	Programs to Reduce Underage Drinking	Grants to develop plans and carry out programs to prevent underage alcohol use. (Not funded)
Sec. 519C(290bb-25c)	Services for Individuals with Fetal Alcohol Syndrome	To provide services to individuals diagnosed with fetal alcohol syndrome or alcohol-related birth defects. (Not funded)

Section PHS Act (42 U.S.C. Citation)	Title	Program Description
Sec. 519D (290bb-25d)	Center of Excellence on Services for Individuals with Fetal Alcohol Syndrome and Alcohol-Related Birth Defects and Treatment for Individuals with Such Conditions and their families	To establish centers of excellence to study prevention and treatment strategies for fetal alcohol syndrome and alcohol-related birth defects.
Sec. 519E (290bb-25e)	Prevention of Methamphetamine Abuse and Addiction	Grants to support expansion of methamphetamine prevention interventions and/or infrastructure development. This program assists localities to expand prevention interventions that are effective and evidence-based and/or to increase capacity through infrastructure development. The goal is to intervene effectively to prevent, reduce or delay the use and/or spread of methamphetamine abuse.
Center for Mental Health Services (CMHS)		
Sec. 520A (290bb-32)	Priority of Mental Health Needs of Regional and National Significance	General authority to provide grants and fund activities intended to increase knowledge on best practices, provide training and technical assistance, and increase capacity of states and local entities to provide for necessary substance abuse prevention efforts.
Sec. 520D (290bb-35)	Services for Youth Offenders	Grants to provide aftercare services to youth offenders who have been discharged from the justice system and have serious emotional disturbances. (Not funded)
Sec.520E (290bb-36)	Youth Suicide Early Intervention and Prevention Strategies (State Grants)	To build on the foundation of prior suicide prevention efforts in order to support States and Tribes in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration. Such efforts must involve public/private collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations.
Sec.520-E1 (290bb-36a)	Suicide Prevention For Children and Adolescents	Grants to complement suicide prevention and early intervention strategies developed in Sec. 520 E. (Not funded)
Sec. 520-E2 (290bb-36b)	Mental and Behavioral Health Services on Campus	To provide funding to support grants to institutions of higher education to enhance services for students with mental and behavioral health problems, such as depression, substance abuse, and suicide attempts, which can lead to school failure.
Sec. 520F (290bb-37)	Centers for Emergency Mental Health	Grants to support designation of hospitals and health centers as Emergency Mental Health Centers. (Not funded)
Sec. 520G (290bb-38)	Grants for Jail Diversion Programs	To promote the transformation of systems to improve services for justice-involved adults with mental illness. Grantees are expected to act through agreements with other public and nonprofit entities to develop and implement programs to divert individuals with a mental illness from the criminal justice system to community-based services.
Sec. 520I (290bb-40)	Grants for the Integrated Treatment of Serious Mental Illness and Co-occuring	Grants to provide integrated treatment services for individuals with a serious mental illness and co-occuring substance abuse disorder. (Not funded)

Section PHS Act (42 U.S.C. Citation)	Title	Program Description
	Substance Abuse	
Sec. 520J (290bb-40)	Mental Health Training Grants	Grants for training on mental illness awareness, and training for emergency services personnel. (Not funded)
Sec. 521 (290cc-21) & Sec. 535(a) (290cc-35)	Projects for Assistance in Transition from Homelessness; PATH Grants to States	Grants to States to provide outreach, mental health and other support services to homeless people with serious mental illness. Outreach is focused on homeless individuals who are not pursuing needed mental health treatment on their own.
Sec. 561(290ff) & Sec. 565(f) (290ff-4)	Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances	Six-year grants to implement, improve and expand systems of care to meet the needs of children with serious emotional disturbances and their families. This approach emphasizes culturally competent care, family driven and youth guided practice, and multi-agency collaboration.
Sec.1920 (a) (300x-35)	Community Mental Health Services Performance Partnership Block Grants	Formula grants to States to support community mental health services for adults with serious mental illness and children with serious emotional disturbance.
Other Authorities		
Sec. 506 (290aa-5)	Grants for the Benefit of Homeless Individuals	Funds the development of comprehensive drug/alcohol and mental health treatment systems for the homeless
Sec 506A (290aa-5a)	Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans	Providing alcohol and drag prevention or treatment services for Indians and Native Alaskans. (Not funded)
SEC. 506B (290aa-5b)	Grants for Ecstasy and Other Club Drugs Abuse Prevention	To carry out education and other community-based programs to prevent abuse of "club drugs" by youth. (Not funded)
Sec. 581 (290hh)	Children and Violence	To fund local communities to assist children in dealing with violence. (Funds awarded under the Department of Education's Safe Schools Healthy Students program)
Sec. 582 (290hh-1)	Grants to Address the Problems of Persons Who Experience Violence and Related Stress. (Child Traumatic Stress Initiative)	Improve treatment and services for all children and adolescents in the United States who have experienced traumatic events. Addresses child trauma issues by creating a national network of grantees that work collaboratively to develop and promote effective community practices for children and adolescents exposed to a wide array of traumatic events.
P.L. 99-319, (Sec. 117) 42USC10827	Protection and Advocacy for Individuals with Mental Illness Act	Protects individuals with mental illness from abuse, neglect, and violations of their civil rights. The program provides grants to independent protection and advocacy agencies which investigate and use legal and other remedies to correct verified incidents.

Appendix B. SAMHSA Authorization and Appropriation Levels (FY2004-FY2008)

Section PHS Act (42USC Code)	Name of Program	Year Created	Authorization	FY2005 Appropriation	FY2006 Appropriation	FY2007 Appropriation	FY2008 Appropriation	Ever Funded (since 2000)
Center for Substance Abuse Treatment (CSAT)								
Sec. 509 (290bb-2)	Priority Substance Abuse Treatment Needs of Regional and National Significance	1992	FY2001-$300,000,000; FY2002 - FY2003 SSN	FY 05 - $348,213,000	$324,107,000	$398,949,000	$316,976,000	Yes - 2002
Sec. 508 (290bb-1)	Residential Treatment Programs for Pregnant and Postpartum Women	1992	FY2001-FY2003 SSN	$9,852,000	$10,890,000	$10,390,000	$11,790,000	Yes - 2004
Sec. 514 (290bb-7)	Substance Abuse Treatment Services for Children and Adolescents	2000	FY2001-$40,000,000; FY2002-FY2003 SSN	$33,957,000	$29,597,000	$29,275,000	$24,278,000	Yes - 2002
Sec. 514A (290bb-8)	Early Intervention Services For Children and Adolescents	2000	FY2001- $20,000,000; FY2002-FY2003 SSN	NF	NF	NF	NF	No
Sec. 514(d) (290bb-9(d))	Methamphetamine and Amphetamine Treatment Initiative	2000	FY2000- $10,000,000; FY2001-FY2002 SSN	NF	NF	NF	NF	No
Sec. 1935 ((a) 200x-35)	Substance Abuse Prevention and Treatment Performance Partnership Block Grants	1992	FY2001 - $2,000,000,000; FY2002-FY2003 SSN	$1,775,555,000	$1,758,591,000	$1,679,391,000	$1,679,528,000	Yes - 2000
Center for Substance Abuse Prevention (CSAP)								
Sec. 516 (290bb-22)	Priority of Substance Abuse Prevention and Needs of Regional and National Significance	1986	FY2001- $300,000,000; FY2002-FY2003 SSN	$179,213,000	$179,160,000	$178,591,000	$175,928,000	Yes - 2002
Sec. 519 (290-bb25)	Services for Children of Substance Abusers	1992	FY2001 - $50,000,000; FY2002-FY2003 SSN	NF	NF	NF	NF	No
Sec. 519A (290bb-25a)	Grants for Strengthening Families	2000	FY2001- 3,000,000; FY2002-FY2003 SSN	NF	NF	NF	NF	No

Section PHS Act (42USC Code)	Name of Program	Year Created	Authorization	FY2005 Appropriation	FY2006 Appropriation	FY2007 Appropriation	FY2008 Appropriation	Ever Funded (since 2000)
Sec. 519B (290bb-25b)	Programs to Reduce Underage Drinking	2000	FY2001- $25,000,000; FY2002-FY2003 SSN	NF	NF	NF	$5,404,000	Yes - 2008
Sec. 519C (290bb-25c)	Services for Individuals with Fetal Alcohol Syndrome	2000	FY2001 - $25,000,000; FY2002-FY2003 SSN	NF	NF	NF	NF	Yes - 2002
Sec. 519D (290bb-25d)	Center of Excellence on Services for Individuals with Fetal Alcohol Syndrome and Alcohol-Related Birth Defects and Treatment for Individuals with such Conditions and Their families	2000	FY2001- $5,000,000; FY2002-FY2003 SSN	$10,000,000	$9,821,000	$9,821,000	$9,821,000	Yes - 2002
Sec. 519E (290bb-25e)	Prevention of Methamphetamine Abuse and Addiction	2000	FY2001- $10,000,000; FY2002-FY2003 SSN	$5,127,000	$3,960,000	$3,960,000	$2,967,000	Yes - 2002
Center for Mental Health Services (CMHS)								
Sec. 520A (290bb-32)	Priority of Mental Health Needs of Regional and National Significance	1988	FY2001- $300,000,000; FY2002-FY2003 SSN	$131,602,000	$108,434,000	$263,263,000	$116,100,000	Yes - 2002
Sec. 520D (290bb-35)	Services for Youth Offenders	2000	FY2001- $40,000,000; FY2002-FY2003 SSN	NF	NF	NF	NF	No
Sec. 520E (290bb-36)	Youth Suicide Early Intervention and Prevention Strategies (State Grants)	2004	FY2005 - $7,000,000 FY2006 - $18,000,000 FY2007 - $30,000,000	$6,924,000	$17,820,000	$17,820,000	$29,476,000	Yes - 2005
Sec.520-E1 (290bb-36a)	Suicide Prevention For Children and Adolescents	2000	2001- $75,00,000 2002-2003 SSN	NF	NF	NF	NF	No
Sec.520-E2 (290bb-36b)	Mental and Behavioral Health Services on Campus	2004	FY2005- $5,000,000; FY2006- 5,000,000; FY2007- $5,000,000	$1,500,000	$4,950,000	$4,950,000	$4,913,000	Yes - 2005
Sec. 520F (290bb-37)	Centers for Emergency Mental Health	2000	FY2001- $25,000,000; FY2002-FY2003 SSN	NF	NF	NF	NF	No
Sec. 520G (290bb-38)	Grants for Jail Diversion Programs	2000	FY2001- $10,000,000 FY2002-FY2003 SSN	$6,944,000	$6,875,000	$6,863,000	$6,684,000	Yes - 2002

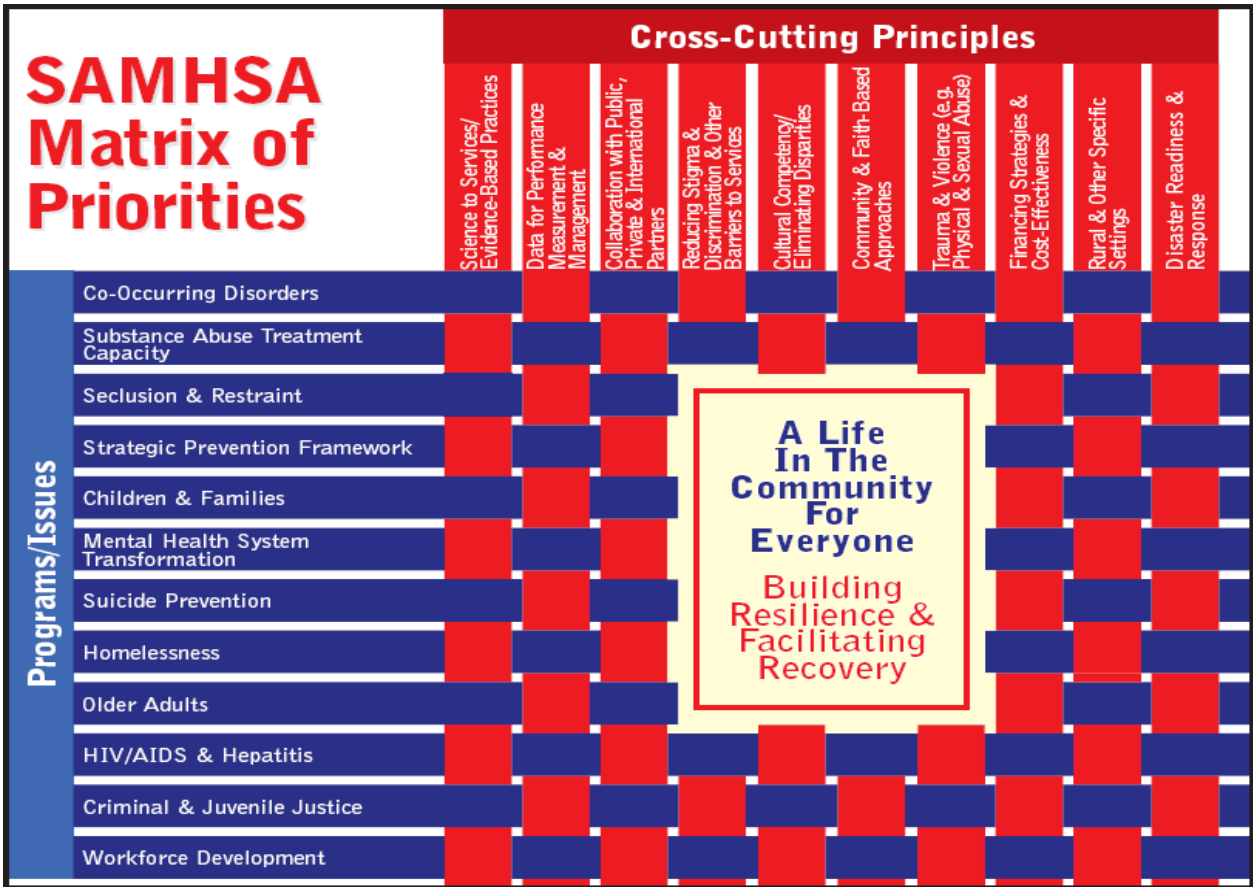
Section PHS Act (42USC Code)	Name of Program	Year Created	Authorization	FY2005 Appropriation	FY2006 Appropriation	FY2007 Appropriation	FY2008 Appropriation	Ever Funded (since 2000)
Sec. 520I (290bb-40)	Grants for the Integrated Treatment of Serious Mental Illness and Co-occuring Substance Abuse	2000	FY2001- $40,000,000 FY2002-FY2003 SSN	NF	NF	NF	NF	No
Sec. 520J (290bb-40)	Mental Health Training Grants	2000	FY2001 - 25,000,000; FY2002-FY2003 SSN	NF	NF	NF	NF	No
Sec. 521 (290cc-21) & Sec. 535(a) (290cc-35)	Projects for Assistance in Transition from Homelessness; PATH Grants to States	1990	Formula; FY2001-FY2003 - $75,000,000 each year	$54,809,000	$54,261,000	$54,261,000	$53,313,000	Yes - 2002
Sec. 561 (290ff) & Sec. 565(f) (290ff-4)	Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances	1992	FY2001- $100,000,000; FY2002-FY2003 SSN	$105,112,000	$104,078,000	$104,078,000	$102,260,000	Yes - 2000
Sec.1920 (a) 300x-35	Community Mental Health Services Performance Partnership Block Grants	1992	FY2001 - $450,000,000; FY2002-FY2003 SSN	$432,756,000	$428,646,000	$428,256,000	$399,735,000	Yes - 2000
Other Authorities								
Sec. 506 (290aa-5)	Grants for the Benefit of Homeless Individuals	1984	FY2001 - $50,000,000; FY2002-FY2003 SSN	$35,973,000	$43,915,000	$34,517,000	$32,600,000	Yes - 2002
Sec 506A (290aa-5a)	Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans	2000	FY2001 - $15,000,000; FY2002-FY2003 SSN	NF	NF	NF	NF	No
SEC. 506B (290aa-5b)	Grants for Ecstasy and Other Club Drugs Abuse Prevention	2000	FY2001 - $10,000,000; Subsequent -SSN	$4,385,000	NF	NF	NF	No
Sec. 581 (290hh)	Children and Violence	2000	FY2001-$100,000,000; FY2002-FY2003 SSN	$78,738,000	$82,202,000	$93,156,000	$93,002,000	Yes - 2002
Sec. 582 (290hh-1)	Grants to Address the Problems of Persons Who Experience Violence and Related Stress. (Child Traumatic Stress Initiative)	2000	FY2001-$50,000,000; FY2002-FY2006 SSN	$29,760,000.00	$29,462,000	$28,068,000	$33,092,000	Yes - 2002

Section PHS Act (42USC Code)	Name of Program	Year Created	Authorization	FY2005 Appropriation	FY2006 Appropriation	FY2007 Appropriation	FY2008 Appropriation	Ever Funded (since 2000)
P.L. 99-319, Sec. 117 42USC10827	Protection and Advocacy for Individuals with Mental Illness Act	1986	FY1992 - $19,500,000; FY1993-FY2003 SSN	$34,343,000	$34,000,000	$34,000,000	$34,880,000	Yes - 2000
Sec. 301;P.L. 98-621 42USC241	Program Management	1984 (P.L. 98-621)	Not applicable	$75,806,000	$76,049,000	$76,042,000	$74,098,000	Yes - 2000

Source: SAMHSA Budget Justifications FY2004 - FY2009.

Notes: NF means "No Funding"; SSN means "Such Sums as may be Necessary."

Appendix C. SAMHSA Matrix of Priorities



Source: SAMHSA.

Appendix D. SAMHSA National Outcome Measures

DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude ▶
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment ▶
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime ▶
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use ▶
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message ▶
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost) [2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices [2]		Under Development	Total number of evidence-based programs and strategies

Source: SAMHSA.

Notes: 1. For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.

2. Required by 2003 Office of Management and Budget's Program Assessment Rating Tool Review.

Appendix E. Useful SAMHSA Resources

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

SAMHSA grant awards by state: http://www.samhsa.gov/statesummaries/index.aspx.

FY2008 Budget justification: http://www.samhsa.gov/Budget/FY2008/SAMHSA08CongrJust.pdf.

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

FY2000 Reauthorization Language: http://www.samhsa.gov/legislate/Sept01/childhealth_toc.htm.

Center for Mental Health Services: http://mentalhealth.samhsa.gov/cmhs/.

Center for Substance Abuse Prevention: http://prevention.samhsa.gov/.

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

Office on Applied Statistics: http://oas.samhsa.gov/.

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

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

National Outcome Measures: http://nationaloutcomemeasures.samhsa.gov/./outcome/index_2007.asp.

SAMHSA grant awards to states: http://www.samhsa.gov/grants/.

Garrett Lee Smith grantee activities: http://www.sprc.org/grantees/show AllStateTribe.asp (state grantees) and http://www.sprc.org/grantees/C_Udescriptions.asp (campus grantees).

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