Administration for Community Living

HSRI

Navigating the State and Local Behavioral Health System Terrain

A Guide for Community-Integrated Community Care Hubs

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List of Exhibits

Acronyms and Abbreviations

BH	Behavioral Health
BHAD	Behavioral Health Advance Directive
CCH	Community Care Hub
COD	Co-Occurring Disorder
DHHS	Department of Health and Human Services
DC	District of Columbia
DDH	Disaster Distress Helpline
IDD	Intellectual and Developmental Disabilities
MH	Mental Health
MHBG	Community Mental Health Services Block Grant
P&A	Protection and Advocacy
PAD	Psychiatric Advance Directive
PAIMI	Protection & Advocacy for Individuals with Mental Illness
RCO	Recovery Community Organization
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SCN	Statewide Consumer Network (grant program)
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SROI	Social Return on Investment
SSA	Single State Authority (or Agency)
SUD	Substance Use Disorder

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Introduction

The organization, funding, and administration of publicly funded mental health and substance use services vary from state to state; within some states, there are regional variations as well. This brief guide provides an overview of these different organizational structures and suggests ways for CBO networks to make connections with the state and local behavioral health (BH) authorities in their area.

Importance of Incorporating BH Services

Substance use disorders (SUD) among older Americans have increased over the past two decades. In 2020, approximately one in ten people ages 50 or older, that is, a total of 11 million people in this age group, had an alcohol or drug use disorder.[1] Excessive substance use at older ages is associated with elevated risk of cognitive decline, dehydration, falls, and adverse interactions with prescription medications. SUD also leads to complications in liver and pancreas diseases, immune system disorders, osteoporosis, diabetes, high blood pressure, stroke, and seizures.[2] Older people are also at high risk of mood disorders. For example, a recent household survey indicated that approximately 40% of the population ages 60 and older felt "nervous, anxious, or on edge" for longer than a day during the past two weeks and about 19% of them had these feelings "nearly every day."[3]

One of the challenges of providing appropriate BH services and supports to older people is the difficulty of differentiating between dementia and BH issues, frequently resulting in a misdiagnosis.[4] Evidence-based BH screening, referral to appropriate treatment, and effective interventions are therefore critical for any organization providing routine services to older adults.[5] Currently, services for older adults in the U.S. are split among sectors and organizations without sufficient linkages or communication pathways, constituting a barrier to effective diagnosis and consistent treatment of BH disorders. Homebound older adults are especially vulnerable to co-occurring physical and mental health conditions and are less likely to receive appropriate diagnosis and treatment.[6]

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[1] Center for Behavioral Health Statistics and Quality. 2021. 2020 National Survey on Drug Use and Health: Detailed Tables. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[2] Kuerbis, A., Sacco, P., Blazer, D.G., & Moore, A.A. (2014). Substance abuse among older adults. *Clinics in Geriatric Medicine, 30*(3), 629-654.
[3] U.S. Census Bureau, Household Pulse Survey, April 2022.
[4] Bottino, C.M.C., de Pádua, A.C, Smid, J., Areza-Fegyveres, R., Novaretti, T., & Bahia, V.S. (2011). Differential diagnosis between dementia and psychiatric disorders: Diagnostic criteria and supplementary exams. *Dementia & Neuropsychologia, 5*(4), 288-296.
[5] SAMHSA—Get Connected: Linking Older Adults with Resources on Medication, Alcohol, and Mental Health. HHS Pub. No. (SMA) 03-3824. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2019.
[6] Qiu, W.Q., Dean, M., Liu, T., George, L., Gann, M., Cohen, J., & Bruce, M.L. (2010). Physical and mental health of homebound older adults: an overlooked population. *Journal of the*

Another unmet service need for older populations is specialized BH care after hospital discharge. Older adults discharged after inpatient psychiatric care have higher rates of re-hospitalization within five years compared to younger adults.[7] Notably, older adults hospitalized for physical conditions are also more likely to be re-hospitalized if they have a co-morbid psychiatric condition. One study found up to 1.4 additional hospital days attributable to psychiatric co-morbidity in adults discharged after a heart condition.[8]

The fragmented nature of BH services for older adults and shortage of providers trained in addressing the needs of this population have consequences for racial health disparities as well. Not only are older adults less likely to seek BH care compared to younger populations, but there is also evidence to suggest that older African Americans tend to be more reluctant than others in the same age group to report a BH condition.[9] BH providers with cultural competence *in addition to* specialized training in older adult care are needed to address this disparity.

An effective strategy for addressing these unmet needs for BH care is for key elder care organizations, such as Area Agencies on Aging, to establish close partnerships with providers in their communities.[10]

The Value of Connecting with State and Local BH Authorities

Although insurance coverage for BH screening and treatment services has expanded in recent years, reimbursement gaps continue to be a barrier for certain services, most notably prevention and recovery supports. Crucial yet non-reimbursable BH services are often funded through federal grants administered by state and local BH authorities who are the best sources of information about these funding streams and mechanisms for accessing them.

As the previous section briefly summarizes, including BH care in services and supports provided to older adults has multiple benefits. Returns for investments in these services include shorter hospital stays and fewer re-hospitalizations after discharge. Additionally, the social returns on investment (SROI) of well-integrated,

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American Geriatrics Society, 58(12),2423-8. doi: 10.1111/j.1532-5415.2010.03161.x. Epub 2010 Nov 10. PMID: 21070195; PMCID: PMC3044592.

[7] Yu, C., Sylvestre, J.D., Segal, M., Looper, K.J., & Rej, S. (2015) Predictors of psychiatric re-hospitalization in older adults with severe mental illness. *International Journal of Geriatric Psychiatry, 30*(11), 1114-1119. doi: 10.1002/gps.4361. Epub 2015 Sep 21. PMID: 26388437.

[8] Sayers, S.L., Hanrahan, N., Kutney, A., Clarke, S.P., Reis, B.F. and Riegel, B. (2007). Psychiatric comorbidity and greater hospitalization risk, longer length of stay, and higher hospitalization costs in older adults with heart failure. *Journal of the American Geriatrics Society, 55*(10), 1585-1591. https://doi.org/10.1111/j.1532-5415.2007.01368.x

[9] Conner, K.O., Copeland, V.C., Grote, N.K., Koeske, G., Rosen, D., Reynolds, C.F. 3rd, & Brown, C. (2010). Mental health treatment seeking among older adults with depression: the impact of stigma and race. *American Journal of Geriatric Psychiatry, 18*(6), 531-43. doi: 10.1097/JGP.0b013e3181cc0366. PMID: 20220602; PMCID: PMC2875324.

[10] Horvitz-Lennon, M., Kilbourne, A. M., & Pincus, H. A. (2006). From silos to bridges: Meeting the general health care needs of adults with severe mental illnesses. *Health Affairs, 25*(3), 659-669. https://doi.org/10.1377/hlthaff.25.3.659

high-quality BH services to older adults deserve serious consideration. SROI calculations go beyond a narrow focus on the fiscal benefits of investments in health and human services to take a broader view of their social value to a wide range of stakeholders and to communities at large. In addition to recent developments in quantitative methods for calculating SROI, organizations increasingly utilize a combination of quantitative, qualitative, and narrative descriptions of the social value of their investments to make a business case.[11] One implication of the SROI approach for the services under consideration here is their contribution to health equity and overall improvements in quality of life for older populations. Although these factors are challenging to reduce to financial returns, their social value is indisputable. Partnerships with state and local BH authorities can provide CBO networks and their lead entities with information about and access to available BH services and other resources in the community, enhancing the SROI of the services and supports they already provide.

[11] American Public Human Services Association (APHSA). (2013). Social return on investment [online]. APHSA Innovation Center Issue Brief. Accessed in September 2022 from https://33igt8427g0w69zms33dqm48-wpengine.netdna-ssl.com/wp-content/uploads/2014/06/Social-Return-on-Investment-Brief.pdf

Structure of State BH Agencies

All states and jurisdictions have one or two federally designated units within their executive branch responsible for managing mental health (MH) and substance use disorder (SUD) services and programs, generally referred to as Single State Agencies (SSA) for their respective areas. In some states, one SSA is responsible for both MH and SUD programs while in others, these two functions are managed by separate agencies. SSAs oversee strategic planning and implementation of the state's behavioral health programs and policies. They manage federal BH funds allocated to their state, including federally mandated performance data collection and reporting. Each SSA has a designated person officially recognized as the authority for the agency's functions.

SSAs are typically located within larger umbrella agencies, such as Departments of Human Services, Health Departments, or combined Health and Human Services Departments. Some states have independent Departments of Mental Health or Behavioral Health.

Exhibit 1 Organizational Affiliation and Contact Information for State BH Authorities

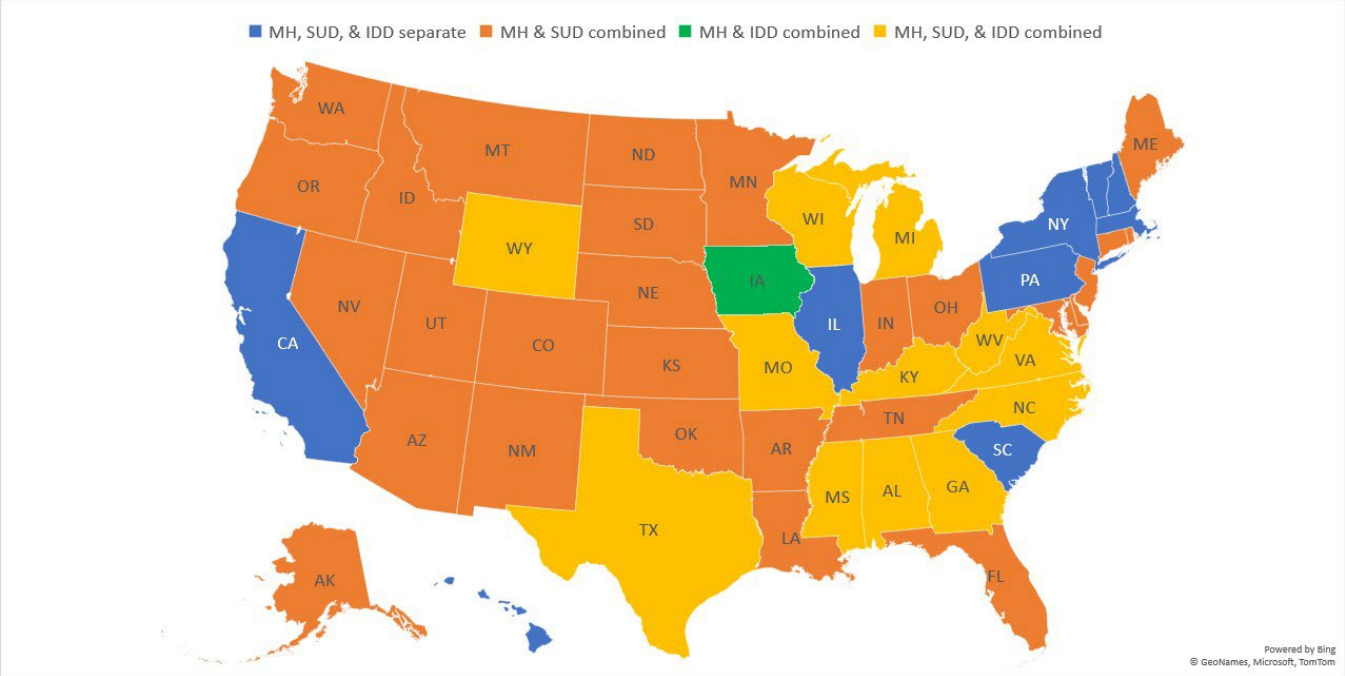
The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains directories for contact information and organizational affiliations of Single State Authorities:

Directory of State Mental Health Authorities

Single State Substance Abuse Agencies Directory

Responsibility for intellectual and developmental disability (IDD) services is also located within the MH and/or SUD SSA in some states. Exhibit 2 maps the organizational structure of behavioral health SSAs across the nation.

Exhibit 2 Organizational Responsibilities for MH, SUD, and IDD Services, 2020-2021



Source: Reproduced from National Association of State Mental Health Program Directors Research Institute (NRI). 2021. State Mental Health Agency Organization. Data for Alaska and Hawaii were not available in the source report but were added based on SSA directories published by SAMHSA.

State mental health authorities use different strategies for distributing the federal funds under their management to community-based mental health programs.

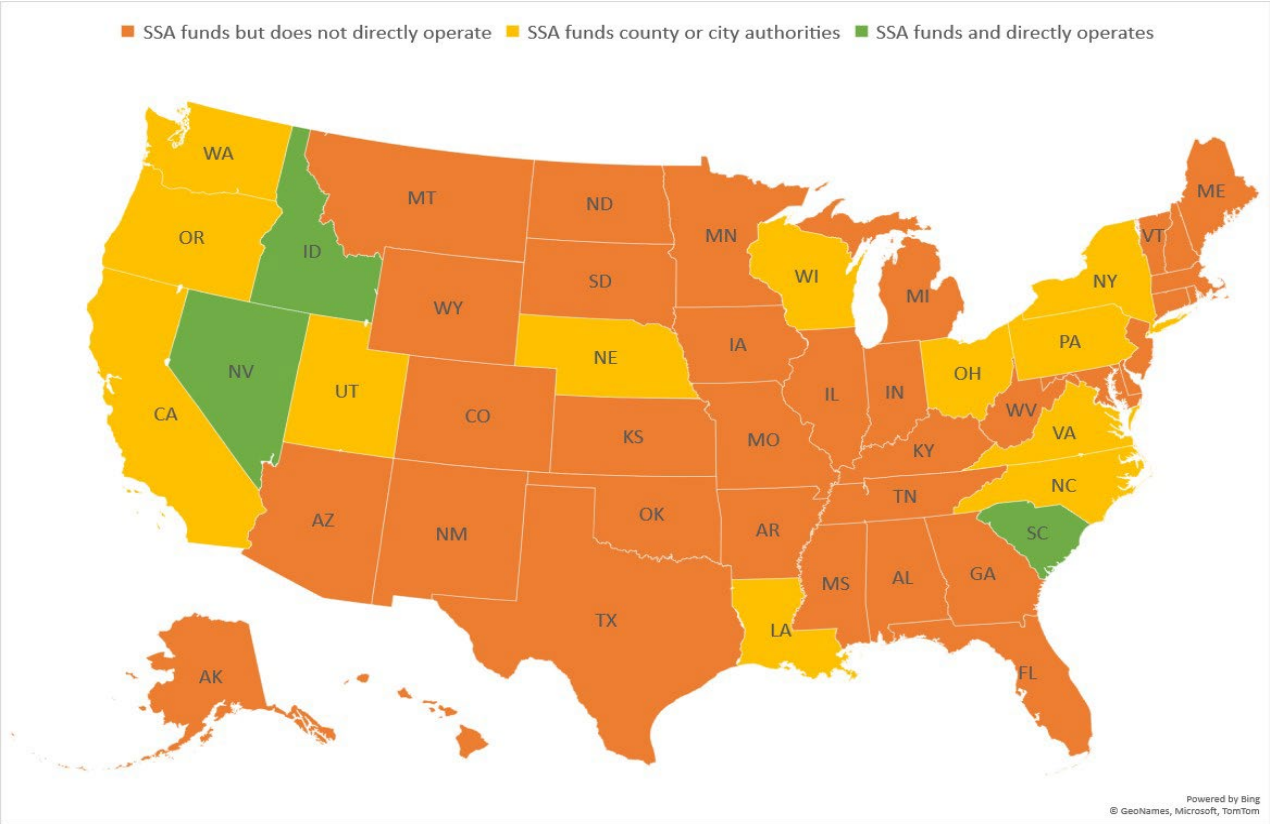
- In the majority of states, the SSA's primary method is to contract with community mental health service providers (typically non-profit organizations) but not directly operate the programs.

- In 13 states, the primary strategy is for the SSA to distribute the funds to local mental health authorities (typically, county or city MH departments) who, in turn, fund and operate community-based programs, either through contract arrangements or by directly operating the programs. This strategy is more common among larger states with more complex health service systems.

- In three states and D.C., the central mental health authority both funds and directly operates community-based programs. In these four cases, community-based providers are employees of the state (or district).

In some states, a combination of the above three strategies is used. Exhibit 3 shows the dominant (primary) strategy in each state.

Exhibit 3 Primary State Strategies for Funding and Operating Community-Based Mental Health Programs, 2020-2021



Source: Reproduced from National Association of State Mental Health Program Directors Research Institute (NRI). 2021. State Mental Health Agency Organization.

Further detail on funding sources for community-based services and BH authorities' responsibilities in managing funding streams is provided in a later section of this document.

BH and Housing Supports

The links between behavioral health and housing stability go both ways. Housing instability exacerbates mental health and substance use challenges and presents a barrier to healthy recovery and wellness maintenance. Likewise, risks of unstable housing are higher for people with BH disorders and such disorders often pose challenges to obtaining permanent housing after an episode of homelessness. This two-way association has led to multiple collaboration efforts between housing and BH agencies.

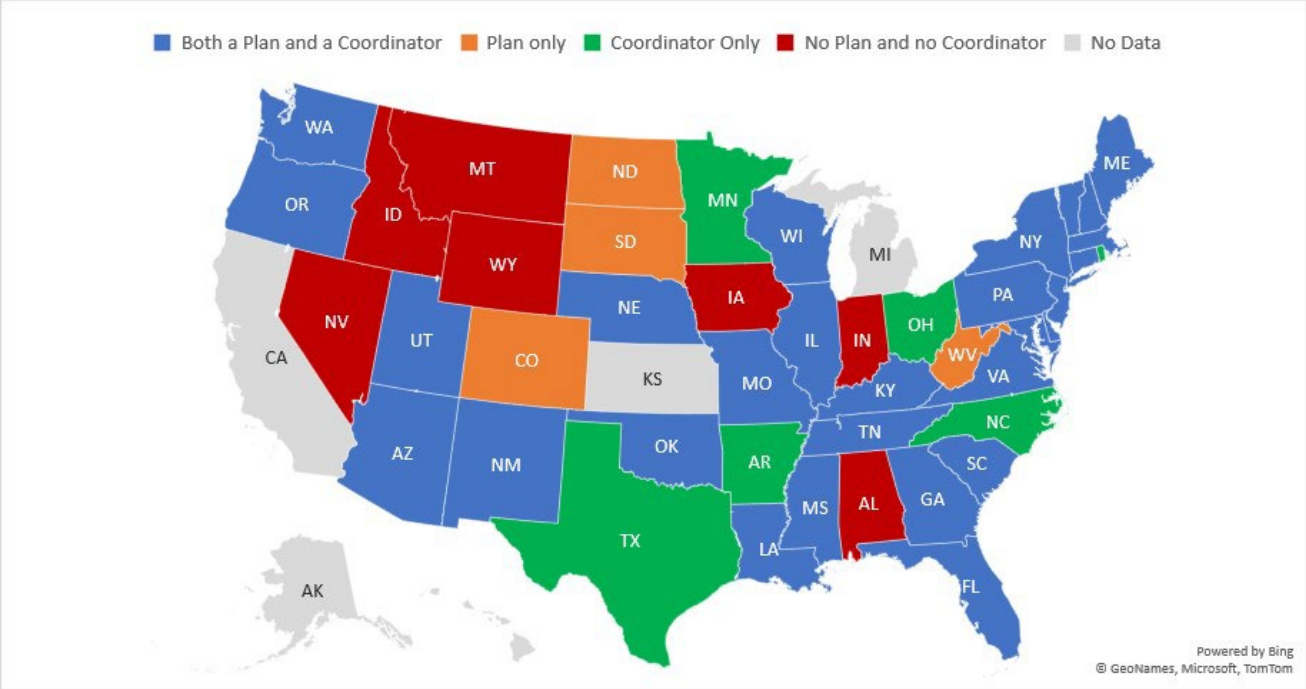
SAMHSA supports homelessness prevention and permanent supported housing initiatives undertaken by BH agencies and community-based BH providers and provides guidance for states and communities to address housing instability among people with serious BH conditions (see, for example, Exhibit 4).

Exhibit 4 SAMHSA's Permanent Supportive Housing Evidence-Based Practices KIT

Permanent Supportive Housing Evidence-Based Practices Resource Kit consists of nine downloadable files with step-by-step guidance for state authorities and community organizations to set up housing support programs, train their staff, establish partnerships, obtain funding, and monitor program performance. The kit also includes a review of the research literature and annotated bibliography on this topic and tools for engaging stakeholders in the program.

In response to SAMHSA's recommendation to state BH authorities to develop strategies and action plans for addressing housing instability among people with serious BH conditions, the majority of state BH authorities now have housing plans incorporated into their strategic plans. Most states have a plan to ensure adequate housing for people with serious BH conditions, or a housing coordinator responsible for increasing affordable housing opportunities for this population, or both (Exhibit 5).

Exhibit 5 Presence of Housing Plans and/or Housing Coordinators to Support People with Serious BH Conditions, 2020-2021



Source: Reproduced from National Association of State Mental Health Program Directors Research Institute (NRI). 2022. Initiatives to Support Housing Services for Individuals with SMI and SED.

The Olmstead Decision

The landmark Supreme Court decision, Olmstead v. L.C. (1999) and subsequent legal actions that interpreted and broadened the scope of the original decision have had an impact on the housing support needs of people with BH conditions, older adults, and people with disabilities. The original decision ruled that unnecessary segregation of people with mental health conditions constitutes discrimination under the Americans with Disabilities Act, mandating that states provide services to people with long-term support needs *in the most integrated settings appropriate to their needs*. That is, anyone who can safely receive home and community-based services cannot be forced to live in segregated congregate settings. The Supreme Court, as part of its decision, encouraged states to develop comprehensive plans to increase community integration, commonly referred to as *Olmstead Plans*. Although most states have housing supports as part of their BH strategic plans, less than half currently have an Olmstead Plan. Bringing states into full compliance with Olmstead is an ongoing effort involving negotiations and consent rulings between the U.S. Department of Justice and state BH authorities.

There is increasing evidence that housing alone does not guarantee full community integration. Some states have started combining education and employment supports with housing supports to better facilitate independent living in the community. Exhibit 6 provides links to state and local resources for full community integration of people with long-term support needs.

Exhibit 6 Lists of State and Local Resources for Integrating People with Long-Term Service and Support Needs into the Community

Alabama	Alaska	Arizona	Arkansas	California
Colorado	Connecticut	Delaware	Florida	Georgia
Hawaii	Idaho	Illinois	Indiana	Iowa
Kansas	Kentucky	Louisiana	Maine	Maryland
Massachusetts	Michigan	Minnesota	Mississippi	Missouri
Montana	Nebraska	Nevada	New Hampshire	New Jersey
New Mexico	New York	North Carolina	North Dakota	Ohio
Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina
South Dakota	Tennessee	Texas	Utah	Vermont
Virginia	Washington	West Virginia	Wisconsin	Wyoming
District of Columbia				

Source: Disability Integration Project at the Atlanta Legal Aid Society, Olmstead Rights.

BH Crisis Services

One consequence of the siloed nature of long-term services and supports is the inconsistency in responding to older adults experiencing BH crises. In many situations, first responders lack skills and experience in geriatric care, resulting in inappropriate crisis response, often exacerbating, rather than stabilizing, the episode. In addition to training first responders in age-appropriate crisis response, familiarizing older adult-serving organizations with their state and local crisis response system would go a long way in ensuring effective communication and appropriate care across the entire crisis response process.

Best practices in crisis response minimally require three core components:

- Crisis call center that receives the initial call and coordinates the crisis response process in real time
- Centralized 24/7 mobile crisis response capability
- Round-the clock crisis receiving and stabilization programs

Further, it is desirable for the system to have a well-formulated set of principles and standard practices shared by all of its crisis response components. State BH authorities are the key actors in developing and managing BH crisis response in their states, although multiple and varied stakeholders typically collaborate in developing and running the system, such as other health and human service agencies, advocacy organizations, and contracted community-based providers. States vary in their crisis response infrastructure and their compliance with best practices. A link to national guidelines for best practices is provided in Exhibit 7.

Exhibit 7 Toolkit for Best Practices in Behavioral Health Crisis Care

National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit describes the core elements of evidence-based crisis care, addresses challenges posed by rural and frontier communities, and provides suggestions for funding, training, and community outreach. Success stories and interviews with stakeholders are also included in the toolkit.

Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

National 988 Lifeline

Beginning in the summer of 2022, the 988 Suicide and Crisis Lifeline now provides a nationwide crisis call center designed to respond to calls or texts from people across the nation experiencing a behavioral health crisis. The center also provides online real time chat capability through 988lifeline.org. The center is staffed with counselors trained in crisis response. Callers can select to speak in English or Spanish, with translation services available in 150 additional languages. Incorporating this service

into existing state and local crisis systems is an ongoing process with variation across states in the speed with which local systems seamlessly align with the national center. State BH authorities are the best sources of information for the status of local alignment efforts.

Community-based organizations are encouraged to inform the people they serve and their broader community about the 988 call center. Exhibit 8 provides a link to the recommended messaging framework for this outreach.

Exhibit 8 Messaging Framework for the 988 Lifeline

The 988 Messaging Framework is intended to provide guidance for state agencies, crisis centers, nonprofit organizations, businesses, foundations, and advocacy groups to spread the word about the 988 Lifeline. It provides detailed information about what 988 is (and isn't) and recommends strategies for developing and disseminating this information with special emphasis on tailoring the message to audiences from diverse community types and cultural/experiential backgrounds.

Source: National Action Alliance for Suicide Prevention.

Person-Centered Crisis Care

Person-centered care – meaning an individualized response that maximizes a person's autonomy and preferences – is often unfeasible *during* the crisis episode, both due to the urgent need for action and the distress of the person in crisis. This, however, does not necessarily mean that it is impossible to provide person-centered crisis care. People can provide advance instructions about their treatment preferences and appoint a representative who is legally authorized to make decisions on their behalf in case they are incapacitated due to a behavioral health crisis. These directives may include where the person prefers to receive care, preferences about certain medication, and even visitors allowed while in a care facility. Legal requirements governing Behavioral Health Advance Directives (sometimes called Psychiatric Advance Directives or PADs) vary from state to state. Exhibit 9 provides links to sources of information about BH Advance Directives across the country.

Exhibit 9 List of State-Specific Sources of Information on BH Advance Directives

Alabama	Alaska	Arizona	Arkansas	California
Colorado	Connecticut	Delaware	Florida	Georgia
Hawaii	Idaho	Illinois	Indiana	Iowa
Kansas	Kentucky	Louisiana	Maine	Maryland
Massachusetts	Michigan	Minnesota	Mississippi	Missouri
Montana	Nebraska	Nevada	New Hampshire	New Jersey
New Mexico	New York	North Carolina	North Dakota	Ohio
Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina
South Dakota	Tennessee	Texas	Utah	Vermont
Virginia	Washington	West Virginia	Wisconsin	Wyoming
District of Columbia	Veteran Affairs			

Source: National Resource Center on Psychiatric Advance Directives.

Funding Streams for BH Programs

Medicaid is the largest public funder of behavioral health services in the United States. For example, 60% of the 45.9 billion dollars controlled by state mental health authorities in 2020 was provided by Medicaid (federal and state match combined).[12] The rest of the revenues came exclusively from state general funds and grants. Although reimbursement for behavioral health services has expanded in recent years, substantial gaps remain. For example, roughly a quarter of all adults with mental illness report that they did not receive the treatment they needed, the most often cited reason being insufficient insurance coverage.[13] Furthermore, crucial BH services such as evidence-based interventions for people at high risk of developing disorders and services to support recovery from disorders, such as peer supports, are the least likely to be covered by insurance plans. Grants are the main sources of funding for non-reimbursable BH services such as these.

Types and Formats of BH Grant Programs

SAMHSA is the main federal agency responsible for BH grant programs. These programs fund services and practices aimed at preventing and treating behavioral health disorders, maintaining wellbeing, and addressing social determinants of health. Most SAMHSA programs are structured in one of two formats:

- **Formula grants** are allocated to all states and other qualifying jurisdictions based on a pre-determined formula that considers factors such as the state's population, level of need for the service, and cost of living. These revenues are managed by state BH authorities and are relatively stable across years; however, states are required to apply annually and account for their funded activities during the previous year.

- **Discretionary grants** are funding streams created in response to emerging service needs and are renewable for a limited period—typically three to five years. Depending on the type of program, grantees may be states, territories, tribes, local agencies, community based organizations, and/or non-profit organizations. These are competitive grants for which qualifying entities submit proposals.

Exhibit 10 summarizes the pathways through which SAMHSA grant funding reaches community based BH programs and services. For Community Care Hubs,

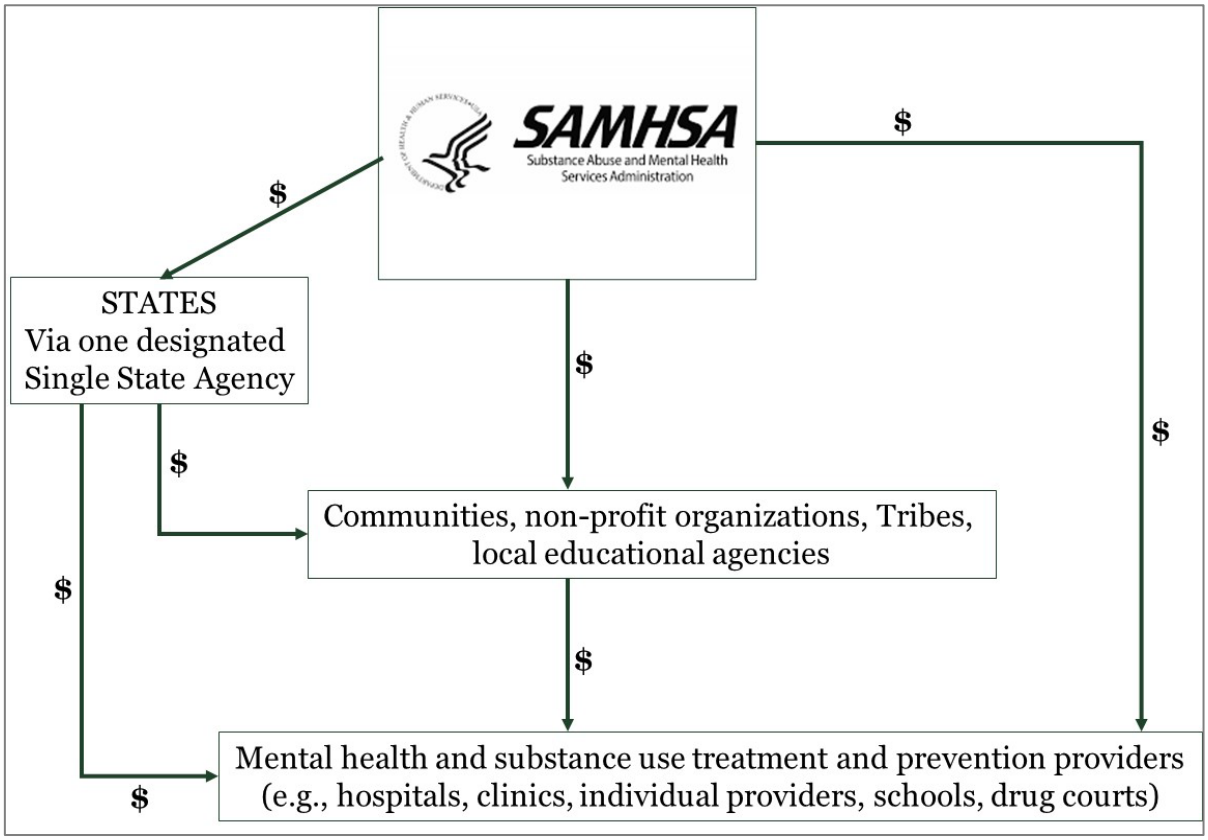
[12] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Unified Reporting System.
[13] Reinert, M., Nguyen, T., & Fritze, D. (2021). The State of Mental Health in America. Alexandria, VA: Mental Health America Inc.

information about these funding streams and entities in their state receiving funding can serve two related purposes:

- Their organization or others in their network may directly qualify for a federal discretionary grant.
- Their state's BH authorities may seek sub-grantees at the community level for a federal funding stream they are managing, and their organization or others in their network may qualify.
- An organization or provider funded through one of these streams may offer free or subsidized services needed by the CCH's clients.

Exhibit 11 provides links to information about current BH grant programs and funded entities, including their funding levels.

Exhibit 10 Pathways for SAMHSA Funding Streams



Source: Congressional Research Service. (2020). Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs. Document # R46426 Prepared for Members and Committees of Congress.

Information about currently available BH grant programs can be found at SAMHSA's Grants Page.

SAMHSA also provides a List of Grant Recipients by State, including their current level of funding.

The rest of this document reviews the major BH grants and their potential relevance for Community Care Hubs.

Protection & Advocacy for Individuals with Mental Illness (PAIMI) Program

The PAIMI Grants are authorized by the Protection and Advocacy for Mentally Ill Individuals Act of 1986 which requires states to:

"… establish and operate a protection and advocacy system for mentally ill individuals which will—

> (A) protect and advocate the rights of such individuals through activities to ensure the enforcement of the Constitution and Federal and State statutes; and
>
> (B) investigate incidents of abuse and neglect of mentally ill individuals if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred."

To support the mandated Protection and Advocacy (P&A) Systems, funds are annually allotted to the 50 states, D.C., five territories, and the American Indian Consortium for Native Americans. These 57 systems provide legal-based services to protect and advocate for the Constitutional rights of adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) and to investigate allegations of abuse, neglect, and rights violations within this population.

During fiscal year 2021, 36 million dollars were allocated to fund states' P&A Systems. During that year, close to 9,000 eligible people were served and resolution of these allegations resulted in positive outcomes including "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."[14]

Of the cases brought to P&A Systems in 2021, 619 involved someone ages 65 or older. One common issue encountered in caring for older adults is widespread comorbidity of dementia with mental illness, often resulting in misdiagnosis, inappropriate hospitalization, or other forms of avoidable seclusion. States' P&A Agencies can help

[14] SAMHSA, Congressional Justification of Estimates for Appropriations Committees, Fiscal Year 2023, p. 139.

resolve these issues and ensure appropriate and safe care for older adults in need of BH supports.

Exhibit 12 Links to State Protection and Advocacy Agencies with PAIMI Funding

Alabama	Alaska	Arizona	Arkansas	California
Colorado	Connecticut	Delaware	Florida	Georgia
Hawaii	Idaho	Illinois	Indiana	Iowa
Kansas	Kentucky	Louisiana	Maine	Maryland
Massachusetts	Michigan	Minnesota	Mississippi	Missouri
Montana	Nebraska	Nevada	New Hampshire	New Jersey
New Mexico	New York	North Carolina	North Dakota	Ohio
Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina
South Dakota	Tennessee	Texas	Utah	Vermont
Virginia	Washington	West Virginia	Wisconsin	Wyoming
District of Columbia				

Source: U.S. Department of Health and Human Services, Tracking Accountability in Government Grants System (TAGGS).

Community Mental Health Services Block Grant

The Community Mental Health Services Block Grant (MHBG) program supports states' BH authorities in developing and implementing plans for providing comprehensive community mental health services. The main target population for programs funded by MHBGs are adults with SMI and children with SED. In this context, SMI is defined as a mental health condition that limits at least one major life activity (e.g., basic or instrumental activities of daily living, participation in family life, school, or workplace).

The state (or territory) BH authority is responsible for managing these funds. They are required to distribute MHBG funds to local governments and non-governmental organizations that provide MH treatment and recovery support services and must ensure that community mental health centers provide screening, outpatient treatment, emergency mental health services, and day treatment programs.

Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse Prevention and Treatment Block Grant (SABG) program funds prevention and treatment services to the state's population impacted by SUD. Community- and faith-based non-governmental organizations can apply to become sub-recipients of SABG funds to provide:

- Prevention services to communities and individuals at high risk of SUD
- Treatment and recovery support services to individuals and families impacted by SUD

States must use at least 20% of their SABG funds for primary prevention programs, defined as strategies directed at at-risk individuals *not* identified to need SUD treatment. Primary prevention strategies include:

- Community education to increase awareness of the extent and consequences of substance use and resources available to impacted people in the community
- Skill building to improve people's ability to cope with risk factors such as stress, trauma, peer pressure, and to make healthy decisions
- Alcohol and drug free social activities and community events aimed at disassociating socializing and entertainment from substance use
- Networking activities and technical assistance to community organizations to strengthen collaborative grassroots efforts to address alcohol and drug problems

States' single-state authorities are the best source of information about the MHBG- and SABG-funded programs in the state. See Exhibit 1 for accessing the directory of agencies in charge of these funds in each state.

Another source of detailed information about the state's BH program structure is the annual Block Grant application documents submitted to SAMHSA. These publicly available documents describe the state's BH programs, budgets, and plans for the future. They can be located on the internet with search terms that include the state's name followed by MHBG or SABG and the word "Application."

Examples of Discretionary Grants with Relevance to CCHs' Activities

As described earlier in this document (see Exhibit 10), community-based organizations can access SAMHSA grant funds either directly or as the sub-recipient of a grant awarded to their state. The following are examples of SAMHSA discretionary grants for which community-based or non-profit organizations are

directly eligible. Program descriptions are direct quotes from the funding opportunity announcements.

Statewide Consumer Network Program[15]

Description: The purpose of this program is to enhance statewide mental health consumer-run organizations' to promote mental health and related service system capacity and infrastructure development to be consumer-centered and targeted toward recovery and resiliency, and consumer-driven by promoting the use of consumers as agents of transformation. The SCN grant program also seeks to address the needs of underserved and under-represented consumers, including those from ethnic, racial, or cultural minority groups; sexual orientation and gender minority individuals; those with histories of chronic homelessness or involvement with the criminal justice system; and those with mental health and co-occurring disorders.

Eligible Applicants: Domestic public and private non-profit entities.

National Suicide Prevention Lifeline and Disaster Distress Helpline Program[16]

Description: The purpose of this program is to: (1) manage, enhance, and strengthen the Lifeline that routes individuals in the United States to a network of certified crisis centers that links to local emergency, mental health, and social services resources; and (2) support the Disaster Distress Helpline (DDH) to assist residents in the United States and its territories who are experiencing emotional distress resulting from disasters and traumatic events. It is expected that this program will increase service capacity and improve behavioral health outcomes by preventing death or injury as a result of suicide and suicide attempts and helping individuals and communities recover from disasters and traumatic events by providing community-based behavioral health outreach, referral to and engagement with treatment as necessary, and psycho-educational services.

Eligible Applicants: Domestic public and private non-profit entities

Targeted Capacity Expansion: Special Projects[17]

Description: The purpose of the program is to implement targeted strategies for the provision of SUD or co-occurring disorder (COD) harm reduction, treatment, and/or recovery support services to support an under-resourced population or unmet need identified by the community. The applicant will identify the specific need or population it seeks to support through the provision of evidence-based SUD or COD harm reduction, treatment, and/or recovery support services. Diversity, equity, and inclusion must be integrated in the provision of services and activities throughout the project, for example, when conducting eligibility assessments, outreach, and engagement or developing policies.

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[15] https://www.samhsa.gov/grants/grant-announcements/sm-22-009
[16] https://www.samhsa.gov/grants/grant-announcements/sm-21-005
[17] https://www.samhsa.gov/grants/grant-announcements/ti-22-002

Eligible Applicants: Domestic public and private non-profit entities

Building Communities of Recovery[18]

Description: The purpose of this program is to mobilize and connect a broad base of community-based resources to increase the prevalence and quality of long-term recovery support for persons with SUD and COD. These grants are intended to support the development, enhancement, expansion, and delivery of recovery support services (RSS) as well as the promotion of and education about recovery. It is expected that these grant activities will be administered and implemented by individuals with lived experience who are in recovery from SUD and COD and reflect the needs and population of the community being served.

Eligible Applicants: Recovery Community Organizations (RCOs) that are domestic private nonprofit entities in states, territories, or tribes

Mental Health Awareness Training Grants[19]

Description: The purpose of this program is to: (1) train individuals (e.g., school personnel, emergency first responders, law enforcement, veterans, armed services members and their families) to recognize the signs and symptoms of mental disorders, particularly SMI and/or serious emotional disturbances (SED); (2) establish linkages with school- and/or community-based mental health agencies to refer individuals with the signs or symptoms of mental illness to appropriate services; (3) train emergency services personnel, law enforcement, fire department personnel, veterans, and others to identify persons with a mental disorder and employ crisis de-escalation techniques; and (4) educate individuals about resources that are available in the community for individuals with a mental disorder. It is expected that this program will prepare and train others on how to appropriately and safely respond to individuals with mental disorders, particularly individuals with SMI and/or SED.

Eligible Applicants: Domestic public and private non-profit entities

Grants for the Benefit of Homeless Individuals[20]

Description: The purpose of this program is to support the development and/or expansion of local implementation of a community infrastructure that integrates substance use disorder treatment, housing services and other critical services for individuals (including youth) and families experiencing homelessness.

Eligible Applicants: Domestic public and private non-profit entities

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[18] https://www.samhsa.gov/grants/grant-announcements/ti-22-014
[19] https://www.samhsa.gov/grants/grant-announcements/SM-21-007
[20] https://www.samhsa.gov/grants/grant-announcements/ti-20-001

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