

HHS ROADMAP FOR BEHAVIORAL HEALTH INTEGRATION

HHS advances the President's Strategy to Address our National Mental Health Crisis through integration.

KEY POINTS

- HHS is committed to providing the full spectrum of integrated, equitable, evidence-based, culturally appropriate, and person-centered behavioral health care to the populations it serves.
- HHS has evaluated key barriers to transforming behavioral health care in line with President Biden's Strategy to Address our National Mental Health Crisis and has identified policy solutions to overcome these barriers.
- HHS will advance the *Strengthen System Capacity* pillar in the President's national strategy by developing a diverse workforce prepared to practice in integrated settings and investing in infrastructure for integrated care.
- HHS will advance the *Connect Americans to Care* pillar by leveraging health financing arrangements, including efforts to fully realize the potential of parity.
- HHS will advance the *Support Americans by Creating Healthy Environments* pillar through investments in behavioral health promotion, upstream prevention, and recovery.

BACKGROUND

In 2020, the past-year prevalence of any mental illness among adults in the United States (U.S.) was 21%, meaning that 52.9 million adults were affected by mental illness.¹ Substance use disorders affected 15% (37.9 million) of U.S. adults, including 6.7% (17 million) of U.S. adults who were affected by both mental illness and substance use disorders.² While data on children's mental health is less readily available, the past-year prevalence of mental health service utilization is approximately one in ten among children ages 3-17.³

This high prevalence of mental and substance use disorders (M/SUD) in the U.S. has been a major concern to policymakers even before the COVID-19 pandemic, as were the profound impacts of M/SUD on the health and well-being of affected individuals, their families and caregivers, and on the resilience of communities. That concern has increased since the pandemic began. Over the course of the pandemic, self-reported symptoms of anxiety have increased, as has the rate of overdose deaths.⁴ Despite this apparent increased need for M/SUD care, use of M/SUD services dropped sharply at the beginning of the pandemic and has been slower to rebound to pre-pandemic levels than other types of health care.⁵

The President's Mental Health Strategy

In recognition of the growing gap between the need for M/SUD care and access to care, and the far-reaching consequences of these conditions, during his first State of the Union address President Biden announced a national strategy to prevent and treat M/SUD. The announcement was accompanied by a *Fact Sheet on President Biden's Strategy to Address our National Mental Health Crisis* (the "[President's Strategy](#)"), which outlined numerous initiatives within each of the three pillars of the strategy.⁶

1. **Strengthen System Capacity:** Expand the supply and diversity of the behavioral health workforce and ensure the full continuum of behavioral health care is available.
2. **Connect Americans to Care:** Bridge the gap between services the system offers and people's ability to get the care they need.
3. **Support Americans by Creating Healthy Environments:** Make "a whole-of-society effort," recognizing the importance of "culture and environment" in promotion, prevention, and recovery.

Since then, the White House has published two additional fact sheets--on [May 31, 2002](#), and [July 29, 2022](#)--highlighting further initiatives that will be pursued across the Federal Government in support of the President's vision.^{7,8}

Along with other federal departments, the U.S. Department of Health and Human Services (HHS) has a significant role in implementing and advancing the President's Strategy. HHS has been leading major initiatives that advance the Biden-Harris Administration's goal of improving behavioral health, which the Department defines as "the promotion of mental health, resilience and well-being; the treatment of M/SUD; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities."⁹ Such initiatives include the [HHS Overdose Prevention Strategy](#), the U.S. Surgeon General's Advisory on [Protecting Youth Mental Health](#), and implementation of [9-8-8](#) as the new National Suicide Prevention Lifeline along with linking 9-8-8 to mobile crisis services.^{10,11} Following the President's call to action in his State of the Union Address, HHS examined what further steps the Department could take to build upon these significant initiatives and transform the delivery of behavioral health care in the U.S.

Integrated Care: A Core Component of the HHS Strategy

Integrated care is critical to transforming care for individuals with M/SUD, and is an HHS strategic priority.¹² The documented aim of integrating behavioral health care into larger health care and social systems dates back almost a century.¹³ Integrated care has been defined differently in different contexts, but it generally aims to treat the whole person's health care needs in a coordinated way that improves health outcomes.* While integration often refers to inclusion of behavioral health services in primary care settings, HHS approaches it more broadly, to also include integration of physical health care into behavioral health settings,¹⁴ and integration of behavioral health care with other specialty areas such as OB/GYN care,¹⁵ as well as in social service and other settings. For example, M/SUD services can be integrated into educational and early childhood care settings to reach youth, and integrated M/SUD services are often a component of evidence-based supportive housing models.¹⁶

HHS leadership recognized that integrated care is an essential strategy for advancing all three pillars of the President's Strategy. Developing a diverse workforce prepared to practice in integrated settings advances the *Strengthen System Capacity* pillar not just by increasing the workforce but also by deploying the workforce more efficiently. Leveraging health care financing arrangements to increase integration advances the *Connect Americans to Care* pillar by reducing limitations on insurance coverage for behavioral health services. Integrating promotion, prevention, and recovery efforts advances the *Support Americans by Creating Healthy Environments* pillar by making care accessible in a wider variety of settings, including community settings. HHS leadership therefore established the following goal statement to focus the Department's additional efforts to support and build upon the President's Strategy:

* See, for example, Peek CJ and the National Integration Academy Council. (2013.) Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No. 13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality

The full spectrum of behavioral health care will be integrated into health care, social service, and early childhood systems to ensure all people have equitable access to evidence-based, culturally appropriate, person-centered care.

HHS then engaged in a Department-wide effort to identify: (1) the most significant challenges to the behavioral health integration goal statement above; and (2) a short list of the most transformational policies to overcome those challenges. In doing so, we drew upon the research evidence, and the knowledge and experience of the Department's behavioral health subject matter experts, leveraging the HHS Behavioral Health Coordinating Council to gather input and craft a whole-of-HHS approach to advancing the President's Strategy via behavioral health integration. The result was the HHS Roadmap for Behavioral Health Integration (the "HHS Roadmap"). This brief summarizes key elements of the HHS Roadmap.

Equity: A Cross-Cutting Priority

Disparities in access to behavioral health care are pervasive and persistent. Most racial and ethnic minority groups remain less likely than non-Hispanic Whites to have health insurance coverage[†] and to receive behavioral health care.^{‡,17} Disparities in health insurance coverage and access to mental health treatment have also been found among residents of rural communities; people who identify as lesbian, gay, bisexual, transgender, or other sexual and gender minority identities (LGBTQI+); people with disabilities;¹⁸ and people with low incomes. While lack of insurance coverage is one of the more quantifiable factors in access to care, other factors also persist as key impediments to care. Examples include stigma; past experiences of discrimination when receiving health care;¹⁹ lack of accessible, culturally and linguistically competent providers in one's community; and other unmet social needs (e.g., transportation, child care coverage).

Accordingly, a cross-cutting priority of the HHS Roadmap is to achieve equity in access to affordable, high-quality, culturally appropriate care for M/SUD, as well as equity in the opportunities for children and youth mental health to flourish in supportive environments. HHS strives to ensure that all communities can benefit from the Department's programs and services, consistent with Executive Order 13985 and Executive Order 14075.²⁰ Components of the HHS Roadmap serve people of all ages with all conditions. Moreover, the HHS Roadmap aims to provide care for underserved populations; people living in underserved areas; families with low incomes; American Indians and Alaska Natives; individuals with disabilities; individuals and families experiencing homelessness; individuals involved with the justice system; children, youth, and families involved with the child welfare system; and survivors of domestic violence, trafficking, and other forms of trauma. The HHS Roadmap has a particular emphasis on supporting providers who come from the communities they serve and are equipped to provide culturally and linguistically appropriate care. The HHS Roadmap aims to enable programs to customize care as appropriate to address diverse needs across sexual orientations, gender identities, races, and ethnicities.

[†] Compared to non-Hispanic Whites, the likelihood of having health insurance coverage differs among non-Hispanic Blacks (-5%); non-Hispanic Native Hawaiian or Other Pacific Islander (-7%); non-Hispanic Asian (-3%); non-Hispanic more than one race (-3%); Hispanic (-16%); non-Hispanic Native American or Alaska Native (no significant difference). ASPE analysis of data on adults aged 18-64 years from the 2018-2019 National Survey on Drug Use and Health. Estimates are adjusted for age and sex.

[‡] Compared to non-Hispanic Whites, the likelihood of receiving mental health care differs among non-Hispanic Black (-40%); non-Hispanic Native American or Alaska Native (-28%); non-Hispanic Native Hawaiian or Other Pacific Islander (-31%); non-Hispanic Asian (-46%); non-Hispanic more than one race (-19%); Hispanic (-35%). ASPE analysis of data on adults aged 18-64 years from the 2018-2019 National Survey on Drug Use and Health. Estimates are adjusted for age and sex.

HOW THE HHS ROADMAP ADVANCES THE PRESIDENT'S STRATEGY

The purpose of this brief is to summarize key elements of the HHS Roadmap. For each pillar of the President's Strategy, we highlight policy approaches that the Department is pursuing to address barriers to fully integrated behavioral health care, and in doing so, to advance the President's vision. **Box 1** summarizes the most significant challenges to integration that were identified, and that have guided HHS's development of policy solutions to enhance integration. HHS supports numerous programs to advance behavioral health, and this brief is not intended to provide an exhaustive overview of the Department's many important activities in this area or to preview all future policy actions that the Department plans to undertake. Rather, we focus on selected, high-impact policies and programs that specifically advance the Department's behavioral health integration goal statement, and that align closely with the President's Strategy. These include several new initiatives that have only recently been publicly announced.

Box 1: Major Challenges to Behavioral Health Integration

- (1) Structural Support for Siloed Care
- (2) Stigma and Mistrust
- (3) Limited Adoption of Technology
- (4) Inconsistent Use of Data and Evidence
- (5) Insufficient Investment in Promotion and Prevention
- (6) Insurance and Financing Limitations
- (7) Workforce Challenges
- (8) Inequitable Engagement of Underserved Populations

Strengthen System Capacity

The *Strengthen System Capacity* pillar of the President's Strategy aims to expand the supply and diversity of the behavioral health workforce and ensure the full continuum of behavioral health care is available.²¹

To deliver on this pillar, the system must have an adequate workforce including not only specialty behavioral health practitioners, but also health care, social service, and early childhood providers trained to recognize and address behavioral health conditions. Engaging a broader set of health and human services providers in delivering behavioral health care is also essential to fully integrated care. However, a number of current *workforce challenges* [Box 1] impede this goal, including shortages, geographic maldistribution, inadequate reimbursement, inadequate education and training opportunities, lack of diversity, and burnout.^{22,23} To overcome these challenges, the Department has identified opportunities to **build a more diverse workforce prepared to practice in integrated settings**, even outside of traditional health care settings such as a hospital or clinic. HHS programs can help recruit, train, and support a diverse workforce capable of offering services that are fully integrated and culturally and linguistically appropriate. Ensuring diversity in the workforce is key to overcoming the lack of trust that often exists between providers and individuals from underserved populations, such as individuals with disabilities, communities of color, LGBTQI+ individuals, and American Indian/Alaska Native persons. A diverse workforce is also essential to improving long-standing inequities in service receipt and promoting delivery of culturally competent care.

To deliver on this pillar, the workforce must also be deployed effectively and efficiently, which may often require team-based care or close coordination between providers in integrated care models. Coordination is often hindered, however, by the gap between behavioral health care providers and physical health care providers in *adoption of technologies* [Box 1] that can facilitate communication, including but not limited to electronic health records and telehealth technologies. The challenges are even greater when considering interoperability between health care providers and social service or early childhood systems. To overcome this challenge, the Department has identified opportunities to **increase behavioral health integration, coordination, and consultation in a range of settings**.

HHS will advance the *Strengthen System Capacity* pillar through investments in the infrastructure that supports behavioral health integration, such as workforce development, technology adoption, and quality

measurement. Examples of publicly announced programs and activities to *Strengthen System Capacity* that address identified challenges to behavioral health integration include:

- The Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Minority Fellowship Program (MFP) awards grants to organizations supporting the training of behavioral health professionals.²⁴ The goal of the MFP is to increase the workforce of practitioners with the skills to serve racial and ethnic minority communities, with the ultimate objective of reducing health disparities and improving behavioral health outcomes for these populations.
- In Spring 2022, SAMHSA established the first ever nationwide directory of opportunities to serve in crisis counselor roles on the 988 Suicide and Crisis Lifeline. This site, samhsa.gov/988jobs, provides direct links to crisis center jobs across the country as part of a holistic strategy to build and sustain the crisis care workforce, with special call-outs for remote work opportunities and Spanish-English bilingual roles.
- In July 2022, the Health Resources and Services Administration (HRSA) announced \$155 million to fund 72 teaching health centers operating primary care medical residency programs that include psychiatry residents.²⁵ HRSA’s Teaching Health Center Graduate Medical Education Program supports primary care residents in being trained to meet the physical and mental health needs of rural and underserved communities. Currently, the program supports over 970 residents.
- The Centers for Medicare & Medicaid Services (CMS) has proposed to incentivize integration of psychologists and social workers into primary care settings by establishing billing codes to account for monthly care integration, where the mental health services furnished by a clinical psychologist or clinical social worker are serving as the focal point of care integration.²⁶
- The Certified Community Behavioral Health Clinic (CCBHC) model, which incorporates a wide range of behavioral health services as well as physical health screenings, is a growing part of the behavioral health system. Since its initial authorization, the CCBHC model has been extended in duration and expanded from a Medicaid demonstration program to a model that is also supported by SAMHSA’s CCBHC-Expansion grants. The Bipartisan Safer Communities Act has expanded to all states the opportunity to participate in the CCBHC model demonstration and made it permanent, which HHS is implementing alongside a rigorous evaluation carried out by ASPE.
- In May 2022, the Department launched a new funding opportunity to establish a Center of Excellence for Building Capacity in Nursing Facilities to Care for Residents with Behavioral Health Conditions.²⁷ The Center of Excellence will provide nursing facility staff with direct consultation, training, and technical assistance in behavioral health. The program is funded by CMS and administered by SAMHSA.
- The Office of the National Coordinator for Health Information Technology (ONC) is leading the coordination across HHS of activities related to health information technology (HIT), including HIT activities that will support the integration of behavioral health care with other care settings. In July 2022, ONC released version 3 of the [United States Core Data for Interoperability](https://www.hhs.gov/healthit/2022/07/20/uscdi-3) (USCDI). The USCDI is a standardized set of health data classes and elements that can be used across care settings to aid in the coordination of care by ensuring that data is represented in an interoperable way.

Connect Americans to Care

The *Connect Americans to Care* pillar focuses on bridging the gap between services the system offers and people's ability to get the care they need.

To deliver on this pillar, services must be affordable. Low affordability of care related to *insurance and other financing limitations* [Box 1] remains one of the most commonly identified challenges to accessing behavioral health care in the U.S. For instance, inability to afford the cost of care was the most commonly cited reason for not receiving such services (cited by about half of respondents) among adults with mental illness who perceived an unmet need for mental health services in the past year in the 2020 National Survey on Drug Use and Health.²⁸ Making care more affordable involves a range of public and private health care financing arrangements, which differ in many ways--the beneficiaries they serve, the services they reimburse, the provider types included in their networks, and more. Affordability of behavioral health services is limited by both supply-side and demand-side funding factors. On the supply-side, for example, insurance may not reimburse providers adequately (or at all) for some evidence-based interventions or for certain services needed by people with co-occurring conditions (e.g., case management, supported employment). Some provider types may not be eligible for reimbursement, and those who are eligible may opt not to accept insurance, resulting in low levels of provider participation in insurance networks. On the demand-side, while the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA) represent historic achievements that together have driven substantial progress towards narrowing gaps in patient cost-sharing and other treatment limitations between M/SUD services and other medical services across a range of health plans, further efforts are needed to close these gaps entirely and fully realize the goal of parity. The idiosyncrasies of each financing system require that solutions be tailored to specific programs. To overcome this challenge, the Department has identified opportunities to **make behavioral health services more affordable** for beneficiaries of Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), and any financing arrangement subject to MHPAEA.

Delivering on this pillar also requires that behavioral health care must be available in settings that people can easily access--particularly individuals at higher risk for behavioral health conditions, those who have faced greater barriers to receiving care due to structural inequities, and those at elevated risk for mortality and other serious adverse outcomes related to their behavioral health conditions. *Inequitable engagement of underserved populations* [Box 1] remains a persistent challenge to ensuring that all communities receive evidence-based care. High-risk populations include people with serious mental illness; underserved populations; people living in underserved areas; families with low incomes; individuals with co-occurring disabilities; individuals and families experiencing homelessness; individuals involved with the justice system; families involved with the child welfare system; and survivors of domestic violence, trafficking, and other forms of trauma. In addition, given the rising prevalence of behavioral health conditions observed among children and adolescents in recent years and particularly during the COVID-19 pandemic,²⁹ as well as the critical shortages of behavioral health care specialists trained to serve pediatric populations,³⁰ HHS also considers children (including infants and toddlers) and adolescents as a high-risk population.³¹ The Department has identified opportunities to **engage high-risk populations in integrated behavioral health care through targeted outreach tailored to their needs**. This is a critical component of expanding access equitably.

HHS will advance the *Connect Americans to Care* pillar through reforms to behavioral health care financing arrangements that will improve the affordability of care combined with additional outreach to engage high-risk communities. Examples of publicly announced programs and activities supporting the *Connect Americans to Care* pillar that address identified challenges to behavioral health integration include:

- For years, members of Congress have proposed to increase Medicare beneficiaries' access to behavioral health services by adding statutory benefit categories for practitioners such as licensed

professional mental health counselors and licensed marriage and family therapists. Currently, payment for the services of these practitioners can only be made under the Medicare Physician Fee Schedule when they perform services under the direct supervision of the billing physician or other practitioner. In the absence of a statutory change that would allow these practitioners to bill independently, CMS has proposed to amend regulatory requirements to allow general supervision, rather than direct supervision, when such clinicians' services are furnished incident to the services of the billing physician or non-physician practitioner.³² Changing the requirement from direct supervision to general supervision is expected to increase access to behavioral health services for Medicare beneficiaries.⁵

- The Center for Medicaid and CHIP Services (CMCS) recently issued a CMCS Informational Bulletin “to remind State Medicaid Agencies of the federal requirements for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.”³³ It includes an overview of behavioral health under EPSDT as well as strategies and examples of high-quality behavioral health services for children including screening, diagnoses, continuity of care, expanding provider capacity, and integration of behavioral health and primary care. It also provides a list of relevant guidance documents in categories such as school-based services, behavioral health benefit design authorities, telehealth, and more.
- HRSA, through the Bipartisan Safer Communities Act, was provided an additional \$80 million in multi-year funds for the Pediatric Mental Health Care Access (PMHCA) grant program, which funds pediatric mental health care teams to provide tele-consultation for providers in settings such as primary care practices, emergency departments, and schools.** Statewide availability of tele-consultation programs like those funded by PMHCA is associated with greater access to children's mental health services.³⁴ As of 2016, however, nearly a quarter of children (23%) resided in states with no such programs, and nearly half of children (49%) resided in states in which such programs were available in some but not all counties.³⁵
- CMS will encourage interdisciplinary whole-person care by authorizing Medicaid coverage and reimbursement of inter-professional consultations and, as a longer-term strategy, test payment models that leverage behavioral health integration to support the delivery of whole-person care.³⁶
- The Administration for Children and Families (ACF) supports Head Start preschool programs (primarily serving children aged 3-4) and Early Head Start programs (serving infants, toddlers, and expectant families).³⁷ Head start services are tailored to income-eligible children and families in local communities across the country, including American Indian/Alaska Native tribal communities and with migrant and seasonal farmworker families working in over 38 states. In addition to the many other comprehensive services Head Start programs provide, they are a conduit to behavioral health services for those most in need. Head Start programs work collaboratively with families, community providers such as health and mental health consultants, and with educational staff and organizational leadership to elevate behavioral health across the entire program. The Office of Head Start has a robust training and technical assistance system at the national and regional level that incorporates a trauma-informed approach in offering supports to programs.
- The Administration for Community Living (ACL) has announced a funding opportunity to establish a National Resource and Technical Assistance Center for People with Co-Occurring Intellectual and Developmental Disabilities (ID/DD) and Mental Health Disabilities. The center--which “will be guided by people with lived experience, including those from underserved communities”³⁸--will build state

⁵ This brief cannot address the public comments on the proposed rule, or the likelihood of the change being included in the final rule.

** PMHCA-funded teams provide other services as well. For more information, see <https://mchb.hrsa.gov/training/pgm-pmhca.asp>.

and local capacity to support those with ID/DD and mental health disabilities. It will support state agencies (with policy development, service design, and coordination) as well as individuals, family members, and professionals (with training, peer-to-peer learning, and other resources).

- HRSA's Health Care for the Homeless program supports coordinated, comprehensive, integrated primary care including M/SUD, serving patients that live on the street, in shelters, or in transitional housing.^{††,39}
- To increase access to care for individuals involved with the justice system, in Fall of 2022 the Department will submit a Report to Congress describing innovative strategies and best practices to help individuals who are currently incarcerated, and returning community members who are otherwise eligible for Medicaid, ensure continuity of coverage and seamless transitions back to the community. The findings will inform the design of a Medicaid 1115 demonstration opportunity to improve care transitions and expand coverage to returning community members.

Support Americans by Creating Healthy Environments

The *Support Americans by Creating Healthy Environments* pillar acknowledges the need for "a whole-of-society effort," recognizing the importance of "culture and environment" in promotion, prevention, and recovery.⁴⁰

Delivering on this pillar will require widespread adoption of interventions that are effective at promoting wellness, preventing M/SUD, and improving outcomes for people in recovery. The *lack of focused investment in culturally relevant, person-centered, and evidence-based promotion and prevention services* [Box 1], including supports for children and individuals with co-occurring disabilities, is a critical gap in achieving integration across settings and advancing equity.⁴¹ To overcome this challenge, the Department has identified opportunities to **align structural supports and financing to integrate promotion and prevention programs in community-based settings** from early childhood to young adulthood, inclusive of schools. These settings have the promise to reach more children, promote healthy development in the environments in which children spend most of their time, prevent the occurrence of behavioral health challenges, and change the trajectory of the mental health crisis facing children.

HHS will advance the *Support Americans by Creating Healthy Environments* pillar by expanding the evidence base for effective promotion and prevention programs operating across diverse settings, and translating the evidence into practice in HHS's grant-funded programs and through reforms to behavioral health care financing arrangements. Examples of publicly announced programs and activities that are aligned with the *Support Americans by Creating Healthy Environments* pillar, and that address identified challenges to integration include:

- The National Institutes of Health (NIH) supports Research to Advance Mental, Emotional, and Behavioral Health Preventive Interventions in School Settings.⁴² In 2022, NIH announced a research funding opportunity on innovative approaches to identifying, understanding, and developing strategies for overcoming barriers to the adoption, adaptation, integration, scale-up and sustainability of evidence-based preventive interventions to support children's mental, emotional, and behavioral health in school settings.
- NIH has also announced research funding opportunities to support the development and testing of strategies to implement and sustain evidence-based mental health preventive interventions in low-

^{††} [Justification of Estimates for Appropriations Committees](#), FY 2023.

resource settings, where such interventions are not currently delivered or are not delivered with fidelity.^{43,44}

- The Centers for Disease Control and Prevention’s (CDC’S) What Works in Schools Program supports schools to provide quality health education, connect students to health and behavioral services, and establish safe and supportive school environments, with a specific focus on increasing school connectedness. What Works in Schools has demonstrated significant reductions in sexual risk and drug use behaviors and improvements in school climate, which can improve adolescent mental health and well-being.⁴⁵
- HRSA’s Bright Futures program provides guidelines to improve the health of infants, children, and adolescents. These guidelines address behavioral health assessments, screenings, and procedures. Certain group health plans and insurance issuers are required to cover preventive services recommended by Bright Futures without cost-sharing, thus making the services more accessible.⁴⁶
- SAMHSA’s Resiliency in Communities After Stress and Trauma (ReCAST) program focuses on communities that have recently faced civil unrest, community violence, and/or collective trauma.⁴⁷ The program promotes behavioral health integration and equitable access to trauma-informed resources, among other goals that support community resilience.
- Project Advancing Wellness and Resiliency in Education (AWARE) builds the capacity of State Educational Agencies, in partnership with State Mental Health Agencies (SMHAs). By strengthening the behavioral health infrastructure, the program advances school-aged children’s wellness and resiliency through increased mental health awareness, universal interventions, identification of students at risk, and access to treatment as indicated across states, territories, and tribal communities. In August, SAMHSA awarded \$13.9 million (\$5.3 million from American Rescue Plan funding) in Project AWARE grants.

DISCUSSION

This brief provides a general overview of the approach HHS is taking to drive toward integrated care within the three pillars of the President’s Strategy and highlights selected programs and policy actions that will get us there. It is not an exhaustive catalogue of all of the behavioral health initiatives across the Department; indeed, as described above, HHS agencies are advancing the HHS Roadmap alongside important efforts already underway such as the HHS Overdose Prevention Strategy and a new three-digit crisis line (9-8-8).^{48,49} The HHS Roadmap represents the Department’s reinvigorated commitment to using every lever available to us to achieve the President’s vision for transforming the U.S. behavioral health system, including collaboration with other departments, Congress, states and localities, and non-governmental stakeholders. Additional individual policy changes in support of the HHS Roadmap and the President’s Strategy will be announced as they can be shared publicly. HHS will closely monitor our progress and the impacts of our initiatives, as we continuously strive to improve the mental health and well-being of the communities that we are so fortunate to serve.

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