DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2012

Substance Abuse and Mental Health Services Administration

Justification of Estimates for Appropriations Committees

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A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
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LETTER FROM ADMINISTRATOR

I am pleased to present the SAMHSA FY 2012 Performance Budget. SAMHSA's FY 2012 budget request reflects a restructuring of SAMHSA's programs to focus resources on making progress on HHS' and SAMHSA's strategic initiatives and improving the Nation's behavioral health service system. A total of $3.6 billion is requested for FY 2012, representing a net increase of $67 million over FY 2010. It restructures SAMHSA's programs to increase effectiveness and efficiency and to provide increased focus on prevention of substance abuse and mental illness and promotion of emotional health, and to assist Tribes in addressing substance abuse and suicide issues within their communities. It also addresses emerging issues such as primary/behavioral health care integration, health information technology in the behavioral health field, and the special behavioral health prevention and treatment needs of military families. In addition, SAMHSA's restructuring invests funding to improve the data systems that monitor the performance of SAMHSA programs and to increase public awareness that behavioral health is essential to health, prevention works, treatment is effective, and people recover.

The Nation's economic situation has put a strain on public funding at both State and Federal levels. For example, almost every State in the Nation has had to reduce its health and social services spending and many anticipate further reductions in the near future. Therefore, SAMHSA's resources are all the more important for States, Tribes, Territories and communities.

SAMHSA needs the ability to implement a flexible, thoughtful and deliberate theory of change to improve the Nation's behavioral health service system. SAMHSA seeks to identify emerging issues, foster innovative solutions to real world problems, demonstrate and disseminate new research or promising practices, and use limited, short-term discretionary grant investments to move evidence-based practices and policies into the Nation's core behavioral health system funded either through Block Grants to States, formula grants to States and Tribes, on-going discretionary grants, State and County funding, Medicaid/Medicare, or private insurance. Therefore, SAMHSA is requesting a new budget line in FY 2012 for Innovation and Emerging Issues which will include new funding to address high priority issues and opportunities emerging as a result of new science, new collaborations, or recent new laws such as the Mental Health Parity and Addiction Equity Act, the Affordable Care Act and the Health Information Technology for Economic and Clinical Health.

To accomplish these goals, SAMHSA's FY 2012 budget: 1) creates the Substance Abuse - State Prevention Grant (SA-SPG), the Mental Health - State Prevention Grant (MH-SPG), and the Behavioral Health - Tribal Prevention Grant (BH-TPG); 2) combines the budget lines for the three Programs of Regional and National Significance (PRNS) into a single account for Innovation and Emerging Issues (IEI); 3) consolidates funding for three different data collection

systems and the evidence-based practice registry into one Performance and Quality Information Systems (PQIS) budget line; 4) consolidates a number of communications contracts funded from across SAMHSA and SAMHSA's previous health information network into a new budget line for Public Awareness and Support (PAS); and 5) consolidates several other activities currently funded from multiple lines within SAMHSA into a single budget line for Regulatory and Oversight Functions (ROF).

The FY 2012 SAMHSA budget represents a bold plan of action to increase effectiveness and efficiency, build on new opportunities including preparing for changes in the Nation's healthcare system, and better meet the behavioral health needs of the Nation. This budget will help SAMHSA support programs providing critical services for those individuals in need of behavioral health care that is not covered by public or private insurance. SAMHSA has spent years supporting a robust discretionary portfolio to test and refine proven practices. Now is the time to begin bringing those practices to scale in every State and Tribe as SAMHSA continues to look for innovative approaches to test in the field and to collaborate with Federal and other partners to chart a course for the future.

[redacted]

Pamela S. Hyde, J.D.
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
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Organizational Structure:
Substance Abuse and Mental Health Services Administration (SAMHSA)

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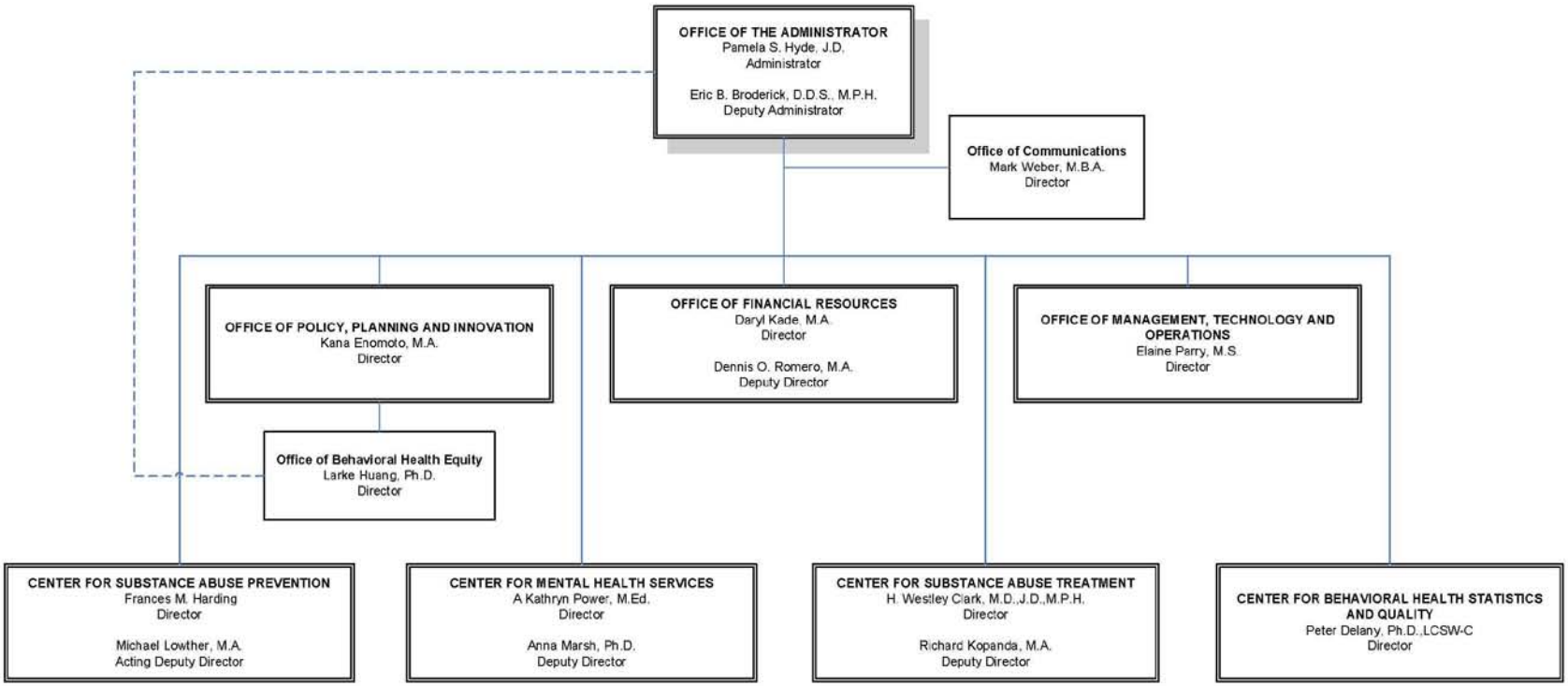

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SAMHSA Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services, is the principal Federal Agency charged with increasing access to substance abuse and mental health services. SAMHSA was established in 1992 and reauthorized in 2000. SAMHSA provides leadership on behavioral health issues nationwide; administers a combination of competitive, formula, and block grant programs and data collection activities; promotes practice improvements and provides information about behavioral health and available services to the public and to behavioral health providers and practitioners. Programs are carried out through the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Center for Behavioral Health Statistics and Quality (CBHSQ). Finally, the Office of Policy, Planning and Innovation (OPPI) is guiding SAMHSA's innovation and emerging issues agenda.

Behavioral health plays a crucial role in the health and well-being of individuals and their communities. SAMHSA is committed to making sure that those who need these services get them through its programs as well as through the health care delivery system and other social, economic and support systems that are run and financed by the Federal, State, and local governments and the private sector. SAMHSA's resources enable service capacity expansion and the implementation of evidence-based practices. SAMHSA seeks to engage and prepare communities to provide effective services by facilitating access to the latest information on prevention, evidence-based practices and accountability standards.

Vision

SAMHSA gears all of its resources—programs, policies, information and data, contracts and grants—toward helping the Nation realize SAMHSA's vision:

- Behavioral Health is essential for health
- Prevention works
- Treatment is effective
- People recover from mental and substance use disorders

SAMHSA leads the Nation in building resilience and facilitating recovery for people with or at risk for mental or substance use disorders and supporting the communities where they live.

Mission

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities and accomplishes this mission by building resilience and facilitating recovery for people with or at risk for mental or substance use disorders and supporting the communities where they live. By providing leadership, voice, funding, and standards, SAMHSA provides the expertise and collaboration necessary to make the most meaningful impact toward achieving this vision. SAMHSA-funded services help individuals achieve or maintain a stable home, a purpose in life, a community, and a healthy lifestyle including being free of abuse of substances or alcohol and free of disabling mental disorders or symptoms. Maintaining funding streams will ensure adequate service capacity for States, Tribes, local governments, and communities while helping to improve practices. Increasing understanding of mental and substance use disorder prevention and treatment services will achieve the full potential of prevention and help people recognize and seek assistance for these health conditions with the same urgency as any other health condition.

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Eight Strategic Initiatives

Behavioral health is an essential part of health service systems and community-wide strategies that work to improve health status and lower costs for families, businesses, and governments. Through continued improvement in the delivery and financing of prevention, treatment, and recovery support services, SAMHSA with its partners can advance and protect the Nation's health. In order to achieve this goal, SAMHSA has identified eight Strategic Initiatives to focus SAMHSA's work on improving lives and capitalizing on emerging opportunities. The eight Initiatives are described below.

1 Prevention of Substance Abuse and Mental Illness

(Fran Harding, Director, Center for Substance Abuse Prevention)

Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This initiative will focus especially on the Nation's high risk youth, youth in Tribal communities, and among military families.

2 Trauma and Justice

(Larke Huang, Director, Office of Behavioral Health Equity)

Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems; and addressing the behavioral health needs of people involved or at risk of involvement in the criminal and juvenile justice systems.

3 Military Families

(Kathryn Power, Director, Center for Mental Health Services)

Supporting America's service men and women – Active Duty, National Guard, Reserve, Coast Guard, and Veterans – together with their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are positive.

4 Health Reform Implementation

(John O'Brien, Senior Advisor for Health Finance)

Broadening health coverage to increase access to appropriate high quality care and to reduce disparities that currently exist between the availability of services for substance abuse, mental disorders, and other medical conditions.

5 Recovery Support

(Kathryn Power, Director, Center for Mental Health Services)

Partnering with people in recovery from mental and substance use disorders to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to social inclusion.

6 Health Information Technology

(Westley Clark, Director, Center for Substance Abuse Treatment)

Ensuring the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general healthcare delivery system in the adoption of Health Information Technology (HIT) and interoperable Electronic Health Records (EHR).

7 Data, Outcomes, and Quality

(Pete Delany, Director, Center for Behavioral Health Statistics and Quality)

Realizing an integrated data strategy that informs policy and measures program impact, leading to improved quality of services and outcomes for individuals, families, and communities.

8 Public Education and Support

(Mark Weber, Director, Office of Communications)

Increasing understanding of mental and substance use disorders to: achieve the full potential of prevention; help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition; and make recovery the expectation.

Overview of the Budget Request

SAMHSA's FY 2012 Budget advances the President's initiative under health care reform and is oriented towards transitioning to a new future of physical and behavioral health care in this country. This future creates both opportunities and imperatives for SAMHSA and other federal partners that have historically focused primarily on the provision of health care services for individuals with or at risk of substance use and mental disorders, especially those who cannot afford access to quality care. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA-funded services help persons achieve a stable home, a purpose in life, a community, and a healthy lifestyle including being free of abuse of substances or alcohol and being free of mental disorders and related problems or uncontrolled symptoms. Additionally, as a leader and voice for behavioral health issues and as a practice improvement agent, SAMHSA also has regulatory, surveillance, and public education responsibilities. SAMHSA works with its partners within HHS and throughout the Federal government, many of whom also provide funding, information or leadership in aspects of the prevention and treatment of or recovery from mental and substance use disorders. SAMHSA also focuses on several key opportunities and challenges rather than spread its limited funding and attention broadly across issues that other partners also address.

The costs of untreated and under-treated substance use and mental illness are staggering. The latest estimate for the societal cost of substance abuse in the United States is more than $510 billion[1] annually. The National Institute of Mental Health estimates the annual total direct and indirect costs of Serious Mental Illness in 2002 to be over $310 billion. Additionally, the Nation's economic situation has put a strain on public funding at both State and Federal levels. Almost every State in the Nation has had to reduce its health and social services spending in the last couple of years. For FY 2010, SAMHSA granted waivers to 19 States and 3 territories that did not meet the Maintenance of Effort (MOE) requirement for the MHBG, the SABG, or both. During that period, the net loss of funding for behavioral health was in excess of $500 million. In FY 2011, SAMHSA expects to grant waivers to 28 States, the District of Columbia, and one territory for the MHBG, the SABG, or both. In addition, Federal support for the Mental Health Block grant is less than in FY 2002 and support for the Substance Abuse Block Grant has not grown by any significant amount over the same period.

The FY 2012 President's Budget request prioritizes funding for new programs to address SAMHSA's top three strategic initiatives: (1) prevention of substance abuse and mental illness; (2) trauma and justice; and (3) military families. SAMHSA is committed to measuring what matters to people currently and what makes a difference in their lives. Overall, the Budget request restructures SAMHSA's programs in preparation for changes in health financing and reinvests funding to improve the data systems that monitor the performance of SAMHSA programs and to increase public awareness that behavioral health is essential for health, prevention works, treatment is effective, and people recover. SAMHSA is undertaking a reconfiguration of Government Performance and Results Act (GPRA) measures to focus on services delivered or people served as the output measure, with specific measures for each individual program area. It focuses on recovery-oriented outcomes.

[1] Miller, T. and Hendrie, D. *Substance Abuse Prevention Dollars and Cents: A Cost Benefit Analysis*. DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.

In addition to the creation of the State, Tribal, and Community Prevention Grants, which includes the Substance Abuse – State Prevention Grants (SA-SPG), the Behavioral Health – Tribal Prevention Grants (BH-TPG), and the Mental Health – State Prevention Grants (MH-SPG), the budget also combines the budget lines for the three Programs of Regional and National Significance (PRNS) into a single account for Innovation and Emerging Issues (IEI). A new budget line is created for Performance and Quality Information Systems (PQIS), which consolidates funding for three different data collection systems (SAIS, TRAC and PMRT) and the National Registry of Evidence-based Programs and Practices (NREPP). The Public Awareness and Support (PAS) budget line is also created, which consolidates funding for a number of communications contracts funded across all three Centers and the SAMHSA Health Information Network (SHIN). Several other activities funded within the Centers have been consolidated into a single budget line for Regulatory and Oversight Functions (ROF).

SAMHSA's FY 2012 Budget is $3.387 billion in budget authority, a decrease of $44 million from the FY 2010 Level. SAMHSA's request prioritizes the reallocation of funding to create the new State, Tribal, and Community Prevention Grants, as well as the Performance and Quality Information Systems, and the Public Awareness and Support budget lines. It also includes funding for two SAMHSA-wide initiatives totaling $14 million for Military Families ($10 million) and Health Information Technology ($4 million). The SAMHSA request includes $395 million to support the Substance Abuse State Prevention Grants; $50 million to support the Behavioral Health Tribal Prevention Grants (allocated from ACA Prevention Funds); $90 million to support the Mental Health State Prevention Grants; $12.9 million to support the Performance and Quality Information Systems; and $13.6 million to support Public Awareness and Support. In addition, the Mental Health Block Grant is increased by $14 million, or three percent, the largest increase since 2005. The Substance Abuse Block Grant for Treatment is increased by $40 million, or three percent, to support the States' behavioral health infrastructure as the States prepare to implement health reform and structure a good and modern system of care. Additionally, key programs that have been shown to be effective are maintained at their FY 2010 levels, including Safe Schools/Healthy Students, Garrett Lee Smith Suicide Prevention activities, Minority AIDS, Minority Fellowship Programs, STOP Under-Age Drinking Act, SBIRT, Pregnant and Post Partum Women program, Access to Recovery, and Criminal Justice Activities. In support of the Administration's Homelessness Prevention initiative, SAMHSA requests $154 million, an increase of $12 million, for housing support services for individuals with mental illness and substance abuse who are or at risk of being homeless.

In 2014, many individuals previously ineligible for Medicaid or unable to obtain commercial insurance for or because of mental and substance use disorders will be covered by Medicaid, commercial insurance through employers or on the private market through health insurance exchanges. This will necessitate recasting the SABG and the MHBG in terms of who they serve and what services they fund. Generally, these Block Grants need to provide funding for those individuals and those services not otherwise funded by other sources such as Medicaid and commercial insurance. The Block Grants will need to be redesigned to operate as a "coordination of benefits" or wrap around services for those priority individuals who are receiving core behavioral health services elsewhere. Block Grants will also need to fund priority services for those priority individuals who remain uninsured and whose untreated behavioral health needs will be a burden on the individual, his/her family and his/her community.

SAMHSA will begin to request different information in State/Territory BG applications regarding specific service approaches and planning activities, capacities and needs for implementing the Affordable Care Act, and proposed responses to priorities outlined by SAMHSA. This request for different information will introduce a message to States that SAMHSA is preparing for a major paradigm shift in the healthcare system, and will signal the direction of future changes. In addition, this State information will tell SAMHSA what kind of technical assistance and resources States may need as they improve their service delivery systems in the midst of fiscal austerity at the State and Federal levels. For some information, SAMHSA plans to encourage a single submission from each State, necessitating coordination across Mental Health and Substance Abuse Authorities and other State departments including State Medicaid and public health authorities. In preparation for the next round of full BG applications, SAMHSA is making necessary adjustments to internal operations to facilitate consistent timing and content of the SABG and the MHBG applications for 2012. To make these transitions, SAMHSA needs to utilize its current authority more fully and be authorized more fully to provide direction and technical assistance to States as the BG priorities change and as serving individuals through multiple funding sources complicates coordination of care. SAMHSA also needs to direct reporting requirements so that successes or failures or areas needing improvement are clearer more quickly so that limited resources are utilized in the context of the much larger and more complex health care delivery and financing systems in each State, and Nationwide.

The first comprehensive National HIV/AIDS Strategy (NHAS) was released in July 2010. SAMHSA was involved in a Federal interagency working group and worked with the Office of National AIDS Policy to develop the NHAS. The Strategy focuses on three overarching goals: reducing the number of new HIV infections, increasing access to care for people living with HIV, and reducing HIV-related health disparities. SAMHSA is committed to supporting the NHAS through the promotion of evidence-based prevention interventions and behavioral health services and treatment for people at risk for or living with HIV/AIDS who have co-occurring mental and/or substance use disorders. SAMHSA is working with Federal partners to ensure that behavioral health services are an integral part of a comprehensive approach to HIV/AIDS prevention, care and treatment.

Finally, SAMHSA is undergoing a major policy review of all grants and contracts for FY 2011, resulting in revisions to its regular contract planning process. The review, which includes those grants and contracts financed by the block grant set-asides, will determine where efficiencies and consolidations may be warranted. The goal of the policy review is to have policy-driven grants and contracts planning and to bring these activities in closer alignment with the mission and vision for SAMHSA.

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Overview of Performance

FY 2012 Performance Overview

SAMHSA's performance measures include outcomes and outputs which allow SAMHSA to effectively manage grants, contracts and data collection activities, and to report performance results to the President, Congress, and other stakeholders.

The FY 2012 Budget includes substantial revisions to SAMHSA's performance measures reported in the Annual GPRA Plan and Annual GPRA Report. The resulting set of measures seeks to capture the following key items for each program: the number of services delivered or people served, a specific measure or two for each individual program area, and a measure that captures client recovery. Further, SAMHSA spent a good deal of time reviewing existing measures to ensure that they were meaningful and met the needs of both program management and policy-makers. This effort resulted in a reduction of measures from almost 200 (as published in the 2011 President's Budget) to around 100 measures in the FY 2012 President's Budget. Although this reduction changes the display of measures in the Annual GPRA Report/Plan, the majority of the measures that have been removed (including NOMS) will continue to be collected and used for program management purposes.

Work on SAMHSA's GPRA measures and other data collection activities are ongoing. SAMHSA is working with internal and external stakeholders on developing appropriate measures of recovery for those with mental or substance use disorders. As these efforts become more defined, the GPRA measures reported in the budget as well as those used for program management may be altered to bring them in line with other cross-cutting efforts.

Support for the HHS Strategic Plan and Other Federal Priorities

SAMHSA data efforts, including GPRA, support many of the priorities of the Secretary and the President. SAMHSA has ongoing activities that relate to each of the Secretarial priorities:

- Transforming Health Care - Through its National Survey on Drug Use and Health, SAMHSA is monitoring the percentage of persons with a mental health or substance use disorder service needs and who have health insurance.

- Advance Scientific Knowledge and Innovation – SAMHSA has established a new Office of Policy, Planning and Innovation to lead cutting edge efforts across SAMHSA and across government.

- Advance the Health, Safety, and Well-Being of the American People - SAMHSA is monitoring trends in mental health and substance abuse disorders. One example is the percentage of youth age 12-20 who report drinking in the past month and taking steps to reduce that percentage to 23.8 percent by 2015 from 27.2 percent in 2009.

- Increase Efficiency, Transparency, and Accountability of HHS programs – SAMHSA is working directly with the HHS Chief Technology Officer to make more SAMHSA data publicly available.

- Strengthen the Nation's Health and Human Services Infrastructure and Workforce – SAMHSA is working with HRSA to examine ongoing technical assistance and training activities and incentives to see if there are more effective and efficient ways of expanding, supporting and reaching the behavioral health workforce.

- SAMHSA is also preparing for implementation of the GPRA Modernization Act of 2010 which endorses improved accountability through quarterly performance data reporting, priority setting and regular senior leadership meetings. SAMHSA is awaiting guidance from OMB and HHS on how this law will be operationalized and has already begun thinking about how to take these new mandates and utilize them internally to improve transparency, accountability and leadership involvement.

SAMHSA is also preparing for implementation of the GPRA Modernization Act of 2010 which endorses improved accountability through quarterly performance data reporting, priority setting and regular senior leadership meetings.

Significant Accomplishments

Over the last several years, SAMHSA has maintained between 58-70 percent target achievement among its GPRA measures published in the budget. The most significant challenge to success was among the FY 2009 and 2010 data. Considering that many of these measures are outcomes (e.g., substance use, housing, and employment) which have been greatly impacted by the economic downturn, SAMHSA has been remarkably successful.

SAMHSA's Strategic Initiatives and a New Vision for Data, Outcomes, and Quality

SAMHSA spent much of CY 2010 developing and refining a Strategic Plan focusing on eight priorities, which will take SAMHSA and its programs into the future. (See earlier section describing the eight initiatives.) The intent of the Data, Outcomes, and Quality initiative is to realize an integrated data strategy that informs policy, measures program impact, and results in improved quality of services and outcomes for individuals, families, and communities. SAMHSA is:

- Implementing an integrated approach for SAMHSA's collection, analysis, and use of data;

- Creating common standards for measurement and data collection to better meet stakeholder needs;

- Improving the quality of SAMHSA's program evaluations and services research; and

- Improving quality and accessibility of surveillance, outcome/performance, and evaluation information for staff, stakeholders, funders, and policymakers.

This revised approach to data, outcomes, and quality is clearly a work in progress and will require continued discussions into CY 2011 and beyond as SAMHSA's work on this initiative unfolds and as SAMHSA engages in discussions with other HHS agencies and stakeholder groups interested in quality and outcome measurement.

Summary of Performance Targets and Results

The FY 2012 Budget includes substantial revisions to SAMHSA's performance measures reported in the Annual GPRA Plan and Annual GPRA Report. The resulting set of measures seeks to capture the following key items for each program: the number of services delivered or people served, a specific measure or two for each individual program area, and a measure that captures client recovery. Further, SAMHSA spent a good deal of time reviewing existing measures to ensure that they were meaningful and met the needs of both program management and policy-makers. This effort resulted in a reduction of measures from almost 200 (as published in the 2011 President's Budget) to around 100 measures in the FY 2012 President's Budget. Although this reduction changes the display of measures in the Annual GPRA Report/Plan, the majority of the measures that have been removed (including NOMS) will continue to be collected and used for program management purposes.

Work on SAMHSA's GPRA measures and other data collection activities are ongoing. SAMHSA is working with internal and external stakeholders on developing appropriate measures of recovery for those with mental or substance use disorders. As these efforts become more defined, the GPRA measures reported in the budget as well as those used for program management may be altered to bring them in line with other cross-cutting efforts.

Table 1: Summary of Performance Targets and Results[2]

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	144	142	99%	99	70%
2008	162	160	99%	110	69%
2009	184	180	98%	106	59%
2010	179	82	46%	50	61%
2011	93	0	N/A	0	N/A
2012	106	0	N/A	0	N/A
2013	83[3]	0	N/A	0	N/A

[2] Table completed using HHS Program Performance Tracking System, 1/19/2011

[3] Total does not include targets for measures that have yet to be established. In most circumstances this includes new programs where baseline data has not yet been collected.

SAMHSA Linkages to HHS Strategic Plan

SAMHSA spent much of CY 2010 developing and refining a Strategic Plan focusing on eight priorities, to guide our programmatic, policy, and management decisions and take SAMHSA and its programs into the future. The eight priorities are: (1) Prevention of Substance Abuse and Mental Illness; (2) Trauma and Justice; (3) Military Families; (4) Health Reform; (5) Recovery Support; (6) Health Information Technology; (7) Data, Outcomes and Quality; and (8) Public Awareness and Support. SAMHSA programmatic activities are guided by these eight priorities and the HHS Strategic Plan. SAMHSA activities support at least one HHS strategic objective; many support more than one.

Many of SAMHSA's activities are focused on the first of its eight priorities: the Prevention of Substance Abuse and Mental Illness. Prevention ties closely to the HHS Strategic Plan Objective 3.D, Promote Prevention and Wellness as well as several other objectives including 1.E, 3.A, 3.B, 3.C. The SAPT and CMHS Block Grants and the majority of the CSAP Innovation and Emerging Issues, including Prevention Prepared Communities focus on these objectives.

SAMHSA's programs (Safe Schools/Healthy Students, National Traumatic Stress network, Project LAUNCH now included in the Mental Health State Prevention Grant, and our Children and Families Programs) focus on Objective 3.A Ensuring the safety, well-being and healthy development of children and youth and are simultaneously being guided by SAMHSA's Trauma and Violence and Prevention initiatives.

SAMHSA recognizes the challenge of serving homeless individuals and understands the incredible need among this population for substance abuse and mental health services. As such, SAMHSA's Recovery Support initiative and the ongoing Homelessness programs (including Services in Supportive Housing, Grants for the Benefit of Homeless Individuals, an ongoing collaboration with HUD, and the PATH formula grant) support Objectives 1.E, 3.B, and 3.C.

SAMHSA further recognizes the changing face of health care service provision and increasing need to modify established programs to meet Health Reform and the development of Health Information Technology. As such, SAMHSA has established initiatives around both of these areas. Programs linked to the Health Reform Initiative are the CMHS and SAPT Block Grants. Programs impacted by Health IT include an ongoing demonstration project as well as the Block Grants.

Lastly, SAMHSA is working to both improve the outcomes of our clients through increasing quality of care and more effectively get our prevention message out through refined Public awareness efforts. The ongoing activities around these two initiatives include health surveillance, other data collection efforts, information dissemination, and expanding the use of evidence-based practices through our technical assistance and training. These programs are closely linked with the HHS objective 2.D, 3.D, 4.C, 5.C.

As the nation moves toward mental health parity and health reform, SAMHSA will continue to examine its eight strategic initiatives to assure that they are consistent with national needs and priorities.

Discretionary All-Purpose Table
FY 2012 Budget Submission
(Dollars in Thousands)

Program Activities	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Mental Health Block Grant	$399,735	$399,735	$413,645
PHS Evaluation Funds	21,039	21,039	21,039
Subtotal, Mental Health Block Grant	**420,774**	**420,774**	**434,684**
Substance Abuse Block Grant	1,375,513	1,375,513	1,419,603
PHS Evaluation Funds	79,200	79,200	74,711
Subtotal, Substance Abuse Block Grant	**1,454,713**	**1,454,713**	**1,494,314**
State, Tribal and Community Prevention Grants	**480,576**	**480,655**	**485,000**
Substance Abuse - State Prevention Grant (non-add)	---	---	*395,000*
Behavioral Health - Tribal Prevention Grant (non-add) 1/	---	---	---
Mental Health - State Prevention Grant (non-add)	*24,993*	*25,000*	*90,000*
Innovation and Emerging Issues	809,714	809,211	745,188
Agency-Wide Initiatives (non-add)	---	---	*14,000*
CMHS (non-add)	*327,842*	*327,689*	*270,893*
CSAP (non-add)	*75,438*	*75,527*	*69,376*
CSAT (non-add)	*406,434*	*405,995*	*390,919*
PHS Evaluation Funds	2,000	2,000	2,000
Subtotal, Innovation and Emerging Issues	811,714	811,211	747,188
Children's Mental Health Services	121,316	121,316	121,316
PATH Homeless Formula Grant	65,047	65,047	65,047
Regulatory & Oversight Functions	55,052	54,938	54,938
Public Awareness and Support	14,006	14,230	---
PHS Evaluation Funds	---	---	13,571
Subtotal, Public Awareness and Support	14,006	14,230	13,571
Performance and Quality Information Systems	30,165	30,987	---
PHS Evaluation Funds	6,596	6,596	12,996
Subtotal, Performance and Quality Information Systems	36,761	37,583	12,996
Health Surveillance and Program Support	79,197	79,197	82,166
PHS Evaluation Funds	22,750	22,750	45,428
Subtotal, Health Surveillance and Program Support	101,947	101,947	127,594
St. Elizabeths Hospital B&F	795	795	---
ACA Prevention Fund			
Primary and Behavioral Health Care Integration	20,000	35,000	20,000
Garrett Lee Smith Youth Suicide Prevention	---	10,000	---
Prevention Prepared Communities	---	---	22,600
Health Surveillance	---	18,000	---
Screening, Brief Intervention, & Referral to Treatment	---	25,000	---
Behavioral Health - Tribal Prevention Grants	---	---	50,000
Subtotal, ACA Prevention Fund	20,000	88,000	92,600
TOTAL, SAMHSA Discretionary PL	**3,582,701**	**3,651,209**	**3,649,248**
Less PHS Evaluation Funds	*131,585*	*131,585*	*169,745*
Less ACA Prevention Funds	*20,000*	*88,000*	*92,600*
TOTAL, SAMHSA Budget Authority	**$3,431,116**	**$3,431,624**	**$3,386,903**
FTEs	**537**	**537**	**544**

1/ Behavioral Health - Tribal Prevention Grant includes $50 million from the ACA Prevention Funds

Summary of Changes
SAMHSA
(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Mental Health Block Grant	$420,774	$420,774	$434,684	+$13,910
Substance Abuse Block Grant	1,454,713	1,454,713	1,494,314	+39,601
State, Tribal and Community Prevention Grants	480,576	480,655	485,000	+4,424
Innovation and Emerging Issues	811,714	811,211	747,188	-64,526
Regulatory & Oversight Functions	55,052	54,938	54,938	-114
Public Awareness and Support	14,006	14,230	13,571	-435
Performance and Quality Information Systems	36,761	37,583	12,996	-23,765
Health Surveillance and Program Support	101,947	101,947	127,594	+25,647
St. Elizabeths Hospital B&F	795	795	---	-795

Summary of the Budget Request:

The SAMHSA President's Budget request is $3.387 billion in budget authority, a $44.2 million decrease from the FY 2010 Enacted Budget. Major strategic realignments include: $395 million for the Substance Abuse - State Prevention Grant; $90 million for the Mental Health - State Prevention Grant; the Behavioral Health - Tribal Prevention Grant ($50 million allocated from ACA Prevention Funds); and $747.2 million from the three Programs of Regional and National Significance budget lines to create the new Innovations and Emerging Issues budget line. Also, $13 million is requested for Performance and Quality Information Systems (PHS Evaluation Funds); and $13.6 million for Public Awareness and Support (PHS Evaluation Funds). Within the Innovation and Emerging Issues budget line, there are new SAMHSA-Wide initiatives totaling $14 million for Military Families ($10 million) and Health Information Technology ($4 million).

Program Increases:

Mental Health Block Grant: (+$13.910 million)
The budget increase provides $13.910 million to the Mental Health Block Grant to maintain State services.

Substance Abuse Block Grant: (+$39.601 million)
The budget increase provides $39.601 million to the Substance Abuse Block Grant to maintain State services.

State, Tribal and Community Prevention Grants: (+$4.424 million)
The budget increase provides $4.424 million for the State, Tribal and Community Prevention Grants over the comparable FY 2010 Level. The increase will support a new Substance Abuse – State Prevention Grant and a new Mental Health – State Prevention Grant. Additionally, the Behavioral Health – Tribal Prevention Grant ($50 million) will be supported by the ACA Prevention Fund.

Health Surveillance and Program Support: (+$25.647 million)
The budget increase provides $25.647 million for Center for Behavioral Health Statistics and Quality data collection activities and other technical assistance, evaluation and data collection activities. The funding will support the national data systems and surveillance activities, including the Drug Abuse Warning Network (DAWN), National Survey on Drug Use and Health (NSDUH), and Drug Abuse Services Information System (DASIS), and $1 million will support the development of the Community Early Warning and Monitoring System (C-EMS) to develop a community-level, early warning system to detect the emergence of new drug threats and to assist in the identification of public health and safety consequences of drug abuse. The funding will also support analytic and evaluation activities responsive to SAMHSA and HHS priorities.

Program Decreases:

Innovation and Emerging Issues: (-$64.526 million)
The net budget decrease reflects savings from grant programs coming to a natural end. The budget includes funding for all ongoing grants Youth Violence Prevention, National Traumatic Stress Network, Primary and Behavioral Health Care Integration, Garrett Lee Smith Suicide Prevention Programs, Suicide Lifeline, Minority Fellowship, Minority AIDS, STOP Under-Age Drinking Act, Fetal Alcohol Center of Excellence, the Center for the Application of Prevention Technologies, Screening, Brief Intervention and Referral to Treatment, Pregnant & Postpartum Women, Targeted Capacity Expansion, Recovery Community Services Program, Access to Recovery, and Problem-Solving Courts. In addition, new funds are available for Homelessness Prevention Programs, Behavioral Health Information Technology, and a Military Families Initiative.

Regulatory and Oversight Functions: (-$0.114 million)
The net budget decrease reflects projected contract savings in Opioid Treatment/Regulatory Activities and Seclusion & Restraint.

Public Awareness and Support: (-$0.435 million)
By consolidating multiple programs and contracts that conduct public awareness and technical assistance activities, SAMHSA is able to realize efficiencies.

Performance and Quality Information Systems: (-$23.765 million)
By consolidating multiple programs and contracts that collect performance data, streamlining operations, and realigning NREPP, SAMHSA is able to realize efficiencies.

St. Elizabeths Hospital Building and Facilities: (-$0.795 million)
The General Services Administration has indicated that additional funding will not be needed from SAMHSA in FY 2012 for environmental remediation at the former St. Elizabeths hospital site.

Appropriation Language
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

For carrying out titles III, V, and XIX of the Public Health Service Act (''PHS Act'') with respect to substance abuse and mental health services and the Protection and Advocacy for Individuals with Mental Illness Act, $3,386,903,000 Provided, That notwithstanding section 520A(f)(2) of the PHS Act, no funds appropriated for carrying out section 520A are available for carrying out section 1971 of the PHS Act: Provided further, That in addition to amounts provided herein, the following amounts shall be available under section 241 of the PHS Act: (1) $74,711,000 to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX; (2) $21,039,000 to carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1920(b) activities shall not exceed 5 percent of the amounts appropriated for subpart I of part B of title XIX; (3) $45,428,000 to carry out national surveys on drug abuse and mental health; (4) $28,567,000 to collect and analyze data , conduct public awareness and technical assistance activities, and evaluate substance abuse treatment programs, and (5) $1,000,000 to collect and analyze data and evaluate mental health programs: Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated under this Act for fiscal year 2012: Provided further, That section 1922(a)(1) of the PHS Act shall not apply to amounts provided herein.

Language Analysis

Language Provision	Explanation
Provided, That notwithstanding section 520A(f)(2) of the PHS Act, no funds appropriated for carrying out section 520A are available for carrying out section 1971 of the PHS Act: Provided further)	No funds from the CMHS PRNS can be used to fund data infrastructure support.
Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated under this Act for fiscal year 2012.	Allows States to receive more than one grant under the Garrett Lee Smith Youth Suicide State-sponsored statewide program.
conduct public awareness and technical assistance activities	Provides PHS evaluation funds to finance public awareness and support which constitutes technical assistance in the new SAMHSA budget structure.
Provided further, That section 1922(a)(1) of the PHS Act shall not apply to amounts provided herein.	Waives the 20% of the Substance Abuse Prevention and Treatment Block Grant minimum expenditure requirement for prevention services; prevention activities will be funded under the new Substance Abuse State Prevention Grants under the new SAMHSA budget structure

Amounts Available for Obligation

	FY 2010 Appropriation	FY 2011 CR	FY 2012 President's Budget
Appropriation:			
Labor/HHS/Ed-Annual Appropriation	$3,431,624,000	3,431,624,000	3,386,903,000
Subtotal, adjusted appropriation	3,431,116,000	3,431,624,000	3,386,903,000
Subtotal, adjusted budget authority	3,431,116,000	3,431,624,000	3,386,903,000
Offsetting Collections from:			
Federal Sources	131,585,000	131,585,000	169,745,000
ARRA	0	0	0
Unobligated balance start of year	239,346	311,781	311,827
Unobligated balance end of year	-311,781	-311,827	-307,763
Unobligated balance expiring	0	0	0
Total obligations	$3,562,628,565	$3,563,208,954	$3,556,652,064

Summary of Changes
(Dollars in Thousands)

2010	
Total estimated budget authority	$ 3,431,116,000
(Obligation)	3,431,116,000
2012	
Total estimated budget authority	3,386,903,000
(Obligation)	3,386,903,000
Net Change	**-$44,213,000**

	FY 2010 Enacted		Change from base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. Annualization of 2011 Commissioned Corps pay costs	---	$ 66,277,000	---	+$22,000
2. Increase for January 2012 pay raise	---	66,277,000	---	+108,000
3. Increase in rental payments to GSA	---	7,023,000	---	+119,000
Subtotal, Built-in Increases	---	---	---	+249,000
B. Program:				
1. Mental Health Block Grant	---	399,735,000	---	+13,910,000
2. Substance Abuse Block Grant	---	1,375,513,000	---	+44,090,000
3. State, Tribal and Community Prevention Grants	---	480,576,000	---	+4,424,000
4. Health Surveillance and Program Support:				
a. Overseas Rightsizing	---	79,197,000	---	+5,000
b. Technical Assistance, Evaluation and Data Activities	---	79,197,000	---	+2,735,000
Subtotal, Program Increases	---	---	---	+65,164,000
Total Increases	---	---	---	**+65,413,000**
Decreases:				
A. Built-in:				
Subtotal, Built-in Decreases	---	---	---	---
B. Program:				
1. Innovation and Emerging Issues	---	809,714,000	---	-64,526,000
2. Regulatory & Oversight Functions	---	55,052,000	---	-114,000
3. Public Awareness and Support	---	14,006,000	---	-14,006,000
4. Performance and Quality Information Systems	---	30,165,000	---	-30,165,000
5. Health Surveillance and Program Support:				
a. HHS Joint Funding Arrangement	---	82,166,000	---	-20,000
6. St. Elizabeths Hospital:	---	795,000	---	-795,000
Subtotal, Program Decreases	---	---	---	-109,626,000
Total Decreases	---	---	---	**-109,626,000**
Net Change, Discretionary Budget Authority	---	---	---	**-$44,213,000**

Budget Authority by Activity

(Dollars in Thousands)

Program Activities	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Mental Health Block Grant	$420,774	$420,774	$434,684
PHS Evaluation Funds (non-add)	(21,039)	(21,039)	(21,039)
Subtotal, Mental Health Block Grant	420,774	420,774	434,684
Substance Abuse Block Grant	1,454,713	1,454,713	1,494,314
PHS Evaluation Funds (non-add)	(79,200)	(79,200)	(74,711)
Subtotal, Substance Abuse Block Grant	1,454,713	1,454,713	1,494,314
Prevention Grants	480,576	480,655	485,000
Innovation and Emerging Issues	811,714	811,211	747,188
PHS Evaluation Funds (non-add)	(2,000)	(2,000)	(2,000)
Subtotal, Innovation and Emerging Issues	811,714	811,211	747,188
Children's Mental Health Services	121,316	121,316	121,316
PATH Homeless Formula Grant	65,047	65,047	65,047
Regulatory & Oversight Functions	55,052	54,938	54,938
Public Awareness and Support	14,006	14,230	---
PHS Evaluation Funds (non-add)	---	---	(13,571)
Subtotal, Public Awareness and Support	14,006	14,230	13,571
Performance and Quality Information Systems	36,761	37,583	---
PHS Evaluation Funds (non-add)	(6,596)	(6,596)	(12,996)
Subtotal, Performance and Quality Information Systems	36,761	37,583	12,996
Health Surveillance and Program Support	101,947	101,947	127,594
PHS Evaluation Funds (non-add)	(22,750)	(22,750)	(45,428)
Subtotal, Health Surveillance and Program Support	101,947	101,947	127,594
St. Elizabeths Hospital B&F	795	795	---
ACA Prevention Fund	20,000	73,750	92,600
TOTAL, SAMHSA Discretionary PL	**3,582,701**	**3,636,959**	**3,649,248**
Less PHS Evaluation Funds	*131,585*	*131,585*	*169,745*
Less ACA Prevention Funds	*20,000*	*73,750*	*92,600*
TOTAL, SAMHSA Budget Authority	**$3,431,116**	**$3,431,624**	**$3,386,903**
FTEs	**537**	**537**	**544**

Authorizing Legislation

Program Description/PHS Act:	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2012 Amount Authorized	FY 2012 President's Budget
NASPER				
Sec. 399O……	Expired	$2,000,000	Expired	$2,000,000
Emergency Response				
Sec. 501……	0	0	0	0
Grants for the Benefit of Homeless Individuals				
Sec. 506……	Expired	$42,750,000	Expired	$47,360,000
Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans				
Sec. 506A*……	0	0	0	0
Grants for Ecstasy and Other Club Drugs Abuse Prevention				
Sec. 506B*……	0	0	0	0
Residential Treatment Programs for Pregnant and Postpartum Women				
Sec. 508……	Expired	$16,000,000	Expired	$16,000,000
Priority Substance Abuse Treatment Needs of Regional and National Significance				
Sec. 509*……	Expired	$354,605,000	Expired	$314,784,000
Substance Abuse Treatment Services for Children and Adolescents				
Sec. 514*……	Expired	$30,678,000	Expired	$30,678,000
Early Intervention Services for Children and Adolescents				
Sec. 514A*……	0	0	0	0
Methamphetamine and Amphetamine Treatment Initiative				
Sec. 514(d)*……	0	0	0	0
Priority Substance Abuse Prevention Needs of Regional and National Significance				
Sec. 516*……	Expired	$529,266,000	Expired	$454,582,000
Prevention, Treatment and Rehabilitation Model Projects for High Risk Youth		.		.
Sec. 517……	0	0	0	0
Services for Children of Substance Abusers				
Sec. 519*……	0	0	0	0
Grants for Strengthening Families				
Sec. 519A*……	0	0	0	0
Programs to Reduce Underage Drinking				
Sec. 519B*……	Expired	$ 7,000,000	Expired	$ 7,000,000

SSAN = Such Sums as Necessary

Authorizing Legislation

Program Description/PHS Act:	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2011 Amount Authorized	FY 2012 President's Budget
Services for Individuals with Fetal Alcohol Syndrome (FAS)				
Sec. 519C*……	0	0	0	0
Centers of Excellence on Services for Individuals with FAS and Alcohol-related Birth Defects and Treatment for Individuals with Such Conditions and Their Families				
Sec. 519D*……	Expired	$9,821,000	Expired	$8,000,000
Prevention of Methamphetamine and Inhalant Abuse and Addiction				
Sec. 519E*……	Expired	0	Expired	0
Priority Mental Health Needs of Regional and National Significance				
Sec. 520A*……	Expired	$179,865,000	Expired	$216,355,000
Youth Interagency Research, Training, and Technical Assistance Centers				
Sec. 520C*……	Expired	$4,957,000	Expired	$4,957,000
Services for Youth Offenders				
Sec. 520D*……	0	0	0	0
Suicide Prevention for Children and Youth				
Sec. 520E1*……	Expired	$29,738,000	Expired	$29,738,000
Sec. 520E2*……	Expired	$4,975,000	Expired	$4,975,000
Grants for Emergency Mental Health Centers				
Sec. 520F*……	0	0	0	0
Grants for Jail Diversion Programs				
Sec. 520G*……	Expired	$6,684,000	Expired	$6,684,000
Improving Outcomes for Children and Adolescents through Services Integration between Child Welfare and MH Services				
Sec. 520H*……	0	0	0	0
Grants for Integrated Treatment of Serious Mental Illness and Co-occurring Substance Abuse				
Sec. 520I*……	0	0	0	0
Mental Health Training Grants				
Sec. 520J*……	0	0	0	0
PATH Grants to States				
Sec. 535(a)……	Expired	$65,047,000	Expired	$65,047,000

SSAN = Such Sums as Necessary

Authorizing Legislation

Program Description/PHS Act:	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2011 Amount Authorized	FY 2012 President's Budget
Community Mental Health Services for Children with Serious Emotional Disturbances Sec. 565 (f)……	Expired	$121,316,000	Expired	$121,316,000
Children and Violence Program Sec. 581*……	Expired	$94,502,000	Expired	$94,333,000
Grants for Persons who Experience Violence Related Stress Sec. 582 **……	Expired	$40,800,000	Expired	$11,300,000
Community Mental Health Services Block Grants Sec. 1920(a)……	Expired	$399,735,000	Expired	$413,735,000
Substance Abuse Prevention and Treatment Block Grants Sec. 1935(a)……	Expired	$1,375,513,000	Expired	$1,419,513,000
Data Infrastructure Development Sec. 1971*……	Expired	0	Expired	0
Other Legislation/Program Description				
Protection and Advocacy for Individuals with Mental Illness Act P.L. 99-319, Sec. 117……	Expired	$36,380,000	Expired	$36,380,000
Program Management:				
Program Management, Sec. 501……	Indefinite	$77,842,000	Indefinite	$80,811,000
SEH Workers' Compensation Fund P.L. 98-621……	Indefinite	$1,355,000	Indefinite	$1,355,000
Total, Program Management……	0	$79,197,000	0	$82,166,000
St. Elizabeths Hospital Building & Facilities Sec. 501……..	0	$795,000	0	0
Data Evaluation Sec. 505……..	0	0	0	0
TOTAL, SAMHSA Budget Authority……	0	$3,431,624,000	0	$3,386,903,000

* Denotes programs that were authorized in the Children's Health Act of 2000. We have the authority to carryout these programs in our general authorities in Section 507, 516 and 520A.

Appropriation History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
2002	$3,058,456,000	$3,131,558,000	$3,073,456,000	$3,138,279,000	1/
2002 Res. H.R. 3061	0	0	0	-$589,000	2/
2002 Res. P.L. 107-216	0	0	0	-$1,681,000	
2003 P.L. 108-5	$3,193,086,000	$3,167,897,000	$3,129,717,000	$3,158,068,000	3/
2003 P.L. 108-7	0	0	0	-$20,521,235	4/
2004 P.L. 108-84	$3,393,315,000	$3,329,000,000	$3,157,540,000	$3,253,763,000	
2004 P.L. 108-199	0	0	0	-$19,856,290	5/
2005 P.L. 108-447 & P.L. 108-309 as mended	$3,428,939,000	$3,270,360,000	$3,361,426,000	$3,295,361,000	6/
2005 H.R. 4818	0	0	0	-$26,895,592	
2006 P.L. 109-149	$3,336,023,000	$3,352,047,000	$3,398,086,000	$3,237,813,000	
2006 Res. P.L. 109-359	0	0	0	-$1,681,000	7/
2006 Section 202	0	0	0	-$2,201,000	
2007 P.L. 109-383	$3,260,001,000	$3,326,341,772	$3,326,341,772	$1,211,654,381	8/
2007 Continuing Resolution	0	0	0	$3,326,341,772	9/
2008 H.R. 2764/P.L. 110-161	$3,167,589,000	$3,393,841,000	$3,404,798,000	$3,291,543,000	
2008 Res. P.L. 110-161	0	0	0	-$57,503,000	10/
2009 H.R. 1105/P.L. 111-8	$3,024,967,000	$3,303,265,000	$3,257,647,000	$3,334,906,000	
2010 H.R. 3288/P.L. 111-117	$ 3,393,882,000	$ 3,429,782,000	$3,419,438,000	$3,431,116,000	11/
2011	$ 3,541,362,000	$ 3,565,360,000	$ 3,576,184,000		
2012	$ 3,386,903,000				

[1/] Reflects Administrative reduction in Section 516 of the Appropriations Bill (H.R. 3061).

[2/] Reflects Administrative reduction in P.L. 107-216.

[3/] Reflects a Rescission mandated by P.L.108-7.

[4/] Reflects SAMHSA's share of the Division E, section 515 reduction on administrative and related expenses and the Division H, section 168(b) rescission of P.L. 108-199.

[5/] Reflects SAMHSA's share of the Division F, section 519(a) reduction on administrative and related expenses and the Division J, section 122(a) rescission of H.R. 4818.

[6/] Reflects SAMHSA's share of the rescission mandated by P.L. 109-359.

[7/] Reflects Section 202 transfer to CMS.

[8/] Reflects Continuing Resolution through February 15, 2007.

[9/] Reflects the whole year appropriation

[10/] Reflects a 1.7 percent across-the-board Rescission from the H.R. 2764/P.L. 110-161.

[11/] Reflects a $508 thousand transfer to HHS

Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2010
Emergency Response Sec. 501O…….……..	2003	$ 25,000,000	2.5% all disc grants	$0
Grants for the Benefit of Homeless Individuals Sec. 506…….……..	2003	$ 50,000,000	$ 16,700,000	$ 42,750,000
Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans Sec. 506A*……..……..	2003	$ 15,000,000	$0	$0
Grants for Ecstasy and Other Club Drugs Abuse Prevention Sec. 506B*……..	2001	$ 10,000,000	$0	$0
Residential Treatment Programs for Pregnant and Postpartum Women Sec. 508……..…….	2003	SSAN	$0	$ 16,000,000
Priority Substance Abuse Treatment Needs of Regional and National Significance Sec. 509*……...…….	2003	$ 300,000,000	$ 322,994,000	$ 354,436,000
Substance Abuse Treatment Services for Children and Adolescents Sec. 514*……	2003	$ 40,000,000	$ 20,000,000	$ 30,678,000
Early Intervention Services for Children and Adolescents Sec. 514A*…….	2003	$ 20,000,000	$0	$0
Methamphetamine and Amphetamine Treatment Initiative Sec. 514**…….	2003	$ 10,000,000	$0	$0
Priority Substance Abuse Prevention Needs of Regional and National Significance Sec. 516*……	2003	$ 300,000,000	$ 138,399,000	$ 192,218,000
Prevention, Treatment and Rehabilitation Model Projects for High Risk Youth Sec. 517…….	2003	SSAN	$ 7,000,000	$0
Services for Children of Substance Abusers Sec. 519*……..…….	2003	$ 50,000,000	$0	$0
Grants for Strengthening Families Sec. 519A*…….…….	2003	$ 3,000,000	$0	$0
Services for Individuals with Fetal Alcohol Syndrome (FAS) Sec. 519C*……	2003	$ 25,000,000	$0	$0
Centers of Excellence on Services for Individuals with FAS and Alcohol-related Birth Defects and Treatment for Individuals with Such Conditions and Their Families Sec. 519D*…….	2003	$ 5,000,000	$ 2,416,000	$ 9,821,000

Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2010
Prevention of Methamphetamine and Inhalant Abuse and Addiction				
Sec. 519E*…….	2003	$ 10,000,000	$ 5,000,000	$0
Priority Mental Health Needs of Regional and National Significance				
Sec. 520A*……	2003	$ 300,000,000	$ 94,289,000	$ 184,822,000
Youth Interagency Research, Training, and Technical Assistance Centers				
Sec. 520C*…….	2007	$ 5,000,000	$ 3,960,000	$0
Services for Youth Offenders				
Sec. 520D*……	2003	$ 40,000,000	$0	$0
Suicide Prevention for Children and Youth				
Sec. 520E (GLS - State Grants)……	2007	$ 30,000,000	$ 17,829,000	$ 29,738,000
Sec. 520E1 (Suicide Prevention for Youth)……	2003	$ 75,000,000	$0	$0
Sec. 520E2 (GLS-Campus Grants)……	2007	$ 5,000,000	$ 4,950,000	$ 4,975,000
Grants for Emergency Mental Health Centers				
Sec. 520F*……	2003	$ 25,000,000	$0	$0
Grants for Jail Diversion Programs				
Sec. 520G*……	2003	$ 10,000,000	$ 6,043,000	$ 6,684,000
Improving Outcomes for Children and Adolescents through Services Integration between Child Welfare and MH Services				
Sec. 520H*…….	2003	$ 10,000,000	$0	$0
Grants for Integrated Treatment of Serious Mental Illness and Co-occurring Substance Abuse				
Sec. 520I*……..	2003	$ 40,000,000	$0	$0
Mental Health Training Grants				
Sec. 520J*……	2003	$ 25,000,000	$0	$0
PATH Grants to States				
Sec. 535(a)……	2003	$ 75,000,000	$ 46,855,000	$ 65,047,000
Community Mental Health Services for Children with Serious Emotional Disturbances				
Sec. 565 (f)……	2003	$ 100,000,000	$ 96,694,000	$ 121,316,000
Children and Violence Program				
Sec. 581*……..	2003	$ 100,000,000	$ 83,035,000	$ 94,333,000
Grants for Persons who Experience Violence Related Stress				
Sec. 582 *…….	2003	$ 50,000,000	$ 20,000,000	$ 40,800,000
Community Mental Health Services Block Grants				
Sec. 1920(a)……..	2003	$ 450,000,000	$ 433,000,000	$ 399,735,000
Substance Abuse Prevention and Treatment Block Grants				
Sec. 1935(a)……	2003	$ 2,000,000,000	$ 1,785,000,000	$ 1,719,391,000
Data Infrastructure Development				
Sec. 1971*…….	2003	SSAN	$ 6,000,000	$0
Other Legislation/Program Description				
Protection and Advocacy for Individuals with Mental Illness Act				
P.L. 99-319, Sec. 117……..	2003	$ 19,500,000	$ 32,500,000	$ 36,380,000
TOTAL, SAMHSA Budget Authority.……		$ 4,222,500,000	$ 3,142,664,000	$ 3,349,124,000

*Denotes programs that were authorized in the Children's Health Act of 2000. SAMHSA has the authority to carryout these programs in our general authorities in Section 507, 516 and 520A.

**Congress authorized two provisions as section 514.

SAMHSA Block Grants
Table of Contents

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SAMHSA Block Grants - Overview

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Mental Health Block Grant……	$420,774	$420,774	$434,684
PHS Evaluation Fund (non-add)……	*21,039*	*21,039*	*21,039*
Substance Abuse Prevention and Treatment Block Grant[1]……	$1,454,713	$1,454,713	$1,494,314
PHS Evaluation Fund (non-add)……	*79,200*	*79,200*	*74,711*
Total, SAMHSA Block Grants……	$1,875,487	$1,875,487	$1,928,998
PHS Evaluation Fund (non-add)……	*$100,239*	*$100,239*	*$95,750*

[1]/ Reflects reallocation of the 20% Prevention Set-Aside in FY 2012 and comparable adjustments in FY 2010 and FY 2011

Authorizing Legislation ..... Section 1911 and 1921 of the Public Health Service Act

FY 2012 Authorization ..... Expired

Allocation Method ..... Formula grant

Public funding, including SAMHSA's Block Grants, supports behavioral health promotion and services for the prevention and treatment of mental and substance use disorders. These services and programs are geared toward highly vulnerable and at-risk populations who tend to be poor, uninsured, and underserved. In particular, public treatment services are prioritized for youth with serious emotional disturbances and adults with serious mental illnesses and addictions. These services provide critical care and infrastructure that support the recovery of persons with significant behavioral health issues and that, if left untreated, would cost businesses, communities, governments and families far more.

The MHBG has not received any significant budget increases in recent years, and yet serves as the backbone of public mental health services for vulnerable populations nationwide. The SABG has received small increases over time, and represents a critical mass of the available dollars for persons with substance use disorders, 61 percent of whom are currently uninsured, who would otherwise continue in their addictions without help and without hope. In both cases, the needs are dire and far outstrip the available dollars.

Due to the way these Block Grants evolved in the 1980s, some assumptions about their nature and use have evolved as well. The common practice of allowing States to use these dollars in an unrestricted, flexible manner without strong accountability measures has become equated with the Block Grant concept across the behavioral health systems and State governments, in general. In the meantime, newer, innovative, and evidence-based services have gone unfunded or without widespread adoption. This "science to service" lag and lack of person-level data have been particularly true with the MHBG. While SAMHSA receives individual client level data from SABG grantees, MHBG grantees only reports aggregate consumer outcomes or lists of programs and services funded by MHBG dollars. The two SAMHSA Block Grants differ on a number of their statutory authorities (e.g., method of calculating Maintenance of Effort requirements, stakeholder input requirements for planning, set-asides for specific populations or programs,

etc.). The Centers within SAMHSA that administer these Block Grants also have different approaches to application requirements and reporting. To compound this variation, States have different structures for accepting, planning, and accounting for the Block Grants and the Prevention Set Aside within the SABG. As a result, how these dollars are spent and what is known about the services and clients that receive these funds vary by Block Grant and by State.

Additionally, because these Block Grants historically have been viewed as flexible State funding, SAMHSA has placed less emphasis on guiding States toward purchasing high-quality and evidence-based services with their Block Grant dollars. Only about 15 percent of SAMHSA's program staff provide oversight to the States on their Block Grant programs (constituting approximately 64 percent of SAMHSA's budget) while about 85 percent of SAMHSA's program staff work with the SAMHSA's discretionary grantees (which include organizations, communities, and States), representing only about 40 percent of SAMHSA's available dollars.

These SAMHSA discretionary dollars are awarded on a competitive basis as short-term (three to five years) grants to States, communities, and organizations for specific activities such as direct services, capacity building, technical assistance, and evaluation. Although these grants have become a significant source of funds for some State or local grantees, they do not provide enough funding for SAMHSA to take these tested approaches to scale nationwide. The limitations of these discretionary grants – they are few in number and fixed in duration and scope – are impediments to sustainability and scalability. In all too many cases, SAMHSA discretionary grants support the local implementation of an evidence-based program or innovative set of services that go away once Federal grant funding ends, even if they show great promise. In other cases, SAMHSA grants fund the same evidence-based practice over and over again, having proved its efficacy and effectiveness in a variety of communities over many years but with no way to move these practices to scale into the Nation's overall behavioral health system. All said, however, SAMHSA's experience is that the Block Grant mechanism, with the changes proposed, offer a viable mechanism to dramatically decrease the time it takes to put evidence based practices in the hands of providers more broadly.

Nevertheless, discretionary grants can and do provide the funding and impetus for major system or practice changes in the community or State where they are funded. When this happens, it is usually because other funds exist (State or local dollars) and State or local leadership is in place and stable over time to sustain and replicate the innovation. However, the current economy and significant turnover in State leadership impede the ability of States and communities to sustain or expand these localized programs, even with significant efforts to build in sustainability plans from the beginning of each grant program. This challenge is especially true in Indian country and other underserved communities or States.

SAMHSA will need to spend more time assisting States and Communities build and maintain more effective behavioral health systems for prevention, treatment, services and recovery supports; and to make its block grant requirements more consistent and effective in terms of State planning, reporting and expenditure obligations. SAMHSA also needs the ability to implement a flexible, thoughtful and deliberate theory of change to improve the Nation's behavioral health systems. That is, SAMHSA needs the ability to identify emerging issues, foster innovative solutions to real world problems, demonstrate and disseminate new research or promising practices, and use limited, short-term discretionary grant investments to move

evidence-based practices and policies into the nation's core behavioral health systems funded either through the BGs to States, Medicaid/Medicare, or private insurance. In order to move innovative, evidence-based solutions rapidly into standard practice in the public behavioral health system, SAMHSA must have the ability to provide – through its Block Grants -- direction to the States on the implementation of a good and modern behavioral health system. The goals of such a system are to help people with or at risk for mental and substance use disorders be resilient, recover, and lead fulfilling lives in America's communities.

SAMHSA needs to spend more time assisting States to build and maintain more effective behavioral health systems for prevention, treatment, services and recovery supports, and to make its Block Grant requirements more consistent and effective in terms of State planning, reporting and expenditure obligations. SAMHSA's FY 2012 Budget focuses on Block Grants while expanding SAMHSA's authority or using existing authority to direct the use of Block Grant dollars by States. SAMHSA is proposing to move proven practices from key discretionary grant programs which are proposed for reduction to scale through the Block Grants. SAMHSA also proposes to create separate prevention programs for the States and for the Tribes to address behavioral health care needs. These programs can be funded under current law as discretionary grants.

In addition to the national economic conditions and the growing prevention science, the passage of the Affordable Care Act (ACA) creates a dynamic that is critical for SAMHSA to address. As indicated above, the SABG and the MHBG have provided significant proportions of the Nation's core behavioral health systems for vulnerable populations for decades. Under the ACA, many individuals previously ineligible for Medicaid or unable to obtain commercial insurance for or because of mental and substance use disorders will be covered by Medicaid, commercial insurance through employers or on the private market or through the State health insurance exchanges. Estimates are that up to 32 million more people will become eligible for health insurance, of which six to ten million will have significant untreated mental health and/or addictions. Of the 32 million newly insured, about half of those individuals, 16 million people, will be eligible for Medicaid including four to six million people with significant untreated mental illness and/or addictions. Many of these individuals will have been treated through the Block Grants and related State MOE[1] dollars or would have been eligible for such services, had there been enough dollars. Many others of the 32 million persons expected to be newly insured will have unidentified or untreated substance abuse and/or depression, anxiety, post traumatic stress, and other mental disorders. Many of these will be treated through primary care settings, utilizing brief interventions and referrals to treatment that will help to prevent more significant disorders later, IF these individuals can be served.

These changes require recasting the SABG and the MHBG in terms of who they serve and what services they fund. Generally, these Block Grants need to provide funding for those individuals and those services not otherwise funded by other sources such as Medicaid and commercial insurance. The services that the Block Grants cover will need to be redesigned to operate as a "coordination of benefits" or wrap around services for those priority individuals who are

[1] Maintenance of Effort-States have to maintain expenditures of non-Federal funds for services no less than the preceding two-year average of expenditures

receiving core behavioral health services elsewhere. BGs will also need to fund priority services for those priority individuals who remain uninsured and whose untreated behavioral health needs will be a burden on the individual, his/her family and his/her community.

SAMHSA will begin to request different information in State BG applications regarding specific service approaches and planning activities, capacities and needs for implementing the Affordable Care Act, and proposed responses to priorities outlined by SAMHSA. This request for different information will introduce a message to States that SAMHSA is preparing for a major paradigm shift in the healthcare system, and will signal the direction of future changes. In addition, this State information will tell SAMHSA what kind of technical assistance and resources they may need as 2014 approaches in the midst of fiscal austerity at the State and Federal levels. For some information SAMHSA plans to require a single submission from each State, necessitating coordination across Mental Health and Substance Abuse Authorities and other State departments including State Medicaid and public health authorities. In preparation for the next round of full BG applications, SAMHSA is making necessary adjustments to internal operations to facilitate consistent timing and content of the SABG and the MHBG applications for 2012.

Community Mental Health Services Block Grant

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Mental Health Block Grant…….....	$420,774	$420,774	$434,684
PHS Evaluation Fund (non-add)…….	*21,039*	*21,039*	*21,039*

Authorizing Legislation .....Section 1911 of the Public Health Service Act

FY 2012 Authorization .....Expired

Allocation Method .....Formula grant

Program Description and Accomplishments

Since 1992, the Community Mental Health Services Block Grant (MHBG) distributes funds to 59 eligible States and Territories through a formula based upon specified economic and demographic factors. The Community Mental Health Block Grant distributes funds to eligible States and territories for a variety of services and for planning, administration and educational activities under the State plan for comprehensive community-based mental health services for children with serious emotional disturbance and adults with serious mental illness. Services funded by the Block Grant include supported employment and supported housing, rehabilitation services, crisis stabilization and case management, peer specialist and consumer-directed services, wrap around services for children and families, jail diversion programs, and services for special populations (people who are homeless, live in rural and frontier areas, and increasingly for military families). The majority of these services are not currently covered under Medicaid, Medicare, or commercial insurance. The MHBG also supports and encourages States to implement proven practices demonstrated in the discretionary portfolio at SAMHSA.

A major provision of the MHBG authorization includes a Maintenance of Effort (MOE) requirement wherein States are required to maintain expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period proceeding the year for which the State is applying for a grant. In FY 2010, due to significant fiscal reductions among many State budgets, approximately one-third of States and Territories had MHBG MOE expenditure shortfalls. The MHBG continues to represent a significant "safety net" source of funding for mental health services for some of the most vulnerable populations across the county. Funding for the MHBG has been flat for the past three years following a reduction from FY 2007 funding. During this time, the number of people served by the State mental health authorities across the country has increased from approximately six million in FY 2006 to 6.3 million in FY 2008. Additionally, in part due to the current economic downturn, State mental health authorities are expecting increasing demand for mental health services.

Ninety-five percent of the funds allocated to the MHBG program are distributed to States through a formula prescribed by the authorizing legislation. Factors used to calculate the allotments include total personal income; State population data by age groups (total population data for Territories); total taxable resources; and a cost of services index factor. States and territories may expend Block Grant funds only to carry out the annual plan, to evaluate programs and services carried out under the plan, and for planning, administration, and educational activities related to providing services under the plan. States also rely on the MHBG for an array of non-clinical activities and services in support of their respective systems of care, e.g., planning, coordination, needs assessment, quality assurance, program development, and evaluation.

The legislation provides a five percent set-aside, which is retained by SAMHSA, to assist the States and Territories in the development of their mental health systems through the support of technical assistance, data collection and evaluation activities. A breakout of the MHBG set-aside funding is provided in a table following the ten-year funding table display.

The Mental Health State Data Infrastructure Grants are funded under the Block Grant Set-aside. This grant program meets the goal of developing State capacity to collect and report data on 21 Uniform Reporting System measures, which include the National Outcome Measures (NOMS). With support of the Data Infrastructure Grants and through the Uniform Reporting System, State Mental Health Authorities provide annual State mental health system data reports to the MHBG program to assure efficiency and effectiveness and to report on program performance. Over the past six years, 59 States and Territories have consistently increased in their ability to provide data, focusing on use of common measures across States. The Data Infrastructure Grant also supports mental health data system development and use of data for policy and program decision making. States must match grant awards at a 100 percent level. SAMHSA is working to initiate client-level data collection through the Uniform Reporting System.

Most States are currently reporting on NOMS for public mental health services within their State through the Uniform Reporting System (URS). The first compilation of State National Outcome Measures data was submitted to Congress in the spring of 2005. For the fifth consecutive year, significantly increased numbers of States have reported on National Outcome Measures domains for both mental health and substance use programs.

State level outcome data for mental health are currently reported by State Mental Health Authorities through the Uniform Reporting System. The following outcomes for services provided during 2009 show that:

- For the 58 States that reported data in the Employment Domain, 21 percent of the mental health consumers were in competitive employment;
- For the 596 States that reported data in the Housing Domain, 83 percent of the mental health consumers were living in private residences;
- For the 58 States and Territories that reported data in the Access/Capacity Domain, State mental health agencies provided mental health services for 21 people per 1,000 population.

- For the 52 States that reported data in the Retention Domain, only nine percent of the mental health patients returned to a State hospital within 30 days of State hospital discharge;
- For the 54 States that reported data in the Perception of Care Domain, 72 percent of adult mental health consumers improved functioning as a direct result of the mental health services they received;

The independent evaluation of the MHBG demonstrates that funds allow States to explore new innovations and strategies, target emerging needs with special programs; pay for non-covered services (e.g., peer support programs) that are recovery-focused and consumer-centered; and create the administrative, organizational, or service delivery linkages that foster community-based, transformed system of mental health services. The study of the program has been completed and the final will be placed on the SAMHSA website in early February 2011. Efforts toward the collection of client-level data across all States for five of the National Outcome Measures are also underway. Additionally, the pilot was designed to collect estimates of the costs of modifying the State IT systems to report all the requested data files and a final project report that summarizes the steps in the process of implementing the pilot and challenges faced. All of this information will be useful as SAMHSA extends Client Level Data reporting to all States. A draft report will be completed in February. A final report on the pilot will be completed by the end of the year which will summarize the extent to which client level outcome data could be reported as well as what resources would be needed to roll out client level data collection and reporting to all States.

Funding History

FY	Amount
2002	$433,000,000
2003	$437,140,000
2004 a/	$434,690,000
2005 a/	$432,756,000
2006 a/	$427,974,000
2007 a/	$428,256,000
2008 a/	$420,774,000
2009 a/	$420,774,000
2010 a/	$420,774,000
2011 a/	$420,774,000

a/ Includes PHS Evaluation funds of $21.8 million in FY 2004 and FY 2005, $21.4 million in FY 2006 and FY 2007, $21.0 million from FY 2008 to FY 2012.

Data Elements Used to Calculate FY 2012 Allotments

Population: States and the District of Columbia July 1, 2009 Population Estimates from U.S. Census Bureau; Territory population estimates as of July 1, 2010 from U.S. Census Bureau.

Total Taxable Resources: 2005, 2006 and 2007 data from U.S. Department of Treasury.

Income: 2007, 2008, and 2009 Total Personal Income for States and District of Columbia from Department of Commerce/Bureau of Economic Analysis.

Cost of Services Index: This index is determined triennially (i.e., it is revised every third fiscal year rather than annually). The most current index is being used for the determination of allotments for FY 2010, FY 2011, and FY 2012. The base wage rate was calculated using wages paid and hours worked from the 2000 Decennial Census for specific occupation-industry categories. The update factor was determined using wages paid and hours worked for base year (FY 1999 for FY 2003 Final Rule), and recent year (FY 2005 for FY 2009 Final Rule), as reported to the Centers for Medicare and Medicaid Services by hospitals participating in the Medicare program. FY 2009 Median Fair Market Rent Estimates from Department of Housing and Urban Development; July 1, 2007 Population Estimates by County/Subcounty from U.S. Census Bureau.

Budget Request

The MHBG always has and will continue to fund those individuals who do not have other sources of funding for care and those services not otherwise covered. The Affordable Care Act (ACA) significantly enhances access to health care, including prevention and treatment services for mental illness for millions of Americans. Many individuals that are supported in whole or in part by current block grant funds will be insured in FY 2014. These individuals will have various outpatient and other services covered under ACA. However, ACA will not enhance access to other support services that are necessary to support an individual's recovery. As individuals become insured through Medicaid or private insurance, many of those individuals remaining uninsured and some of those services not covered for those who are insured will be funded through MHBG dollars.

Under ACA, the block grant funds will be used for four purposes: 1) to fund priority treatment and support services for individuals that will not be insured or for whom coverage is terminated for short periods of time; 2) to fund priority treatment and support services that are not covered by Medicaid, Medicare or private insurance offered through the exchanges and that show proven success in improving outcomes and/or supporting recovery; 3) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health services and to plan the implementation of new services on a nationwide basis; and 4) to bring effective programs to scale.

The FY 2012 President's Budget request is $434.7 million, a $13.9 million increase from the FY 2010 Level. Starting in FY 2012 the Mental Health Block Grant funds will be used to provide additional supports for children with serious emotional disturbance and persons at risk of acquiring these conditions. This budget will support 59 grants to States and Territories. In FY 2012, 3.2 percent of the Budget Authority appropriated for the MHBG will be set aside pursuant to section 241 of the Public Health Service Act. These resources will be used to support activities such as evaluation, data collection, and technical assistance of the MHBG.

Over the next year, policy and operational decisions will need to be made that affect SAMHSA, other Federal agencies, State authorities, providers, and individuals and families that benefit

from services and supports underwritten by SAMHSA block grants. SAMHSA will work with States and Territories to increase accountability for those funds, as well as bringing best practices and evidence-based practices to scale.

To start preparing for the realignment and restructuring of SAMHSA Block Grants, SAMHSA developed and States completed a FY 2011 Application Addendum for both the MHBG and SABG, to compare and gain more insights on these two major funding programs. In FY 2012, SAMHSA will begin to request different information in State BG applications regarding specific service approaches and planning activities, capacities and needs for implementing the Affordable Care Act, and proposed responses to priorities outlined by SAMHSA. This request for different information will introduce a message to States that SAMHSA is preparing for a major paradigm shift in the healthcare system, and will signal the direction of future changes. States have the option to submit a joint application for their MHBG and SABG to ensure better program coordination, collaboration, and efficiency of using funds for behavioral health services.

SAMHSA/Center for Mental Health Services
Set-Aside Activities
(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Funding Sources			
Budget Authority			
Program Management	$2,000	$2,000	$2,000
National Health Interview Survey (non-add)	*2,000*	*2,000*	*2,000*
PHS Evaluation Funds			
Mental Health Block Grant Set-Aside	21,039	21,039	21,039
Program Management	1,000	1,000	1,000
NSDUH Mental Health Surveillance (non-add)	*1,000*	*1,000*	*1,000*
Total Program Level	$24,039	$24,039	$24,039

Mental Health Block Grant Set-Aside Activities

State Data Systems	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
State Data Infrastructure Grants	$6,851	$6,850	$6,850
State Data Infrastructure Contracts	435	---	---
Subtotal, State Data Systems	**7,286**	**6,850**	**6,850**
National Data Collection			
National MH Data Contracts	2,030	2,348	1,790
Subtotal - National Data Collection	**2,030**	**2,348**	**1,790**
Technical Assistance (TA)			
TA to States	11,294	11,411	11,970
FTE Support (non-add)	*2,210*	*2,551*	*2,750*
Subtotal, Technical Assistance	**11,294**	**11,411**	**11,970**
Program Evaluation			
Development of Spending Estimates for MH/SAT	429	430	429
Subtotal, Program Evaluation	**429**	**430**	**429**
TOTAL, MH Block Grant Set-Aside	**$21,039**	**$21,039**	**$21,039**

Outcomes and Outputs

Community Mental Health Services Block Grant

Table 1: Key Performance Indicators for Mental Health Block Grant

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
2.3.14: Number of people served by the public mental health system[2] *(Output)*	FY 2009: 6,430,635 (Target Exceeded)	6,300,000	6,340,320	+40,320
2.3.11: Number of evidence based practices (EBPs) implemented[3] *(Output)*	FY 2009: 4.3 per State (Target Exceeded)	4.2 per State	4.2 per State	Maintain
2.3.15: Rate of consumers (adults) reporting positively about outcomes *(Outcome)*	FY 2009: 71.6% (Target Not Met)	72%	72%	Maintain
2.3.16: Rate of family members (children/adolescents) reporting positively about outcomes *(Outcome)*	FY 2009: 65.2% (Target Not Met but Improved)	73%	67%	-6%
2.3.81: Percentage of service population receiving any evidence based practice *(Outcome)*	FY 2009: 7.2 % (Target Exceeded)	7.2 %	7.2 %	Maintain

[2]The FY 2010, FY 2011 and FY 2012 targets have been set at 6.3 million persons served (slightly lower than the most recent actual) based on the expectation that the current recession will impact the service delivery systems of the State Mental Health Authorities and may result in fewer persons receiving mental health care nationally.

[3]National average of evidence-based practices per state, based on 35 States reporting. Excludes Medication Management and Illness Self-Management, which continue to undergo definitional clarification

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2012 DISCRETIONARY STATE/FORMULA GRANTS
Community Mental Health Services Block Grant Program
CFDA # 93.958

STATE/TERRITORY	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate	+/- FY 2010
Alabama	$6,030,049	$6,043,224	$6,068,781	+$38,732
Alaska	710,941	699,955	708,706	-2,235
Arizona	9,383,677	9,524,857	9,616,355	+232,678
Arkansas	3,687,284	3,684,620	3,701,900	+14,616
California	53,676,045	53,470,793	53,202,825	-473,220
Colorado	6,560,592	6,618,166	6,647,041	+86,449
Connecticut	4,233,212	4,172,385	4,135,527	-97,685
Delaware	730,894	736,297	752,726	+21,832
District Of Columbia	772,964	763,690	753,517	-19,447
Florida	26,711,963	26,381,061	26,508,905	-203,058
Georgia	13,141,697	13,303,932	13,362,785	+221,088
Hawaii	1,991,184	1,967,992	1,956,778	-34,406
Idaho	1,806,946	1,815,091	1,823,687	+16,741
Illinois	15,774,494	15,721,669	15,492,957	-281,537
Indiana	7,887,788	7,944,223	7,915,313	+27,525
Iowa	3,370,840	3,374,230	3,323,966	-46,874
Kansas	3,116,308	3,122,152	3,097,349	-18,959
Kentucky	5,420,187	5,412,148	5,415,890	-4,297
Louisiana	5,293,123	5,424,261	5,539,438	+246,315
Maine	1,649,042	1,643,710	1,629,114	-19,928
Maryland	7,281,807	7,308,278	7,351,039	+69,232
Massachusetts	8,050,963	8,073,592	8,160,512	+109,549
Michigan	12,810,013	12,798,172	12,557,496	-252,517
Minnesota	6,831,525	6,850,165	6,835,821	+4,296
Mississippi	3,942,229	3,961,974	3,951,312	+9,083
Missouri	6,959,268	7,007,039	7,032,955	+73,687
Montana	1,191,479	1,187,436	1,185,306	-6,173
Nebraska	1,943,546	1,937,291	1,926,025	-17,521
Nevada	3,678,154	3,668,825	3,711,740	+33,586
New Hampshire	1,510,763	1,503,859	1,494,068	-16,695
New Jersey	11,561,060	11,481,491	11,347,605	-213,455
New Mexico	2,365,487	2,360,459	2,376,256	+10,769
New York	23,725,265	23,484,085	23,172,903	-552,362
North Carolina	11,162,694	11,316,517	11,404,753	+242,059
North Dakota	$746,161	$737,998	$736,313	-$9,848

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2012 DISCRETIONARY STATE/FORMULA GRANTS
Community Mental Health Services Block Grant Program
CFDA # 93.958

STATE/TERRITORY	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate	+/- FY 2010
Ohio	$13,695,234	$13,792,762	$13,762,718	+$67,484
Oklahoma	4,390,515	4,348,099	4,367,994	-22,521
Oregon	4,963,996	4,979,213	4,983,949	+19,953
Pennsylvania	14,485,712	14,409,512	14,539,192	+53,480
Rhode Island	1,387,146	1,375,754	1,369,668	-17,478
South Carolina	5,726,309	5,808,930	5,894,597	+168,288
South Dakota	863,186	865,047	867,768	+4,582
Tennessee	7,723,117	7,759,542	7,794,726	+71,609
Texas	32,209,069	32,256,069	32,508,255	+299,186
Utah	3,048,064	3,109,620	3,131,038	+82,974
Vermont	743,593	739,208	730,765	-12,828
Virginia	9,999,072	10,009,499	10,062,553	+63,481
Washington	8,463,723	8,485,053	8,575,408	+111,685
West Virginia	2,411,707	2,399,115	2,373,101	-38,606
Wisconsin	7,463,832	7,462,992	7,424,808	-39,024
Wyoming	455,056	436,923	454,771	-285
State Sub-total	**393,738,975**	**393,738,975**	**393,738,975**	**0**
American Samoa	84,418	85,886	86,680	+2,262
Guam	229,028	233,507	235,991	+6,963
Marshall Islands	82,265	84,439	85,932	+3,667
Micronesia	140,202	140,596	139,813	-389
Northern Marianas	112,792	67,376	63,043	-49,749
Puerto Rico	5,154,286	5,190,495	5,191,365	+37,079
Palau	50,000	50,000	50,000	0
Virgin Islands	143,034	143,726	143,201	+167
Territory Sub-Total	**5,996,025**	**5,996,025**	**5,996,025**	**0**
Total States/Territories	**399,735,000**	**399,735,000**	**399,735,000**	**0**
SAMHSA Set-Aside	**21,039,000**	**21,039,000**	**21,039,000**	**0**
Transfer	0	0	13,910,000	+13,910,000
TOTAL, MHBG	**$420,774,000**	**$420,774,000**	**$434,684,000**	**+$13,910,000**

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Substance Abuse Prevention and Treatment Block Grant

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Substance Abuse Prevention and Treatment Block Grant 1/……..	$1,454,713	$1,454,713	$1,494,314
PHS Evaluation Fund (non-add)…….	*79,200*	*79,200*	*74,711*
1/ Reflects reallocation of the 20% Prevention Set-Aside in FY 2012 and comparable adjustments in FY 2010 and FY 2011			

Authorizing Legislation .....Section 1921 of the Public Health Services Act[4]

FY 2012 Authorization .....Expired

Allocation Method ..... Formula Grants

Program Description and Accomplishments

The Substance Abuse Prevention and Treatment Block Grant Program (SABG) distributes funds to 60 eligible States, Territories, the District of Columbia and the Red Lake Indian Tribe of Minnesota to plan, carry out, and evaluate substance abuse treatment and recovery support services provided for individuals, families, and communities impacted by substance abuse and substance use disorders (SUD).

This formula grant program provides funding based upon specified economic and demographic factors and is administered by SAMHSA's Center for Substance Abuse Treatment. All Block Grant applications must include an annual plan that contains detailed provisions for complying with each funding agreement specified in the legislation, and describes how the applicant intends to expend the grant. The current law includes specific provisions and funding set-asides, such as a 20 percent prevention set-aside; an HIV/AIDS early intervention set-aside; requirements and potential reduction of the Block Grant allotment with respect to sale of tobacco products to those under the age of 18; a maintenance of effort requirement; and "hold harmless" provisions that limit fluctuations in allotments as the total appropriation changes from year to year.

The program's overall goal is to support and expand substance abuse treatment services while providing maximum flexibility to the States. States and Territories may expend Block Grant funds only for the purpose of planning, carrying out, and evaluating activities related to these services. Targeted technical assistance is available for the States and Territories through CSAT's State Systems Technical Assistance Project. The Block Grant requires States to maintain expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period proceeding the year for which the State is applying for a grant. Given the current economic situation, SAMHSA is aware that a number of States may experience challenges meeting the maintenance of effort requirement in the Federal FY 2011 grant cycle, and is monitoring the situation closely.

[4] Appropriation language will notwithstand the 20% prevention set-aside and allow for the movement of these funds into a separate State Prevention Grants for behavioral health; State will still be able to spend SAPTBG funds for prevention services

Of the amounts appropriated for the Block Grant program, 95 percent are distributed to States through a formula prescribed by the authorizing legislation. Factors used to calculate the allotments include total personal income; State population data by age groups (total population data for territories); total taxable resources; and a cost of services index factor.

The Block Grant is critically important to the States because it provides them the flexibility to respond to local and/or regional emergent issues impacting health, public health, and public safety through a consistent Federal funding stream. Individuals who are currently in need of such services may fall into several categories, such as no insurance or limited health insurance coverage for substance use disorder treatment and recovery support services, or may have been mandated to enter SUD treatment through public safety and/or public welfare systems. As previously indicated, there will continue to be individuals and families without health insurance or whose health insurance benefit will not cover certain services, e.g. recovery supports. Such individuals rely on services funded by the Block Grant. States also rely on the Block Grant for an array of non-clinical activities and services in support of their respective systems of care, e.g. planning, coordination, needs assessment, quality assurance, program development, and evaluation. The independent evaluation of the original Substance Abuse Prevention and Treatment Block Grant program (http://tie.samhsa.gov/SAPT2010.html#Evaluation) demonstrated how States have leveraged the statutory requirements of this Block Grant to expand existing or establish new treatment capacity in underserved areas of States and to improve coordination of services with other State systems.

As seen in the following table, the Block Grant Program has been successful in expanding treatment capacity in the latest year for which actual data are available (FY 2008) by supporting almost 2.3 million admissions to treatment programs receiving public funding. Outcomes data for the Block Grant Program also show positive results. At discharge, clients have demonstrated high abstinence rates from both illegal drug (73.7 percent) and alcohol (78.2 percent) use.

State Substance Abuse Authorities reported the following outcomes for services provided during 2007, the most recent year data is available:

- For the 51 States that reported data in the Abstinence from Drug/Alcohol Use Domain for alcohol, 50 of 51 identified improvements in client abstinence. Forty-three of these States reported improvements based on information submitted to the Treatment Episode Data Set (TEDS) and seven reported improvements based on their own data collection systems.
- Similarly, for the 51 States that reported data in the Abstinence from Drug/Alcohol Use Domain for drug use, 50 of 51 identified improvements in client abstinence. Forty-three of these States reported improvements based on information submitted to TEDS and seven reported improvements based on their own data collection systems.
- For the 51 States that reported data in the Employment Domain, 46 of 51 identified improvements in client employment. Forty of these States reported improvements based on information submitted to TEDS and six reported improvements based on their own data collection systems.

- For the 51 States that reported in the Criminal Justice Domain, 35 of 40 reported an increase in clients with no arrests based on data reported to TEDS.
- For the 51 States that reported data in the Housing Domain, 35 of 47 identified improvements in stable housing for clients based on data reported to TEDS.

Funding History

FY	Funding	FTEs
2002	$1,725,000,000	
2003	$1,753,932,000	
2004 a/	$1,779,146,000	
2005 a/	$1,775,555,000	
2006 a/	$1,757,425,000	40
2007 a/	$1,758,591,000	40
2008 a/	$1,758,728,000	40
2009 a/	$1,778,591,000	40
2010 a/	$1,454,713,000	40
2011 a/	$1,454,713,000	40

a/ Includes $79.2 million from the PHS evaluation funds.

Data Elements Used to Calculate State Allotments

Population Data: States and the District of Columbia July 1, 2008 Population Estimates) from U.S. Census Bureau; Territory population estimates as of July 1, 2009 from U.S. Department of Commerce.

Total Taxable Resources: 2005, 2006 and 2007 data from U.S. Department of Treasury.

Income: 2006, 2007, and 2008 Total Personal Income for States and District of Columbia from Department of Commerce/Bureau of Economic Analysis.

Cost of Services Index: This index is determined triennially (i.e., it is revised every third fiscal year rather than annually). The most current index is being used for the determination of allotments for FY 2010, FY 2011, and FY 2012. The base wage rate was calculated using wages paid and hours worked from the 2000 Decennial Census for specific occupation-industry categories. The update factor was determined using wages paid and hours worked for base year (FY 1999 for FY 2003 Final Rule), and recent year (FY 2005 for FY 2009 Final Rule), as reported to the Centers for Medicare and Medicaid Services by hospitals participating in the Medicare program. FY 2009 Median Fair Market Rent Estimates from Department of Housing and Urban Development; July 1, 2007 Population Estimates by County/Sub-county from U.S. Census Bureau.

Budget Request

The Affordable Care Act (ACA) significantly enhances access to health care, including prevention and treatment services for mental illness for millions of Americans. Many individuals that are supported in whole or in part by current block grant funds will be insured in FY 2014. These individuals will have various outpatient and other services covered under ACA. However, ACA will not enhance access to other support services that are necessary to support an individual's recovery.

Under ACA, the block grant funds will be used for four purposes: 1) to fund priority treatment and support services for individuals that will not be insured or for whom coverage is terminated for short periods of time); 2) to fund priority treatment and support services that are not covered by Medicaid, Medicare or private insurance offered through the exchanges and that show proven success in improving outcomes and/or supporting recovery; and 3) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health services and to plan the implementation of new services on a nationwide basis; and 4) to bring effective programs to scale.

SAMHSA needs to begin planning now for the FY 2014 effective dates of critical aspects of the ACA. This will require that SAMHSA use FY 2011, 2012 and 2013 to transition the block grant to these three purposes. This transition includes strengthening SAMHSA's authority regarding the States' use of Block Grant funds, and a shift in SAMHSA staff functions to support and provide technical assistance for States as they move through these changes.

The FY 2012 Budget Request is for $1.494 billion, an increase of approximately $39.6 million over the FY 2010 Level. This reflects a comparability adjustment of $343 million down to $1.454 billion to transfer funding for the 20 percent SABG prevention set-aside to the new Substance Abuse - State Prevention Grants. It also includes an increase in funding of approximately $39.6 million to bring the total for the program over the adjusted FY 2010 level. In FY 2012, 3.2 percent of the Budget Authority appropriated for the SABG will be set aside pursuant to section 241 of the Public Health Service Act. These resources will be used to support activities such as evaluation, data collection, and technical assistance of the SABG.

Over the next year, policy and operational decisions will need to be made that affect SAMHSA, other Federal agencies, State authorities, providers, and individuals and families that benefit from services and supports underwritten by SAMHSA block grants. SAMHSA intends to work with States and Territories to increase accountability for these funds, as well as bringing best practices and evidence-based practices to scale. States and Territories will also be allowed to utilize a portion of the SABG funds to augment the Substance Abuse State Prevention Grant funding for additional prevention services if the submitted application indicates a desire to do so in the plan for expenditure of these dollars.

To start preparing for the realignment and restructuring of SAMHSA Block Grants, SAMHSA developed and States completed a FY 2011 Application Addendum for both the SABG, and MHBG to compare and gain more insights on these two major funding programs. In FY 2012, SAMHSA will begin to request different information in State BG applications regarding specific

service approaches and planning activities, capacities and needs for implementing the Affordable Care Act, and proposed responses to priorities outlined by SAMHSA. This request for different information will introduce a message to States that SAMHSA is preparing for a major paradigm shift in the healthcare system, and will signal the direction of future changes. States have the option to submit a joint application for their SABG and MHBG to ensure better program coordination, collaboration, and efficiency of using funds for behavioral health services.

Outcomes and Outputs

Substance Abuse Block Grant Treatment Activities

Table 2: Key Performance Indicators for Substance Abuse Block Grant – Treatment Activities

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.43: Number of admissions to substance abuse treatment programs receiving public funding[5] *(Output)*	FY 2008: 2,272,250 (Target Exceeded)	1,881,515	1,937,960	+56,445
1.2.48: Percentage of clients reporting no drug use in the past month at discharge *(Outcome)*	FY 2009: 75.7% (Target Exceeded)	70.3%	74%	+3.7%
1.2.49: Percentage of clients reporting no alcohol use in the past month at discharge *(Outcome)*	FY 2009: 81.5% (Target Exceeded)	74.7%	78%	+3.3%
1.2.50: Percentage of clients reporting being employed/in school at discharge *(Outcome)*	FY 2009: 42.9% (Target Met)	43.9%	43%	-0.9%
1.2.51: Percentage of clients reporting no involvement with the Criminal Justice System *(Outcome)*	FY 2009: 92% (Target Exceeded)	88.9%	92%	+3.1%
1.2.85: Percentage of clients receiving services who had a permanent place to live in the community *(Outcome)*	FY 2009: 92.0 % (Target Met)	92.0 %	92.0 %	Maintain

[5]Formerly Number of Clients Served. Wording change approved by OMB 12/4/07.

Synar

Table 3: Key Performance Indicators for Substance Abuse Block Grant – Synar Amendment

Measure	Most Recent	FY 2011	FY 2013	FY 2013
2.3.49: Number of States (including Puerto Rico) whose retail sales violations is at or below 20%[6] *(Outcome)*	FY 2009: 52 (Target Met)	52	52	Maintain
2.3.62: Number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% *(Outcome)*	FY 2009: 34 (Target Exceeded)	26	34[7]	+8

[6]The 20% retail sales violation data apply to the 50 states, D.C., and Puerto Rico.

[7]The target rate for 2012 and 2013 have been increased. Although States continue to face funding cuts to their youth tobacco access enforcement programs due to weak economic conditions, SAMHSA anticipates that new funding available to States from the FDA as a result of the Tobacco Control Act will help to offset State budget cuts and greatly increase the amount and reach of enforcement of youth access laws taking place in States, which SAMHSA expects to result in lower RVRs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2012 DISCRETIONARY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

STATE/TERRITORY	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate	+/- FY 2010
Alabama	$23,932,208	$23,932,208	$19,265,992	-$4,666,216
Alaska	4,958,281	4,958,281	3,991,533	-966,748
Arizona	37,421,345	37,421,345	30,125,066	-7,296,279
Arkansas	13,381,171	13,381,171	10,772,159	-2,609,012
California	251,659,105	251,659,105	202,591,519	-49,067,586
Colorado	26,393,425	26,393,425	21,247,330	-5,146,095
Connecticut	17,071,088	17,071,088	13,742,629	-3,328,459
Delaware	6,744,716	6,744,716	5,429,656	-1,315,060
District Of Columbia	6,744,716	6,744,716	5,429,656	-1,315,060
Florida	100,688,583	100,688,583	81,056,686	-19,631,897
Georgia	50,698,151	50,698,151	40,813,208	-9,884,943
Hawaii	7,660,446	7,660,446	6,166,840	-1,493,606
Idaho	6,931,273	6,931,273	5,579,838	-1,351,435
Illinois	70,114,715	70,114,715	56,444,001	-13,670,714
Indiana	33,423,005	33,423,005	26,906,308	-6,516,697
Iowa	13,571,229	13,571,229	10,925,160	-2,646,069
Kansas	12,333,978	12,333,978	9,929,143	-2,404,835
Kentucky	20,736,291	20,736,291	16,693,204	-4,043,087
Louisiana	25,939,847	25,939,847	20,882,189	-5,057,658
Maine	6,744,716	6,744,716	5,429,656	-1,315,060
Maryland	32,090,222	32,090,222	25,833,386	-6,256,836
Massachusetts	34,451,972	34,451,972	27,734,651	-6,717,321
Michigan	58,098,674	58,098,674	46,770,804	-11,327,870
Minnesota	24,981,718	24,981,718	20,110,873	-4,870,845
Red Lake Indians	615,708	615,708	495,659	-120,049
Mississippi	14,307,367	14,307,367	11,517,768	-2,789,599
Missouri	26,248,614	26,248,614	21,130,754	-5,117,860
Montana	6,744,716	6,744,716	5,429,656	-1,315,060
Nebraska	7,920,131	7,920,131	6,375,892	-1,544,239
Nevada	13,897,818	13,897,818	11,188,072	-2,709,746
New Hampshire	6,744,716	6,744,716	5,429,656	-1,315,060
New Jersey	47,103,249	47,103,249	37,919,227	-9,184,022
New Mexico	9,009,024	9,009,024	7,252,477	-1,756,547
New York	115,911,639	115,911,639	93,311,605	-22,600,034
North Carolina	40,041,719	40,041,719	32,234,529	-$7,807,190

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2012 DISCRETIONARY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

STATE/TERRITORY	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate	+/- FY 2010
North Dakota	$5,500,894	$5,500,894	$4,428,350	-$1,072,544
Ohio	66,891,165	66,891,165	53,848,967	-13,042,198
Oklahoma	17,775,259	17,775,259	14,309,503	-3,465,756
Oregon	17,998,935	17,998,935	14,489,568	-3,509,367
Pennsylvania	59,291,507	59,291,507	47,731,063	-11,560,444
Rhode Island	6,744,716	6,744,716	5,429,656	-1,315,060
South Carolina	20,685,249	20,685,249	16,652,114	-4,033,135
South Dakota	5,086,794	5,086,794	4,094,989	-991,805
Tennessee	29,850,946	29,850,946	24,030,716	-5,820,230
Texas	136,456,180	136,456,180	109,850,446	-26,605,734
Utah	17,194,033	17,194,033	13,841,602	-3,352,431
Vermont	5,438,864	5,438,864	4,378,414	-1,060,450
Virginia	43,237,320	43,237,320	34,807,063	-8,430,257
Washington	35,098,858	35,098,858	28,255,409	-6,843,449
West Virginia	8,740,456	8,740,456	7,036,273	-1,704,183
Wisconsin	28,190,657	28,190,657	22,694,144	-5,496,513
Wyoming	3,534,119	3,534,119	2,845,049	-689,070
State Sub-Total	**1,683,031,528**	**1,683,031,528**	**1,354,880,108**	-328,151,420
				$0
American Samoa	362,204	368,518	299,407	-62,797
Guam	982,668	1,001,931	815,152	-167,516
Northern Marianas	483,945	289,096	217,763	-266,182
Puerto Rico	22,115,030	22,271,328	17,931,867	-4,183,163
Palau	117,852	116,775	94,101	-23,751
Marshall Islands	352,969	362,308	296,824	-56,145
Micronesia	601,551	603,270	482,939	-118,612
Virgin Islands	613,703	616,696	494,639	-119,064
Territory Sub-Total	**25,629,922**	**25,629,922**	**20,632,692**	-4,997,230
				$0
Total States/Territories	**1,708,661,450**	**1,708,661,450**	**1,375,512,800**	**-333,148,650**
SAMHSA Set-Aside	**89,929,550**	**89,929,550**	**74,711,200**	**-15,218,350**
Transfer	0	0	44,090,000	+44,090,000
TOTAL SAPTBG [1/]	**$1,798,591,000**	**$1,798,591,000**	**$1,494,314,000**	**-$304,277,000**

[1/] Funding reflects an adjusted base without funding for the 20% prevention set-aside. Notwithstanding any other provision of law, section 1922(a) of the Public Health Service Act

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SAMHSA State, Tribal, and Community Prevention Grants
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SAMHSA State, Tribal, and Community Prevention Grants - Overview
(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
State, Tribal, and Community Prevention Grants.....	**$480,576**	**$480,655**	**$535,000**
Substance Abuse - State Prevention Grants (non-add).....	---	---	*395,000*
Behavioral Health - Tribal Prevention Grants (non-add).....	---	---	*50,000*
ACA Prevention Fund (non-add)	---	---	*(50,000)*
Mental Health - State Prevention Grants (non-add).....	*24,993*	*25,000*	*90,000*
Project LAUNCH (non-add).....	*(24,993)*	*(25,000)*	*(25,000)*

Authorizing Legislation .....Section 516 and 520A of the PHS Act

FY 2012 Authorization .....N/A

Allocation Method ..... Discretionary Grants

Prevention of substance abuse and mental illness and emotional health promotion are essential components of the National Prevention Council's National Prevention and Health Promotion Strategy to improve the health of individuals, families and communities and reform the Nation's health care system. The development of any comprehensive prevention strategy must include the prevention of substance abuse and mental illness as essential components to achieving and maintaining overall health for the American people.

In FY 2012, SAMHSA is requesting funding that creates three new behavioral health programs specifically focused on States and Territories, and Tribes. The purpose of these new programs is to help States/Territories and Tribes develop and implement effective practices, strategies, and policies to prevent substance abuse and mental illness and to promote emotional health. These programs are based on the latest prevention science that has demonstrated the benefits of building emotional health in helping to prevent substance abuse and mental illnesses. The Substance Abuse – State Prevention Grants, Behavioral Health – Tribal Prevention Grants, and Mental Health – State Prevention Grants will encourage States/Territories and Tribes to both strengthen substance abuse prevention activities and make promotion of emotional health a priority. The President and the Congress have both emphasized the critical role of disease prevention and health promotion in the overall health and wellness of the American people. These efforts directly support that priority.

A World Health Organization (WHO) report estimates that 26.2 percent of Americans ages 18 and older (about one in four adults) suffer from a diagnosable mental disorder in a given year. Mental illness is among the top causes for disability claims and is the leading cause of disability in the U.S. and Canada among people ages 15-44. The Institute of Medicine (IOM) estimates the cost of mental, emotional and behavioral disorders among youth to be approximately $247 million. Over 33,000 Americans die every year as a result of suicide. With an average age of onset for mental disorders occurring before age 14, and three-quarters of adult mental illnesses

beginning before age 25, a focused approach on disease prevention is necessary in order to reduce the impact of mental illness on society.

Similarly, substance abuse is a significant burden to American society. Nearly 5000 deaths are attributable to underage drinking each year. Furthermore, on any given day, an average of 8,000 people over the age of 12 initiate illicit drug use for the first time. According to the National Institute on Drug Abuse (NIDA), estimates of the total overall costs of substance abuse in the United States including health costs, crime-related costs and lost productivity exceed half a trillion dollars annually. This includes an estimated $181 billion for illicit drugs, $168 billion for tobacco, and $185 billion for alcohol.

Recent research has demonstrated consistently that substance use disorders and many mental illnesses are preventable The currently available science reviewed in 2009 by the IOM in its report entitled *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*, describes risk factors that can be lessened and protective factors that can be enhanced by utilizing multiple institutions/messages and community interventions to build emotional health in young children and help prevent substance abuse, depression, conduct disorder and other behavioral health issues among adolescents. These risk and protective factors are similar, regardless of whether the goal is reduced substance abuse or reduced depression and anxiety disorders. While there are similar factors, there are also unique factors for substance abuse. Likewise, these risk and protective factors must be addressed within multiple institutions in a community – schools, churches, community centers, homes, primary care settings, etc. – over time, in order to see measurable differences that are sustained for youth and for communities.

States and Territories are critical partners in the work of communities. States and Territories set policies, support community institutions and often direct or influence how services are funded and implemented and how collaborations are created or sustained. Without the commitment of States/Territories, the Nation's communities will not be successful as a whole in making the population based changes needed to raise emotionally healthy children who grow into healthy adolescents and productive adults.

The FY 2012 President's Budget request is $535 million for these three new prevention programs, including $395 million for the Substance Abuse - State Prevention Grants, $50 million for the Behavioral Health - Tribal Prevention Grants (funded from ACA Prevention Funds) and $90 million for the Mental Health - State Prevention Grant. Funding for the Substance Abuse - State Prevention Grants includes funding from realignment of the 20 percent Prevention Set-aside requirement of the SAPT Block Grant ($345 million) along with funding previously used for the Strategic Prevention Framework program ($51 million). Funding for the Mental Health - State Prevention Grants includes recycled funding from discretionary mental health programs. Funding for the Behavioral Health - Tribal Prevention Grants is requested from the Prevention and Public Health Fund of the ACA.

Substance Abuse - State Prevention Grants

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Substance Abuse - State Prevention Grants.....	$0	$0	$395,000

Authorizing Legislation ..... Section 516 of the PHS Act

FY 2012 Authorization .....N/A

Allocation Method ..... Discretionary Grants

Purpose

SAMHSA proposes to introduce a new Substance Abuse – State Prevention Grant (SA-SPG) starting in FY 2012, focusing exclusively on preventing substance abuse. The SA-SPG represents a significant advance in the Nation's approach to prevention in several ways. First, it creates a sustainable and predictable source of prevention funding for the 50 States, the District of Columbia (DC), and eight Territories that will require focus on high risk communities and youth. Second, it will move the Strategic Prevention Framework State Incentive Grant (SPF-SIG) approach to scale across the Nation. Third, it requires that States and Territories use a comprehensive, data-driven planning process to identify and address problems in communities, and holds States and the Territories accountable for achieving measurable outcomes for their residents.

Background

The SA-SPGs draw upon the strengths of both block grant and discretionary approaches. First, through the 20 percent prevention set-aside of the current formula-based Substance Abuse Prevention and Treatment Block Grant (SABG) program, SAMHSA will ensure funding availability and decision-making authority for prevention at the State level. At the same time, SAMHSA has guided the development of data-driven, needs-based, evidence-proven methods for facilitating substance abuse prevention through its discretionary programs, including the SPF-SIG. The new SA-SPG program integrates key aspects of both approaches in a systematic and logical approach designed to avoid duplication, improve coordination, increase accountability, prioritize high-need communities, focus exclusively on substance abuse prevention and require States and Territories to support communities in achieving outcomes. The SA-SPG program will build on the success of the planning approach promoted through the SPF-SIG, bringing it to scale nationwide and shepherding successes into the next step of development.

The SA-SPG provides prevention funding to ensure that every State and Territory makes prevention of substance abuse a priority. The SASPG will allow States and Territories to address substance abuse prevention at three levels: universal prevention, which addresses populations at

large; selected prevention, which targets subgroups of the population who share common risks of developing substance abuse disorders (such as children with a family history of substance abuse or schools in high poverty areas); and indicated prevention, which addresses individuals with multiple risk factors, early symptoms, or behaviors that are precursors for substance abuse, but who do not require treatment for substance abuse. States/Territories and communities will be able to utilize environmental and individual prevention approaches to achieve measurable results. This new program supports SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, which aims to create prevention prepared communities where individuals, families, schools, workplaces, and communities take action to strengthen protective factors and reduce risk factors for substance abuse (including tobacco) and to create environmental changes that support community living without the use of substances of abuse.

Structure and Required Activities:

The program will consist of discretionary grants to States and Territories. States and Territories will continue to be eligible for these funds beyond the initial award so long as they meet the requirements of renewal applications, provide the necessary annual reports, and show continued movement toward implementing their approved plans.

Each State and Territory will be required to develop a data-driven strategic plan based on information from its epidemiological work group which will be approved by SAMHSA. The plan must address, at a minimum: substance abuse, underage drinking (including adults' providing alcohol to minors) and binge drinking; prescription drugs; tobacco use; and it should provide for coordinated services for children, youth, and young adults from birth through age 25 (including working with schools). While the focus will be on youth, additional age groups, conditions, and services may be addressed if supported by the State or Territory needs assessment. The plan will reflect the results of an assessment of need, a review of the resources and capacity within the State or Territory, and in local communities, a plan for carrying out the strategy, monitoring the strategy as it is implemented, and an evaluation to identify strengths and weaknesses.

States and Territories will be allowed to retain up to 15 percent of the funds for State-level activities to achieve positive outcomes, including the operation of a State or Territory prevention advisory group, epidemiological work group, training and technical assistance to communities, data collection and evaluation, development and dissemination of State or Territory-wide messages and resources, and oversight and monitoring of funded communities. States and Territories will be able to use funds for coordinated workforce development, training in evidence-based practices, and the development of coordinated infrastructure and service delivery systems in high need communities. Up to five percent of the grant funds may be used for administrative costs.

States and Territories will be required to allocate at least 80 percent of the funds to local high-risk, high-need communities to organize coalitions or other approaches to carry out activities in keeping with the plan while addressing the particular needs of the community. Each community selected for funding will be responsible for aligning its programming with the plan. In carrying out these activities, the State or Territory, and communities receiving these funds will be

required to establish a comprehensive community plan that utilizes evidence-based and/or proven successful programs, policies or practices.

Other Requirements:

The SA-SPG will also contain restrictions and limitations similar to those that currently are in the other SAMHSA discretionary programs, including prohibiting the use of funds for cash payments to participants (except for certain designated incentive payments), construction or major renovation of buildings, as a match for any other Federal program, or for services in jails and prisons. Using CSAP Discretionary authority, this new SA-SPG can be more directive and increase accountability of Federal funds, and it will require States and Territories to monitor and report on specific program outcomes, while continuing to allow States and Territories to use additional SABG funds for prevention services should they so choose and plan to do so.

States and Territories that would have received a continuation SPF-SIG or Partnerships for Success grant would be strongly encouraged to use SA-SPG funds to continue the services and activities provided under those grants to reach their natural conclusion in accordance with their sustainability plans.

The final allocation for this program will reflect a formula that considers the population and prevention needs analysis; and that will ensure each State receives no less than the amount received under the previous SABG 20 percent prevention set-aside in FY 2010, assuming the amount proposed is appropriated by Congress.

Funding History

FY	Amount
2007	$0
2008	$0
2009	$0
2010	$0
2011	$0

Budget Request

The FY 2012 President's Budget request is $395 million, an increase of $395 million from the FY 2010 Level. That amount includes funding from combining the 20 percent prevention set-aside ($343 million) requirement of the SABG, along with $51 million in funding from the previous Strategic Prevention Framework program.

Outcomes and Outputs

Substance Abuse - State Prevention Grants

Table 1: Key Performance Indicators for Substance Abuse - State Prevention Grants

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
2.3.85: Number of persons served (Output)	N/A	N/A	TBD	N/A
2.3.90: Percentage of youth age 12-20 who report drinking in the past month (HHS Strategic Plan measure) (Outcome)	FY 2009: 27.2 % (Historical Actual)	N/A	TBD	N/A
2.3.97: Percentage of youth age 12-25 who report misuse of prescription drugs	N/A	N/A	TBD	N/A

The performance measures above are preliminary and are still being refined. As plans for the SPG are finalized, the performance measures and targets will be re-evaluated and modified. It is expected that measures of emotional health will also be added.

Grant Award Table

(whole dollars)	FY 2010	FY 2011	FY 2012
Number of Awards	0	0	59
Average Award	$0	$0	$2,156,924
Range of Awards	$0	$0	$23,355 - $50,331,821

Behavioral Health - Tribal Prevention Grants

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Behavioral Health - Tribal Prevention Grants	$---	$---	$50,000
ACA Prevention Fund (non-add)	---	---	*(50,000)*

Authorizing Legislation .....Section 516 and 520A of the PHS Act

FY 2012 Authorization .....N/A

Allocation Method ..... Discretionary Grants

Purpose

SAMHSA proposes to introduce a new Behavioral Health – Tribal Prevention Grant (BH-TPG) starting in FY 2012, focusing exclusively on promoting overall behavioral health by preventing alcohol and substance abuse and by preventing suicides in the 565 Federally-recognized Tribes. Promotion of strong emotional health is an important contributor to the prevention of substance abuse and some mental illnesses as well as in reducing their negative impact on Tribal communities. The BH-TPG represents a significant advance in the Nation's approach to substance abuse and suicide prevention in several ways. First, it recognizes that emotional health is part of overall health and thus supports the Tribes in addressing overall health, including preventing and reducing substance abuse, suicides and mental illness, in a coordinated manner. Second, it establishes a single coordinated mental health and substance abuse program for all Federally-recognized Tribes. Third, SAMHSA will consult and work closely with Tribes and Tribal leaders to develop a comprehensive, data-driven planning process to identify and address the most serious issues in each Tribal community. Recognizing the Federal obligation to help Tribes deal with physical and behavioral health issues, SAMHSA will work in consultation with Tribes to determine the best approaches.

Bringing Substance Abuse and Suicide Prevention to Scale for all Tribes

The proposal recognizes that Tribes currently receive different levels of mental health and substance abuse prevention services. Through the BH-TPG, all Tribes would be eligible for a base funding amount, with the remaining funds distributed to best serve the Tribal populations. SAMHSA will hold consultation(s) consistent with SAMHSA's Tribal Consultation Policy to determine how these funds would be best distributed to address as many of the needs of the Tribes as possible. The BH-TPG provides enhanced substance abuse (including alcohol) and suicide prevention funding to the Tribes to assure that their pressing needs are being met. This effort follows the lead of the President and Congress who have emphasized the importance of emotional health, prevention, and health promotion.

Structure and Required Activities

The program will provide funds to Tribes who choose to apply. This will enable Tribes to develop a comprehensive plan to address the most pressing need based on treatment data as well as in consultation with SAMHSA. The plan would address the prevention of substance abuse and suicide, and will provide for coordinated services. This planning activity is one of the basic components of the Tribal Law and Order Act (TLOA) and the Indian Alcohol and Substance Abuse Act, which SAMHSA is charged to coordinate in statute. Tribes will continue to be eligible for these funds beyond the three-year time frame so long as they meet the requirements of renewal applications, provide the necessary annual reports, and show continued movement toward implementing their approved plans.

The plan will reflect the results of an assessment of need, a review of the resources and capacity within the Tribal communities, a plan for carrying out the strategy, a monitoring of the strategy as implemented, and an evaluation of the strategy to identify strengths and weaknesses. SAMHSA will review and approve the plans.

Tribes will be allowed to use a set percentage (determined after consultation with Tribes) of the funds for a combination of service and service-related activities, development and dissemination of prevention messages, and provider development and linkage building to support the Tribes in achieving outcomes. Funding for infrastructure activities will enable the Tribe to build service capacity. The Tribe will present data to support how the allocation will support infrastructure and/or provision of services. In carrying out these activities, the Tribe will be required to use comprehensive, evidence-based programming, and/or proven successful programming, based on either mainstream science or proven Tribal traditions. Up to 20 percent of the grant funds may be used to fund key support and development activities, such as operation of a Tribal prevention advisory group, support for a Tribal community coalition, access to an epidemiological work group, training and technical assistance to communities, data collection and evaluation, and oversight and monitoring of activities.

Approximately 75 percent of Federally-recognized tribes have a total enrollment of 2,000 or fewer persons and a greater percentage of these tribes have limited internal capacity or infrastructure in place to implement and support needed behavioral health services. Smaller Tribes will have the opportunity to work in collaboration with other small Tribes to maximize the impact of the resources. SAMHSA will consult with the smaller Tribes to ensure that their needs are being met while reducing service overlap.

To ensure that providers in both the mental health and substance abuse fields are trained in both substance abuse and mental illness prevention and emotional health concepts and practices, Tribes will be able to use funds for coordinated workforce development, training in evidence-based practices, and the development of coordinated infrastructure and service delivery systems.

Budget Request

The FY 2012 President's Budget Request is $50 million through the Prevention and Public Health Fund of the ACA. Approximately half of the funding would be allocated as a "base

level" to Federally-recognized Tribes that make an application to receive these funds. It is anticipated that the base amount each Tribe would be eligible for is approximately $50,000, depending on the number of Tribes that apply. Larger Tribes may be eligible for additional funding based on some combination of population and need. The remaining funds will be distributed to best serve the population. The details of the funds distribution will be determined in consultation with Tribes.

Outcomes and Outputs

Behavioral Health - Tribal Prevention Grants

Table 2: Key Performance Indicators for Behavioral Health - Tribal Prevention Grants

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
2.3.92: Number of persons served (Output)	N/A	N/A	TBD	N/A
2.3.93: Percentage of youth age 12-20 who report drinking in the past month (Outcome)	N/A	N/A	TBD	N/A
2.3.98: Percentage of persons aged 12 and older who report suicidal ideation	N/A	N/A	TBD	N/A

The Behavioral Health - Tribal Prevention Grants will hold tribes accountable for achieving measurable outcomes for their citizens. Program performance measures are still being developed and will be provided at a later date.

Grant Award Table

(whole dollars)	FY 2010	FY 2011	FY 2012
Number of Awards	0	0	565
Minimum Award	$0	$0	$50,000

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Mental Health - State Prevention Grants

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Mental Health - State Prevention Grants.....	$24,993	$25,000	$90,000
Project LAUNCH (non-add).....	*(24,993)*	*(25,000)*	*(25,000)*

Authorizing Legislation ..... Section 520A of the PHS Act

FY 2012 Authorization .....N/A

Allocation Method ..... Discretionary Grants

Purpose

In FY 2008, Congress provided funding to implement the Linking Actions for Unmet Needs in Children's Health (Project LAUNCH) Wellness Initiative. Project LAUNCH promotes and enhances the wellness of young children by increasing grantees' capacity to develop infrastructure and implement prevention/promotion strategies necessary to promote wellness for young children. LAUNCH has been focused on children aged zero through eight. The FY 2012 Budget proposes expanding this program construct into State Prevention Grants which will promote the wellness of children, youth and young adults up to age 25 building on the findings and recommendations of the 2009 IOM report on *Preventing Mental, Emotional, and Behavioral Disorders Among Youth People*. The overall purpose of this new discretionary grant program is to provide support to States and Territories in their efforts to implement State-wide comprehensive prevention strategies to address the prevention of mental illnesses and reduce the impact of mental illness on America's communities.

The MH-SPG program will provide funding for all States and U.S. Territories in order to:

- Use evidence-based practices to promote known protective factors for mental health in children and youth and to reduce risk factors for mental illness and substance abuse;
- Prevent or delay the onset of mental illnesses and prevent suicide; and,
- Build mental health promotion and mental illness prevention capacity and infrastructure at the State, local, and community levels.

Background

The 2009 Institute of Medicine Report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People* provides evidence that a set of risk and protective factors affects the development of mental and substance use disorders in youth. For example, children with strong coping skills who live in safe, stable families and communities tend to develop certain mental illnesses less often than those who have not had these advantages. Although many mental illnesses have a biological basis, improvements in these personal, family, and community factors can help prevent, delay, and/or reduce the severity of these illnesses. Evidence also

demonstrates that community risk and protective factors, such as poverty, violence, gangs, etc. can have a negative impact on the healthy development of young people in neighborhoods. Community norms, values, and beliefs are powerful factors in fostering positive community and youth development. Collectively, improvements in these areas can reduce the impact of mental illness on America's communities.

The MH-SPG will require States and Territories to address mental health promotion and mental illness prevention at three levels of prevention practice: Universal, which addresses populations at large; selective, which targets individuals or subgroups of the population whose risk of developing mental, emotional, or behavioral disorders is significantly higher than average (such as children with a family history of abuse or schools in high poverty areas); and indicated, which addresses individuals with early symptoms or behaviors that are precursors for a disorder, but are not yet diagnosable. SAMHSA will require States and Territories to consider and utilize environmental and policy approaches as well as individual approaches in developing the application for these funds. This coordinated approach supports SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, which aims to create prevention prepared communities where individuals, families, schools, workplaces, communities, and States and Territories take action to promote emotional health and to prevent mental illness, substance abuse (including tobacco), and suicide.

Moving Mental Health Promotion and Mental Illness Prevention to a National Scale

The new Mental Health – State Prevention Grant program brings the success realized in SAMHSA's discretionary grant programs to a broader scale. States and Territories will be required to use data to identify communities at highest risk and select proven mental health promotion and mental illness prevention programs and practices based on community needs. A statewide approach to comprehensive prevention planning will help bring these proven practices to an operational and implementation scale.

By providing a stable and predictable source of funding through the MH-SPG, SAMHSA will support the development of a mental health promotion/mental illness prevention infrastructure in every State and Territory. This new grant program will require States and Territories to work across child-serving and other human service systems (e.g., State and local education authorities, schools, maternal and child health, public health, primary care, juvenile justice, child welfare, substance abuse, and faith communities) to engage and leverage existing Federal, State, and local resources already dedicated to or aligned with the prevention of mental, emotional, and behavioral disorders.

The MH-SPG program is based on recommendations within the 2009 Institute of Medicine's Report, "*Preventing Mental, Emotional, and Behavioral Disorders Among Young People*," which outlined recommendations for building partnerships across Federal, State, and local agencies, and research institutions to address risk factors that can lead to mental illness. As recommended by the IOM Report, the MH-SPG program will promote protective factors and implement evidence-based programs that prevent or delay the onset of mental disorders and prevent suicide by supporting resilience and healthy development among children, youth, and young adults. In so doing, States and Territories will help improve the Nation's behavioral health

and reduce individual, community and governmental costs associated with substance abuse and mental illness.

The MH-SPG program will require State agencies to use data to identify evidence-based mental health promotion and mental illness prevention activities, programs, practices, and policies for implementation in high-need/high-risk communities. States and Territories will be expected to respond to a set of prevention principles that will guide the MH-SPG, including being culturally competent, community-led, data-driven, evidence-based, and outcomes-oriented. This will be an infrastructure and service delivery grant program that will provide a comprehensive prevention process and will support an array of activities to help grantees build a solid foundation for delivering and sustaining effective mental illness prevention services and reducing problems associated with mental illness.

Following a comprehensive needs assessment process, grantees will develop Statewide plans for enhancing the prevention infrastructure, training, and service systems at the State and local levels. Ultimately, States and Territories will assist and support high-risk/high-need communities to promote mental health, reduce mental and substance use disorders, and prevent suicide among children, youth, and young adults.

The MH-SPG program will provide targeted prevention funding to the States and Territories to ensure that every State makes the promotion of mental health and the prevention of mental illness a priority. This effort follows the lead of the President and Congress who, in passing health care legislation, emphasized the importance of prevention as an essential element of overall health.

Structure and Required Activities

The MH-SPG program will be a discretionary formula grant program. States and Territories will continue to be eligible for these funds beyond initial grant award so long as they meet the requirements of each renewal application, provide the necessary annual reports, and show continued movement toward implementing their approved plans.

Each State/Territory will be required to develop a strategic plan based on national, State/Territory, and local epidemiological data sources and should describe a system with appropriate monitoring, funding and workforce resources. The plan must address, at a minimum, coordinated mental health promotion, mental illness prevention, and suicide prevention services for children, youth, and young adults from birth through age 25. States and Territories will be expected to work across child and youth serving systems (including working with schools) and may include school readiness, violence/trauma prevention, suicide prevention, depression, conduct/oppositional defiant disorder, ADHD, eating disorders, high risk behavior, and anxiety disorders as priority areas. States and Territories will be expected to indicate the evidence-base, utilizing the IOM report or other relevant scientific evidence, of the programs, services and activities they plan to fund. Data tracking the outcome of these expenditures, specifically decreasing disorders, risk factors, and suicide attempts and completions, and increasing protective factors and/or emotional health in the communities funded.

States and Territories will be required to allocate most of the funds to local communities to organize and carry out the promotion and prevention activities identified in the State plan while addressing the particular needs of communities. The final allocation strategy, including limitations for administrative expenditures, for this new grant program is currently under development and will allow all States and Territories to be eligible to receive a Mental Health – State Prevention Grant.

Using the CMHS PRNS authority, this new MH-SPG can be more directive and increase accountability of Federal funds and it will require States and Territories to monitor and report on specific program outcomes.

Budget Request

The FY 2012 President's Budget request is $90 million, including $25 million to continue grants funded under the current Project LAUNCH and $65 million available for new Mental Health-State Prevention Grants (MH-SPG). As grants reach their natural end, funding will be recycled from LAUNCH into the new MH-SPGs to expand and enlarge the LAUNCH construct Nationwide.

Outcomes and Outputs

Table 3: Key Performance Indicators for Mental Health - State Prevention Grant

Measure	Most Recent Result	Performance Target Associated with FY 2010 PB	Performance Target Associated with FY 2012 Request	Performance Target +/- FY 2011 Performance Target
2.3.94: Number of persons served (Output)	N/A	N/A	TBD	N/A
2.3.95: Number of persons trained in mental illness prevention or mental health promotion (Outcome)	N/A	N/A	TBD	N/A
2.3.99: Percentage of youth age 12-25 who experienced a Major Depressive Episode in the past 12 months	N/A	N/A	TBD	N/A

SAMHSA/Innovation and Emerging Issues
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SAMHSA/Innovation and Emerging Issues

Summary of Programs

(Dollars in Thousands)

Innovation and Emerging Issues	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Agency-Wide Initiatives	---	---	$14,000
CMHS	327,842	327,689	270,893
CSAP	75,438	75,527	69,376
CSAT	406,434	405,995	390,919
PHS Evaluation Funds	2,000	2,000	2,000
Subtotal, Innovation and Emerging Issues	$811,714	$811,211	$747,188
ACA Prevention Fund			
Primary and Behavioral Health Care Integration	20,000	35,000	20,000
Garrett Lee Smith Youth Suicide Prevention	---	10,000	---
Prevention Prepared Communities	---	---	22,600
Screening, Brief Intervention, & Referral to Treatment	---	25,000	---
Health Surveillance	---	18,000	---
Subtotal, ACA Prevention Fund	20,000	88,000	42,600
Total PL, Innovation and Emerging Issues	$831,714	$899,211	$789,788

The Innovation and Emerging Issues (IEI) programs include $839.8 million, including $92.6 million from the ACA Prevention Fund to support all grant continuations as well as targeted investments in new initiatives. The FY 2012 Budget embraces a new vision for SAMHSA which employs the discretionary grants as testing grounds for innovative approaches that, once proven, will be brought to scale nationwide by leveraging the Block Grants and State-level prevention grants. The programmatic activities include:

- $56.6 million for Agency-Wide Initiatives, including Prevention Prepared Communities, Primary and Behavioral Health Integration, Military Families, and Health Information Technology.

- $270.9 million for Mental Health activities, including Primary and Behavioral Health Care Integration, Suicide Prevention, Youth Violence Prevention, Minority AIDS, Minority Fellowships, and Homelessness Prevention. This includes a HHS/HUD Homelessness Prevention and Housing Initiative, which is a cross-SAMHSA collaboration with CSAT.

- $69.4 million for Substance Abuse Prevention activities, including Minority AIDS, STOP UAD Act, Fetal Alcohol Spectrum Disorder Center of Excellence, Minority Fellowships, and Science and Service Program Coordination.

- $392.9 million for Substance Abuse Treatment activities, including SBIRT, Targeted Capacity Expansion, Pregnant & Postpartum Women, Access to Recovery, Minority AIDS, Homeless Programs, Criminal Justice Activities, and Minority Fellowships. This includes a HHS/HUD Homelessness Prevention and Housing Initiative, which is a cross-SAMHSA collaboration with CMHS. The funding also includes $2.0 million in PHS Evaluation Funds for evaluation of SBIRT.

The IEI program includes grants formerly organized in the Programs of Regional and National Significance for the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment. The program lines and their associated funding have been realigned into the IEI budget line, and comparable adjustments for FY 2010 and FY 2011 have been made.

In July 2010, the Obama Administration released the first comprehensive National HIV/AIDS Strategy for the United States (NHAS). The NHAS was the result of unprecedented public input, including 14 HIV/AIDS community discussions held across the country, as well as an online suggestions process, various expert meetings and other inputs. Senior officials at SAMHSA were involved in a Federal interagency working group that reviewed recommendations from the public and worked with the Office of National AIDS Policy to develop the NHAS. The Strategy focuses on three overarching goals: reducing the number of new HIV infections, increasing access to care for people living with HIV, and reducing HIV-related health disparities.

SAMHSA is committed to supporting the NHAS through the promotion of evidence-based prevention interventions and behavioral health services and treatment for people at risk for or living with HIV/AIDS who have co-occurring mental and/or substance use disorders. A mental and/or substance use disorder can facilitate HIV transmission and also may negatively impact housing stability, adherence to drug protocols, and acceptance of behavioral health treatment and services for people living with HIV/AIDS. Thus, behavioral health services are intrgral to a comprehensive approach to HIV/AIDS prevention, care and treatment.

SAMHSA specifically is working with its Federal partners to 1) improve the coordination of behavioral health resources and services for racial and ethnic minorities at risk for or living with HIV/AIDS living in the 12 cities most impacted by HIV/AIDS; 2) develop a behavioral health and HIV/AIDS webpage and related materials that will be located on AIDS.Gov and disseminated through the use of social marketing; 3) assess HIV testing capacity and frequency in SAMHSA funded drug-treatment centers; 4) address the needs of people living with HIV/AIDS who are homeless; 5) address the prejudice and discrimination related to HIV/AIDS; and 6) develop self-directed and wellness-centered approaches to behavioral health care for people living with HIV/AIDS.

Agency-Wide Initiatives
(Dollars in Thousands)

Agency-Wide Initiatives	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Military Families Initiative	---	---	$10,000
Health IT Demonstration Project	---	---	4,000
Subtotal, Agency-Wide Initiatives	**---**	**---**	**$14,000**
ACA Prevention Fund			
Primary and Behavioral Health Care Integration	20,000	35,000	20,000
Prevention Prepared Communities	---	---	22,600
Subtotal, ACA Prevention Fund within IEI 1/	**20,000**	**35,000**	**42,600**
Total PL, IEI - Agency-Wide Initiatives	**$20,000**	**$35,000**	**$56,600**

1/ Narrative for the Behavioral Health Tribal Prevention Grant can be found in the State, Tribal and Community Prevention Grants Chapter

Authorizing Legislation ..... Sections 509, 516, and 520A of the Public Health Service Act

FY 2012 Authorization .....Expired

Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts

Program Description and Accomplishments

SAMHSA considers States and Tribes key partners in transforming healthcare in America and believes that it is imperative to maintain and grow their funding and capacity during this time of transition. As States, Tribes and communities are most familiar with the behavioral health service needs of their populations, it is important to maintain the critical balance between supporting service capacity and identifying emerging best practices. Accordingly, SAMHSA proposes funding for an SAMHSA-wide budget line for Innovation and Emerging Issues. In coordination with SAMHSA's Block Grants and Prevention Grants, where evidence-based practices will be brought to scale, the Innovation and Emerging Issues program would support States, Tribes and communities in testing new approaches, seeking out best-practices, and developing improved services. Additionally, current programs that show promise are continued so that the lessons learned can be fully incorporated into a State's action plan.

Funding History

FY	Amount
2007	$0
2008	$0
2009	$0
2010	$0
2011	$0

Budget Request

The FY 2012 President's Budget request is $36.6 million. This funding level reflects new funding for new initiatives that show promise, funding for Military Families, Health Information Technology, and the Prevention Prepared Communities (funded out of the ACA Prevention Fund).

Military Families Initiative

The FY 2012 President's Budget request includes $10 million for the Military Families Initiative. There is an increasing need to counter the impact of deployment and trauma-related stress on military families, particularly children. As the Federal agency in charge of behavioral health for all Americans, SAMHSA's role will shift from supporting to leading through partnerships and providing services and supports as needed. This initiative will address the behavioral health needs of military service personnel and their families served through the public health service system. Utilizing a two-phased funding approach, it would support infrastructure development, including coordination and capacity building as well as direct service supports for prevention, treatment and recovery support services for those communities most impacted by the needs of service members, veterans, and their families. The request includes $3.5 million for Policy Academies and $6.5 million to support direct service grants.

The first phase addresses the requisite infrastructure and capacity building at the state level for forming collaborative relationships among agencies responsible for providing behavioral health services and those entities such as the Department of Defense, Department of Veterans Affairs, National Guard Bureau, and National Guard and Reserve Units who are responsible for service members, veterans and their families. The participation of these key Federal, State and local partners is critical for successful matching/mapping of service resources and population need. Support for infrastructure and capacity building would be accomplished through funding of an expanded series of Policy Academies which would be offered to all States and Territories. These Policy Academies would provide a forum for all States and Territories to consider how existing policies, program resources, and service infrastructure influence the ability of services to respond to the target groups, and whether there are efficiencies or modifications to systems or operations that might improve those responses. The overall goal of the Policy Academy is to facilitate the establishment of a State-wide readiness plan to comprehensively addressing the behavioral health needs of military service members, Veterans and their families and strengthens behavioral

health care systems and services for returning service members, Veterans, and their families through ongoing collaboration at the State and local levels.

The impact and sustainability of the work of the Policy Academies would be strengthened through funding that would be made available to the participating States and Territories of each Academy to (1) provide support for the implementation of components of the strategic plan for infrastructure and coordination for two years following their participation in the Academy; (2) develop and implement a GIS mapping system/strategy for the State/Territory to coordinate existing resources and areas of need; (3) promote information exchange between behavioral health and military and veteran agencies; and (4) promote training of providers to offer informed and quality care to this population. Proposed funding for infrastructure and capacity building through Policy Academies is $3.5 million. This will provide support for up to 30 States.

The second phase of funding proposes to provide direct support for behavioral health prevention, treatment and recovery support services for communities most impacted by behavioral health needs of service members, veterans, and their families. Grants will be provided to States and/or communities demonstrating high rates of military populations (including Active Duty, National Guard, Reserve and Veteran) in local/regional populations. SAMHSA will work collaboratively with our HHS partners at HRSA, ACF and IHS as well as other Federal partners including the Departments of Veterans Affairs, Defense, and the National Guard Bureau on this initiative.

These service grants would provide funding for a menu of evidence-based behavioral health prevention, treatment and recovery support services, as well as strategies designed to link the target population to needed services, and would provide direct assistance to those individuals and communities most in need of resources for this population. Grants would be made to based on the quality of their application that outlines both need and proposed service strategies, including strategies that reduce barriers to care and promote accessibility, and on evidence of existing or planned mechanisms to ensure awareness of and connection to existing DoD and VA resources as needed. An environmental scan of existing promising prevention strategies and treatment programs would be conducted to provide a menu of services that states/communities can draw upon in developing their applications The grants would include an evaluation protocol to determine not only the effectiveness of the grants but also to determine those most effective strategies and services to support future service planning. Proposed funding for direct service grants to support the behavioral health service needs of military members and their families is $6.5 million and will support up to 10 States.

Health Information Technology Demonstrations

The FY 2012 President's Budget request includes $4 million for health information technology (HIT) that will focus on creating pilot implementation projects related to behavioral health (BH) data standards developed in 2011. SAMHSA will work with States and discretionary grantees who will participate in the pilots. Projects will focus on the following three areas in 2012:

1) Interoperable privacy, confidentiality, and patient consent in electronic health records (EHR) and health information exchanges (HIE). Specific activities include the following:

- Identify and refine policies and requirements that identify terms of choice for patient privacy consent directives.
- Translate policy statements into machine and human readable, near natural language (NNL) access and use control specifications.
- Translate NNL specifications into "tags" that code access, use, and disclosure requirements within clinical data elements, clinical record segments, or entire records.

2) Work on BH data interoperability using national standard constructs will include the following:

- Develop specific data standards using vocabulary adopted by Office of the National Coordinator for Health Information Technology (ONC).
- Develop and collect data on BH quality and performance measures;
- Partner with other Federal agencies in the adoption of national vocabulary standards in EHR systems, personal health record (PHR) systems, and HIEs.
- Test open-source Web services that can be re-used by specialty behavioral health prevention and treatment providers nationwide.

3) Develop an implementation guide for each behavioral health quality measure which:

- Includes a model of suggested clinical workflow where each quality measure can be documented during normal service delivery with meaningful use standard clinical data.
- Includes specifications needed to automatically report each quality measure and supporting data to public authorities.
- Describes how to objectively document behavioral health needs, services delivered, and service outcomes across entire State safety nets.
- Describes how standard clinical data may be mapped to screening or assessment instrument questions.

Prevention Prepared Communities

The Prevention Prepared Communities program is a cornerstone of the National Drug Control Strategy and is designed to lay the foundation for a national, evidence-based, community-oriented system to prevent the onset and progression of substance use and associated mental, emotional, and problems (e.g., school dropout, delinquency, and violence), among children and youth ages 9 to 25 years. A collaborative effort of the Department of Health and Human Services, the Department of Education, and the Department of Justice, in partnership with the Office of National Drug Control Strategy, the PPC program will provide local communities and States with resources to implement a comprehensive array of drug prevention programs and policies based on identified needs. Specifically, the PPC program will fund communities at a level that enhances their current capacity for strategic planning and operation within States that have established cross-agency collaborations, data collection, and technical assistance infrastructure. The FY 2012 President's Budget request includes $22.6 million from the ACA Prevention Fund for PPCs.

The Prevention Prepared Communities program will assist States and communities in developing and implementing effective mental illness and substance abuse prevention practices, strategies,

and policies that will promote the wellness of individuals age 9-25 and the communities in which they live. The program builds on scientific evidence that a common set of risk and protective factors contributes to a range of mental, physical, and behavioral problems, including substance abuse and other unhealthy behaviors. The initiation and use of substances share early common developmental pathways with other mental, emotional, and behavioral problems. As youth develop, however, risk factors specific to substance use emerge and must be considered when designing drug prevention programs. Thus, targeting risk factors and promoting protective factors can prevent substance abuse and some mental illnesses as well as other negative outcomes. The goal of Prevention Prepared Communities is to improve community and individual level wellness, and health promotion outcomes in a comprehensive, collaborative way. Performance measures will be collected at both the community and individual level. Measures will include population-based indicators of community wellness and at an individual level will include measures of positive mental health, abstinence from substance abuse, better juvenile justice outcomes and improved academic achievement.

Under this program, grantee communities will use data-based approaches to identify their predominant substance abuse and mental health issue(s), and will select and implement evidence-based strategies to target the identified risk and protective factors contributing to these issues. Evidence-based strategies may include individual- and family-focused prevention programs and practices, environmental strategies, community-wide public education campaigns, school-based curricula, and parenting, social, and life skills training Grantees will collaborate with appropriate service providers for ages 9-25 to ensure the utilization of best practices for universal, selective, and indicated populations.

Outcomes and Outputs

Military Families

Table 1: Key Performance Indicators for Military Families Initiative

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.4.26: The number of behavioral health outcomes for military personnel and their families served through SAMHSA supported programs (HHS Strategic plan Measure) *(Outcome)*	N/A	N/A	TBD	N/A
3.4.27: Percentage of adults receiving services who report improved functioning *(Outcome)*	N/A	N/A	TBD	N/A

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.4.28: Percentage of children receiving services who report improved functioning *(Outcome)*	N/A	N/A	TBD	N/A
3.4.29: Percentage of adults receiving services who had a permanent place to live in the community *(Outcome)*	N/A	N/A	TBD	N/A

Prevention Prepared Communities

Table 2: Key Performance Indicators for Prevention Prepared Communities

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.3.04: Percent funded communities with reduced school dropout rates *(Outcome)*	N/A	N/A	TBD	N/A
3.3.05: Percent funded communities with reduced rates of domestic violence *(Outcome)*	N/A	N/A	TBD	N/A
3.3.06: Number of youth in funded communities who report that they talk with one or more parent/guardian at least 15 minutes every day *(Output)*	N/A	N/A	TBD	N/A

Size of Awards

(Whole Dollars)	FY 2010	FY 2011	FY 2012
Number of Awards	0	0	65
Average Award	$0	$0	$246,154
Range of Awards	N/A	N/A	$193,000-$1,500,000

SAMHSA Innovation & Emerging Issues
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SAMHSA/Center for Mental Health Services
Innovation & Emerging Issues

Summary of Programs

The Mental Health Innovation & Emerging Issues (IEI) support States and communities in carrying out an array of activities to improve the quality and availability of services in priority areas. The FY 2012 President's Budget request for SAMHSA Mental Health IEI includes $270.9 million which covers 22 programmatic activities that include:

- $42.0 million for Mental Health Homelessness Prevention Programs (includes the joint Homeless Initiative Program) and Homelessness Education Programs to reduce the prevalence and impact of mental disorders in the homeless and improve the transition from homelessness into stable and permanent housing, including the joint initiative with the Center for Substance Abuse Treatment and the Department of Housing and Urban Development;

- $14.0 million for Primary & Behavioral Health Care Integration to promote more integrated services between primary care services and mental health services, by providing funding resources to facilitate screening and referral for necessary primary care prevention and treatment needs. This program also utilizes $20 million from the Affordable Care Act Prevention Fund to further expand the program to implement health care reform activities;

- $48.1 million for Suicide Prevention Programs to improve public and professional awareness of suicide and promote prevention. The activities include Garrett Lee Smith Suicide grants to States and Colleges, the AI/AN Suicide Prevention Initiative, the Garrett Lee Smith Suicide Prevention Resource Center, as well as the Suicide Lifeline;

- $11.3 million for National Traumatic Stress Network to improve treatment and services intervention for children and adolescents exposed to traumatic events, by funding a network of grantees to disseminate the assessment and treatment strategies developed through the Network and provide direct trauma-informed services to children and youth;

- $94.3 million for Youth Violence Prevention activities. The Youth Violence Prevention activities include the Safe Schools/Healthy Students collaborative program with U.S. Departments of Education and Justice, and the College Emergency Preparedness initiative;

The Mental Health programs underwent a performance assessment in 2005. The assessment cited clear purpose, strong financial management, and effective targeting as strong attributes. The assessment also reported the program lacked a clear design linking all projects to performance goals and did not collect performance data from all grantees or use performance data to hold grantees accountable for improving outcomes. As a result of the performance assessment, the program has implemented an automated web-based performance system, the

Transformation Accountability System, for all of its services programs and is working to expand use of the system to the remaining programs. SAMHSA is also working on the development and implementation of common performance measures for its technical assistance, infrastructure development, and prevention programs.

SAMHSA/Center for Mental Health Services
Mechanism Table by APT
(Dollars in Thousands)

Innovation & Emerging Issues	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget		FY 2012 PB +/- 2010	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Grants/Cooperative Agreements:								
Continuations	300	$126,895	330	$123,969	306	$105,905	-24	-$18,064
New/Competing	166	49,016	116	53,651	73	30,770	-43	-22,881
Supplements	0	1,478	0	0	0	0	0	0
Subtotal	**466**	**177,389**	**446**	**177,620**	**379**	**136,675**	**-67**	**-40,945**
Contracts:								
Continuations	43	136,713	43	140,733	35	128,277	-8	-12,456
New/Competing	7	13,741	10	9,336	5	5,941	-5	-3,395
Supplements	0	0	0	0	0	0	0	0
Subtotal	**50**	**150,453**	**53**	**150,069**	**40**	**134,218**	**-13**	**-15,851**
Total, IEI CMHS	**516**	**327,842**	**499**	**327,689**	**419**	**270,893**	**-80**	**-56,796**

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SAMHSA/Innovation and Emerging Issues – Mental Health Services

(Dollars in Thousands)

Innovation & Emerging Issues	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Co-Occurring State Incentive Grant	$2,168	$2,168	$2,168
Youth Violence Prevention	94,393	94,502	94,333
National Traumatic Stress Network	40,798	40,800	11,300
Children and Family Programs	9,100	9,194	6,486
Consumer and Family Network Grants	6,223	6,236	4,966
MH System Transformation and Health Reform	29,179	29,106	10,623
Primary and Behavioral Health Care Integration 1/	13,987	14,000	14,000
Community Resilience and Recovery Initiative	4,979	5,000	5,000
Suicide Lifeline	5,522	5,522	5,522
GLS - Youth Suicide Prevention - States	29,617	29,738	29,738
GLS - Youth Suicide Prevention - Campus	4,972	4,975	4,975
AI/AN Suicide Prevention Initiative	2,944	2,944	2,944
GLS - Suicide Prevention Resource Center	4,957	4,957	4,957
Homelessness Prevention Programs	32,265	32,250	39,696
Homelessness Education Programs	2,306	2,306	2,306
Older Adult Programs	4,810	4,814	0
Minority AIDS	9,283	9,283	9,283
HIV/AIDS Education	966	974	774
Criminal and Juvenile Justice Programs	6,684	6,684	6,684
Congressional Projects	5,975	5,975	0
Practice Improvement and Training	9,454	9,001	7,878
Consumer and Consumer Support TA Centers	1,927	1,927	1,927
Minority Fellowship Program	4,279	4,279	4,279
Disaster Response	1,054	1,054	1,054
TOTAL, IEI-CMHS	**$327,842**	**$327,689**	**$270,893**

1/ In FY 2012, additional $20 million is allocated from the ACA Prevention Fund for PBHCI

Authorizing Legislation .... Sections 506, 516, 520, 581, and 582 of the Public Health Service Act

FY 2012 Authorization .....Expired

Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements

Co-Occurring State Incentive Grant

Program Description and Accomplishments

The Co-Occurring State Incentive Grant program, jointly administered with CSAT, develops and enhances the infrastructure and increases grantee capacity to provide comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring mental health and substance abuse disorders. It is estimated that 5.4 million adults in the U.S. are affected by co-occurring mental and substance abuse disorders (National Survey on Drug Use and Health, 2007). SAMHSA will continue to promote State and local capacity to address the prevention, treatment, and recovery support needs of people with and at risk for co-occurring disorders including the promotion of resiliency and access to recovery support services for people with co-occurring disorders.

Youth Violence Prevention

Program Description and Accomplishments

The Safe Schools/Healthy Students Initiative supports the implementation and enhancement of integrated, comprehensive community-wide plans that create safe and drug-free schools and promote healthy childhood development. In 2009, school districts participating in the Safe Schools/Healthy Students Initiative reported a 15 percent decrease in violent incidents. Eighty-four percent of staff at grantee schools said the Safe Schools/Healthy Students Initiative had improved school safety, 77 percent said it had reduced violence on campus, and 75 percent said it had reduced violence in the community.

Since 1999, the U.S. Departments of Education, Health and Human Services, and Justice have collaborated on the Safe Schools/Healthy Students Initiative. The Safe Schools/Healthy Students Initiative is a discretionary grant program that provides students, schools, and communities with Federal funding to implement an enhanced, coordinated, comprehensive plan of activities, programs, and services that focus on promoting healthy childhood development and preventing violence and alcohol and other drug abuse. Eligible local educational agencies or a consortium of local educational agencies, in partnership with their community's local public mental health authority, local law enforcement agency, and local juvenile justice entity, are able to submit a single application for Federal funds to support a variety of activities, curriculums, programs, and services. This grant program supports 146 school districts across the country, spanning rural, tribal, suburban and urban areas as well as diverse racial, ethnic and economic sectors. Each local strategic plan addresses five required elements across the three sectors: 1) safe school environments and violence prevention activities; 2) alcohol, tobacco, and other drug prevention activities; 3) student behavioral, social, and emotional supports; 4) mental health services; and, 5) early childhood social and emotional learning programs. Grantees have developed organizational, informational, and programmatic systems that bring together many diverse sectors of the community, creating the capacity for comprehensive system reform so that all agencies concerned with the welfare of children and families could collaborate on an ongoing basis. The national cross-site evaluation has found a 15% decrease in the number of students involved in violent incidents; a 12% decrease in the number of students reporting that they had

experienced or witnessed violence from year one of the grant period to year three; and that most staff at grantee schools reported that the Initiative had made their schools safer.
In FY 2010, 3,223,075 children were served by the Safe Schools/Healthy Students Initiative. Since baseline was set in 2006, the number served has nearly tripled and the target has been exceeded each year.

The Safe Schools/Healthy Students program is expected to serve 116 communities and over 2.3 million children in FY 2012. SAMHSA anticipates the percentage of children showing improvement in substance abuse, violent incidents, and mental health referrals to remain constant in FY 2012.

Following the tragic shooting events at Virginia Polytechnic Institute and State University (Virginia Tech) in 2007, SAMHSA and the Department of Education instituted a joint initiative called the College Emergency Preparedness program. These competitive grants provide funding to institutions of higher education to develop and implement emergency management plans and protocols for preventing campus violence that include mental health and other needs of individuals as well as developing written plans for assessing and addressing the mental health needs of students who may be at risk of causing campus violence.

National Child Traumatic Stress Network

Program Description and Accomplishments

In FY 2001, Congress authorized the National Child Traumatic Stress Initiative (NCTSI) to improve treatment, services and interventions for children and adolescents exposed to traumatic events. The NCTSI funds a national network of grantees that collaborate to develop and promote effective community practices for children and adolescents exposed to a wide array of traumatic events. Domestic public and private nonprofit entities are eligible to apply for grants. Centers are located in or associated with a diverse group of organizations, such as universities, community mental health centers, children's hospitals, children's advocacy centers, State government agencies, schools, and refugee programs. NCTSI experts provide training and technical support on intervention approaches to reduce the traumatic effects of disasters on children/adolescents and their families in the immediate and longer term phases of disaster response. Since its inception, the National Child Traumatic Stress Network (NCTSN) has expanded its reach across the country, with current grantees in twenty-nine States. It has provided training or education on child trauma to over 900,000 individuals; more than 95,000 people were trained in 2009 in nearly 3,000 annual training/education events. In FY 2009, 76 percent of children receiving services had improved outcomes (percentage showing clinically significant improvement).

NCTSI continues to impact the care of thousands of children in systems such as child welfare, schools, and juvenile justice through the training and consultation provided to these systems. The program has implemented new output measures to track numbers trained as well as number of screenings and assessments for better overall management.

In FY 2012 SAMHSA proposes to build on the work of the first phase of the NCTSI and implement an expansion of the initiative that will ensure that the core practices developed by the current NCTSN are delivered to children and youth in need. The Phase I of the NCTSN will fund grants to disseminate the assessment and treatment strategies developed through NCTSN and provide direct trauma-informed services to children and youth. The program will provide mental health professionals, including personnel in the disciplines of psychiatry, psychology, social work, psychiatric nursing, and marriage and family therapy, with a didactic and experiential program that will increase their capacity to recognize, diagnose, and treat children and adolescents exposed to trauma and their families. The primary goal of this effort is to increase the number of qualified behavioral health personnel trained to deal with the special problems of traumatized children and adolescents, particularly in areas and settings with severe shortages of behavioral health professionals or where children are most at risk for exposure to trauma such as children of military families and homeless children and families. This will ensure that the core evidence-based practices developed by the NCTSN are delivered to children and adolescents in need.

Phase II of this initiative would take advantage of the creativity and flexibility inherent in the NCTSN to provide proactive assistance and appropriate interventions in addressing emerging traumatic events such as the loss of a parent among children of military veterans. In addition, it will allow the Network to respond to needs of children and youth impacted by the trauma of unexpected national emergencies and disasters. It also provides SAMHSA with the opportunity to align the NCTSN efforts to many of the SAMHSA Strategic Initiatives, such as Trauma and Justice, Military Families, Data, Outcomes and Quality, and Prevention of Substance Abuse and Mental Illness.

SAMHSA expects to award up to 10 new NCTSN grants in FY 2012. A training and technical assistance center would also be funded, which would support the national education and training efforts for the grantees and the field. In-person training would be of short duration (no more than five days) and would be supplemented with online distance education resources, including web-based training and technical assistance materials and resources, web conferencing and a blog. Grants would be awarded to public or private nonprofit institutions and organizations, and State and local government agencies to select individuals for training in the evidence-based practices that have been tested and proven effective within the NCTSN and to provide trainee stipends and other allowances (i.e., travel expenses, materials fees, etc.) for individuals enrolled in the training program.

Children and Family Programs

Program Description and Accomplishments

The Children and Family's Healthy Transitions Program uses a system of care approach to promote a seamless transition to independence and the successful adaptation of adult roles and responsibilities for youth and young adults with serious mental health conditions and their families. Young people with serious mental health conditions (often with co-occurring substance

abuse) face a difficult transition to adulthood compared to their peers. Moreover, youth who age out of child-serving systems may have difficulty obtaining developmentally appropriate, culturally-competent and appealing services and supports as they move into adulthood. These at-risk youth are better able to navigate the transition to adulthood by making available evidence-based, age-appropriate services and supports and create supportive State-level policies.

The Circles of Care program provides tribal and urban Indian communities with tools and resources to build systems of care to promote mental health for children, youth and their families in American Indian and Alaska Native (AI/AN) communities by developing the capacity and infrastructure necessary to plan and implement these systems. As a result, 13 of 23 grantees secured Children's Mental Health Initiative (CMHI) funding, either directly or indirectly to implement the grantee's model.

Consumer & Family Network Grant

Program Description and Accomplishments

The Consumer and Family Network grant program is an effort to promote consumer, family, and youth participation in the development of policies, programs, and quality assurance activities related to the mental health systems reform.

The Statewide Consumer Network program focuses on the needs of adult mental health consumers aged 18 and older by strengthening the capabilities of State-wide consumer-run organizations to be catalysts for transforming the mental health and related systems in their State; thereby ensuring a focus on consumer recovery and resilience. It establishes sustainable mechanisms for integrating the consumer voice in State mental health and allied systems to expand service system capacity and support policy and program development. The program promotes skill development with an emphasis on leadership and business management, as well as coalition/ partnership building and economic empowerment as part of the recovery process for consumers.

The Statewide Family Network provides education and training to increase family organization capacity for policy and service development by: 1) strengthening organizational relationships; 2) fostering leadership and business management skills among families of children and adolescents with serious emotional disturbance; and 3) identifying and address the technical assistance needs of children and adolescents with serious emotional disturbances and their families. The Statewide Family Network focuses on families: parents, primary caregivers of children, youth and young adults. Young adults are eligible up to age 18, up to age 21 if they have an Individualized Education Plan, or up to age 26 if transitioning to the adult system.

Mental Health System Transformation and Health Reform

Program Description and Accomplishments

SAMHSA supports the President's efforts to reform health care by engaging in activities that support the transformation of the mental health system. These include the Mental Health Transformation Grants and Prevention Practices in Schools grants.

In FY 2010, SAMHSA awarded 20 Mental Health Transformation Grants (formerly Mental Health State Incentive Grants) that will promote the adoption and implementation of permanent transformative changes in how communities manage and deliver mental health services. In an effort to reach a larger number of communities, the FY 2010 Mental Health Transformation grant awards are smaller than the earlier grant awards and leverage existing infrastructures to accelerate capacities to address critical system and capacity reform needs in their respective communities. In order to complement the efforts of other SAMHSA programs, FY 2010 funding for Mental health Transformation Grants focused on services for adults with or at-risk for serious mental illnesses. Grantees are now expected to implement evidence-based or best practices that will create or expand capacity to address prevention of mental illness, trauma-informed care, screening, treatment and support services for military personnel, housing and employment supports. Necessary changes to policies and organizational structures to support improved mental health services will also be supported along with workforce training, implementation of evidence-based practices, and improving access to quality mental health services.

In FY 2010, SAMHSA awarded 22 Prevention Practices in Schools grants. The purpose of this program is to prevent aggressive and disruptive behavior among young children in the short term and prevent antisocial behavior and the use of illicit drugs in the longer term. Grantees will implement an evidence-based practice in schools, specifically the Good Behavior Game, a behavioral classroom management strategy that involves helping children learn how to work together. The approach of this practice facilitates a positive learning environment and has been shown to decrease disruptive behavior in the classroom.

In FY 2012, SAMHSA will continue to provide technical assistance and support States and communities in implementing flexible solutions to address the burdensome problems of substance abuse, mental illnesses, and co-occurring disorders in the criminal justice system through collaboration between the Center for Substance Abuse Treatment and the Center for Mental Health Services. This approach helps local courts find the model that best meets their needs and capacities. It also encourages partnership with the behavioral health system to allocate treatment and recovery support services effectively and efficiently.

Primary & Behavioral Health Care Integration (PBHCI)

Program Description and Accomplishments

Physical health problems among people with mental illnesses impact quality of life and contributes to premature deaths, where these individuals die much earlier than the general population. While several factors contribute to this disparity, empirical findings indicate that early mortality among people with serious mental illnesses is clearly linked to the lack of access to primary care services.

In FY 2009, SAMHSA initiated the Primary and Behavioral Health Care Integration (PBHCI) Program and funded 13 PBHCI grants. PBHCI grantees began providing primary care services to consumers with serious mental illness in February 2010, and are currently engaged in a variety of activities which including developing electronic health record systems, developing data collection systems, and perhaps most importantly, providing primary care and health/wellness

services. In FY 2010, SAMHSA awarded 43 additional grants, mainly funded with Affordable Care Act's Prevention funds. These will be fully supported in FY 2012.

The PBHCI program will provide resources to facilitate screening and referral for necessary primary care prevention and treatment needs; develop a registry/tracking system for all primary care needs; provide care management, individualized person-centered planning and coordination to increase consumer participation and follow up with all primary care screening, assessment and treatment services; provide prevention and wellness support services (including nutrition consultation, health education and literacy, tobacco cessation, peer support specialists, self-help/management programs); and develop processes for referral and follow-up for needed treatments that are not appropriately provided in a primary care setting. By building the necessary partnerships, grantees will expand their offerings of primary healthcare services for people with mental illnesses, resulting in improved health status. By making available coordinated primary care services in community-based behavioral health settings, grantees will improve the overall wellness and physical health status of people with serious mental illnesses

The PBHCI program supports the coordination and integration of primary care services into publicly-funded community behavioral health settings. The expected outcome of improved health status for people with serious mental illness will be achieved by encouraging grantees to engage in necessary partnerships, expand infrastructure, and increase the availability of primary health care and wellness services to individuals with mental illness. Partnerships between primary care and behavioral health organizations are deemed crucial to this program**.** The population of focus for this grant program is individuals with serious mental illness served in the public mental health system.

SAMHSA expects that people with serious mental illnesses will show improvement in their physical health status through participation in this program. This grant program supports SAMHSA's Pledge for Wellness 10 by 10 Campaign to prevent and reduce early mortality among people with mental illness by 10 years over the next 10 years. It is expected that better coordination and integration of primary and behavioral health care will lead to outcomes including improved access to primary care services; improved prevention, early identification and intervention to avoid serious health issues including chronic diseases; enhanced capacity to holistically serve those with mental and/or substance use disorders; and better overall health status of consumers.

SAMHSA is collaborating with the HHS/Assistant Secretary for Planning and Evaluation (ASPE) on the evaluation for this program, which seeks to address three main questions of interest: 1) is it possible to integrate the services provided by primary care providers and community-based behavioral health agencies; 2) does the integration of primary and behavioral health care lead to improvements in the mental and physical health of the population with serious mental illnesses and/or substance use disorders served by these integrated models; 3) which models of integrated primary and behavioral health care lead to better mental and physical health impacts for the population served.

In FY 2010, SAMHSA, in partnership with the Health Resources and Services Administration (HRSA), funded a Training and Technical Assistance Center for Primary and Behavioral Health

Care Integration (TTA-PBHCI). The purpose of this program is to serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development. The TTA-PBHCI grantee will be expected to provide support in two core areas: 1) technical assistance and support to SAMHSA and HRSA grantees and 2) serve as a national technical assistance resource to the general public including generating and disseminating best practice materials from Federal partners such as HRSA, Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH) and other partners.

Community Resiliency & Recovery Initiative (CRRI)

Program Description and Accomplishments

In FY 2010 SAMHSA initiated the Community Resilience and Recovery Initiative (CRRI) grant program and awarded three grants over the next four years to support this initiative. This place-based initiative seeks to support evidence-based early interventions to address behavioral health problems, such as increased substance and alcohol use, family violence and increased incidence of mental health problems for individuals and communities experiencing heightened levels of stress, anxiety, and grief related to the economic downturn. This includes the opportunity to support collaboration with community law enforcement and drug courts where appropriate. This Initiative places a special focus on communities facing significant increases in unemployment.

Suicide Lifeline

Program Description and Accomplishments

The National Suicide Prevention Lifeline, 1-800-273-TALK, coordinates the network of 147 crisis centers across the U.S. providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night.

The National Suicide Prevention Lifeline routes calls from anywhere in the U.S. to a network of certified local crisis centers that can link callers to local emergency, mental health, and social services resources, averaging nearly 54,000 calls per month answered. In July 2007, SAMHSA partnered with the Department of Veterans Affairs to provide and ensure 24/7 access to a veterans suicide prevention hotline. This hotline has answered an average of more than 6,000 calls from veterans per month and more than 700 calls per month from veteran's families. The National Suicide Prevention Lifeline is also responding to calls from active duty military and their families. In addition, the Lifeline has been increasingly responding to letters and emails sent to the White House from people in crisis for a variety of reasons, including the impact of the economic downturn. SAMHSA is in the process of developing a suicide hotline outcome measure to determine the number of people who contacted the Lifeline who believe the call prevented them from taking their lives. This new data collection will help inform SAMHSA and HHS on the vital impact the Lifeline is having across the Nation.

In September 2008, SAMHSA awarded six grants to the National Suicide Prevention Lifeline crisis centers to provide follow up to suicidal callers. Evaluation and research findings indicate

that the immediate aftermath of suicidal crises is a time of heightened risk for suicide but has great potential for suicide prevention. Preliminary data from this program indicate that when asked by an independent evaluator "To what extent did the counselor's calling you stop you from killing yourself," more than 50% of those receiving follow up phone contact responded "a lot." In FY 2010, SAMHSA added six more crisis center grants to continue to help address the need for critical follow up services and supports for people contacting the Lifeline.

GLS Youth Suicide Prevention

Program Description and Accomplishments

The Garrett Lee Smith (GLS) Memorial Act authorizes SAMHSA to manage two significant youth suicide prevention programs and a resource center. The GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program currently supports 35 States, 16 Tribes or Tribal organizations, and one Territory in developing and implementing youth suicide prevention and early intervention strategies involving public-private collaborations among youth serving institutions. The GLS Campus Suicide Prevention program currently provides funding to 38 institutions of higher education to prevent suicide and suicide attempts. The GLS Suicide Prevention Resource Center develops effective strategies and best practices to ensure the field has access to the most crucial information. SAMHSA supports an innovative training and technical assistance project that helps tribal communities mobilize existing social and educational resources by facilitating the development and implementation of comprehensive and collaborative community based prevention plans to reduce violence, bullying, and suicide among American Indian /Alaska Native youth.

The importance of suicide prevention measures during this difficult economic time cannot be overstated. Researchers have shown a relationship between sustained high rates of unemployment and increased risk for and incidence of suicide. In calendar year 2010, the Lifeline answered 691,874 calls, an average of 1,896 calls per day from people at risk for suicide, more than 60,000 in the last recorded month alone. Between 30-40% of the calls are linked to economic distress or concerns about unemployment. National Suicide Prevention Lifeline crisis centers across the nation are responding to people in suicidal crises. Urgent supplemental funding was provided to the crisis centers in 2009 as well. At the same time these centers are threatened with significant cutbacks in funding from State and local governments and other sources of support.

SAMHSA supports an array of initiatives designed to improve public and professional awareness of suicide as a preventable public health problem and to enhance the ability of systems that promote prevention, intervention, and recovery. Each of the five major grant programs in SAMHSA's suicide prevention portfolio advances the National Strategy for Suicide Prevention.

In addition to programs that build suicide prevention capacity, SAMHSA also supports the Suicide Prevention Resource Center. This initiative promotes the implementation of the National Strategy for Suicide Prevention and enhances the nation's mental health infrastructure by providing States, government agencies, private organizations, colleges and universities, and suicide survivor and mental health consumer groups with access to the science and experience that can support their efforts to develop programs, implement interventions, and promote policies

to prevent suicide. The Suicide Prevention Resource Center works with and supports prevention networks to reduce suicides, community by community. Prevention networks are coalitions of organizations and individuals working together to promote suicide prevention including State-wide or tribal coalitions, community task forces, regional alliances, and professional groups.

AI/AN Suicide Prevention

Program Description and Accomplishments

SAMHSA supports an innovative training and technical assistance project that helps tribal communities mobilize existing social and educational resources by facilitating the development and implementation of comprehensive and collaborative community based prevention plans to reduce violence, bullying, and suicide among American Indian/Alaska Native youth. To date, nearly 200,000 Tribal members in 20 communities and 2,100 Alaska Natives in five villages have been provided specialized technical assistance and support in suicide prevention and related topic areas for these communities. In addition, over 750 community members were trained in prevention and mental health promotion in these communities.

Homelessness Prevention and Housing Program

Program Description and Accomplishments

Homelessness can be prevented. Current estimates for the number of people experiencing homelessness on any given night in the U.S. is approximately 664,000 of which 124,000 are single adults who are chronically homeless. Approximately 30 percent of the chronically homeless population has a serious mental illness and around two-thirds have a primary substance use disorder or other chronic health condition that create major difficulties in accessing and maintaining stable, affordable, and appropriate housing.

The goal of SAMHSA's Strategic Initiative on Recovery Support is to provide supportive permanent housing and reduce the barriers that homeless persons with mental and substance use disorders and their families experience when accessing effective programs that sustain recovery and permanent supportive housing. Two programs are helping to suppor the goals of this Strategic Initiative. The Grants for the Benefit of Homeless Individuals (GBHI) program was created to enable communities to expand and strengthen their treatment services for homeless individuals with substance use disorders, or with co-occurring substance use and mental disorders. SAMHSA will fund programs that demonstrate treatment effectiveness in serving homeless, runaways, street youth, and homeless veterans and move them to transition into permanent supportive housing. Funds are also used to expand and strengthen substance abuse treatment services for homeless, alcohol-dependent persons who have histories of public inebriation, frequent emergency room visits, and arrests. Services include outreach, screening and assessment, referral, direct treatment, and wrap-around services, all directed to permanent and stable housing.

The Services in Supportive Housing (SSH) program was created to help end chronic homelessness by funding treatment and support services to individuals and families in coordination with permanent supportive housing programs and resources. The SSH program provides comprehensive services that focus on outreach, engagement, intensive case management, mental health services, substance abuse treatment, benefits support, and linkage to permanent housing. The target population is individuals and families with severe mental illness or a co-occurring mental and substance use disorder who have been continuously homeless for at least one year or have had at least four episodes of homelessness in the past three years.

The SSH program helps to prevent or reduce chronic homelessness by funding wrap-around services for individuals and families experiencing chronic homelessness in coordination with existing permanent supportive housing programs and resources. This innovative approach provides intensive individualized support services to people with serious psychiatric conditions and those with co-occurring mental and substance use disorders and linkages to housing resources. Research indicates that this combination of long-term housing and wrap-around services leads to improved residential stability and reductions in psychiatric symptoms (Shern, et al., 1994). This program provides individuals and families who experience chronic homelessness the appropriate services and treatment needed to stay housed in a permanent setting.

As of January 2011, the SSH grantees have provided cumulatively over 3,605 persons with comprehensive and coordinated mental health and related services. More than half (55 percent) of the people served demonstrated improvement in behavioral functioning and represent. With the expansion of the SSH program in FY 2010, SAMHSA expects to triple the number of individuals provided supportive housing services and provide needed supports to their family members. Five new SSH grants were awarded in FY 2010.

The FY 2012 Budget request for this program is aligned with "Opening Doors: the Federal Strategic Plan to Prevent and End Homelessness" which was released in June 2010. This program is an essential piece to accomplishing the goals of the Plan.

Minority AIDS

Program Description and Accomplishments

The purpose of the Minority AIDS program is to enhance and expand the provision of effective, culturally competent HIV/AIDS-related mental health services in minority communities for persons living with HIV/AIDS and having a mental health need. The Centers for Disease Control and Prevention (CDC) reports significantly higher rates of HIV/AIDS among people of color. Blacks accounted for 51 percent and Hispanics accounted for 18 percent of all HIV/AIDS cases diagnosed in 2007 in the 34 States with name-based reporting (CDC, 2009). Psychiatric and psychosocial complications frequently are not diagnosed or addressed either at the time of diagnosis or through the course of the HIV/AIDS disease process. When untreated, these complications are associated with increased morbidity and mortality, impaired quality of life, and

numerous medical and/or behavioral challenges, such as non-adherence with the treatment regimen. Eligible applicants are domestic public and private nonprofit entities.

Criminal & Juvenile Justice Programs

Program Description and Accomplishments

Data from the 2008 National Survey on Drug Use and Health show that there were 10.6 million adults aged 18 or older who reported an unmet need for mental health care in the past year. This included 5.1 million adults who did not receive any mental health services in the past year. The data also show that of the 2.5 million Americans with co-occurring serious mental illiness (SMI) and substance abuse disorder, over one third (39.5%) of these adults received no treatment at all. Studies of criminal populations have found even higher rates of co-occurring psychiatric and substance use disorders than the general population.[1]

Since 2002, SAMHSA has administered the Jail Diversion Program for Adults involved in the criminal justice system and has awarded grants to 40 States and communities. Over the past 30 years, the criminal justice system has become a repository for a large number of individuals with SMI who are arrested for a wide range of crimes[2]. The purpose of this initiative is to divert individuals with mental illness from the criminal justice system to more appropriate, community-based treatment and recovery support related services including primary health care, housing, and job counseling/placement. In 2008, the Jail Diversion Program expanded focus to include individuals with trauma-related mental disorders in an effort to reach the growing number of individuals with post-traumatic stress disorder involved in the criminal justice system, with a specific priority for veterans. The program also limited eligibility to States to pilot local diversion programs and replicate them State-wide. To date, grantees have conducted over 79,000 screenings and diverted over 3,300 persons with mental illness from jail to community treatment services. Nineteen of the 24 earliest grantees continued their programs after SAMHSA funding ended.

Practice Improvement/Training

Program Description and Accomplishments

SAMHSA addresses the need for disseminating key information such as best-practices and evidence base to the mental health delivery system and achieving health care reform by engaging in activities that support the mental health system transformation and reform. These activities include Historically Black Colleges and Universities (HBCU) – Center of Excellence, Elimination of Mental Health Disparities, and Peer Review activities.

The purpose of the HBCU - Center of Excellence is to network the 103 HBCUs throughout the U.S. and promote workforce development through expanding knowledge of best practices,

[1] Serious Mental Illness and Arrest, Swartz and Lurigio, 2007

[2] Serious Mental Illness and Arrest, Swartz and Lurigio, 2007

leadership development and encouraging community partnerships that enhance the participation of African-Americans in the substance abuse treatment and mental health professions. The comprehensive focus of the HBCU – Center for Excellence will simultaneously expand service capacity on campuses and in other treatment venues. The goals of the HBCU-Center for Excellence are to: expand and enhance the existing national network of HBCUs to foster the development of programs, and to facilitate collaboration and the exchange of information related to substance abuse and mental health; provide culturally appropriate substance abuse and mental health disorder resources to HBCUs; and to promote workforce development in substance abuse and mental health by exposing HBCU students to a wide range of opportunities in the field, including, but not limited to internships, mentoring and leadership trainings.

Consumer & Consumer Support TA Centers

Program Description and Accomplishments

Consumer and Consumer Supported TA Centers foster a recovery-oriented, consumer-driven system of care to enhance consumer self-determination and recovery by helping people decrease their dependence on expensive social services and avoid inappropriate use of inpatient hospitalization through the use of alternative interventions. The program helps improve collaboration among consumers, families, advocates, providers and administrators which facilitates transforming community mental health services to be more consumer driven and family focused.

Minority Fellowship Program (MFP)

Program Description and Accomplishments

In a partnership of CMHS, CSAP and CSAT, this program increases the knowledge of issues related to ethnic minority mental health and substance use disorders, as well as improves the quality of mental health and substance abuse prevention and treatment delivered to ethnic minorities by providing stipends to doctoral level students to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental health/substance abuse services to underserved minority populations. 125 individuals were trained in FY 2009. Since its start in 1973, the Minority Fellowship Program (MFP) has helped to support doctoral-level training of ethnic minority psychiatrists, psychologists, psychiatric nurses, and social workers. These individuals often serve in key leadership positions in mental health and substance abuse direct services, services supervision, services substance direct services, services supervision, services research, training, and administration.

Disaster Response

Program Description and Accomplishments

The Emergency and Disaster Mental Health National Technical Assistance Center supports individuals and communities faced with the behavioral health impact of natural and man made disasters. In addition, this National Center supports the FEMA Crisis Counseling Assistance. The FEMA Crisis Counseling Assistance and Training Program (CCP) is an inter-agency agreement between SAMHSA and the Federal Emergency Management Agency (FEMA) that supplies supplemental financial assistance to provide crisis counseling services to disaster survivors to promote recovery and mitigate the need for traditional behavioral health services. These counseling services assist individuals and communities in recovering from the challenging effects of natural and human caused disasters through the provision of community-based outreach and psycho-educational services. CCP provided over 1.2 million face-to-face encounters in FY 2008. In October 2009, the CCP Online Data Collection and Evaluation System was released and is a significant advancement for the CCP's data collection.

IEI - CMHS Funding History*

FY	Amount
2007	$251,447,000
2008	$274,154,000
2009	$315,883,000
2010	$327,842,000
2011	$327,689,000

* The funding history is based on a comparable basis to previous funding levels to reflect the revised budget restructure.

Budget Request

The FY 2012 President's Budget request is $270.9 million, a decrease of $56.9 million from the FY 2010 Level. The request will support 306 grant and 35 contract continuations, as well as 73 new grants and five new contracts. The funding level enables the continuation of most programmatic activities. The Older Adults program will be terminated. Ten new NCTSN grants, 19 GLS-States grants, 21 GLS-Campus grants, 22 Homelessness Prevention grants (including 12 new HHS/HUD Homelessness Prevention and Housing Initiative), and one new Suicide Lifeline grant will be awarded. The Budget phases out funding for new awards, including: Children and Family Programs, Consumer and Family Network Grants, Mental Health System Transformation and Health Reform, and Practice Improvement and Training. No continuing grant awards will be terminated. SAMHSA will work with the States to use their Block Grant and Substance Abuse and Mental Health Prevention Grants to implement the practices learned from these programs.

Outcomes and Outputs

Co-Occurring State Incentive Grants
As the Co-Occurring State Incentive Grants are coming to an end in FY 2009 and no new grants are planned, performance measures for this program will no longer be reported.

Youth Violence Prevention

Table 1: Key Performance Indicators for Youth Violence Prevention

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.2.04: Number of children served *(Outcome)*	FY 2010: 2,328,500 (Target Met)	2,328,500	2,328,500	Maintain
3.2.10: Percentage of students who receive mental health services *(Outcome)*	FY 2010: 59.3% (Target Not Met)[3]	66%	66%	Maintain
3.2.29: Percentage of middle and high school students who have been in a physical fight on school property *(Outcome)*	FY 2010: 19.0% (Target Exceeded)	27.0%	27.0%	Maintain
3.2.30: Percentage of middle and high school students who report current substance abuse *(Outcome)*	FY 2010: 24.0% (Target Exceeded)	20.0%	20.0%	Maintain

[3] This number includes data from a large cohort of grantees funded in 2009. The 2010 result is derived from 60 new grantees and 27 continuing grantees. Full implementation of services does not occur until later in 1st year of program. Thus decrease may reflect the impact of the larger new cohort.

National Child Traumatic Stress Initiative (NCTSI)

Table 2: Key Performance Indicators for National Traumatic Stress Network

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.2.02: Percentage of children receiving services showing clinically significant improvement (HHS Strategic Plan Measure) *(Outcome)*	FY 2010: 43% (Target Not Met)[4]	69%	69%	Maintain
3.2.23: Unduplicated count of the number of children and adolescents receiving trauma-informed services *(Outcome)*	FY 2010: 1,959 (Target Not Met but Improved)	3,217	480	-2,737
3.2.24: Number of child-serving professionals trained in providing trauma-informed services *(Outcome)*[5]	FY 2009: 95,186 (Target Not Met but Improved)	100,800	23,800	-77,000

[4] Lower number reflects a return to the methodology used to calculate GPRA that was originally used in FY 2006.

[5] FY 2010 data is not available due to transfer to TRAC system data collection. Data will be available for FY 2011.

Mental Health System Transformation Grants

Key Performance Indicators for Mental Health System Transformation Grants[6,7,8]

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.11: Number of persons in the mental health and related workforce trained in specific mental-health related practices/activities as a result of the grant *(Outcome)*	FY 2010: 60,924 (Target Exceeded)	746	2,000	+1,254

Suicide Prevention

Table 3: Key Performance Indicators for Suicide Prevention Activities

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
2.3.59: Total number individuals trained in youth suicide prevention[9] *(Outcome)*	FY 2010: 35,371 (Target Met)	35,371	35,371	Maintain
2.3.60: Total number of youth screened[10] *(Output)*	FY 2010: 3,729 (Target Exceeded)	3,360	3,360	Maintain
2.3.61: Number of calls answered by the suicide hotline *(Output)*	FY 2010: 664,932 (Target Exceeded)	555,132	555,132	Maintain

[6] Program was formally known as Mental Health State Incentive Grants for Transformation

[7] This program is still under development and performance measures will be added once the program is finalized. In the interim, targets for FY 2012 and FY 2013 have been included and are subject to change.

[8] FY 2011 targets for this program drop off due to grants coming to a natural end.

[9] This measure has been revised for the FY 2011 President's Budget. Previously the measure was cumulative. It has been revised to report its data annually. As a result, targets for FY 2009 and 2010 were adjusted and data provided here may appear to differ from those previously published.

[10] This measure has been revised for the FY 2011 President's Budget. Previously the measure was cumulative. It has been revised to report its data annually. As a result, targets for FY 2009 and 2010 were adjusted and data provided here may appear to differ from those previously published in the FY 2010 President's Budget.

Mental Health Services – Homelessness Programs

Table 4: Key Performance Indicators for Mental Health Homelessness Prevention Programs[11]

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.4.01: Number of clients served *(Output)*	FY 2010: 3,491 (Target Exceeded)	2,262	2,734	+472
3.4.02: Percentage of adults receiving services who report improved functioning *(Outcome)*	FY 2010: 63.9% (Target Not Met but Improved)	68.4%	68.4%	Maintain
3.4.03: Percentage of adults receiving services who were currently employed *(Outcome)*	FY 2010: 13.7 % (Target Not Met but Improved)	15.6%	15.6%	Maintain
3.4.05: Percentage of adults receiving services who had a permanent place to live in the community *(Outcome)*	FY 2010: 79.4 % (Target Exceeded)	60.6%	74.2%	+13.6%
3.4.06: Percentage of adults receiving services who had improved social support *(Outcome)*	FY 2010: 70 % (Target Not Met but Improved)	78 %	78 %	Maintain

[11] Prior to FY 2010 president's Budget, Homelessness data was reported in the CMHS Other Capacity table

Key Performance Indicators for Mental Health – Other Capacity[12]

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.05: Percentage of clients receiving services who report improved functioning *(Outcome)*	FY 2010: 52.7% (Target Not Met)	54%	54%	Maintain
1.2.82: Percentage of clients receiving services who had a permanent place to live in the community *(Outcome)*	FY 2010: 74.4 % (Target Exceeded)	67.7 %	67.7 %	Maintain
1.2.83: Percentage of clients receiving services who are currently employed *(Outcome)*	FY 2010: 17.2 % (Target Exceeded)	14.0 %	14.0 %	Maintain

Table 5: Key Performance Indicators for Mental Health – Science and Service Activities[13,14]

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.4.06: Number of people trained by CMHS Science and Service Programs *(Output)*	FY 2010: 5,835 (Target Exceeded)	4,237	3,390	-847
1.4.08: Percentage of participants who report implementing improvements in treatment methods on the basis of information and training provided by the program *(Outcome)*	N/A	N/A	N/A	N/A

[12] Prior to 2008, includes Jail Diversion, Older Adults, HIV/AIDS, and Services in Supportive Housing programs. Beginning in 2009, data from Services in Supportive Housing will be reported under Homelessness Activities. In 2010, Primary and Behavioral Health Care Integration and Healthy Transitions was added.

[13] Prior to 2008, includes HIV/AIDS education and Historically Black Colleges and Universities National Resource Center for Substance Abuse and Mental Health.

[14] In the FY 2010 President's Budget it was erroneously noted that Statewide Family/Consumer TA Center contributed to the Science and Services measures. This is not the case and thus has been removed from the list of participating programs.

Measure	Most Recent	FY 2011	FY 2013	FY 2013
1.4.09: Number of individuals trained by SAMHSA's Science and Services Program (HHS Strategic Plan Measure) *(Output)*	FY 2010: 38,624 (Historical Actual)[15]	N/A	N/A	N/A

Grant Award Table

(Whole Dollars)	FY 2010	FY 2011	FY 2012
Number of Awards	476	482	332
Average Award	$408,817	$410,703	$393,127
Range of Awards	$15,000-$6,000,000	$15,000-$6,000,000	$15,000-$6,000,000

[15] NOTE: Data are preliminary and do not reflect all program accomplishments during FY 2010. Reporting periods for component programs vary and, therefore, are complete for only a portion of them. Final data for all programs will be available in August 2011.

SAMHSA Innovation and Emerging Issues
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SAMHSA/Center for Substance Abuse Prevention
Innovation & Emerging Issues

Summary of Programs

The Substance Abuse Prevention Innovation & Emerging Issues programs (IEI) support States and communities in carrying out an array of activities to improve the quality and availability of services in priority areas. The FY 2012 President's Budget request for SAMHSA Substance Abuse Prevention IEI includes $69.4 million which covers five programmatic activities, a decrease of $6.1 million from the FY 2010 Continuing Resolution. The request includes:

- $41.4 million for Minority AIDS Initiative (MAI) to continue delivering and sustaining high quality and accessible substance abuse and HIV prevention services in the form of continuation grants;

- $7.0 million for Sober Truth on Preventing Underage Drinking (STOP Act) to continue to provide grants to organizations that are currently receiving or have received grant funds under the Office of National Drug Control Policy's Drug-free Communities Act of 1997 to either enhance an existing focus or to add a focus on preventing underage drinking;

- $4.4 million for Science and Service Program Coordination which primarily supports two key technical assistance contracts that enable SAMHSA to focus on two critical issues: assisting Tribes in obtaining support and implementing outreach to complement the Tribal Prevention Grant; development and implementation of policy changes to prevent underage drinking.

- $8.0 million for the Fetal Alcohol Spectrum Disorders (FASD) initiative to continue efforts to prevent Fetal Alcohol Spectrum Disorder and increase functioning and quality of life for individuals and their families impacted by these disorders.

- $8.5 million to continue provision of technical assistance to maximize effectiveness through the Centers for the Application of Prevention Technologies.

The Substance Abuse Prevention IEI underwent a program assessment in 2004. The assessment cited strong purpose and design, ambitious targets, and strong program management as key attributes of the program. Since the program assessment, the program has implemented the Strategic Prevention Framework, has refined its outcome measures, and has improved data collection and reporting.

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SAMHSA/ Center for Substance Abuse Prevention
Mechanism Table by APT
(Dollars in Thousands)

	FY 2010 Actual		FY 2011 CR		FY 2012 Pres. Budget	
	No.	Amount	No.	Amount	No.	Amount
Innovation and Emerging Issues						
Grants/Cooperative Agreements:						
Continuations	159	25,161	225	44,501	222	43,919
New/Competing	82	22,666	1	3,950	0	0
Subtotal	**241**	**47,827**	**226**	**48,451**	**222**	**43,919**
Contracts:						
Continuations	10	24,048	11	27,076	10	25,457
New	3	3,563	0	0	0	0
Subtotal	**13**	**27,611**	**11**	**27,076**	**10**	**25,457**
Subtotal, Innovation and Emerging Issues	**254**	**$75,438**	**237**	**$75,527**	**232**	**69,376**

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SAMHSA/Innovation and Emerging Issues - Substance Abuse Prevention
(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
MAI.....			
STOP Act.....			
Congressional Projects			
Science & Service Program Coordination.....			
Fetal Alcohol Center of Excellence.....			
Center for the Application of Prevention Technologies.			
Minority Fellowship Programs.....			

Authorizing Legislation ..... Section 516, 519B, 519E, 520A of the PHS Act

FY 2012 Authorization .....Expired

Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts

Minority AIDS Initiative (MAI)

Program Description and Accomplishments

SAMHSA/CSAP's Minority AIDS Initiative (MAI), implemented in FY 1999, supports efforts to reduce health disparities in minority communities by delivering and sustaining high quality and accessible substance abuse and HIV prevention services. The program strategies include implementing evidence-based prevention practices targeting subpopulations, conducting HIV testing and referral for treatment, and preventing/reducing the risk of substance use disorders and/or HIV. Grantees are required to target one or more high-risk populations such as African American women, adolescents, or individuals who have been released from prisons and jails within the past two years.

The MAI has funded ten cohorts of grants, with currently 122 active grants funded from cohorts six through ten, from FY 2005-2010. All grantees are required to use SAMHSA's Strategic Prevention Framework as the model on which they develop their long-range and annual strategic plans for delivering prevention services. Program results show an increase of participants' awareness of the risk of substance use and HIV, increased numbers of people undergoing HIV tests, and a decrease in participants' use of alcohol or illicit drugs. In FY 2010, SAMHSA developed two new grant programs (the *Capacity Building Initiative* and the *Ready To Respond Initiative*). Within each sub-program, grantees select an at-risk population to target:

- The *Capacity Building Initiative* targets 18-24 year old at-risk populations, including minority students on college campuses;

- The *Ready To Respond Initiative* allows experienced grantees that have successfully provided evidence-based substance abuse and HIV prevention services through the Strategic Prevention Framework to expand those services to a high-risk subpopulation.

Sober Truth on Preventing Underage Drinking Act (STOP Act)

Program Description and Accomplishments

The Sober Truth on Preventing Underage Drinking Act (STOP Act), signed into law in 2006, is the nation's first comprehensive legislation on underage drinking. It establishes a national media campaign aimed at underage drinking, funds underage-drinking programs in communities, and prevents underage drinking by bolstering community-based coalitions.

This program provides grants to organizations that are currently receiving or have received grant funds under the Office of National Drug Control Policy's Drug-free Communities Act of 1997 to either enhance an existing focus or to add a focus on preventing underage drinking. This program will strengthen the collaborative efforts and increase participation among all stakeholders (e.g., community organizations, coalitions, local and State governments). The initial program, funded in FY 2008, provided 79 four year grants to local communities with up to $50,000 per community per year. In FY 2010, a total of 99 grants received funding under this initiative to strengthen these important efforts.

Another component of the STOP Act is the National Adult-Oriented Media Public Services Campaign, with funding of $1 million in FY 2010. The Underage Drinking Prevention campaign urges parents to speak with their children, age 11-15, about underage drinking in order to delay the onset of and ultimately reduce underage drinking. Nationwide, more than 37 percent of the estimated 10.1 million underage drinkers were provided free alcohol by adults 21 or older (2008 NSDUH). Research shows that parents of teens generally underestimate the extent of alcohol used by youth and its negative consequences, with the vast majority viewing underage drinking as "inevitable." Many parents also find it difficult to know how or when to start a conversation with their children about underage drinking. Through TV, radio, print and outdoor activities, SAMHSA's multicultural campaign seeks to overcome parents' misperceptions about underage drinking by creating a greater urgency around the issue and encourages them to communicate with their children about alcohol at an early age. Parents and viewers are encouraged to visit www.stopalcoholabuse.gov, funded through the media campaign, to get information about teens and alcohol, as well as tips on how to initiate conversations with their children about underage drinking.

The third important component of the STOP Act is the Federal Interagency Coordinating Committee on the Prevention of Underage Drinking, with funding of $1 million in FY 2010. The Committee will support planning for the Annual Report on State Underage Drinking Prevention and Enforcement Activities. The development of this report will include some of the information required in the STOP Act, as well as starting work on the development of a plan to improve the collection, measurement, and consistency of reporting Federal underage alcohol data. In FY 2008, 40 percent of coalitions reported at least a five percent improvement in past 30-day alcohol use in at least two grades.

These activities together can enhance and expand the capacity of community coalitions through establishing and strengthening collaborations with communities, private non-profit agencies, Federal, State, local and tribal governments to enhance intergovernmental cooperation and coordination on the issue of underage drinking.

Fetal Alcohol Spectrum Disorders (FASD)

Program Description and Accomplishments

The Fetal Alcohol Spectrum Disorder (FASD) Center for Excellence, initiated in 2001, is the largest alcohol abuse prevention initiative within SAMHSA. The FASD Center for Excellence identifies and disseminates information about innovative techniques and effective strategies for preventing FASD and increases functioning and quality of life for individuals and their families impacted by these disorders. The FASD Center for Excellence identifies gaps and trends in the field, synthesizes findings, and develops appropriate materials about FASD for health and social service professionals, communities, States, and tribal organizations. The FASD Center of Excellence has provided more than 550 trainings, technical assistance events, and consultations to approximately 24,000 individuals in the U.S., Territories, and internationally. One of the FASD Center of Excellence's key early activities was to establish a database of FASD materials. This database is now searchable and contains more than 13,000 resources, including FASD literature, publications, posters, and public service announcements (PSAs). The FASD Center of Excellence also disseminates information through a FASD web site and an information resource center hotline, through which it responds to inquiries and contacts from individuals around the world.

The FASD Center for Excellence is advancing the field of FASD prevention and treatment by learning what works in States and communities with specific populations using evidence-based interventions. Fifteen local, State and juvenile courts are implementing prevention programs and eight are implementing diagnosis and intervention programs. All programs are completing their second year of implementation. Key current activities include:

- Achieving buy-in from stakeholders and partners;
- Attending trainings and technical assistance calls to strengthen techniques for implementing the interventions and to address questions resulting from implementation;
- Implementing data collection, storage, and reporting mechanisms developed to support evaluation activities;
- Implementing screening and program services to eligible women and children;
- Convening task forces meetings to provide ongoing direction and feedback on implementation and evaluation issues; and
- Refining plans for the upcoming year based on lessons learned in the first two years.

In addition, SAMHSA is and will continue to work in conjunction with the Centers for Disease Control and Prevention (CDC) on FASD-related initiatives.

Center for the Application of Prevention Technologies (CAPTs)

Program Description and Accomplishments

In existence for more than a decade, the Center for the Application of Prevention Technologies (CAPT) promotes state-of-the-art behavioral health prevention technologies through three core strategies: 1) establishment of technical assistance networks using local experts from each of their five regions; 2) development of training activities; and 3) innovative use of communication media such as teleconference and video conferencing, online events, and Web-based support. These training and technical assistance activities are designed to build the capacity of SAMHSA grantees and develop the skills, knowledge, and expertise of their prevention workforce. These activities will help support the delivery of effective prevention programs and practices and the development of accountability systems for performance measurement and management. Through interagency agreements, the CAPT also provides training and technical assistance to additional client groups such as the U.S. Department of Education's Grants to Reduce Alcohol Abuse Program.

The CAPT promotes a 3-tiered strategic approach to effective prevention throughout the provision of their skill-building training and capacity-building technical assistance: 1) build capacity at the State or grantee level, 2) prepare States to roll out the Strategic Prevention Framework process at the local level, and 3) work directly with States and their communities to select and implement effective prevention programs and practices, integrate prevention efforts across State systems, and sustain these efforts.

During FY 2009, the CAPT devoted 18,000 hours to provide 1,427 capacity-building technical assistance services to 5,243 individuals representing 350 organizations, resulting in the delivery of 100,000 hours of client service. In addition, it delivered 535 on-site and web-based events to advance SAMHSA's Strategic Prevention Framework priorities, the majority of which were skill development trainings and training-of-trainers. Collectively, the CAPT provided 3,745 hours of training to 14,226 individuals from 60 States, Territories, and Tribes. Ninety-eight percent of recipients of substantive CAPT services reported that the service had been useful to them in their work, and ninety-four percent reported that the service substantively enhanced their ability to provide effective prevention services.

Science and Service Program Coordination

Program Description and Accomplishments

The Science and Service Program Coordination category primarily supports two key contracts that enable SAMHSA to address two critical issues: Native American substance abuse prevention, and underage drinking.

The Native American Center for Excellence (NACE) supports behavioral health outreach activities to Tribal nations and organizations to help them to apply for SAMHSA and other Federal agency grants and to have a clear understanding of the need for coordinating prevention

funding, establishing and implementing prevention policies and evidence-based programs, utilizing strategic planning, and developing infrastructure. The Center also provides technical assistance to these communities to develop and implement their outreach activities. In addition, the NACE website and environmental scan report, collect, and disseminate information on both cultural- and evidence-based prevention and intervention strategies for the public, grantees, and grantors.

NACE has developed training and technical assistance to build learning communities of tribal members, content experts, and other stakeholders. In addition, NACE continues to build content expertise and knowledge dissemination in five prevention domains (youth, community, family, schools, and Tribal leaders/policy) through routine literature reviews, focused peer-to-peer discussion groups, and development of technical papers and abstracts. NACE also supports SAMHSA's efforts to expand eligibility to grant programs to Federally-approved Tribal organizations through technical assistance and developing linkages between Native communities as mentors in this effort. This program will support the Tribes in the implementation of the new Tribal Prevention Grant.

The Underage Drinking Prevention Education Initiative combats underage drinking and provides effective and appropriate prevention programs, activities, and strategies. In addition, it supports States and their communities by providing training to get the community organized, build capacity, and plan for sustainability around the prevention of underage alcohol use. The funding assists in reaching out to more than 50 million families, their children, and other youth-serving organizations through town-hall meetings, technical assistance, guidance, activities, information about promising approaches, and materials and tools that help concerned members of the community organize around underage drinking issues.

The Underage Drinking Prevention Education Initiative engages parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences. In 2010, this initiative supported a national forum to bring together States from the Governor's level to begin a dialogue around State plans for addressing the underage drinking issue in each State. In addition, funds will be provided to support efforts to mobilize States and their communities, families, and youth with the opportunity to engage in discussion on the seriousness of underage drinking as a public health issue and the strategies needed to reduce and prevent youth alcohol use. The initiative will also work with the STOP Act grantees to continue the synergy that was created through previous town hall meetings and the national forum in implementing appropriate activities and strategies to prevent underage drinking.

Funding History*

FY	Amount
2007	$ 65,949,000
2008	$ 72,120,000
2009	$ 73,910,000
2010	$ 75,438,000
2011	$ 75,527,000

* The funding history is based on a comparable basis to previous funding levels to reflect the revised budget restructure.

Budget Request

The FY 2012 President's Budget request is $69.4 million, a decrease of $6.1 million from the FY 2010 level. The request will support 222 grants and 10 contracts. This level of funding enables the continuation of all programmatic activities. No continuing grant awards will be terminated. SAMHSA will work with the States to use their Block Grant and Substance Abuse and Mental Health Prevention Grants to implement the practices learned from these programs.

Outcomes and Outputs

Minority AIDS Initiative: Substance Abuse Prevention, HIV Prevention and Hepatitis Prevention for Minorities and Minorities Re-entering Communities Post-Incarceration (HIV)

Table 1: Key Performance Indicators for Minority AIDS Initiative[1,2,3]

Measure	Most Recent	FY 2011	FY 2013	FY 2013
2.3.56: Number of individuals exposed to substance abuse/hepatitis education services *(Output)*	FY 2009: 3,431 (Target Exceeded)	1,535[4]	1,535	Maintain

[1] Previously, data collected in a given FY were reported in the following year. For example, results for 2008 would reflect data collected in 2007. In order to achieve consistency across SAMHSA, reporting has been revised so that results for a given FY reflect data actually collected in that year, except where otherwise noted.

[2] HIV Cohort 7 serves different population groups so baseline data from this cohort will be established and entered in FY 2011.

[3] The out years of this program are under development and performance measures will be added once the program is finalized. In the interim, targets for FY 2011 and FY 2012 have been included and are subject to change.

[4] This measure is expected to decline and change from substance abuse/hepatitis education to substance abuse/HIV education in FY 2011 following the close-out of Cohort 6 grants and newer Cohorts not yet functioning at optimum levels. Cohort 7 and later cohorts are not focusing on hepatitis education, but rather focusing on HIV education.

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
2.3.82: Percent of program participants that rate the risk of substance abuse as moderate or great (all ages) *(Outcome)*	FY 2009: 94.4 % (Baseline)	94.4 %	94.4 %	Maintain
2.3.83: Percent of program participants who report no use of alcohol at pre-test who remain non-users at post-test (all ages) *(Outcome)*	FY 2009: 91.2 % (Baseline)	91.2 %	91.2 %	Maintain
2.3.84: Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (all ages) *(Outcome)*	FY 2009: 92.6 % (Baseline)	92.6 %	92.6 %	Maintain

Sober Truth on Preventing Underage Drinking

Table 2: Key Performance Indicators for Sober Truth on Preventing Underage Drinking (STOP Act)

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.3.01: Percentage of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades[5] *(Outcome)*	FY 2009: 53.3% (Target Exceeded)	41%	46.7%	+5.7%

[5] The FY 2010, 2011, 2012, and 2013 targets were based on the baseline number calculated last year using FY 2008 data (40.0%). This baseline is based on data submitted by these coalitions before they were awarded a STOP Act grant. Starting with FY 2009, CSAP is evaluating the impact of STOP Act funds on the outcome measures. To do this for the FY 2009 calculation, CSAP selected coalitions that submitted data collected after their STOP funds had a chance to make an impact. The cutoff point was 3 months after receipt of the grant award. Any data collected before that date were considered inappropriate for assessing the impact of STOP funds. Only 17 coalitions met this criterion in FY 2009 so the 53.3% is based on that very small number of grantees. Conversely, the baseline figure (40%) was based on data from a larger number of grantees, so CSAP has higher confidence in that number. Altering the targets through 2013 based on the small N in the 2009 data reported to date would probably result in targets that are not as realistic as the 41% based on a more representative sample of coalitions. For this reason, CSAP recommends keeping the targets as they are until more robust actuals can be collected.

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.3.02: Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades *(Outcome)*	FY 2009: 53.8% (Target Not Met)	63.4%	63.4%	Maintain
3.3.03: Percentage of coalitions that report improvement in youth perception of parental disapproval on the use of alcohol in at least two grades *(Outcome)*	FY 2009: 42.9% (Target Not Met)	56.7%	56.7%	Maintain

Science and Service Program Coordination

Table 3: Key Performance Indicators for Prevention – Science and Service Activities

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
2.3.71: Number of people provided technical assistance (TA) Services[6] *(Output)*	FY 2009: 18,985 (Target Not Met)	21,420	13,143	-8,277
2.3.74: Percentage of TA recipients who reported that the TA recommendations have been fully implemented[7] *(Outcome)*	FY 2009: 65.1% (Target Exceeded)	54%	60.2%	+6.2%
2.3.75: Number of persons receiving prevention information directly[8] *(Output)*	FY 2009: 505 (Target Not Met)	550[9]	368[10]	-182

[6] Updated to include Center for the Application of Prevention Technology (CAPT), Native American Center of Excellence (NACE), Fetal Alcohol Spectrum Disorders Center of Excellence (FASD), MEI, and Prevention Fellowships.

[7] Includes only the CAPT.

[8] Includes Town Hall Meetings and FASD.

Measure	Most Recent	FY 2011	FY 2013 Performance with FY 2012	FY 2013 Performance Target
1.4.09: Number of individuals trained by SAMHSA's Science and Services Program (HHS Strategic Plan Measure) *(Output)*	FY 2010: 38,624 (Historical Actual)[11]	N/A	N/A	N/A

Grant Award Table

(whole dollars)	FY 2010	FY 2011	FY 2012
Number of Awards	241	226	222
Average Award	$198,452	$214,385	$197,833
Range of Awards	$25,000 - $335,000	$25,000 - $500,000	$25,000 - $500,000

[9] The Town Hall Meetings (THM) are conducted only in even-numbered years, so the targets in odd-numbered years reflect only the direct TA activities of FASD.

[10] The Town Hall Meetings (THM) are conducted only in even-numbered years, so the targets in odd-numbered years reflect only the direct TA activities of FASD.

[11] NOTE: Data are preliminary and do not reflect all program accomplishments during FY 2010. Reporting periods for component programs vary and, therefore, are complete for only a portion of them. Final data for all programs will be available in August 2011.

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SAMHSA/Center for Substance Abuse Treatment
Innovation & Emerging Issues

Summary of Programs

The Substance Abuse Treatment Innovation & Emerging Issues programs (IEI) support States and communities in carrying out an array of activities to improve the quality and availability of services in priority areas. The FY 2012 President's Budget request for SAMHSA Substance Abuse Treatment IEI includes $392.9 million which covers 14 programmatic activities. The request includes:

- $27.1 million for Screening, Brief Intervention, and Referral to Treatment (SBIRT) for continuation grants/cooperative agreements to add screening and brief intervention/referral services within States, campuses and general medical settings, and an evaluation of the program;

- $17.4 million for Targeted Capacity Expansion for continuation grants/cooperative agreements to units of State and local governments and tribal entities to expand or enhance a community's ability to provide rapid, strategic, comprehensive, integrated, community-based responses to a specific, well-documented substance abuse capacity problem;

- $98.5 million for the Access to Recovery Program (ATR) to support continuation grant awards to States and Tribal organizations through a recovery-oriented system of care approach to service delivery utilizing electronic vouchers and client choice;

- $30.7 million for Children and Family Programs for continuation grants/cooperative agreements to address the gaps in substance abuse services by providing services to adolescents and their families/primary caregivers using previously proven effective practices that are family centered;

- $47.4 million for Treatment Systems for Homeless continuation grants/cooperative agreements to enable communities to expand and strengthen their substance abuse treatment services for homeless (including chronically homeless) individuals with substance abuse disorders, or with co-occurring substance abuse disorders and mental illness;

- $65.9 million for Minority AIDS continuation grants/cooperative agreements to provide substance abuse treatment services, pre-treatment services, including the provision of literature and other materials to support behavior change, facilitation of access to drug treatment, HIV/AIDS testing and counseling services, and the provision of other medical and social services available in the local community;

- $67.6. million for Criminal Justice activities, to support continuation grants/cooperative agreements for Drug Court grants that provide treatment, housing, vocational, and employment services; for Family Treatment Drug Courts; and for Ex-Offender Re-entry programs to provide screening, assessment and comprehensive treatment, and recovery services to offenders reentering the community.

The Substance Abuse Treatment IEI underwent a program assessment in 2002. The assessment cited strong design and positive impact as strong attributes of the program. As a result of the assessment, the program is providing benchmark data to allow grantees to gauge how they perform compared to other grantees in their program area; including language in new program announcements (as appropriate) around incentives and disincentives based on grantee performance; and to improve the integration of the monthly tracking system of performance that supports monitoring of grantees by team leaders and project officers.

SAMHSA/Center for Substance Abuse Treatment
Mechanism Table by APT
(Dollars in Thousands)

Innovations & Emerging Issues	FY 2010 Actual No.	FY 2010 Actual Amount	FY 2011 CR No.	FY 2011 CR Amount	FY 2012 Pres. Budget No.	FY 2012 Pres. Budget Amount	FY 2012 Request +/- 2010 No.	FY 2012 Request +/- 2010 Amount
Grants/Cooperative Agreements:								
Continuations	446	$189,436	510	$288,596	411	$256,244	-35	$66,808
New/Competing	204	152,357	113	52,516	173	72,613	-31	-79,744
Supplements	(8)	1,100	0	0	0	0	-8	-1,100
Subtotal	**650**	**342,893**	**623**	**341,112**	**584**	**328,857**	**-66**	**-14,036**
Contracts:								
Continuations	25	59,377	34	63,683	32	58,512	+7	-865
New/Competing	14	5,947	3	3,200	2	5,550	-12	-397
Supplements	0	0	0	0	0	0	0	0
Subtotal	**39**	**65,324**	**37**	**66,883**	**34**	**64,062**	**-5**	**-1,262**
Subtotal, IEI	**689**	**$408,217**	**660**	**$407,995**	**618**	**$392,919**	**-71**	**-$15,298**

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SAMHSA/Innovation and Emerging Issues - Substance Abuse Treatment

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 CR	FY 2012 Pres. Budget
Co-occurring State Incentive Grants (SIGs)	4,262	4,263	4,263
Screening, Brief Intervention and Referral to Treatment	29,106	29,106	29,106
TCE - General	29,022	28,989	17,411
Pregnant & Postpartum Women	16,000	16,000	16,000
Strengthening Treatment Access and Retention	1,773	1,775	1,675
Recovery Community Services Program	5,669	5,236	2,450
Access to Recovery	99,380	98,954	98,454
Children and Family Programs	30,576	30,678	30,678
Treatment Systems for Homeless	42,530	42,750	47,360
Minority AIDS	65,911	65,988	65,988
Criminal Justice Activities	67,189	67,635	67,635
Congressional Projects	4,593	4,593	---
Minority Fellowship Program	547	547	547
Special Initiatives/Outreach	2,509	2,400	2,271
Addiction Technology Transfer Centers	9,150	9,081	9,081
TOTAL, IEI CSAT	**$408,217**	**$407,995**	**$392,919**

Authorizing Legislation ..... Section 506, 508, 509, 514 of the PHS Act

FY 2012 Authorization .....Expired

Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts

Co-Occurring State Incentive Grants (COSIGs)

Program Description and Accomplishments

The COSIG program has two primary goals: to develop and enhance the infrastructure of States and their treatment service systems and to increase the capacity of States to provide accessible, effective, comprehensive, coordinated/integrated, evidence-based treatment services to persons with co-occurring mental and substance use disorders and their families. The Co-Occurring program has been administered collaboratively by the Center for Mental Health Services and the Center for Substance Abuse Treatment, with the initial five-year COSIG grants awarded to seven States in 2003. The most recent awards were made in 2007.

COSIG grants support capacity-building, infrastructure development, and enhancement goals and activities over the five-year term of the projects. States identified the following elements as important for infrastructure development and enhancement: screening and assessment; complementary licensure and credentialing requirements; service coordination and network building; financial planning and information sharing. While the COSIG program has focused primarily on infrastructure development and enhancement, several grantees have exercised an option to conduct pilot services projects within their States. The grantees are supported by the

Co-Occurring Center for Excellence (COCE), which provides training and technical assistance. The COCE is co-funded by SAMHSA/CSAT and CMHS.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Program Description and Accomplishments

Screening, Brief Intervention and Referral to Treatment (SBIRT) was initiated in SAMHSA/CSAT in FY 2003, using cooperative agreements to expand and enhance the State or Tribal organization's continuum of care. The purpose of the program is to integrate screening, brief intervention, referral, and treatment services within general medical and primary care settings. According to SAMHSA's National Survey on Drug Use and Health (NSDUH), in 2008 approximately 21 million people needed treatment for a substance use disorder but did not receive it. Of those, 95 percent did not feel they needed treatment. Therefore, most people with or at risk for a substance use disorder are unlikely to seek help from the specialty treatment system. They are far more likely to present in some other medical setting.

Substance abuse is one of our Nation's most significant public health challenges, and the SBIRT approach can intervene early in the disease process before individuals achieve dependency, and can motivate the addicted client to engage in substance abuse treatment. Research and clinical experience supports the use of the SBIRT approach to provide effective early identification and interventions in primary care and general medical settings. Early identification can decrease total healthcare costs by arresting progression toward addiction. SBIRT also can identify persons with more serious problems and encourage them to obtain appropriate specialty treatment services.

Since the beginning of this program, more than one million individuals have been screened. Of those, 23% required a brief intervention, brief treatment or referral to specialty treatment programs. The first cohort of SBIRT cooperative agreements was awarded in 2003 to six States and one Tribal entity. Cooperative agreements were awarded to four more States in 2006 and four in 2008. In 2005, 12 Treatment Capacity Expansion (TCE), Screening and Brief Intervention (SBI) grants were awarded to colleges and universities to address campus drinking and drug use. In 2008, in an effort to incorporate SBIRT into general health care practice, 11 grants were awarded to embed SBIRT training and practice in medical residency programs. In 2009, an additional six grants were awarded, increasing the number of medical residency programs to 17. In FY 2010, SAMHSA/CSAT supported continuation of eight State SBIRT grants and seventeen Medical Residency SBIRT Training grants.

The SBIRT cooperative agreements require grant recipients to effect practice change throughout the spectrum of medical practice. This is achieved through implementation of SBIRT programs in all levels of primary care, including hospitals, trauma centers, health clinics, nursing home, employee assistance programs, and school systems. Practice change is also envisioned as altering the educational structure of medical schools by developing and implementing SBIRT curriculum as standard and permanent practice.

SBIRT has great future potential for promoting changes to the entire primary care medical service delivery system. Expansion of the SBIRT program would be expected to include dentistry, pediatrics and adolescent care organizations, community health and mental health agencies, and other locations where primary care services are offered. New diagnostic codes have been adopted by 16 U.S. States, making it easier for doctors to get reimbursed for screening Medicaid patients.

Targeted Capacity Expansion-General (TCE-General)

Program Description and Accomplishments

Targeted Capacity Expansion (TCE-General) program was initiated in FY 1998 to help community's bridge gaps in treatment services. TCE funding supports grants to units of State and local governments and tribal entities to expand or enhance a community's ability to provide rapid, strategic, comprehensive, integrated, community-based responses to a specific, well-documented substance abuse capacity problem. TCE projects use grant funding to expand and/or enhance treatment capacity using evidence-based treatment practices, report on performance measurements, and address cultural relevance in their treatment and recovery services. Since FY 1998, grants have been awarded to address the following targeted populations or urgent, unmet and emerging treatment needs: American Indian and Alaska Natives, Asian Americans, Pacific Islanders, rural areas, methamphetamine abuse, e-therapy, grassroots partnerships, and other populations.

Pregnant & Postpartum Women (PPW)

Program Description and Accomplishments

Women with substance use disorders and their children, particularly those living at or near the poverty line, are among the most vulnerable of populations, and they often have histories of physical violence, sexual abuse, co-occurring mental health disorders, and HIV/AIDS. Their children often have multiple health, developmental, and social problems, and are at risk for neglect, abuse, and removal from their families and communities. The risk of infant mortality is highly correlated with a pregnant mother's substance abuse, lack of prenatal care, and demographic factors, such as poverty and a lower level of education.

The national treatment infrastructure has not kept pace with the demand or complexity of needs experienced by this population, such as access to primary health care, mental health care, social and recovery support services. Services are also often lacking for their minor children impacted by the perinatal and environmental effects of maternal substance use and abuse. To improve the overall treatment outcomes for the family unit as a whole, service must be designed to address the needs of fathers of the children, partners of the women, and other extended family members. Meeting the needs of the entire family requires coordination of services with multiple agencies and across systems that often have different philosophies and approaches.

SAMHSA/CSAT's Pregnant and Postpartum Women (PPW) program has supported gender and culturally specific residential treatment service grants for pregnant, postpartum, and other

parenting women. Using a family-centered treatment approach, with women and their minor children at the center, the program has focused on the strengths and resources of the entire family, supporting sustained recovery for individual family members, and improving overall family functioning.

Strengthening Treatment Access & Retention (STAR)

Program Description and Accomplishments

CSAT joined with the Robert Wood Johnson Foundation (RWJF) in an initiative to substantially increase client access and retention using process improvement methods. Under a program titled *Network for the Improvement of Addiction Treatment (or NIATx)*, CSAT awarded 13 Strengthening Treatment Access and Retention (STAR) grants and RWJF awarded 27 Paths to Recovery grants to support implementation of organizational improvements that included: streamlining client intake, assessment and appointment scheduling procedures; eliminating paperwork duplication; extending clinic hours; contacting client no shows; eliciting customer feedback; and using clinical protocols (e.g., motivational interviewing and motivational incentives to engage clients during the initial phase of treatment). The NIATx initiative demonstrated that process improvement skills can be successfully transferred to treatment organizations. Grantees also participated in a learning network that included semi-annual learning sessions, process improvement coaching, web resources, information sharing, and peer-to-peer learning opportunities.

Based on the NIATx program success, CSAT funded a follow-on effort in 2006, the Strengthening Treatment Access and Retention – State Implementation (STAR-SI) program, an infrastructure initiative that promotes State-level implementation of process improvement methods to improve access to and retention in outpatient treatment. Under STAR-SI, program grantees have: (1) used process improvement methods to improve both State and treatment agency level organizational processes that impact client access to and retention in outpatient substance abuse treatment services; (2) developed provider and payer capacity to implement process improvement methods through the operation of peer-to-peer learning networks; (3) partnered with outpatient treatment providers, including, when applicable, the State treatment provider association and key fiscal intermediaries, in program design and implementation; and (4) implemented performance management systems to track progress and provide feedback to participating treatment providers on performance outcomes.

In FY 2010, STAR initiative provided technical assistance and support to six SAMHSA/CSAT discretionary grant programs and over 50 treatment organizations to improve client access, retention and handoffs to other levels of care. STAR also conducted a learning collaborative with over 300 treatment providers on how to improve third party billing practices in anticipation of the transition to increasing Medicaid clients under health care reform.

Recovery Community Services Program (RCSP)

Program Description and Accomplishments

The Recovery Community Services Program (RCSP) responds to the need for community-based recovery support services that help prevent relapse and promote long-term recovery. Such services can reduce the strain relapse places upon the already overburdened treatment system and minimize the negative effects of relapse when it does occur, as well as contribute to a better quality of life for people in recovery and their families and communities. The purpose of the RCSP is to design and deliver peer-to-peer recovery support services that help to prevent relapse and promote sustained recovery from alcohol and drug use disorders.

The RCSP program has targeted a variety of underserved groups including women; gay, lesbian, and transgender populations; African-American; Latino; rural populations; persons recently released from incarceration; the homeless; and adolescents. In addition, the RCSP program serves family members and allies of individuals in recovery. The primary targets for the RCSP initiative are people with a history of alcohol and/or drug problems who are in or are seeking recovery, along with their family members and significant others, and include both providers and recipients of recovery support services. RCSP grants provide a wide range of services such as peer coaching, peer support groups, life skills workshops, peer-led resource connector programs for housing, employment, educational assistance, vocational rehabilitation and training, leadership development, alcohol and drug free events, and recovery drop-in centers.

Access to Recovery (ATR)

Program Description and Accomplishments

Access to Recovery (ATR) provides grants to States, Tribes, and Tribal organizations to carry out voucher programs that expand substance abuse treatment capacity and promote choice among clinical treatment and recovery support providers in order to facilitate client recovery from substance abuse. The objectives of the program are to expand substance abuse treatment capacity by increasing the number and types of providers (including faith-based and grass-roots providers), to allow clients to play a more significant role in the development of their treatment plans through the use of electronic vouchers, and to link clinical treatment with critical recovery support services such as childcare, transportation, and mentoring. The populations served through ATR include the following: youth, users of methamphetamine, individuals involved with the criminal justice system, and women with dependent children. ATR enhances accountability by measuring outcomes and monitoring data to deter fraud and abuse.

ATR was launched in 2004 when 15 three-year grants were awarded, which provided services to almost 200,000 clients. A second cohort of 24 three-year ATR grants was awarded in September 2007. The second ATR cohort was projected to serve a target number of 30,000 clients in its first year (FY 2008); however, the actual number served was more than 50,000. The number served in FY 2009 was approximately 89,600 which exceeded the target of 65,000 clients. FY 2010 outcome data show that 82.9% of the clients had success achieving and maintaining no past month substance use. In addition, by six month follow-up, 47 percent reported being housed; 96

percent had no involvement in the criminal justice system; and 91 percent reported being socially connected.

The third ATR cohort was expanded to a four-year program. ATR is designed to: (1) allow recovery to be pursued through personal choice and many pathways; (2) require grantees to manage performance based outcomes that demonstrate client successes; and, (3) expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services. The recommended target is 225,000 clients for this third cohort, which began in FY 2010, with approximately 33,500 to be served in the first year, 70,750 clients to be served in the two subsequent years, and 50,000 to be served in the final year.

Children & Family Programs

Program Description and Accomplishments

Despite the availability of effective substance abuse treatment practices for adolescents and their families/primary caregivers, these practices are not being adequately utilized in the field. In response, SAMHSA/CSAT created the Adolescent Treatment grants which are designed to address the gaps in substance abuse services by providing services to adolescents and their families/primary caregivers using previously proven effective practices that are family centered.

Forty-eight grantee sites across the nation are implementing the Assertive Community Reinforcement Approach and the Assertive Continuing Care (ACRA/ACC) treatment interventions. ACRA and ACC were developed with funding from SAMHSA/CSAT and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and have proven effective in building community capacity for family centered treatment. These approaches are in the public domain, allow for cost-effective training of multiple staff, and are amenable to a train-the-trainers approach, ensuring sustainability over time.

The Family Centered Treatment grantees are receiving training and ongoing coaching for their clinical supervisors and clinicians that will lead to certification in the ACRA/ACC intervention model. In addition, each site has received training and certification to conduct a standardized bio-psychosocial clinical assessment that identifies substance use disorders, co-occurring mental health disorders, and family support and functioning. Utilizing this intensive process ensures that a standardized implementation of the intervention is completed. Important lessons to be learned from these grantee sites include how to effectively implement and sustain best and proven practices in community based agencies.

In addition to the Adolescent Treatment grant programs, SAMHSA/CSAT has been collaborating with the Administration for Children and Families (ACF) through an inter-agency agreement to fund a National Center on Substance Abuse and Child Welfare. The vast majority of children, particularly babies, who are placed in protective custody, have a parent with a substance use disorder. Thus, it is imperative that child welfare, substance abuse treatment providers, and the courts work efficiently together. This program provides technical assistance and training to grantees awarded under an ACF grant program entitled “Targeted Grants to Increase the Well Being of and to Improve the Permanency Outcomes for Children Affected by

Methamphetamine and Other Substance Abuse". Activities include in-depth technical assistance, working more closely with legislators and Governors' offices, forging more extensive partnerships with family drug courts, and planning greater emphasis on work with Tribes.

Treatment Systems for Homelessness

Program Description and Accomplishments

SAMHSA/CSAT manages two grant portfolios under its Grants for the Benefit of Homeless Individuals (GBHI) program, both of which provide focused services to individuals with a substance use disorder or who have co-occurring substance use and mental health disorders. Through a recovery and public health oriented system of care, grantees are encouraged to address gender, age, race, ethnicity, sexual orientation, disability status, veteran's status, and criminal justice status as these issues relate to both co-occurring disorder services and to substance use disorder services for homeless individuals.

The purpose of the GBHI program is to enable communities to expand and strengthen their substance abuse treatment services for homeless (including chronically homeless) individuals with substance abuse disorders, or with co-occurring substance abuse disorders and mental illness and move them to permanent supportive housing. SAMHSA/CSAT funds programs that demonstrate treatment effectiveness in serving runaways, homeless and street youth, homeless veterans, and other support services to move and maintain chronically homeless individuals with mental and substance use disorders into permanent supportive housing. In addition, SAMHSA/CSAT provides funds for expansion and strengthening substance abuse treatment services for homeless, alcohol-dependent persons who have histories of public inebriation, frequent emergency room visits, arrests, mental illness, or co-occurring substance use and mental health disorders.

Through this grant program, grantees link substance abuse treatment services with housing programs and other services (e.g. mental health treatment, primary care). Funds support direct services, including the following types of activities: conducting outreach and pre-service strategies to expand access to treatment services to underserved populations; purchasing or providing direct treatment (including screening, assessment, and care management) services for populations at risk; purchasing or providing "wrap-around" services; and collecting data using specified tools and standards to measure and monitor substance abuse treatment services and costs. In particular, programs are encouraged to implement evidence-based practices that result in treatment outcomes such as abstinence from alcohol and substance use, reduced criminal justice system involvement, employment, and stable housing.

In FY 2008, consistent with congressional intent, SAMHSA/CSAT began allocating part of its GBHI funds for grants that address services in supportive housing (SSH). Like SAMHSA/CSAT's GBHI grants for the homeless population, the SSH grants seek to expand and strengthen treatment services for persons who are homeless by providing linkages to appropriate treatment for substance use or other support services. SAMHSA/CSAT defines services in supportive housing for the purposes of the SSH grants as housing that is permanent, affordable,

and linked to health, mental health, employment, and other support services. This approach combines long-term, community-based housing assistance and intensive individualized treatment and recovery support services to chronically homeless individuals with substance use disorders. It is a cost-effective combination of affordable housing with substance abuse treatment services that helps people live more stable, productive lives and leads to reductions in substance use.

The GBHI and SSH grants are complementary approaches that provide a comprehensive response to homeless persons living with substance use. Both support the implementation of effective, evidence-based practices, and the combination of the two approaches allows SAMHSA/CSAT to support communities in reaching their homeless populations in need of treatment wherever they are found, whether in supportive housing or other community-based settings.

Since the inception of the GBHI program, SAMHSA/CSAT homeless grants have served 43,956 individuals. The currently active portfolio has served over 12,855 individuals. Each grantee collects information on the clients that are served through the grant funds. The information is entered into a Web-based data system that allows for tracking and accountability of grantee performance on the goals outlined in the grant proposal. Outcome data available for a subset of clients served by the program through the active GBHI grantees show that individuals demonstrate:

- 79.7 percent increase in employment or engaging in productive activities;
- 163.4 percent increase in persons with a permanent place to live in the community;
- 38.3 percent increase in no past months substance use;
- 23.9 percent improvement in no/reduced alcohol or illegal drug related health, behavioral or social consequences.

The FY 2012 Budget request for this program is aligned with "Opening Doors: the Federal Strategic Plan to Prevent and End Homelessness" which was released in June 2010. This program is an essential piece to accomplishing the goals of the Plan.

Minority AIDS

Program Description and Accomplishments

Minority AIDS grants are awarded to community-based organizations with two or more years of experience in the delivery of substance abuse treatment and related HIV/AIDS services. Funded programs target one or more of the following high-risk substance abusing populations: African American, Hispanic/Latino, and/or other racial/ethnic minority communities; women, including women with children; adolescents; men who inject drugs; and individuals who have been released from prisons and jails within the past two years.

In addition to providing substance abuse treatment services, pre-treatment services are provided, including the provision of literature and other materials to support behavior change, facilitation

of access to drug treatment, HIV/AIDS testing and counseling services, and the provision of other medical and social services available in the local community.

In FY 2010, SAMHSA/CSAT's TCE/HIV program served approximately 15,750 individuals. Of these individuals, approximately 68 percent were between the ages of 25 and 54 years. Approximately 31 percent identified themselves as Hispanic/Latino in ethnicity; 46 percent as African American; 22 percent white; 2 percent Asian, Native Hawaiian or Pacific Islander; and 4 percent as American Indian/Alaska Native.

Criminal Justice Activities

Program Description and Accomplishments

Criminal justice activities include grant programs which focus on diversion, alternatives to incarceration, and re-entry from incarceration for adolescents, teens, and adults with substance use disorders, and/or co-occurring substance use and mental disorders. Criminal justice program grantees are tasked with providing a coordinated and comprehensive continuum of supervision, programs and services to help members of the target population become productive, responsible and law abiding citizens. In addition, the program provides States and communities the flexibility they need to tailor court solutions to local needs in order to break the patterns of incarceration and recidivism associated with drugs, alcohol, and co-occurring mental disorders.

Drug Courts

Problem solving courts are designed to combine the sanctioning power of courts with effective treatment services for a range of populations and problems such as alcohol and/or drug use, child abuse/neglect or criminal behavior, mental illness, and veterans issues. In 2007, the criminal justice system was the largest single source of referrals to substance abuse treatment. As treatment drug courts and other problem solving courts addressing drug and other behavioral health-related issues are being established at a high rate, communities are challenged to find sufficient substance abuse treatment and recovery support resources for people referred by the courts.

The number of such courts in the nation with a focus on drug treatment has increased, from 1,200 in 2005 to over 2,400 in 2010. Even with the increase in the availability of these courts, there is a limited amount of treatment, mental health, and recovery support services available. Approximately 10 percent of individuals in need of substance abuse treatment within the criminal justice system actually receive treatment as part of their justice system supervision.

In FY 2010, SAMHSA/CSAT funded 8 new Juvenile Treatment Drug Court grants for three years at an average cost of $325,000 per year. There were also three new Juvenile Treatment Drug Court grants that were funded in collaboration with the Department of Justice (DOJ)/Office of Juvenile Justice and Delinquency Prevention (OJJDP) and in partnership with Robert Wood Johnson for four years at an average cost of $200,000 per year. This collaborative program was initiated in FY 2009, with the award of three grants. These funds will provide services to

support substance abuse treatment, assessment, case management, and program coordination for those in need of treatment drug court services. Priority for the use of funding will be given to address gaps in the continuum of treatment.

In FY 2010, SAMHSA/CSAT funded 17 new Adult Treatment Drug Court grants for three years at an average cost of $325,000 per year. Also in FY 2010, SAMHSA and DOJ/Office of Justice Programs /Bureau of Justice Affairs (BJA) developed a joint program to enhance court services, coordination, and substance abuse treatment capacity of adult drug courts. The purpose of this joint initiative is for applicants to submit one application that outlines a comprehensive strategy for enhancing drug court capacity. SAMHSA and BJA jointly funded 28 new Adult Treatment Drug Court grants. Each grantee was awarded one separate grant from each agency, representing an innovative braided funding opportunity. This collaboration was modeled after the successful SAMHSA and DOJ/OJJDP collaborative Juvenile Treatment Drug Court grant program.

Children exposed to methamphetamine laboratories not only face great physical danger from chemical contamination and fire explosions, but they are at a heightened risk for abuse, neglect, and continued social and developmental problems. In addition, substance use and addiction are frequently associated with the neglect and abuse of children and this has placed an immense burden on the dependency courts, child welfare systems, and treatment providers. To address this situation, the Administration provided assistance to the Children Affected by Methamphetamine/Family Treatment Drug Court program in FY 2010. These grants will provide a Child Case Coordinator to link available community-based social services resources that will focus on the trauma to these youngest victims caused by substance abuse/methamphetamine use in the family and concurrent criminal justice involvement. This program will provide a collaborative approach to child case coordination of services for these children of methamphetamine-addicted parents by including judges, treatment providers, child welfare specialists, and attorneys. In FY 2010, SAMHSA/CSAT funded 12 grants at $370,000 per year for up to four years.

In FY 2012, SAMHSA will continue to provide technical assistance and support States and communities in implementing flexible solutions to address the burdensome problems of substance abuse, mental illnesses, and co-occurring disorders in the criminal justice system through collaboration between the Center for Substance Abuse Treatment and the Center for Mental Health Services. This approach helps local courts find the model that best meets their needs and capacities. It also encourages partnership with the behavioral health system to allocate treatment and recovery support services effectively and efficiently.

Offender Re-entry Program

The justice system is seen as the nexus of public health and public safety, given the number of individuals involved in both drugs and crime who cause significant impact on American society. In 2002, the estimated cost to society of drug abuse was $180.9 billion; $107.8 billion of that total was associated with drug-related crime, including criminal justice system costs and costs borne by victims of crime. The cost of treating drug abuse (including research, training and prevention) was estimated at $15.8 billion – a fraction of the overall costs to society.

Research shows that for the drug-involved offender's most positive gains made as the result of prison-based treatment rapidly dissipate if the individual is not linked to effective community-based services upon return to the community. In FY 2002, with the number of reentering offenders totaling over 625,000 persons, Federal agencies began to respond to the accompanying public safety and public health issues by funding new programs such as the Serious and Violent Offender Re-entry Initiative and the Prisoner Re-entry Initiative. SAMHSA participated as a Federal partner in both of these initiatives. In FY 2004, SAMHSA's Young Offender Re-entry Program (YORP) was initiated with the awarding of 12 grants to expand and enhance treatment capacity for juveniles and young offenders returning to their communities from correctional or detention facilities. This offender re-entry initiative was designed to facilitate reintegration into the community by providing pre-release screening, assessment and transition planning in institutional corrections settings and linking clients to community-based treatment and recovery services upon release. In FY 2005, a second cohort of 13 grants was funded as part of an $11 million effort to respond to the escalating number of alcohol and drug involved offenders returning to the community.

SAMHSA recognizes the need to continue efforts to return and reintegrate offenders back into the community by providing substance abuse treatment and other related re-entry services while also ensuring public safety for the community and family. The Offender Re-entry Program (ORP) grants provide screening, assessment and comprehensive treatment and recovery support services to offenders reentering the community, as well as offenders who are currently on or being released from probation or parole. In FY 2009, SAMHSA/CSAT funded 24 new ORP grants and 18 in FY 2010. These grants are funded for three years at an average cost of $400,000 per year.

SAMHSA and DOJ/Bureau of Justice Assistance share a mutual interest in supporting and shaping offender re-entry-treatment services, as both agencies fund "offender re-entry" programs. These two Agencies have a longstanding partnership regarding criminal justice-substance abuse treatment issues. SAMHSA and DOJ/Bureau of Justice Assistance have developed formal agreements to further encourage and engage in mutual interests and activities related to criminal justice-treatment issues. SAMHSA and DOJ/Bureau of Justice Assistance will continue to plan and coordinate relevant activities. Offender Re-entry Program grantees are expected to seek out and coordinate with local Federally-funded offender re-entry initiatives, including DOJ/Bureau of Justice Assistance's Prisoner Re-entry Initiative or "Second Chance Act" offender re-entry programs, as appropriate.

Minority Fellowship Program (MFP)

Program Description and Accomplishments

In a partnership with CMHS, CSAP and CSAT, this program increases the knowledge of issues related to ethnic minority mental health and substance use disorders, as well as improves the quality of mental health and substance abuse prevention and treatment delivered to ethnic minorities by providing stipends to doctoral level students to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental health/substance abuse services to underserved minority populations. 125

individuals were trained in FY 2009. Since its start in 1973, the Minority Fellowship Program (MFP) has helped to support doctoral-level training of ethnic minority psychiatrists, psychologists, psychiatric nurses, and social workers. These individuals often serve in key leadership positions in mental health and substance abuse direct services, including supervision, direct services, services research, training, and administration.

Addiction Technology Transfer Centers (ATTCs)

Program Description and Accomplishments

The Addiction Technology Transder Center (ATTC) Network is comprised of one national coordinating center and fourteen geographically dispersed regional ATTCs covering all States, the District of Columbia, Puerto Rico, the Virgin Islands, and U.S. Territories in the Pacific. The Regional Centers support national activities and implement programs and initiatives in response to regional needs, decreasing the gap in time between the release of new scientific findings and evidence-based practices and the implementation of these interventions by front-line clinicians. ATTCs disseminate evidence-based and promising practices to addictions treatment/recovery professionals, public health/mental health personnel, institutional and community corrections professionals, and other related disciplines. The ATTC program dissemination models include technical assistance; training events; a growing catalog of educational and training materials; and an extensive array of Web-based resources created to translate the latest science for adoption into practice by the substance use disorders treatment workforce. The ATTCs are highly responsive to emerging challenges in the field.

Data show that over 23,000 people were trained in 2010, exceeding the target of 20,516. Approximately 96 percent of participants report implementing improvements in treatment methods based on the information they received from the training they attended.

Special Initiatives/Outreach

Program Description and Accomplishments

Special Initiatives/Outreach activities include: a grant program for Historically Black Colleges and Universities (HBCU) – Center for Excellence, which is an innovative national resource center dedicated to continuing the effort to network the 103 HBCUs throughout the U.S. The HBCU – Center for Excellence promotes workforce development through expanding knowledge of best practices and leadership development that enhance the participation of African-Americans in the substance abuse and mental health professions. The HBCU – Center for Excellence also supports a policy academy which focuses on workforce development, leadership development, cross-systems collaboration, cultural competency and eliminating disparities. The HBCU – Center for Excellence collaborate with other HHS agencies including HHS/Office of Minority Health (OMH), to achieve the objectives of various Executive Orders on educational excellence for minority populations.

In FY 2010, SAMHSA/CSAT entered into an inter-agency agreement with the Agency for Healthcare Research and Quality (AHRQ) to examine and graphically display selected trends in

hospital-based stays for mental health and substance abuse treatment. This work was used to write a chapter in the annual AHRQ publication, "Healthcare Cost and Utilization Project (HCUP) Facts and Figures: Statistics on Hospital Based Care in the US 2008." This report drew attention to the extensive hospital resources devoted to people with mental and substance use disorders, some of which may be more effectively and efficiently served in community-based settings with a recovery-based system of care approach.

Through the HBCU-Center for Excellence, approximately 19 Substance Abuse Treatment Workforce Development pilots were funded to provide opportunities for more students to obtain practical experience in the addictions field. This program has increased the number of students interning in behavioral health and has established or increased HBCU partnerships with local, regional and State behavioral health partners, primarily substance abuse, committed to increasing diversity in the addictions field.

IEI - CSAT Funding History *

FY	Amount
2007	$343,254,000
2008	$344,167,000
2009	$358,323,000
2010	$408,217,000
2011	$407,995,000

* The funding history is based on a comparable basis to previous funding levels to reflect the revised budget restructure.

Budget Request

The FY 2012 President's Budget request is $392.9 million, a decrease of $15.3 million from the FY 2010 level. The request will support 584 grants and 34 contracts. This level of funding enables the continuation of all programmatic activities. The Budget phases out funding for new awards, including: Targeted Capacity Expansion, Recovery Community Services Program, and Special Initiatives/Outreach. No continuing grant awards will be terminated. SAMHSA will work with the States to use their Block Grant and Substance Abuse and Mental Health Prevention Grants to implement the practices learned from these programs.

Outcomes and Outputs

Co-Occurring State Incentive Grants

As the Co-Occurring State Incentive Grants are coming to an end in FY 2009 and no new grants are planned, performance measures for this program will no longer be reported.

Screening, Brief Intervention and Referral to Treatment

Table 1: Key Performance Indicators for Screening, Brief Intervention and Referral to Treatment

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.40: Number of clients served *(Output)*	FY 2010: 275,473 (Target Exceeded)	139,650	139,650	Maintain
1.2.41: Percentage of clients receiving services who had no past month substance use *(Outcome)*	FY 2010: 34% (Target Not Met)	50%	50%	Maintain

Access to Recovery

Table 2: Key Performance Indicators for Access to Recovery

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.32: Number of clients gaining access to treatment[1] *(Output)*	FY 2010: 69,552 (Target Exceeded)	33,500	70,750	+37,250
1.2.33: Percentage of adults receiving services who had no past month substance use *(Outcome)*	FY 2010: 82.9% (Target Exceeded)	82%	83%	+1%

[1] Initial Access to Recovery grants were made in August 2004, close to the end of FY 2004. Services were not necessarily provided in the same year Federal funds were obligated. Thus, although the baseline reported for FY 2005 represented people served in FY 2005, most of the funding consisted of FY 2004 dollars. With the FY 2004 grants, it was estimated that 125,000 clients would be served over the three year grant period. The second cohort of grants was awarded in September 2007.

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.35: Percentage of adults receiving services who had no/reduced involvement with the criminal justice system *(Outcome)*	FY 2010: 96.3% (Target Exceeded)	96%	96%	Maintain
1.2.36: Percentage of adults receiving services who had improved social support *(Outcome)*	FY 2010: 91.1% (Target Exceeded)	91%	91%	Maintain

Treatment System for Homelessness (GBHI)

Table 3: Key Performance Indicators for Treatment System for Homelessness

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.4.22: Percentage of clients receiving services who had no past month substance use *(Outcome)*	FY 2010: 66 % (Target Not Met)	67.4 %	67.4 %	Maintain
3.4.23: Number of clients served *(Output)*	FY 2010: 5,398 (Target Not Met)	7,005	7,005	Maintain
3.4.24: Percentage of clients receiving services who were currently employed or engaged in productive activities *(Outcome)*	FY 2010: 32 % (Target Not Met but Improved)	32.7 %	32.7 %	Maintain
3.4.25: Percentage of clients receiving services who had a permanent place to live in the community *(Outcome)*	FY 2010: 29.4 % (Target Exceeded)	25.6 %	25.6 %	Maintain

Table 4: Key Performance Indicators for Criminal Justice – Juvenile and Adult Drug Courts

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.63: Percentage of juvenile clients receiving services who were currently employed or engaged in productive activities *(Outcome)*	FY 2009: 89% (Target Exceeded)	88%	88%[2]	Maintain
1.2.64: Percentage of juvenile clients receiving services who had a permanent place to live in the community *(Outcome)*	FY 2009: 79% (Target Not Met)	82%	82%	Maintain
1.2.65: Percentage of juvenile clients receiving services who had no involvement with the criminal justice system *(Outcome)*	FY 2009: 92% (Target Not Met)	95%	95%	Maintain
1.2.67: Percentage of juvenile clients receiving services who had no past month substance use *(Outcome)*	FY 2009: 73% (Target Met)	73%	73%	Maintain
1.2.70: Number of juvenile clients served *(Output)*	FY 2009: 376 (Target Not Met)	1,463[3]	1,463	Maintain
1.2.72: Percentage of adult clients receiving services who were currently employed or engaged in productive activities[4] *(Outcome)*	FY 2010: 57% (Target Met)	57%	57%	Maintain
1.2.73: Percentage of adult clients receiving services who had a permanent place to live in the community[5] *(Outcome)*	FY 2010: 42.3% (Target Exceeded)	42%	43%	+1%

[2] Targets reflect a decrease in funding anticipated for this program.

[3] This target has been revised from the FY 2010 President's Budget based on the FY 2010 Appropriation.

[4] Targets set for this measure in the FY 2010 President's Budget were based on Juvenile Drug Court data. Data for Adult Drug Courts clients is now available. As a result, the targets for FY 2010, 2011 and 2012 have been revised to be more appropriate to the population of this program.

[5] Targets set for this measure in the FY 2010 President's Budget were based on Juvenile Drug Court data. Data for Adult Drug Courts clients is now available. As a result, the targets for FY 2010, 2011 and 2012 have been revised to be more appropriate to the population of this program.

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.74: Percentage of adult clients receiving services who had no involvement with the criminal justice system *(Outcome)*	FY 2010: 93% (Target Met)	93%	93%[6]	Maintain
1.2.76: Percentage of adult clients receiving services who had no past month substance use *(Outcome)*	FY 2010: 85.4% (Target Exceeded)	73%	73%[7]	Maintain
1.2.79: Number of adult clients served [8] *(Output)*	FY 2010: 3,533 (Target Exceeded)	5,265	5,265	Maintain

Table 5: Key Performance Indicators for Criminal Justice – Ex-Offender Re-Entry

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.80: Number of clients served *(Outcome)*	FY 2010: 1,772 (Target Exceeded)	2,912[9]	2,912	Maintain
1.2.81: Percentage of clients who had no past month substance use *(Outcome)*	FY 2010: 77.5% (Target Exceeded)	70%	69%	-1%

[6] Targets reflect a decrease in funding anticipated for this program.

[7] Targets reflect a decrease in funding anticipated for this program.

[8] Targets set for this measure in the FY 2010 President's Budget were based on Juvenile Drug Court data. Data for Adult Drug Courts clients is now available. As a result, the targets for FY 2010, 2011, and 2012 have been revised to be more appropriate to the population of this program.

[9] This target has been revised from the FY 2010 President's Budget based on the FY 2010 Appropriation.

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.84: Percentage of clients receiving services who had no involvement with the criminal justice system *(Outcome)*	FY 2010: 94.9 % (Target Not Met)	95%	96 %	+1%

Table 6: Key Performance Indicators for Treatment – Other Capacity[10]

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.2.25: Percentage of adults receiving services who had no past month substance use *(Outcome)*	FY 2010: 67.9% (Target Exceeded)	62%	66%	+4%
1.2.26: Number of clients served *(Output)*	FY 2010: 37,365 (Target Exceeded)	34,784	34,784	Maintain
1.2.27: Percentage of adults receiving services who were currently employed or engaged in productive activities *(Outcome)*	FY 2010: 46% (Target Not Met but Improved)	47%	47%	Maintain
1.2.28: Percentage of adults receiving services who had a permanent place to live in the community *(Outcome)*	FY 2010: 49% (Target Met)	49%	49%	Maintain
1.2.29: Percentage of adults receiving services who had no involvement with the criminal justice system *(Outcome)*	FY 2010: 96% (Target Exceeded)	95%	96%	+1%

[10] Includes TCE General, HIV/AIDS Outreach, Addiction Treatment for Homeless Persons, Assertive Adolescent and Family Treatment, Family and Juvenile Drug Courts, Young Offender Re-Entry Program, Pregnant and Post-Partum Women, Recovery Community Service – Recovery, Recovery Community Service – Facilitating, and Child and Adolescent State Incentive Grants.

Table 7: Key Performance Indicators for Treatment – Science and Service Activities[11]

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
1.4.01: Percentage of participants who report implementing improvements in treatment methods on the basis of information and training provided by the program *(Outcome)*	FY 2010: 96.2% (Target Exceeded)	90%	90%	Maintain
1.4.02: Number of individuals trained per year *(Output)*	FY 2010: 23,034 (Target Exceeded)	20,516	20,516	Maintain
1.4.09: Number of individuals trained by SAMHSA's Science and Services Program (HHS Strategic Plan Measure) *(Output)*	FY 2010: 38,624 (Historical Actual)[12]	N/A	N/A	N/A

Size of Awards

(whole dollars)	FY 2010	FY 2011	FY 2012
Number of Awards	650	623	584
Average Award	$343,485	$372,891	$380,581
Range of Awards	$300,000 - $550,000	$300,000 - $580,000	$300,000 -$580,000

[11] Includes Knowledge Application Program, Faith Based Initiatives, Strengthening Treatment Access and Retention, Addiction Technology Transfer Centers, and SAMHSA Conference Grants.

[12] NOTE: Data are preliminary and do not reflect all program accomplishments during FY 2010. Reporting periods for component programs vary and, therefore, are complete for only a portion of them. Final data for all programs will be available in August 2011.

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Children's Mental Health Services Program

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Budget Authority.....	$121,316	$121,316	$121,316

Authorizing Legislation .....Section 561 to 565 of the Public Health Service Act

FY 2012 Authorization .....Expired

Allocation Method .....Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

The Children's Mental Health Services Program was first authorized in 1992. The program supports the development of comprehensive, community-based systems of care for children and adolescents with serious emotional disorders and their families. Systems of care is an approach to the delivery of services that recognizes the importance of family, school and community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural and social needs. Accordingly, a system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families.

Since 1993, the program has funded 164 grantees across the country; serving 95,884 children, and adolescents and their families. Grants are funded for a total of six years, with an increasing non-Federal match requirement over the term of the award. The match requirement is intended to promote sustainability of the local systems of care beyond the grant period. Sixty-four percent of system of care communities sustained five years post-Federal funding.

National program evaluation data collected for more than a decade indicate that systems of care are successful, resulting in many favorable outcomes for children, youth and their families, including:

- Sustained mental health improvements, including improvements for participating children and youth in clinical outcomes after six months of program participation;
- Improvements in school attendance and achievement;
- Reductions in suicide-related behaviors;
- Decreases in utilization of inpatient care and reduced costs due to fewer days in inpatient care;
- Significant reductions in contacts with law enforcement agencies.

A hallmark of this program is that youth and families partner with providers and policy makers in service delivery and system reform planning and decision-making. In addition to the substantial roles children, youth, and families play in the care they receive, services are delivered

in the least restrictive environment with evidence-based treatments and interventions. Care management ensures that planned services and supports are delivered appropriately and effectively.

Funding History

FY	Amount
2007	$104,078,000
2008	$102,260,000
2009	$108,373,000
2010	$121,316,000
2011	$121,316,000

Budget Request

The FY 2012 President's Budget request is $121.3 million, the same as the FY 2010 Level. The funding will fully support 62 grant continuations and five contracts.

Outcomes and Outputs

Children's Mental Health Services

Table 1: Key Performance Indicators for Children's Mental Health Services

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.2.16: Number of children receiving services (Output)[1]	FY 2010: 4,930 (Target Not Met)	13,051	4,930	-8,121
3.2.25: Percentage of children receiving services who report social support (Outcome)	FY 2010: 85.7 % (Target Not Met)	87.6 %	87.6 %	Maintain

[1] FY 2010 source for this measure has been transferred from the cross-site evaluation to the TRAC data collection system. The lower actual and subsequent targets are due to the fact that grantee use of the TRAC system is slower than expected.

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.2.26: Percentage of children receiving services who report improved functioning (Outcome)	FY 2010: 51.3 % (Target Exceeded)	50.2 %	50.2 %	Maintain
3.2.27: Number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the program (Output)	N/A	N/A	TBD	N/A
3.2.28: Number of organizations that entered into formal written tier/intra-organizational agreements (e.g. MOUs/MOAs) to improve mental health-related practices/activities as a result of the grant (Output)	N/A	N/A	TBD	N/A

Grant Awards Table

(Whole Dollars)	FY 2010	FY 2011	FY 2012
Number of Awards	75	66	61
Average Award	$1,283,200	$1,495,136	$1,613,377
Range of Awar	$330,000-$2,000,000	$330,000-$2,000,000	$330,000-$2,000,000

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Projects for Assistance in Transition from Homelessness

(Dollars in thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Budget Authority.....	$65,047	$65,047	$65,047

Authorizing Legislation .....Section 521 of the Public Health Service Act

FY 2012 Authorization .....Expired

Allocation Method .....Formula grant

Program Description and Accomplishments

In 1990, the Stewart B. McKinney Homeless Assistance Amendments Act authorized the Projects for Assistance in Transition from Homelessness (PATH) program. PATH is unique in that it alone is authorized to address the needs of individuals with serious mental illness (SMI) and/or SMI with a co-occurring substance use disorder who are experiencing homelessness or are at risk of homelessness. PATH connects this largely un-served population to critical services and resources to assist them on the road of recovery. PATH funds community-based outreach, mental health, substance abuse, case management and other supportive services, and a limited set of housing services in 483 communities from all 50 States, the District of Columbia, Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, and the Northern Mariana Islands.

The PATH formula calculates State allotments based on the population living in urbanized areas. These population data are updated after each census. This program requires matching funds of $1 to every $3 of Federal funds. In the past several years, State and local matching funds exceeded the required amount. The PATH program has been highly successful in targeting assistance to individuals with SMI who are homeless or are at-risk for homelessness or experiencing a co-occurring mental and substance use disorder. The PATH budget supports 56 grants to States and Territories, as well as centralized activities like technical assistance and evaluation.

In 2008, the PATH program contacted 134,932 homeless persons, ten percent short of the target of 150,000. The program has begun to implement several activities to increase its performance on all the National Outcome Measures. Regarding the required match of $1 for every $3 of Federal funds, previously PATH grantees reported on the number of persons served by Federal PATH funds only. Grantees will now report on all persons served using Federal and matching funds and will expand reporting of outcomes for clients.

PATH implemented other activities to assure greater consistency of data collection and reporting to improve performance. In 2009, PATH developed national definitions for outreach, enrollment and engagement. Online training on these definitions was provided for all 56 State grantees and 483 local providers. In addition, a partnership has been established with the Department of Housing and Urban Development (HUD) to determine the feasibility of having all PATH

grantees collect and report PATH data in the Homeless Management Information System (HMIS).

In December 2009, PATH began a process to prepare grantees to report in HMIS, involving a series of webinar-based exposure trainings, onsite regional trainings, intensive peer-to-peer and technical assistance activities, and online course, and pilot testing. Some States adopted the HMIS for their use early on with great success. These "early adopters" will serve as mentors and peer-to-peer trainers to those who are at the beginning stages of HMIS adoption.

Involving consumers in the PATH program is essential. The program established a PATH consumer-provider network that developed a consumer involvement curriculum to assist in the planning, design, and delivery of PATH at the local, State, and national levels. Located at http://pathprogram.samhsa.gov, the recently re-designed PATH website provides tools and information for consumers, PATH providers, other homeless service providers, policy makers and the general public. It also presents opportunities for providers working with individuals who are homeless to connect with each other.

Funding History

FY	Amount
2007	$54,261,000
2008	$53,313,000
2009	$59,687,000
2010	$65,047,000
2011	$65,047,000

Data Elements Used to Calculate FY 2012 Allotments

Population: 2000 Population (all ages combined) of Urbanized Areas from U.S. Census Bureau for the States, the District of Columbia and Puerto Rico (2000 Census); no population data required for the Territories.

Budget Request

The FY 2012 President's Budget request is $65.0 million, same level as the FY 2010 Level. The funding level will continue all current programmatic activities.

Outcomes and Outputs

Projects to Assist in the Transition from Homelessness

Table 1: Key Performance Indicators for Projects to Assist in the Transition from Homelessness

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.4.15: Percentage of enrolled homeless persons who receive community mental health services (Outcome)	FY 2009: 49% (Target Exceeded)	47%	50%	+3%
3.4.16: Number of homeless persons contacted (Outcome)	FY 2009: 165,954 (Target Exceeded)	182,000	182,000	Maintain
3.4.17: Percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome)	FY 2009: 50% (Target Not Met)	55%	55%	Maintain
3.4.20: Number of PATH providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits (Output)	FY 2009: 5,104 (Target Exceeded)	5,420	5,420	Maintain

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2011 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

STATE/TERRITORY	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate	+/- FY 2010
Alabama	$588,000	$588,000	$588,000	$0
Alaska	300,000	300,000	300,000	0
Arizona	1,184,000	1,184,000	1,184,000	0
Arkansas	300,000	300,000	300,000	0
California	9,073,000	9,073,000	9,073,000	0
Colorado	973,000	973000	973000	0
Connecticut	863,000	863,000	863,000	0
Delaware	300,000	300,000	300,000	0
District Of Columbia	300,000	300,000	300,000	0
Florida	4,081,000	4,081,000	4,081,000	0
Georgia	1,518,000	1,518,000	1,518,000	0
Hawaii	300,000	300000	300000	0
Idaho	300,000	300,000	300,000	0
Illinois	2,950,000	2,950,000	2,950,000	0
Indiana	1,033,000	1,033,000	1,033,000	0
				0
Iowa	338,000	338,000	338,000	0
Kansas	366,000	366,000	366,000	0
Kentucky	475,000	475000	475000	0
Louisiana	768,000	768,000	768,000	0
Maine	300,000	300,000	300,000	0
Maryland	1,287,000	1,287,000	1,287,000	0
Massachusetts	1,707,000	1,707,000	1,707,000	0
Michigan	1,993,000	1,993,000	1,993,000	0
Minnesota	821,000	821,000	821,000	0
Mississippi	300,000	300,000	300,000	0
Missouri	936,000	936,000	936,000	0
Montana	300,000	300,000	300,000	0
Nebraska	300,000	300,000	300,000	0
Nevada	508,000	508,000	508,000	0
New Hampshire	300,000	300,000	300,000	0
New Jersey	2,349,000	2,349,000	2,349,000	0
New Mexico	300,000	300,000	300,000	0
New York	4,697,000	4,697,000	4,697,000	0
North Carolina	1,139,000	1,139,000	1,139,000	0
North Dakota	$300,000	$300,000	$300,000	$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2011 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

STATE/TERRITORY	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate	+/- FY 2010
Ohio	$2,215,000	$2,215,000	$2,215,000	$0
Oklahoma	449,000	449,000	449,000	0
Oregon	599,000	599,000	599,000	0
Pennsylvania	2,487,000	2,487,000	2,487,000	0
Rhode Island	300,000	300,000	300,000	0
South Carolina	568,000	568,000	568,000	0
South Dakota	300,000	300,000	300,000	0
Tennessee	898,000	898,000	898,000	0
Texas	4,482,000	4,482,000	4,482,000	0
Utah	530,000	530,000	530,000	0
Vermont	300,000	300,000	300,000	0
Virginia	1,428,000	1,428,000	1,428,000	0
Washington	1,304,000	1,304,000	1,304,000	0
West Virginia	300,000	300,000	300,000	0
Wisconsin	861,000	861,000	861,000	0
Wyoming	300,000	300,000	300,000	0
State Sub-total	**60,868,000**	**60,868,000**	**60,868,000**	**0**
American Samoa	50,000	50,000	50,000	0
Guam	50,000	50,000	50,000	0
Northern Marianas	50,000	50,000	50,000	0
Puerto Rico	1,053,000	1,053,000	1,053,000	0
Virgin Islands	50,000	50,000	50,000	0
Territory Sub-Total	**1,253,000**	**1,253,000**	**1,253,000**	**0**
Total States/Territories	**62,121,000**	**62,121,000**	**62,121,000**	**0**
Set Aside	**2,926,000**	**2,926,000**	**2,926,000**	**0**
TOTAL PATH	**$65,047,000**	**$65,047,000**	**$65,047,000**	**$0**

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SAMHSA Regulatory & Oversight Functions

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Regulatory & Oversight Functions

(Dollars in Thousands)

Regulatory and Oversight Functions	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Seclusion and Restraint	$2,482	$2,449	$2,449
Protection and Advocacy (PAIMI)	36,380	36,380	36,380
Mandatory Drug Testing	5,202	5,206	5,206
Opioid Drug Treatment Regulatory Activities	8,988	8,903	8,903
Prescription Drug Monitoring (NASPER)	2,000	2,000	2,000
TOTAL, Regulatory and Oversight Functions	**$55,052**	**$54,938**	**$54,938**

Authorizing Legislation ..... Section 501, 509, 516, 519B, 519E, 520A, 399O of the PHS Act; ..... Section 102 of the PAIMI Act

FY 2012 Authorization .....Expired

Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts

The programs realigned within Regulatory and Oversight Functions include program lines formerly in the Programs of Regional and National Significance for the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment. The programs lines and their associated funding have been realigned into the ROF budget line, and comparable adjustments for FY 2010 and FY 2011 have been made. These programs include, Opioid Drug Treatment, Mandatory Drug Testing, Prescription Monitoring, Seclusion and Restrain, and Protection and Advocacy for Individuals with Mental Illness (PAIMI).

Seclusion & Restraint

Program Description and Accomplishments

This program supports States/Tribes in their efforts to adopt best practices to reduce and ultimately eliminate the use of restraint and seclusion in institutional and community based settings that provide mental health services including services for people with co-occurring substance abuse and mental health disorders.

In FY 2010, SAMHSA awarded the National Technical Assistance Center for Trauma and Justice: Promoting Alternatives to Seclusion and Restraint and Implementation of Trauma Informed Care. The overall purpose of the technical assistance center is to provide national leadership in reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health and behavioral healthcare systems, and to divert people with substance use and mental disorders from criminal and juvenile justice systems into trauma-informed treatment and recovery.

Protection and Advocacy for Individuals with Mental Illness

Program Description and Accomplishments

The Protection and Advocacy for Individuals with Mental Illness Program (PAIMI) provides formula grant awards to support protection and advocacy systems designated by the Governor of each State and the Territories, and the Mayor of the District of Columbia. State protection and advocacy systems monitor facility compliance with respect to the rights of individuals through activities that ensure the enforcement of the Constitution and Federal and State laws. State protection and advocacy systems monitor public and private residential care and treatment facilities and non-medical community-based facilities for children and youth. The Budget Request will support 57 grants to States and Territories. An independent evaluation of the program was completed in FY 2009 which confirmed that PAIMI programs provide those with psychiatric disability a voice in the exercise of their rights and are highly successful in achieving client and system goals and objectives.

In 2008, the PAIMI program:

- Provided casework to 4,425 children and adolescents and 13,043 adults and elderly individuals with mental illness;
- Closed 14,772 cases, of which 4,271 were related to abuse, 2,860 to neglect, and 7,641 to a violation of individual rights;
- Resolved 87 percent of alleged abuse cases, 84 percent of alleged neglect cases, and 89 percent of alleged rights violations cases that resulted in positive change for the client in her/his environment, community, or facility.

The FY 2011 funding will serve over 22,000 persons in FY 2012, drawing upon a marginal cost analysis conducted for this program (which estimated an average cost per complaint resolved successfully in FY 2009 of $3,164). For complaints of alleged abuse that resulted in positive change for the client in her or his environment, community, or facility as a result of PAIMI involvement, the outcome has improved each year from 78% in FY 2005 to 87% in FY 2008.

The PAIMI program underwent a performance assessment in 2005. The assessment cited the fact that the program serves a clear need and is reporting positive outcomes as strong attributes of the program. As a result of the performance assessment, the program has provided grantees with guidelines as to how to calculate the number of PAIMI-eligible individuals impacted; has provided technical assistance on the right to access facilities, consumers, and information through the National Disability Rights Network; and an independent evaluation of the program was conducted. This program is one of eight protection and advocacy (P&A) programs housed in three Federal departments. The different reporting and evaluation requirements translate into a significant paperwork burden for recipients. To help remedy this problem, HHS, along with the Department of Education and the Social Security Administration, is committed to improving federal program coordination related to the monitoring and evaluating of these programs.

Data Elements Used to Calculate FY 2012 Allotments

Population: July 1, 2009 Population Estimates (all ages combined) from U.S. Census Bureau for the States, the District of Columbia, and Puerto Rico. July 1, 2010 Population Estimates (all ages combined) from U.S. Census Bureau for the Territories other than Puerto Rico.

Income: 2009 Per Capita Income from Department of Commerce/Bureau of Economic Analysis.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2012 DISCRETIONARY STATE/FORMULA GRANTS
Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA # 93.138

STATE/TERRITORY	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate	+/- FY 2010
Alabama	$453,033	$451,210	$453,124	+$91
Alaska	430,800	430,800	430,800	0
Arizona	615,499	636,135	635,901	+20,402
Arkansas	430,800	430,800	430,800	0
California	3,157,066	3,156,541	3,146,731	-10,335
Colorado	430,800	430,800	431,213	+413
Connecticut	430,800	430,800	430,800	0
Delaware	430,800	430,800	430,800	0
District Of Columbia	430,800	430,800	430,800	0
Florida	1,639,586	1,642,945	1,648,480	+8,894
Georgia	919,227	932,582	936,659	+17,432
Hawaii	430,800	430,800	430,800	0
Idaho	430,800	430,800	430,800	0
Illinois	1,118,508	1,111,634	1,107,122	-11,386
Indiana	613,654	612,763	612,730	-924
Iowa	430,800	430,800	430,800	0
Kansas	430,800	430,800	430,800	0
Kentucky	430,800	430,800	430,800	0
Louisiana	430,800	430,800	430,800	0
Maine	430,800	430,800	430,800	0
Maryland	460,430	458,172	457,986	-2,444
Massachusetts	516,687	516,280	523,381	+6,694
Michigan	956,242	944,052	944,864	-11,378
Minnesota	452,067	447,934	451,832	-235
Mississippi	430,800	430,800	430,800	0
Missouri	561,160	558,480	554,121	-7,039
Montana	430,800	430,800	430,800	0
Nebraska	430,800	430,800	430,800	0
Nevada	430,800	430,800	430,800	0
New Hampshire	430,800	430,800	430,800	0
New Jersey	695,242	688,789	688,996	-6,246
New Mexico	430,800	430,800	430,800	0
New York	1,581,203	1,585,334	1,597,390	+16,187
North Carolina	869,277	881,640	883,864	+14,587
North Dakota	430,800	430,800	430,800	0

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2012 DISCRETIONARY STATE/FORMULA GRANTS
Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA # 93.138

STATE/TERRITORY	FY 2010 Appropriation	FY 2011 Pres. Budget	FY 2012 Estimate	+/- FY 2011
Ohio	$1,085,963	$1,080,596	$1,073,598	-$12,365
Oklahoma	430,800	430,800	430,800	0
Oregon	430,800	430,800	430,800	0
Pennsylvania	1,110,883	1,099,490	1,103,290	-7,593
Rhode Island	430,800	430,800	430,800	0
South Carolina	441,509	446,302	446,340	+4,831
South Dakota	430,800	430,800	430,800	0
Tennessee	593,337	595,120	597,534	+4,197
Texas	2,184,785	2,194,491	2,213,502	+28,717
Utah	430,800	430,800	430,800	0
Vermont	430,800	430,800	430,800	0
Virginia	666,229	665,862	659,708	-6,521
Washington	561,991	564,558	564,949	+2,958
West Virginia	430,800	430,800	430,800	0
Wisconsin	517,377	516,223	512,792	-4,585
Wyoming	430,800	430,800	430,800	0
State Sub-total	**33,833,355**	**33,849,533**	**33,877,707**	**+28,174**
American Samoa	230,800	230,800	230,800	0
Guam	230,800	230,800	230,800	0
Northern Marianas	230,800	230,800	230,800	0
Puerto Rico	665,045	648,867	620,693	-44,352
Virgin Islands	230,800	230,800	230,800	0
Territory Sub-Total	**1,588,245**	**1,572,067**	**1,543,893**	**-28,174**
American Indian Consortiu	230,800	230,800	230,800	0
Total States/Territories	**35,652,400**	**35,652,400**	**35,652,400**	**0**
SAMHSA Set-Aside	**727,600**	**727,600**	**727,600**	**0**
TOTAL, MHBG	**$36,380,000**	**$36,380,000**	**$36,380,000**	**$0**

Mandatory Drug Testing

Program Description and Accomplishments

The Federal Drug-Free Workplace Mandatory Drug Testing program, initiated in 1986 by Executive Order #12564 and Public Law 100-71 in 1987, provides funding for accreditation and ongoing quality assurance of laboratories that perform mandatory drug testing for Federal and non-Federal employees across the nation. The National Laboratory Certification Program is a core and crucial component that impacts all Executive Branch agencies related to public safety and national security clearance, including pre-hire and periodic testing for over 400,000 of the approximately 2.2 million non-uniformed service Federal employees, such as the Federal Bureau of Investigation, the Drug Enforcement Administration, and many others in the Department of Defense and the intelligence agencies. The contract is also critical to support employee drug testing federally mandated by the Department of Transportation and the Nuclear Regulatory Commission, in total approximately 6.8 million drug tests per year. The mandatory drug testing program is further supported by the CSAP Workplace Helpline, a toll-free telephone service for business and industry that answers questions about drug abuse in the workplace. The Workplace Helpline receives requests for assistance from small business owners who represent the vast majority of enterprise in the American economy, and from individuals regarding prescription drugs, illicit drugs, and alcohol use.

Opioid Drug Treatment/Regulatory Activities

Program Description and Accomplishments

SAMHSA/CSAT employs a number of contracts that support its regulatory efforts and monitoring activities of opioid treatment programs. Some examples include:

- Certification of Opioid Treatment Programs (OTPs) that use Methadone, Subutex, or Suboxone to treat patients with opioid dependence. SAMHSA carries out this responsibility by enforcing the regulations that established the accreditation-based system, and it is accomplished in coordination with the Drug Enforcement Administration (DEA), States, Territories, and the District of Columbia. An OTP must comply with applicable State licensing requirements to operate as an OTP and must meet regulatory requirements set forth in Title 42 Code of Federal Regulations Part 8 (42 CFR Part 8). Within the regulations there is also a requirement for each OTP to achieve formal accreditation by a SAMHSA/CSAT recognized accreditation body.
- Physician Clinical Support System-Methadone, a national mentoring network offering support (clinical updates, evidence-based outcomes, and training) to physicians and other medical professionals in the appropriate use of methadone for the treatment of chronic pain and opioid addiction. This program also addresses the nation's rise in methadone-associated deaths that has been spurred by misuse/abuse, and fatal drug interactions involving methadone and other prescription medications, over the counter medications, and illicit drugs
- Physician Clinical Support System-Buprenorphine, a program designed to assist practicing physicians that wish to incorporate into their practices the treatment of prescription opioid and heroin dependent patients using the medication buprenorphine. The goal of this program

is to expand access to office-based buprenorphine treatment by first providing expert education and training to physicians on the appropriate use of buprenorphine, and to then certify their eligibility to treat opioid dependent patients.

- Opioid Treatment Technical Assistance Program (OTTAP), of which the primary objective is to educate and prepare OTPs to achieve accreditation by SAMHSA's approved accreditation bodies. Accreditation has been shown to improve treatment and access to treatment for patients and provides the opportunity for OTPs to incorporate best practices in their treatment programs. Other goals include improving OTP administration and management, increasing staff retention, providing more OTP staff training, increasing availability of comprehensive services and emergency services, and improving patient outcomes. Even though most OTPs have been able to achieve initial accreditation (approximately 97% of over 1,160 active OTPs are accredited), continuing technical assistance is considered necessary to assist OTPs in maintaining accreditation, as they are subject to re-survey, occurring at least triennially.

Prescription Drug Monitoring
National All Schedules Prescription Electronic Reporting (NASPER)

Program Description and Accomplishments

The National All Schedules Prescription Electronic Reporting Act (NASPER), is a formula grant program, that was authorized in 2005 (Public Law 109-60) and received its first appropriation in FY 2009. The purpose of this program is to: 1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that health care providers and law enforcement officials and other regulatory bodies have access to accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and 2) develop, based on the experiences of existing State controlled substance monitoring programs, a set of best practices to guide the establishment of new State programs and the improvement of existing programs.

By requiring standards for security, privacy, confidentiality and interoperability, NASPER expands the utility of prescription monitoring programs (PMPs), allowing more States to share information internally and regionally with neighboring States, a key shortcoming of the existing system. In addition, the expansion and establishment of prescription monitoring systems has the potential for assisting in the early identification of patients at risk for addiction. Early identification of individuals in need of treatment is a key public health concern and leads to enhanced substance abuse treatment interventions.

As of 2009, approximately 40 States had an operational PMP or current legislation authorizing establishment of PMPs. Although current State PMPs vary, they essentially require that pharmacies, physicians, or both, submit information on prescriptions dispensed for certain controlled substances as mandated by State law. Prescriber and patient information relating to prescriptions issued for controlled stimulants, sedatives/depressants, anxiolytics, narcotics and other covered drugs is transmitted to a central office within each State.

The allocation formula for the NASPER grant program distributes one percent of the appropriation to each eligible State, with an additional amount distributed based on the ratio of the number of pharmacies in the State to the number of pharmacies in all States.

The Secretary must approve grants to all States that are qualified (defined as the 50 States and the District of Columbia). To qualify for a grant award, a State must submit an application that meets all the NASPER requirements including the following: the State must demonstrate that it has enacted legislative or regulatory authority for a PMP; the State must have penalty provisions for unauthorized patient information disclosures; the State must include substances in Schedules II-IV in its PMP; and the State must agree to collect information in accordance with standards developed by the Department.

To implement NASPER and the 2009 appropriation, the Department was required to solicit Federal Register Notice (FRN) comments on proposed minimum standards. Before developing proposed minimum standards, and issuing the FRN, SAMHSA sought input from and consulted with the field and also obtained the Secretary's delegation of authority to implement NASPER. Several States and pharmacy entities subsequently commented on the proposed minimum standards. SAMHSA carefully considered the comments and incorporated revised minimum standards into the request for applications (RFA). A total of thirteen States submitted applications for grants, and each applicant subsequently received an award of FY 2009 funds. A new RFA was published in FY 2010.

In 2009, SAMHSA reported that the misuse of prescription drugs decreased significantly between 2007 and 2008 among those aged 12 and older, including among adolescents, according to the 2008 National Survey on Drug Use and Health (NSDUH). The report also indicated that progress has been made in curbing other types of illicit drug use. For example, past month methamphetamine use among those aged 12 and older dropped sharply from approximately 529,000 people in 2007 to 314,000 in 2008. Similarly, the level of current cocaine use among the population aged 12 and older has decreased from 1.0 percent in 2006 to 0.7 percent in 2008. Promising results from the latest survey also were also found for the most part among youth (12 to 17 year olds). Among youth there was a significant decline in overall past month illicit drug use, from 11.6 percent in 2002 to 9.3 percent in 2008. Although the rate of current marijuana use among youth has remained level at about 6.7 percent over the past few years there have been significant decreases in the current use of alcohol, cigarettes and non-medical use of prescription drugs since 2007. Non-medical use of prescription drugs dropped from 3.3 percent in 2007 to 2.9 percent in 2008.

The State Allotment calculation assumes that all 50 States and the District of Columbia will apply and are approved. The count of pharmacies in each State is based on the most recent data provided on the Drug Enforcement Administration's (DEA) website. FY 2010 and FY 2011 calculations assume no change to the most recent data provided by the DEA and assumes that all 50 States and the District of Columbia will apply and be approved. In 2009, 13 States applied for and were approved for funding.

To be eligible to receive a grant under NASPER, the State must demonstrate that the State has enacted legislation or regulations to permit the implementation of the State controlled substance

monitoring program and the imposition of appropriate penalties for the unauthorized use and disclosure of information maintained in such program. Additional requirements for applications are set forth under 42 U.S.C. section 399(O)(c), and include budget cost estimates, interoperability standards, uniform electronic formats, access to information, penalties for unauthorized disclosures and other issues.

Funding History

FY	Amount
2007	$49,079,000
2008	$51,669,000
2009	$54,448,000
2010	$55,052,000
2011	$54,938,000

Budget Request

The FY 2012 President's Budget request is $54.9 million, a decrease of $0.1 million from the FY 2010 Level. The funding level will continue all current programmatic activities.

Outcomes and Outputs

Protection & Advocacy

Table 1: Key Performance Indicators for Protection and Advocacy

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.4.12: Number of people served by the PAIMI program (Outcome)	FY 2009: 16,951 (Target Not Met)	22,325	17,900[1]	-4,425

[1] Target was reduced to reflect most recent actual given previous two years of performance results were off nearly 30 percent and not due to any 2012 budget reductions.

Measure	Most Recent Result	FY 2011 Performance Target Associated with FY 2010 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2011 Performance Target
3.4.19: Number attending public education/constituency training and public awareness activities (Output)	FY 2009: 92,953 (Target Not Met but Improved)	120,000	92,953[2]	-27,047
3.4.21: Increase percentage of complaints of alleged **abuse, neglect, and rights violations** substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, or elimination of other barriers to personal decision-making, as a result of PAIMI involvement (Outcome)	FY 2009: 88.0 % (Historical Actual)	87.0 %	87.0 %	Maintain

Grant Award Table

(Whole Dollars)	FY 2010	FY 2011	FY 2012
Number of Awards	75	73	73
Average Award	$527,832	$529,485	$529,485
Range of Awards	$22,000-$3,156,541	$22,000-$3,156,541	$22,000-$3,156,541

[2] Target was reduced to reflect most recent actual given previous two years of performance results were off nearly 30 percent and not due to any 2012 budget reductions.

Public Awareness and Support

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Program Level.....	$14,230	$14,230	$13,571
PHS Evaluation Funds (non-add)……..…..…..….....	---	---	*13,571*

Authorizing Legislation .....Section 501, 509, 516 and 520A of the PHS Act

FY 2012 Authorization .....Expired

Allocation Method ..... Contracts

Program Description and Accomplishments

Too many Americans are not getting the help they need, and many opportunities to prevent and intervene early are being missed. By combining sound public health practices with science-based training, communications and marketing approaches, the Public Awareness and Support Initiative will reduce the disparities between people in need and receiving prevention and treatment services by improving training and increasing education about 1) confronting discrimination and misinformation; 2) increasing public knowledge about the effectiveness of treatment and opportunities for recovery; 3) educating the public about self, peer, and family care; and 4) improving understanding about how to access treatment and insurance coverage for mental health and substance use services.

The purpose of the Public Awareness and Support Initiative is to increase understanding of mental and substance use disorders to achieve the full potential of prevention, help people recognize signs and symptoms and seek assistance with the same urgency as any other health condition, and make recovery the expectation. Training and education principles and techniques can be used to target behavior changing strategies needed to achieve this goal.

To better utilize limited funding resources, SAMHSA is proposing to restructure public awareness and support training and education activities. The funding for SAMHSA training and education activities will be consolidated into one budget line that incorporates separate SAMHSA budget lines. Creating a single budget line administered by SAMHSA's Office of Communications will create a consistent approach across SAMHSA for application of training and education principles and techniques. This new approach will help align training and education activities with SAMHSA priorities and devote resources toward achieving the purpose of the Public Awareness and Support Initiative.

Background

The use of training and education principles and techniques is a well-established, science-based strategy capable of influencing a target audience to voluntarily accept, reject, modify, or abandon a behavior for the benefit of individuals, groups, or society as a whole. For example, the National High Blood Pressure Education Program (NHBPEP), established in 1972, demonstrates success from using a strategic planning framework and a marketing mix. The year the program began, less than one-fourth of the American population knew of the relationship between hypertension, stroke, and heart disease. Today, more than three-fourths of the American population understands this connection. As a result, virtually all Americans have had their blood pressure measured at least once, and three-fourths of the population has it measured every six months. Just as Americans are aware of the connection between hypertension, stroke and heart disease and take action to monitor their blood pressure, they should become aware of the connection between mental and substance use disorders and health and take action to prevent and treat these conditions.

Mental and substance use disorder prevention, treatment and recovery support services provide people in need with the opportunity for improved health and well-being. It is currently projected that mental illness and substance abuse will become the leading cause of disability in the world by 2020 unless significant action is taken to increase access and improve the understanding of these health conditions. Substance abuse and mental illness prevention and treatment services are clearly a critical component of health care and community-based strategies that advance and protect the Nation's health. Expenditures for these services ultimately lower costs for families, businesses, and governments. For example, studies have shown that the cost-benefit ratios for programs for early treatment and prevention for addictions and mental illnesses range from 1:2 to 1:10, which means that every $1.00 invested could yield $2.00 to $10.00 savings in health costs, criminal and juvenile justice costs, educational costs, lost productivity, etc.

While American attitudes are generally favorable toward prevention and treatment efforts, millions of Americans who could benefit from these services never receive help. SAMHSA's National Survey on Drug Use and Health (NSDUH) suggests that people do not receive help for substance abuse or mental health disorder for various reasons including fear/misinformation, potential for discrimination, concern about confidentiality, and not knowing where to go for help.

Opportunities for preventing or intervening early to mitigate the morbidity and mortality associated with these disorders are often missed. Current research indicates that half of all mental illnesses begin by age 14 and three-fourths begin by age 24. Initial symptoms typically precede a disorder by two to four years. Preventing and/or delaying initiation of substance abuse can reduce the potential need for treatment later in life. For example, among the 14 million adults aged 21 or older who were classified as having past year alcohol dependence or abuse, more than 13 million (95%) had started drinking alcohol before age 21. In one study, 94% of primary care physicians failed to diagnose substance use disorders properly. Over 33,000 people die by suicide in the U.S. every year. Approximately 90% of people who die by suicide had a mental disorder and 40% had visited their primary care doctor within the past month – yet the question of suicide was seldom raised.

Behavioral health is essential to health and public understanding of this concept is key to improving health status and reducing costs to families, communities and governments. As a result, SAMHSA has launched the Public Awareness and Support Initiative which is being advised by the SAMHSA Communications Governance Council. As part of the Public Awareness and Support Initiative, the SAMHSA is consolidating 88 websites, combining multiple 800 numbers into a single point of entry, creating and promoting a single user-friendly facility locator service, and building a public engagement strategy using social media to create a consistent message and purpose across multiple disparate platforms. This will consolidate resources and implement a transmedia communications strategy that segments and targets public, provider and payer audiences with behavioral health information critical to improving health and reducing costs. Rather than multiple entry points for behavioral health information, the Initiative will create a single interaction point for the public for communication products, services and messages related to behavioral health.

A transmedia approach is required to reach diverse U.S. populations, each having a distinct set of wants, needs and communications channels. Traditional media (broadcast, print and news) and expanded online engagement, social and mobile media, interaction and community building will be used to increase the visibility and impact of behavioral health resources. Elements of this new communications approach and public engagement strategy includes web, social media (e.g. Twitter[1], Facebook[2], YouTube[3], etc), analytics and metrics, media monitoring, graphic design, mapping/geospatial, data/API development, video/multimedia, mobile messaging, and ongoing assessments of new and emerging technologies.

The Public Awareness and Support Initiative is being driven by research with SAMHSA stakeholders, including web-based public engagement strategies/platforms, and applies the communications and marketing principles of customer research and audience segmentation, message development and evaluation. Because it is based on customer needs and input, the Public Awareness and Support Initiative is dynamic and evolving based on the shifting landscape of communications technologies and government involvement with the public.

Budget Request

The FY 2012 President's Budget request is $13.6 million, which reflects the consolidation of funding available for the SHIN and web development contracts from across SAMHSA to support SAMHSA-wide public awareness and technical assistance activities. It also reflects efficiencies realized through the consolidation of multiple web development contracts, resulting in more streamlined operations without loss of capabilities.

[1] These are trademarked names of their respective websites.
[2] These are trademarked names of their respective websites.
[3] These are trademarked names of their respective websites.

Outcomes and Outputs

Public Awareness Activities

Table 1: Key Performance Indicators for Public Awareness and Support[4]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.3.76: Number of persons receiving prevention information indirectly from advertising, broadcast, or website[5] (Output)	FY 2009: 1,443,077 (Target Exceeded)	906,707[6]	1,250,000[7]	+343,293[8]
4.4.06: Percentage of persons reporting knowledge of how to find treatment services for mental and substance use disorders (Outcome)	N/A	N/A	TBD	N/A
4.4.07: Percentage of persons indicating they were screened by a health care provider for mental and substance use disorder (Outcome)	N/A	N/A	TBD	N/A
4.4.08: Percentage of persons taking steps to prevent mental and substance use disorders in their lives (Outcome)	N/A	N/A	TBD	N/A
4.4.09: Percentage of parents reporting they are comfortable talking to their children about alcohol and drugs (Outcome)	N/A	N/A	TBD	N/A

[4] There is no delay between fiscal year funding and the performance year.

[5] Includes Town Hall Meetings, FASD, and MEI (Community Outreach).

[6] This is the FY 2011 performance target associated with the FY 2010 PB since there is a delay between fiscal year funding and performance year.

[7] This is the FY 2013 performance target associated with the FY 2012 request since there is a delay between fiscal year funding and performance year.

[8] This is the delta between the FY 2013 performance target and the FY 2011 performance target.

Performance & Quality Information Systems

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Program Level…	$30,165	$30,987	$12,996
PHS Evaluation Fund…	*$6,596*	*$6,596*	*$12,996*

Authorizing Legislation .....Section 501, 509, 516, and 520A of the PHS Act

FY 2012 Authorization .....Expired

Allocation Method .....Contract

Program Description and Accomplishments

In January 2010, SAMHSA launched a new initiative focusing on data, outcomes, and quality. The goal of this initiative is to strengthen the integration of data begun with the previous data strategy. This new initiative will allow SAMHSA to meet the Administration's expectations for high quality and accessible data and create new opportunities to meet the information needs of individuals, families, and communities. A guiding principle of this new data strategy is that the data be meaningful and useful for decision-making and policy development. Central to this strategy is improving the balance in the collection of prevention and treatment data for substance use and mental disorders, providing clarity in how performance measures are collected and used, developing new systems for coordinating across systems, and then disseminating quality information in a readily accessible format.

SAMHSA leadership has determined that integrating both performance data and information on the quality and effectiveness of interventions better serve State and community needs and promotes quality improvement efforts consistent with the President's health care reform goals. This new initiative will coordinate the performance measurement efforts with quality improvement activities and promote greater efficiencies in the collection, analysis, and reporting of data and other information. It will also facilitate accountability and improve the quality and accessibility of data and other information for use by program staff, grantees, and the public. An important function of these activities will be its capacity to collect and disseminate data across prevention and mental health and substance abuse programs that share goals and funding lines; something extremely difficult given the current systems.

In FY 2011, SAMHSA will take steps to modify the Substance Abuse Information System (SAIS), Prevention Management Reporting and Training Tool (PMRT) and the Transformation Accountability System (TRAC) to incorporate both substance abuse and mental health performance measures. Concurrently, SAMHSA will develop a new Request for Proposal (RFP) for a consolidated data warehouse system. This initiative will incorporate the management and outcome measurement needs of each Center while providing greater access by grantees and other shareholders.

Concurrent with the effort to integrate the performance management data systems, SAMHSA will take steps to closely coordinate the activities of the National Registry of Evidence-based Programs and Practices (NREPP) with the data reporting systems. In this way, information on effective interventions can inform agency efforts to improve service activities and outcomes for individuals who suffer from or who are at risk for mental and substance use disorders. Activities to advance the dissemination of these efforts will be further guided by the results of the ARRA-CER funded study on effective dissemination practices to be completed by 2012.

Funding History

FY	Amount
2007	$0
2008	$0
2009	$0
2010	$0
2011	$0

Budget Request

The FY 2012 President's Budget request is $13.0 million, with $11 million for the performance management system and $2 million for the NREPP program. By September 2011, SAMHSA will develop an acquisition proposal for an integrated performance measurement and management platform to be operational in FY 2012. The performance management system will adapt current systems to accept cross-cutting mental health and substance abuse data from all of SAMHSA's programs. $24.8 million is reduced from the Services Accountability, and Program Coordination and Evaluation budget lines to reflect comparability adjustments and projected savings.

Outcomes and Outputs

Performance and Quality Information Systems

Table 1: Key Performance Indicators for Performance and Quality Improvement Systems[1]

Measure	Most Recent	FY 2010	FY 2012	FY 2012 +/-
4.4.10: Combined count of webpage hits, hits to the locator, and hits to SAMHDA for SAMHSA-supported data sets (Output)	FY 2009: 4,833,000 (Baseline)	5,195,000	6,000,300	+805,300
4.4.11: Number of evidence-based programs or practices in review (Output)	FY 2010: 40 (Target Met)	40	44	+4

[1] There is no delay between fiscal year funding and performance year.

SAMHSA/Center for Behavioral Health Statistics and Quality
(Dollars in thousands)

CBHSQ Activities	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget
National Data Collection			
DAWN	$17,000	$17,000	$12,000
NSDUH	47,000	47,000	59,000
National Analytic Center	2,500	2,500	3,500
DASIS	12,094	12,094	12,850
C-EMS	---	---	1,000
Data Archive	1,500	1,500	1,500
FTE/Operations	2,605	2,605	3,640
TOTAL PL, CBHSQ	**$82,699**	**$82,699**	**$93,490**

Program Description

The data collection, analytic, and quality standards programs at SAMHSA support a number of federal, State, local, and Tribal governments, as well as researchers and non-governmental organizations, to develop timely and credible data and statistical information to improve the quality and outcomes of services provided to individuals, families, communities and tribal communities.

There are three structural components within SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) supporting an integrated data strategy that informs policy and measures program impact at the national, State, Territory, community and program level. These components include survey and data collection, evaluation and analysis, and quality and performance improvement.

Budget Request

The FY 2012 President's Budget request for SAMHSA's data initiatives is $93.5 million, an increase of $10.8 million from the FY 2010 Level. CBHSQ's budget is funded from the SABG Set-Aside as well as Health Surveillance & Program Support. $85.0 million is requested for data collection and surveillance activities. This funding request includes $59 million for the National Survey on Drug Use and Health (NSDUH), $12 million for the Drug Abuse Warning Network (DAWN), $13 million for the Drug Abuse Services Information System (DASIS) and $1 million is requested to support the development of the Community Early Warning and Monitoring

System (CEMS). NSDUH serves as the nation's primary source for information on the incidence, prevalence of substance use and mental disorders and related health conditions. DAWN is a national public health surveillance system that monitors emergency room visits for drug and mental illness-related problems. This represents a partnership with the National Center for Health Statistics/CDC which is expected both to increase response rates and improve the quality of data available to help inform public policy and prevention and treatment initiatives. These changes are consistent with proposals presented in previous budgets. DASIS is the primary source for data on treatment and treatment admissions. One aspect of this program is the treatment locator which is accessed more than 2 million times a year by individuals, families, community groups and organizations to identify appropriate treatment services. The DASIS project is currently piloting two new programs with the intent to integrate mental health facilities surveys and mental health treatment admissions. SAMHSA expects to integrate these efforts in FY 2012 and to field an integrated survey in FY 2013. $6.1 million is requested to support analytic and evaluation activities responsive to SAMHSA and HHS priorities. This funding request includes support for the National Analytic Center which supports a range of analyses and report writing on policy- and practice-specific topics in response to requests from SAMHSA Centers, HHS agencies (CDC, AHRQ, FDA, and the Surgeon General's Office), the Office of National Drug Control Policy, and the Department of Justice. The funding also supports the Substance Abuse and Mental Health Data Archive (SAMHDA) which serves as SAMHSA's primary repository for public access data files. SAMHDA provides free access and on-line analytic tools to the public. Funds within this request will also be used to develop a program for providing public access to restricted files to expand the use and application of data collected under the survey contracts. Funding will also support analytic staff positions to meet the demands for additional analyses and reports in support of health reform efforts.

Additionally, within the Performance and Quality Information Systems line, $13 million is requested for quality and performance measurement efforts. This funding request includes $10 million for a consolidated data platform that provides a uniform collection and reporting system that will provide SAMHSA management and staff with the ability to analyze programs at various levels (state, program, community, etc.), provide each Center with tailored information in real-time about the progress and activities of their grantees, and provide data to grantees to support them in the efficient and effective implementation of projects. This is a reduction of approximately $5 million spent across the three programmatic centers which currently gather data through three unique data systems. The funding also includes $3 million for the continuation of the National Registry of Evidence-based Programs and Practices which is a searchable online system that supports States, communities in identifying and implementing evidence-based mental health promotion, substance abuse prevention, and substance abuse and mental health treatment interventions.

Health Surveillance and Program Support

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Program Level	**$101,947,000**	**$101,947,000**	**$127,594,000**
Budget Authority (non-add)	*79,197,000*	*79,197,000*	*82,166,000*
PHS Evaluation Funds (non-add)	*$22,750,000*	*$22,750,000*	*$45,428,000*
FTEs			
(Health Surveillance and Program Support)	**485**	**485**	**485**
(Block Grant Set-aside)	**52**	**52**	**59**
Total, FTE	**537**	**537**	**544**

Authorizing Legislation .....Section 501 of the Public Health Service Act

FY 2012 Authorization .....Indefinite

Allocation Method .....Direct Federal/Intramural, Contracts, Other

Program Description and Accomplishments

The Health Surveillance and Program Support budget supports the majority of SAMHSA staff who plan, direct, and administers SAMHSA programs and who provide technical assistance and program guidance to States, mental health and substance abuse professionals, clients, and the general public. SAMHSA staffing represents a critical component of the budget. Staff not financed directly through the Health Surveillance and Program Support account provide direct State technical assistance and are funded through the five percent Block Grant set-asides. There are currently 52 FTEs dedicated to Block Grant technical assistance. This budget supports contracts for monitoring State formula and block grants and the national surveys. In addition, this budget supports the Unified Financial Management System, administrative activities such as human resources, information technology and the centralized services provided by Program Support Center and the Department.

National Surveys
(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget
PHS Evaluation Funds			
CBHSQ Data Collection Activities	$21,750	$21,750	$43,779
NSDUH Mental Health	1,000	1,000	1,000
Data Archive - Restricted Use	0	0	649
Total, PHS Evaluation Funds	**22,750**	**22,750**	**45,428**
Budget Authority			
CDC National Health Interview Survey	2,000	2,000	2,000
Total, Budget Authority	**2,000**	**2,000**	**2,000**

Funding History

FY	Amount	FTEs
2007	$76,714,000	528
2008	$75,381,000	544
2009	$77,381,000	549
2010	$101,947,000	535
2011	$101,947,000	535

Budget Request

The FY 2012 President's Budget request is $127.6 million, an increase of $25.6 million over the FY 2010 Level. This reflects an increase in Budget Authority of $2.9 million and an increase in PHS Evaluation Funds of $22.7 million. These increases will be used to finance technical assistance, evaluation and data collection activities associated with the new substance abuse, mental health and behavioral health prevention programs, and to continue and enhance State technical assistance capacity in all 10 HHS regional offices. SAMHSA is currently assessing the impact of restructuring its budget and the results of a major policy review of all grants and contracts on providing additional assistance to the States within the Health Surveillance and Program Support budget. These funds will also be used to address the goals and objectives of the Data, Outcomes and Quality Strategic Initiative lead by CBHSQ. Additional details on the CBHSQ budget can be found in the preceding chapter. Finally, SAMHSA is undergoing a review of its contracts which is expected to result in revisions to its regular contract planning process. The review, which includes those activities financed by the block grant set-asides, will determine where efficiencies and consolidations may be warranted. The goal of the review is to have policy-driven grants and contracts planning process and to bring these activities in closer alignment with the mission and vision for SAMHSA.

Summary of Changes

(Dollars in Thousands)

Increases:	
Built-in:	
Annualization of Commisioned Corps pay raise	+22
Increase for January Pay raise 1/	+108
Increase in rental payments to GSA	+119
Additional FTEs	+1,225
Subtotal, Built-in	**+1,473**
Program:	
Overseas Rightsizing	+5
Technical Assistance, Evaluation and Data Activities	+12,398
CBHSQ Data Evaluation Activities BA/PHS Evaluation Funds	+10,791
Subtotal, Program	**+23,194**
Total, Increase	**+24,667**
Program:	
HHS Joint Funding Arrangement	-20
Subtotal, Program	**-20**
Total, Decreases	**-20**
Net Change	**+$24,647**

1/ Reflects 0% and 1.4% pay raise for civilian and military personnel, respectively

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Saint Elizabeths Hospital
Building and Facilities

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
Budget Authority	**$795,000**	**$795,000**	**$0**

Authorizing Legislation .....Section 501 of Public Health Service Act

FY 2012 Authorization .....Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

On December 9, 2004, the Department of Health and Human Services (DHHS) transferred the West Campus of the St. Elizabeths Hospital to the General Services Administration (GSA). Along with this transfer, the DHHS and GSA signed a Memorandum of Agreement outlining each agency's responsibilities and requirements with regards to the transfer and subsequent associated activities.

One such requirement was for DHHS to pay for any further actions necessary to remediate (clean-up) hazardous substances found on the site after the date of transfer. Following the transfer, GSA discovered the remnants of a former landfill. Preliminary samples collected from various depths showed the presence of lead, dioxins, and other hazardous substances. As a result of the Memorandum of Agreement, DHHS is responsible for covering the cost of actions required to remediate this contamination.

Budget Request

The FY 2012 budget does not include additional funding to support the Department's environmental remediation activities at St. Elizabeths Hospital. In consultation with GSA, the Assistant Secretary for Administration has determined that funding through FY 2010 is sufficient to address current remediation activities.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

RESOURCE SUMMARY

	FY 2010 Enacted [4]	FY 2011 CR	FY 2012 Pres. Budget
Drug Resources by Function			
Prevention	566,218	566,476	550,514
Treatment	1,991,169	1,990,900	2,027,965
Total, Drug Resources by Function	**2,557,387**	**2,557,376**	**2,578,479**
Drug Resources by Decision Unit [1]			
Substance Abuse Block Grant (Treatment)	**1,454,713**	**1,454,713**	**1,494,314**
State, Tribal and Community Prevention Grants	**455,486**	**455,655**	**---**
Behavioral Health - Tribal Prevention Grants	**---**	**---**	**25,000**
Substance Abuse - State Prevention Grants	**---**	**---**	**395,000**
Innovation and Emerging Issues [2]			
Prevention	75,438	75,527	94,476
Treatment	408,434	407,995	399,419
Total, Innovation and Emerging Issues	**483,872**	**483,522**	**493,895**
Regulatory & Oversight Functions [3]			
Prevention	5,206	5,206	5,206
Treatment	10,903	10,903	10,903
Total, Regulatory & Oversight Functions	**16,109**	**16,109**	**16,109**
Public Education and Support			
Prevention	2,749	2,749	2,714
Treatment	8,808	8,808	10,857
Total, Public Education and Support	**11,557**	**11,557**	**13,571**
Performance and Quality Information Systems [3]			
Prevention	6,950	6,950	2,599
Treatment	26,753	26,923	10,397
Total, Performance and Quality Information Systems	**33,703**	**33,873**	**12,996**
Health Surveillance and Program Support			
Prevention	20,389	20,389	25,519
Treatment	81,558	81,558	102,075
Total, Health Surveillance and Program Support	**101,947**	**101,947**	**127,594**
Total, Drug Resources by Decision Unit	**2,557,387**	**2,557,376**	**2,578,479**
Drug Resources Personnel Summary			
Total FTEs (direct only)	**537**	**537**	**544**
Drug Resources as a Percent of Budget			
Total Agency Budget	**$3,582,701**	**$3,651,209**	**$3,649,248**
Drug Resources Percentage	**71.4%**	**70.0%**	**70.7%**

Footnotes

[1] SAMHSA's budget structure has been realigned; please see previous individual sections of this submission for further explanation of the changes. Includes $25 million Tribal Prevention Grant funded out of ACA Prevention Funds

[2] A detailed breakout of programs within the Innovation and Emerging Issues can be found on the following page; does not include Mental Health Programs. Reflects funding for Prevention Prepared Communities ($22.6 million) for Prevention in FY 2012 form the ACA Prevention Fund; does not reflect ACA Prevention Fund allocation funding for SBIRT ($25.0 million) and Health Surveillance ($18.0 million) in FY 2011.

[3] Regulatory and Oversight Functions reflects Mandatory Drug Testing for Prevention; Opioid Treatment and NASPER for Treatment. Performance and Quality Information Systems reflects pro-rated portion of the consolidated data collection platform for Prevention; Opioid Treatment and NASPER for Treatment. Performance and Quality Information Systems reflects pro-rated portion of the consolidated data collection platform for Prevention and Treatment.

[4] FY 2010 budget reflects a total reduction of $508,000 transferred to HHS, of which $339,000 was under Drug budget lines. FY 2011 funding reflects the comparable adjustment with the exclusion of $25 million of related HRSA funding and approximately $17 million for Mental Health Joint Initiatives funding.

Drug Budget IEI Split between Prevention and Treatment FY 2010-FY 2012
(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Pres. Budget
IEI-CSAP			
Minority AIDS Initiative	$41,385	$41,385	$41,385
STOP Act	7,000	7,000	7,000
Prevention Prepared Communities [1/]	0	0	22,600
Congresional Projects	3,950	3,950	0
Science and Service Program Coordination	4,845	4,789	4,409
Minority Fellowship Program	71	71	71
Fetal Acohol Syndrome	9,820	9,821	8,000
Center for the Application of Prevention Technologies	8,367	8,511	8,511
Agency Wide Initiatives			
Military Families	0	0	2,500
Total, CSAP	**$75,438**	**$75,527**	**$94,476**
IEI-CSAT			
PHS Evaluation Funds	$2,000	$2,000	$2,000
Co-occurring State Incentive Grants (SIGs)	4,262	4,263	4,263
Screening, Brief Intervention and Referral to Treatment	27,106	27,106	27,106
TCE - General	29,022	28,989	17,411
Pregnant & Postpartum Women	16,000	16,000	16,000
Strengthening Treatment Access and Retention	1,773	1,775	1,675
Recovery Community Services Program	5,669	5,236	2,450
Access to Recovery	99,380	98,954	98,454
Children and Family Programs	30,576	30,678	30,678
Treatment Systems for Homeless	42,530	42,750	47,360
Minority AIDS	65,911	65,988	65,988
Criminal Justice Activities	67,406	67,635	67,635
Congressional Projects	4,593	4,593	0
Minority Fellowship Program	547	547	547
Special Initiatives/Outreach	2,509	2,400	2,271
Addiction Technology Transfer Centers	9,150	9,081	9,081
Agency Wide Initiatives			
Health IT	0	0	4,000
Military Families	0	0	2,500
Total, CSAT	**$408,434**	**$407,995**	**$399,419**
Total, Drug Budget IEI	**$483,872**	**$483,522**	**$493,895**

1/ Funded out of ACA Prevention Funds

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MISSION

The Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to build resilience and facilitate recovery for people with, or at risk for, substance abuse and mental illness. SAMHSA supports the *President's National Drug Control Strategy* through a broad range of programs focusing on prevention and treatment of drug use. Major programs for FY 2012 will include the Substance Abuse Block Grant, the new State Substance Abuse Prevention grant, competitive grant programs reflecting Innovation and Emerging Issues (IEI), programs funded through the Prevention and Public Health Fund of the ACA Prevention Fund (including Prevention Prepared Communities and the new Behavioral Health – Tribal Prevention Grants), and a Prescription Drug Monitoring program (NASPER). These programs are administered through SAMHSA's Centers for Substance Abuse Prevention (CSAP) and Substance Abuse Treatment (CSAT).

METHODOLOGY

SAMHSA distributes drug control funding into two functions: prevention and treatment. Included in prevention are SAMHSA/CSAP funds supporting the new State Substance Abuse Prevention grant, competitive grant programs reflecting Innovation and Emerging Issues (IEI), programs funded through the Prevention and Public Health Fund of the ACA Prevention Fund (including Prevention Prepared Communities and the new Behavioral Health – Tribal Prevention Grants), and 20% of SAMHSA Program Management funds. Included in treatment are SAMHSA/CSAT funds supporting Programs of Regional and National Significance (PRNS), 100% of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds, 80% of SAMHSA Program Management funds, and all funding that supports the Prescription Drug Monitoring Program (NASPER).

BUDGET SUMMARY

In FY 2012, SAMHSA requests a total of $2,578.479 million for drug control activities, which is an increase of $21.1 million over the FY 2010 level. The Budget directs resources to activities that have demonstrated improved health outcomes and that increase service capacity. SAMHSA has eight major drug-related decision units: Substance Abuse Block Grant, State Substance Abuse Prevention Grants, Innovation and Emerging Issues, Regulatory and Oversight Functions, Public Education and Support, Performance and Quality Information Systems, Affordable Care Act Prevention Fund, and Program Management. Each decision unit is discussed below:

Innovation and Emerging Issues – Prevention

Total FY 2012 Request: $94.5 million
(Reflects $18.9 million increase from 2010)

The Substance Abuse Prevention Innovation and Emerging Issues programs (IEI) support States and communities in carrying out an array of activities to improve the quality and availability of services in priority areas.

The FY 2012 President's Budget request for SAMHSA Substance Abuse Prevention IEI includes $94.5 million which covers seven programmatic activities, an increase of $18.9 million from the FY 2010 level primarily due to not funding the Congressional Projects. The request includes: $41.4 million for Minority AIDS; $7.0 million for Sober Truth on Preventing Underage Drinking (STOP Act); $8.0 million for the Fetal Alcohol Spectrum Disorders (FASD) contract; $8.5 million to continue provision of technical assistance to maximize effectiveness through the Centers for the Application of Prevention Technologies; and $7.0 million for other IEI activities such as Science and Service Program Coordination, Military Families, and Minority Fellowships Program.

Minority AIDS Initiative

Total FY 2012 Request: $41.4 million
(Reflects same level as 2010)

SAMHSA/CSAP's Minority AIDS Program, implemented in FY 1999, supports efforts to reduce health disparities in minority communities by delivering and sustaining high quality and accessible substance abuse and HIV prevention services. The program strategies include implementing evidence-based prevention practices targeting subpopulations, conducting HIV testing and referral for treatment, and preventing/reducing the risk of substance use disorders and/or HIV. Grantees are required to target one or more high-risk populations such as African American women, adolescents, or individuals who have been released from prisons and jails within the past two years.

The Minority AIDS Program has funded ten cohorts of grants, with currently 122 active grants funded from cohorts six through ten, from FY 2005-2010. In FY 2010, SAMHSA developed two new grant programs (the *Capacity Building Initiative* and the *Ready To Respond Initiative*). Within each sub-program, grantees select an at-risk population to target:

- The *Capacity Building Initiative* targets 18-24 year old at-risk populations, including minority students on college campuses;
- The *Ready To Respond Initiative* allows experienced grantees that have successfully provided evidence-based substance abuse and HIV prevention services through the Strategic Prevention Framework to expand those services to a high-risk subpopulation.

The request supports 122 continuations in FY 2012.

Sober Truth on Preventing Underage Drinking Act (STOP Act)

Total FY 2012 Request: $7.0 million
(Reflects same level as 2010)

The Sober Truth on Preventing Underage Drinking Act (STOP Act) provides grants to organizations that are currently receiving or have received grant funds under the Office of National Drug Control Policy's Drug-free Communities Act of 1997 to either enhance an existing focus or to add a focus on preventing underage drinking. This program will strengthen the collaborative efforts and increase participation among all stakeholders (e.g. community organizations, coalitions, local and State governments). The initial program, funded in FY 2008, provided 79 four year grants to local communities with up to $50,000 per community per year. In FY 2010, a total of 99 grants received funding under this initiative to strengthen these important efforts.

Fetal Alcohol Center of Excellence

Total FY 2012 Request: $8.0 million
(Reflects $1.8 million decrease from 2010)

The Fetal Alcohol Spectrum Disorder (FASD) Center for Excellence, initiated in 2001, is the largest alcohol abuse prevention initiative within SAMHSA. The Center for Excellence identifies and disseminates information about innovative techniques and effective strategies for preventing Fetal Alcohol Spectrum Disorder and increases functioning and quality of life for individuals and their families impacted by these disorders.

Center for the Application of Prevention Technologies

Total FY 2012 Request: $8.5 million
(Reflects a $0.1 million increase from 2010)

The Center for the Application of Prevention Technologies (CAPT) promotes state-of-the-art prevention technologies through three core strategies: 1) establishment of technical assistance networks using local experts from each of their five regions; 2) development of training activities; and 3) innovative use of communication media such as teleconference and video conferencing, online events, and Web-based support. These training and technical assistance activities are designed to build the capacity of SAMHSA grantees and develop the skills, knowledge, and expertise of their prevention workforce. These activities will help support the delivery of effective prevention programs and practices and the development of accountability systems for performance measurement and management. Through interagency agreements, the CAPT also provides training and technical assistance to additional client groups such as the U.S. Department of Education's Grants to Reduce Alcohol Abuse Program.

Other IEI Activities

Total FY 2012 Request: $7.0 million
(Reflects $2.1 million increase from 2010)

The FY 2012 Budget includes resources of $7.0 million for other IEI activities such as Science and Service Program Coordination, Military Families, and Minority Fellowships Program.

Innovation and Emerging Issues – Treatment

Total FY 2012 Request: $399.4 million
(Reflects $9.0 million decrease from 2010)

The Substance Abuse Treatment Innovation and Emerging Issues programs (IEI) support States and communities in carrying out an array of activities to improve the quality and availability of services in priority areas.

The FY 2012 President's Budget request for SAMHSA Substance Abuse Treatment IEI includes $399.4 million which covers sixteen programmatic activities, a decrease of $9.0 million from the FY 2010 level primarily. The request includes: $99.0 million for Access to Recovery; $29.1 million for Screening, Brief Intervention and Referral to Treatment; $47.4 million for Treatment Systems for Homeless; $67.6 million for Criminal Justice Activities of which $43.7 million will fund Drug Courts and $22.5 million for Ex- Offender Reentry.

Access to Recovery

FY 2012 Request: $98.9 million
(Reflects same level as 2010)

FY 2012 resources for ATR reflect $99.0 million to support a new Request for Applications (RFA) for a third cohort (approximately 30 new grants). The RFA expanded ATR to a 4-year program. ATR is designed to: (1) allow recovery to be pursued through personal choice and many pathways; (2) require grantees to manage performance based outcomes that demonstrate client successes; and, (3) expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services. The program is administered through recognized Tribal Organizations or through the Single State Authority overseeing substance abuse activities. ATR uses vouchers, coupled with state flexibility and executive discretion, to offer an opportunity to create positive change in substance use disorder treatment and recovery service delivery across the Nation.

Screening, Brief Intervention and Referral to Treatment Activities

FY 2012 Request: $27.1 million
(Reflects same level as 2010)

Substance abuse is one of our Nation's most significant public health challenges, and the SBIRT approach can intervene early in the disease process before individuals achieve dependency, and can motivate the addicted client to engage in substance abuse treatment. Since the beginning of this program, more than one million individuals have been screened. Of those, 23% required a brief intervention, brief treatment or referral to specialty treatment programs. The FY 2010 resources of $27.1 million supported continuation of eight State SBIRT grants, and seventeen Medical Residency SBIRT Training grants. The FY 2012 Budget will fully fund the continuation of four State grants (four State grants will end in September 2011) and seventeen Medical Residency Training programs.

Treatment Drug Courts

FY 2012 Request: $43.7 million

(Reflects same level as 2010)

Drug courts are problem-solving courts which help reduce recidivism and substance abuse among offenders and increase an offender's likelihood of successful rehabilitation through early, continuous, and intense judicially supervised treatment, mandatory periodic drug testing, community supervision, and appropriate sanctions and other habilitation services. In FY 2010, SAMHSA funded 17 new adult Problem Solving Court grants and 8 new juvenile Problem Solving Court grants for three years at an average cost of $325,000 per year. There were also 3 new juvenile Problem Solving Court grants that were funded in collaboration with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the Department of Justice for four years at an average cost of $200,000 per year. These funds will provide services to support substance abuse treatment, assessment, case management, and program coordination for those in need of treatment drug court services. Priority for the use of funding will be given to address gaps in the continuum of treatment.

In FY 2010, SAMHSA and the Office of Justice Programs /Bureau of Justice Affairs (BJA) developed a joint program to enhance court services, coordination, and substance abuse treatment capacity of adult drug courts. The purpose of this joint initiative is for applicants to submit one application that outlines a comprehensive strategy for enhancing drug court capacity. SAMHSA and BJA jointly funded 28 new adult Problem Solving Court grants. Each grantee was awarded one separate grant from each agency, representing an innovative braided funding opportunity. This collaboration was modeled after a successful collaborative grant program initiated in FY 2009 between SAMHSA and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to support juvenile drug courts.

Ex-Offender Re-Entry Program

FY 2012 Request: $22.6 million

(Reflects $4.6 million increase from 2010)

SAMHSA recognizes the need to continue efforts to return and reintegrate offenders back into the community by providing substance abuse treatment and other related re-entry services while also ensuring public safety for the community and family. The ex-offender re-entry grants provide screening, assessment and comprehensive treatment and recovery support services to offenders reentering the community, as well as offenders who are currently on or being released from probation or parole. The FY 2012 request of $22.6 million will provide $12.2 million for continuation of 28 grants and $10.4 million for the award of approximately 24 new grants.

Treatment Systems for Homeless Programs

FY 2012 Request: $47.4 million

(Reflects $4.6 million increase from 2010)

SAMHSA/CSAT manages two grant portfolios under its Grants for the Benefit of Homeless Individuals (GBHI) program, both of which provide focused services to individuals with a substance use disorder or who have co-occurring disorders. Through a recovery and public health oriented system of care, grantees are encouraged to address gender, age, race, ethnicity, sexual orientation, disability status, veteran's status, and criminal justice status as these issues

relate to both substance use disorder services and co-occurring disorder services for homeless individuals. The FY 2012 Budget reflects resources of $47.4 million to support continuation of 85 grants of which $4.2 million will support a new cohort of approximately nine new grants. The FY 2010 GBHI portfolio includes services in supportive housing (SSH) grants that seek to expand and strengthen treatment services for clients already in housing that is permanent, affordable, and linked to health, employment, and other support services. This approach combines long-term, community-based housing assistance with intensive individualized treatment and recovery support services.

Other IEI Treatment Programs

FY 2012 Request: $158.4 million
(Reflects $8.6 million decrease from 2010)

The FY 2012 Budget includes resources of $158.4 million for several other Treatment Capacity programs including: Co-occurring State Incentive Grants; Strengthening Treatment Access and Retention; the Minority AIDS Initiative; Children and Family Programs; Pregnant and Post-Partum Women (PPW); Recovery Community Services Program (RCSP); Minority Fellowship Program; Special Initiatives/Outreach; Addiction Technology Transfer Centers; Military Families, Health Information Technology; and Targeted Capacity Expansion (TCE) General. The FY 2012 Budget includes funds for continuing grants and contracts in the various programs, and reflects discontinuation of one-time Congressional projects. Grant funding will be used to enhance overall drug treatment quality by incentivizing treatment providers to achieve specific performance targets. Examples of grant awards could include supplements for treatment providers who are able to connect higher proportions of detoxified patients with continuing recovery-oriented treatment; or for outpatient providers who are able to successfully retain greater proportions of patients in active treatment participation for longer time periods.

Substance Abuse Prevention and Treatment Block Grant

FY 2012 Request: $1.419 billion
(Reflects an increase of $44.0 million from 2010)

The overall goal of the SABG is to support and expand substance abuse treatment services, while providing maximum flexibility to states. States and territories may expend their funds only for the purpose of planning, carrying out, and evaluating activities related to these services. States may provide SABG funds to community and faith-based organizations to provide services. Of the amounts appropriated for the SABG, 95 percent are distributed to states through a formula prescribed by the authorizing legislation. Factors used to calculate the allotments include total personal income; state population data by age groups (total population data for territories); total taxable resources; and a cost of services index factor. Remaining funds are used for data collection, technical assistance, and program evaluation, which are retained by SAMHSA for these purposes. The set-aside is distributed among CSAP, CSAT, and CBHSQ for purposes of carrying out the functions prescribed by the SABG legislation. The FY 2010 resources of $1.455

billion provided grant awards to 60 jurisdictions: states, territories, the District of Columbia, and the Red Lake Band of Chippewa Indians in Minnesota. These resources will support approximately 2 million treatment episodes. The SABG program in FY 2011 is funded at the same level as FY 2010, and will provide support to the current 60 jurisdictions for a similar level of prevention and treatment services. The FY 2012 request of $1.499 billion will provide support to the current 60 jurisdictions for a similar level of treatment services.

Substance Abuse – State Prevention Grants

FY 2012 Request: $395.0 million
(Reflects $395.0 million increase from 2010)

SAMHSA proposes a new Substance Abuse - State Prevention Grant (SA-SPG) starting in FY 2012, focusing exclusively on preventing substance abuse. The SA-SPG represents a significant advance in the Nation's approach to prevention in several ways. First, it creates a sustainable and predictable source of prevention funding for all States that will require focus on high risk communities and youth. Second, it will move the Strategic Prevention Framework State Incentive Grant (SPF-SIG) approach to scale. Third, it requires that States use a comprehensive, data-driven planning process to identify and address problems in communities, and holds States accountable for achieving measurable outcomes for their citizens.

The program will consist of 3-year discretionary grants to States. The final allocation for this program will reflect a formula that considers the population and prevention needs analysis, and that will ensure each State receives no less than the amount received under the SABG 20% set-aside in FY 2010. Each State will be required to develop a data-driven strategic plan based on information from its epidemiological work group. States may retain 15% of the funds for infrastructure activities to support the communities in achieving outcomes. Key State activities are operation of a State prevention advisory group and epidemiological work group, training and technical assistance to communities, data collection and evaluation, development and dissemination of statewide messages and resources, and oversight and monitoring of funded communities. States will be able to use funds for coordinated workforce development, training in evidence-based practices, and the development of coordinated infrastructure and service delivery systems. Up to an additional 5% of the grant funds may be used for administrative costs.

Health Surveillance and Program Support

FY 2012 Request: $127.6 million
(Reflects $25.6 million increase from 2010)

The FY 2012 resources of $127.6 million, support staffing and activities to administer SAMHSA programs. Program Management supports the majority of SAMHSA staff who plan, direct, and administer agency programs and who provide technical assistance and program guidance to states, mental health and substance abuse professionals, clients, and the general public. In addition, Program Management includes funding for a portion of the survey activities conducted by the SAMHSA Center for Behavioral Health Statistics and Quality (CBHSQ). Agency staffing represents a critical component of the budget. There are currently 57 members of the SAMHSA staff who provide direct state technical assistance and are funded through the 5% Block Grant

set-asides. Program Management also includes: contracts for block grant investigations (monitoring); support for the Unified Financial Management System (UFMS); administrative activities such as Human Resources, Information Technology, and centralized services provided by the Program Support Center and the Department of Health and Human Services. The FY 2011 Budget reflects increased funding for current CBHSQ National Surveys and for a new CBHSQ initiative to design, develop, and field-test a community-level early warning system to detect emergence of new drug threats and to assist in identifying the public health and public safety consequences of drug abuse. SAMHSA/CBHSQ will be working closely and collaboratively with NIDA, NIAAA, and ONDCP on all development and deployment aspects of this system.

Regulatory and Oversight Functions

FY 2012 Request: $16.1 million

(Reflects same level as 2010)

These programs include, Opioid Drug Treatment, Mandatory Drug Testing, Prescription Monitoring. SAMHSA employs a number of contracts that support its regulatory efforts and monitoring activities. Some examples include:

- Certification of Opioid Treatment Programs (OTPs) that use Methadone, Subutex, or Suboxone to treat patients with opioid dependence by a SAMHSA/CSAT recognized accreditation body.
- Physician Clinical Support System-Methadone, a national mentoring network offering support (clinical updates, evidence-based outcomes, and training) to physicians and other medical professionals in the appropriate use of methadone for the treatment of chronic pain and opioid addiction. This program also addresses the nation's rise in methadone-associated deaths that has been spurred by misuse/abuse, and fatal drug interactions involving methadone and other prescription medications, over the counter medications, and illicit drugs
- Physician Clinical Support System-Buprenorphine, a program designed to assist practicing physicians that wish to incorporate into their practices the treatment of prescription opioid and heroin dependent patients using the medication buprenorphine.
- Opioid Treatment Technical Assistance Program (OTTAP), of which the primary objective is to educate and prepare OTPs to achieve accreditation by SAMHSA's approved accreditation bodies necessary to assist OTPs in maintaining accreditation, as they are subject to re-survey, occurring at least triennially.
- The Federal Drug-Free Workplace Mandatory Drug Testing program, initiated in 1986 by Executive Order 12564 and the Public Law 100-71 in 1987, provides funding for accreditation and ongoing quality assurance of laboratories that perform mandatory drug testing for Federal and non-Federal employees across the nation. The National laboratory Certification Program is a core and crucial component that impacts all Executive Branch agencies related to public safety and national security clearance.
- The National All Schedules Prescription Electronic Reporting Act (NASPER), is a formula grant program, that was authorized in 2005 (Public Law 109-60) and received its first appropriation in FY 2009. The purpose of this program is to: 1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that health care providers and law enforcement officials and other regulatory bodies have access to

accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and 2) develop, based on the experiences of existing State controlled substance monitoring programs, a set of best practices to guide the establishment of new State programs and the improvement of existing programs.

Public Education and Support

FY 2012 Request: $13.6 million

(Reflects a $2.0 million increase from 2010)

The FY 2012 Budget Request is $13.6 million, which reflects the consolidation of funding available for the SHIN and web development contracts from across SAMHSA. It also reflects efficiencies realized through the consolidation of multiple web development contracts, resulting in more streamlined operations without loss of capabilities. These efficiencies generate a savings of $5.0 million, which would result in the total funding needed to support these activities to be nearly $19 million if the consolidations were not undertaken.

Performance and Quality Information Systems

FY 2012 Request: $13.0 million

(Reflects a $20.7 million decrease from 2010)

The FY 2012 Budget Request is $13.0 million, with $11 million for the performance management system and $2 million for the NREPP program, the same level as the FY 2011 President's Budget. By September 2011, SAMHSA will develop an acquisition proposal for an integrated performance measurement and management platform to be operational in FY 2012. The performance management system will adapt current systems to accept cross-cutting mental health and substance abuse data from all of SAMHSA's programs. $24.8 million is reduced from the Services Accountability, and Program Coordination and Evaluation budget lines to reflect comparability adjustments and projected savings.

Prevention Prepared Communities

FY 2012 Request: $22.6 million

(Reflects $22.6 million increase from 2010)

The Prevention Prepared Communities program will assist communities in developing community prevention systems offering evidence-based prevention of substance abuse and mental illness across the course of childhood and adolescence in multiple community venues. The program builds on scientific evidence that a) a common set of risk factors is predictive of a range of negative outcomes, such as academic failure (including school dropout), aggression, violence, delinquency, and substance use; b) mental, emotional, and behavioral problems tend to co-occur; c) some experiences early in development are highly predictive of later positive and negative outcomes; d) intervening early and throughout childhood and adolescence can reduce risk factors and change children's trajectories in a positive fashion; and e) shared community

environments can play an influential role in supporting healthy behaviors. The FY 2012 President's Budget request is $22.6 million. Of the total amount, $20.6 million will support up to 48 grants to states and communities and $2 million for evaluation.

Behavioral Health – Tribal Prevention Grants

FY 2012 Request: $25.0 million

(Reflects $25.0 million increase from 2010)

SAMHSA proposes to introduce a new Behavioral Health – Tribal Prevention Grant (BH-TPG) starting in FY 2012, focusing exclusively on promoting overall behavioral health by preventing alcohol and substance abuse and by preventing suicides. Promotion of strong emotional health is an important contributor to the prevention of substance abuse and some mental illnesses as well as in reducing their negative impact on Tribal communities. The BH-TPG represents a significant advance in the Nation's approach to alcohol abuse and suicide prevention in several ways. First, it recognizes that emotional health is part of overall health and thus supports the Tribes in addressing overall health, including preventing and reducing substance abuse, suicides and mental illness, in a coordinated manner. Second, it establishes a single coordinated program for all Federally-recognized Tribes. Third, SAMHSA will consult and work closely with Tribes and Tribal leaders to develop a comprehensive, data-driven planning process to identify and address the most serious issues in each Tribal community. Recognizing the Federal obligation to help Tribes deal with physical and behavioral health issues, SAMHSA will work in consultation with Tribes to determine the best approaches.

Performance

Introduction

This section on the FY 2010 performance of SAMHSA programs is based on agency GPRA documents and other agency information. The tables include performance measures, targets, and achievements for the latest year for which data are available.

Over the past several years, SAMHSA, in collaboration with the states, has identified a set of standardized National Outcome Measures (NOMs) that are monitored across all SAMHSA programs. The NOMs have been identified for both treatment and prevention programs and have common methodologies for data collection and analysis.

SAMHSA continues to implement on-line data collection and reporting systems for mental health, substance abuse prevention and treatment programs, and has assisted states in developing their data infrastructures.

Substance Abuse Prevention and Treatment Block Grant (SAPTBG)

SABG		
Selected Measures of Performance	*FY 2010 Target*	*FY 2010 Actual*
Percent of clients reporting no drug use in the past month at discharge	70.3%	TBR – Nov 2011
Number of admissions to substance abuse treatment programs receiving public funding	1,881,551	TBR – Nov 2012

Discussion

SAMHSA has established a data-driven block grant mechanism which monitors the National Outcome Measures (NOMs) and improves data collection, analysis, and utilization. Data for the treatment NOMs are drawn from a combination of sources, including the Web Block Grant Application System (WEBBGAS). A major milestone was reached when the reporting of NOMs was made mandatory in the FY 2008 SABG Application**.**

In 2005, the CSAT and CSAP funded an Independent Evaluation of the Substance Abuse Prevention and Treatment Block Grant (SABG) Program. The evaluation was completed in December of 2008. The purpose of the evaluation was to assess the extent to which the SABG Program is effective, functioning as intended, and achieving desired outcomes.

The evaluation resulted in a number of key findings, which include: a demonstrated positive effect on the health and lives of substance abuse treatment clients; the SAPTBG as a major impetus for improving State prevention and treatment systems' infrastructure and capacity; States' ability to leverage SAPTBG requirements, resources, and Federal guidance to sustain and improve their systems; demonstration of effective federal and state management of the program; and a contribution to the development and maintenance of successful State collaborations with other agencies and stakeholders concerned with preventing and treating substance abuse.

Data on FY 2010 achievements are not yet available. For FY 2009, the Block Grant program exceeded the target (1,881,515) for the number of clients served: a total of 2,132,206 clients. The FY 2009 data show that 81.5% of clients had abstained from alcohol at discharge, 75.7% had abstained from drug use (exceeding the 2009 target of 69%), 42.9% were employed, and 92% reported having no involvement with the criminal justice system.

20% Prevention Set-Aside

SABG – 20% Prevention Set-Aside		
Selected Measures of Performance	*FY 2010 Target*	*FY 2010 Actual*
Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17)	*45.1%*	*TBR—August 2011*
Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 12-20)	*51%*	*TBR—August 2011*
Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 12-17)	*52.9%*	*TBR—August 2011*
Number of participants served in prevention programs	17,482,060	*TBR—August 2011*

Discussion

States are placing an increased emphasis on implementing the Strategic Prevention Framework (SPF) with SABG funds. As a result, the strategic plans developed by their local SAPT-funded communities ensure the: a) identification of populations with the greatest need for evidence-based prevention programs, practices and policies; b) allocation resources where most they are most needed; and c) achievement of outcomes through a data-driven process. To assist with these tasks, the SPF provides States and their funded communities with an array of tools designed to monitor the performance of their programs.

For example, the City of Quincy, Massachusetts has—in collaboration with Impact Quincy—successfully worked toward the goal of reducing fatal and non-fatal opioid overdoses over the past two years. Using the SPF, Impact Quincy has been able to develop training materials to educate and help create awareness about opioid overdose and related issues among active users, bystanders, healthcare providers, and criminal justice personnel. The trainings provide important information on recognizing the signs of overdose; prevention and management strategies (such as rescue breathing and calling 911); and overdose reversal strategies (such as administration of nasal Naloxone).

Impact Quincy's efforts have led to critically important policy and practice changes that have impacted the way Quincy Police and Fire Department personnel respond to overdoses. All

Quincy Police Department officers are now required to be trained in the use of nasal Naloxone and are authorized to carry it to respond to overdose emergencies during all shifts. In addition, Norfolk County Community Corrections inmates are now receiving opioid overdose trainings and, as appropriate, are connected with treatment services upon release. The commitment of the Mayor of Quincy and other city officials, as well as key stakeholders within the community, has also been a vital component to this community's success.

In terms of actual performance, data for FY 2010 are not yet available and are expected to be reported during August 2011. However, FY 2009 actual performance data showed that the 20% Prevention Set-Aside of the SABG served a total of 112,716,508 participants through prevention programs, practices and strategies—exceeding its target of serving 17,482,060 participants [1,2].

In addition, data showed that other FY2009 targets were exceeded including: a) the percentage of States showing an increase in state-level estimates of survey respondents—ages 12 through 17—who rated the risk of substance abuse as 'moderate' or 'great' (Target 45.1%; Actual 58.8%[3]); b) the percentage of States that reported a decrease in 30-day use of alcohol among participants ages 12 through 20 (Target 51%; Actual 72.5%); and c) the percentage of States that reported a decrease in 30-day use of other illicit drugs among participants ages 12 through 17 (Target 52.9%; Actual 56.9%).

Programs of Regional and National Significance (PRNS)

Treatment PRNS		
Selected Measures of Performance	*FY 2010 Target*	*FY 2010 Actual*
Percentage of adults receiving services who were currently employed or engaged in productive activities	51%	44.5%
Percentage of adults receiving services who had a permanent place to live in the community	49%	49.0%
Percentage of adults receiving services who had no involvement with the criminal justice system	94%	96.0%
Increase percentage of adults receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences	66%	87.6%
Percentage of adults receiving services who had no past month substance use	62%	67.9%
Number of clients served[4]	34,784	30,156

[1] Data based off of information reported by SABG grantees through the WEBBGAS.

[2] It is important to note that many prevention programs, practices and strategies implemented through the 20% Prevention Set-Aside of the SABG are at the population-level and, as a result, may include duplicate counts.

[3] Data based off of 2008 NSDUH pooled estimates (2006/2007 and 2007/2008).

[4] Total of SAMHSA's CSAT Capacity programs excluding Access to Recovery and the Screening, Brief Intervention, and Referral to Treatment Program.

[5] Measures reflect those clients served in currently active grants for the year shown. Data are collected at a six month follow-up point. Client length of stay varies by case; therefore, some may be discharged by this point while others are still in treatment.

Discussion

The Treatment PRNS provides funding to implement service improvements, using proven evidence-based approaches, system changes, and programs to promote identification and increase the availability of practices with potential for broad service improvement. The PRNS enables SAMHSA's CSAT to address emerging issues in the field. CSAT integrates data and performance into program and management decisions via, a real-time data reporting system. Staff routinely monitor grantees' progress to ensure that program goals and objectives are being met**.**

The Programs of Regional and National Significance are made up of many different services programs. One of these is the Screening, Brief Intervention, and Referral to Treatment program (SBIRT), implemented in 2003. In FY 2010, SBIRT provided over 275,000 substance abuse screenings in primary care and generalist settings.

Normalizing Alcohol and Drug Screening in Colorado[5]

José Esquibel has a dream: to make screening for alcohol and substance abuse problems as routine as diabetes screening in every health care facility in Colorado. And the Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant the state received from SAMHSA is helping to make that dream a reality. Eight hospitals, six primary care settings, and eight HIV clinics across the state are already using the SBIRT approach. Funding for serving the HIV clinics comes from the state's Ryan White CARE Act funding.

A project partner called the Colorado Clinical Guidelines Collaborative is helping to spread the word by condensing best practices in various subject areas into two-page guides distributed to its network of physicians. To further ensure sustainability, the project is also targeting health care payers. The state recently passed a law requiring that insurance companies in Colorado pay for alcohol screenings beginning in January 2010. Now the project is taking the message to the public. "We want to communicate to the public that someone should be asking them questions about how alcohol and drugs affect their health whenever they're in a health care setting," said Mr. Esquibel.

The Access to Recovery program, also a key PRNS program, was implemented in 2005. Data from that program follows:

ATR		
Selected Measures of Performance	*FY 2010 Target*	*FY 2010 Actual*
Percentage of adults receiving services who had no past month substance use	82%	82.9%
Percentage of adults receiving services who had improved family and living conditions	53%	43.6%
Percentage of adults receiving services who had no	96%	96.3%

[5] Excerpted from SAMHSA News, November/December 2009, Volume 17, Number 6
SAMHSA News is the national newsletter of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS)."

involvement with the criminal justice system		
Percentage of adults receiving services who had improved social support	91%	91.1%
Percentage of adults receiving services who were currently employed or engaged in productive activities	54%	49.5%
Average cost per client through ATR	$1,572	$1,374
Number of clients gaining access to treatment	65,000	69,522

Discussion

The Access to Recovery (ATR) program provides grants to States, Tribes, and Tribal organizations to undertake voucher programs that expand substance abuse treatment capacity and promote choice among clinical treatment and recovery support providers.

In 2010, the ATR program substantially exceeded its target for the number of clients served: 69,522 clients as compared to the target of 65,000. Moreover, the program's achievements include a number of positive developments measured at the time of discharge: an abstinence level of 82.9%, an employment level of 49.5%, an improved social support level of 91.1%, and a level of 96.3% of clients having no involvement with the criminal justice system.

Juvenile and Adult Drug Courts

Introduction

The data for the treatment completion measure is collected from clients upon discharge from the program. The other two measures are collected at 6 month follow-up post intake. SAMHSA grantees are required to have an 80% follow-up rate at 6 months post intake. Given the variation in data collection time points, it is possible to have data reported for one measure but not the other depending on data availability.

Substance Abuse Drug Courts		
Selected Measures of Performance	*FY 2010 Target*	*FY 2010 Actual*
Percentage of adults receiving services who had a permanent place to live in the community	42%	42.3%
Percentage of adult clients that complete treatment	53%	45.6%
Percentage of adults receiving services who had no involvement with the criminal justice system	93%	93.0%

Discussion

The Drug Court program provides funding to address the treatment needs of substance-using individuals involved in a Drug Court. The Program is designed to provide holistic treatment and wrap-around services to criminally-involved substance-using individuals in order to assist them in achieving and maintaining abstinence from substance use along with improving their overall quality of life.

This program funds several types of grants including those specifically for juvenile or adult clients and those focused on families. SAMSHA reports performance data for the Adult and Juvenile Drug Courts separately. As a result, the data and targets are reported separately based on which grants are currently funded (Adult or Juvenile). Since Adult Drug Courts were recently funded, the results are shown here.

The Adult Drug Court Program demonstrated successful results in 2010, meeting or exceeding targets related to housing and criminal justice involvement. The Adult Drug Court Program did not meet its target for treatment completion; however, SAMHSA considers this to be within acceptable range of the target set.

Prevention PRNS

Prevention PRNS		
Selected Measures of Performance	*FY 2010 Target*	*FY 2010 Actual*
Percent of SPF SIG states showing a decrease in state level estimates of survey respondents (age 12-17) who report 30-day use of other illicit drugs[6]	59.8%	TBR - August 2011
Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who rate the risk of substance abuse as moderate or great	78.7%	TBR - August 2011
HIV: Percent of program participants (age 12-17) that rate the risk of substance abuse as moderate or great	87.0%	TBR - August 2011
HIV: Percent of participants (age 18 and up) who used illicit drugs at pre-test who report a decrease in 30-day use at post-test	70.6%	TBR - August 2011

Discussion

The Prevention PRNS include a number of major programs such as the Strategic Prevention Framework State Incentive Grants (SPF SIG) and the Minority Substance Abuse/HIV Prevention Initiative (MAI).

The SPF SIG is a public health approach that requires participating States—as well as their funded communities—to apply the multiple steps of the SPF[7] before implementing programs related to substance abuse prevention. Therefore, the SPF SIG requires grantees to focus initial efforts and resources on developing and/or expanding current infrastructure, as well as increasing their capacity to implement prevention programs[8]. By initially targeting and improving infrastructure and capacity, results obtained through the implementation of selected prevention programs and strategies will, over time, have stronger, more lasting effects on participants. It is important to note that, because communities are required to complete steps 1 through 3 prior to implementation, a lag may exist between the awards of grants and when community and/or state-

[6] SPF SIGs are Strategic Prevention Framework State Incentive Grants

[7] SPF process includes the following five steps: Assessment, Capacity, Planning, Implementation, and Evaluation

[8] While the first three steps of the SPF process are completed by the State prior to funding communities; communities are required to complete the entire SPF after receiving funds from the State

level changes are observed. In addition, any changes in state-level estimates of use and non-use may be affected by numerous factors outside of the prevention programs, and, as a result, cannot be solely attributed to the SPF SIG[9].

Unlike the SPF SIG, the MAI program funds communities (rather than states) and focuses on increasing community capacity to deliver substance abuse evidence-based prevention services with a focus on HIV. The MAI program was redesigned in FY 2007 to incorporate the SPF within program activities; as a result, baseline data were collected for new measures that reflected the change in the program's structure.

Data regarding actual performance for FY 2010 are not yet available and are expected to be reported during August 2011. However, FY 2009 actual performance data showed that the SPF SIG program nearly met its target regarding the percentage of states showing a decrease in 30-day use of illicit drugs among participants ages 12 through 17 (Target 59.8%; Actual 59.6%). In addition, results also showed an improvement in the percentage of States showing an increase in the perception of risk from substance abuse among participants ages 12 through 17 between FY 2008 (47.1 %) and FY 2009 (55.3%).[10]

For the MAI program—specifically the HIV 6-cohort—FY 2009 actual performance data showed that the program exceeded its target regarding the percentage of participants—ages 12 through 17—who rated the risk of substance abuse as 'moderate' or 'great' (Target: 76.6%; Actual 90%). Results also showed an improvement in the percentage of participants (ages 18 and up) who used illicit drugs at pre-test, but reported a decrease in 30-day use at post-test between FY 2008 (59.1%) and FY 2009 (62.2%).

[9] The current cohort of SPF SIG grants are ending in FY 2011. However this model is being implemented in several other planned programs for FY 2012.

[10] It is important to note that these data are based on aggregate estimates across cohorts that started at different times; as a result, caution must be used in their interpretation.

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Substance Abuse and Mental Health Services Administration
Object Classification Tables – Direct
(Dollars in Thousands)

Object Class - Direct Budget Authority	FY 2011 Estimate	FY 2012 Estimate	FY 2012 +/- FY 2011
Direct Obligations 1/:			
Personnel Compensation:			
Full Time Permanent (11.1)	$45,244	$45,071	-$173
Other than Full-Time Permanent (11.3)	1,853	1,846	-7
Other Personnel Compensation (11.5)	972	968	-4
Military Personnel Compensation (11.7)	4,079	4,148	+69
Special personal services payments (11.8)	105	106	+1
Subtotal Personnel Compensation:	**52,253**	**52,139**	**-114**
Civilian Personnel Benefits (12.1)	11,930	11,884	-46
Military Personnel Benefits (12.2)	2,094	2,129	+35
Benefits for Former Personnel (13.1)	0	0	0
Subtotal Pay Costs:	**66,277**	**66,152**	**-125**
Travel (21.0)	1,658	1,785	+127
Transportation of Things (22.0)	44	45	+1
Rental Payments to GSA (23.1)	7,023	7,142	+119
Rental Payments to Others (23.2)	1	1	0
Communications, Utilities and Misc. Charges (23.3)	744	756	+12
Printing and Reproduction (24.0)	2,744	2,788	+44
Other Contractual Services:			0
Advisory and Assistance Services (25.1)	29,261	27,008	-2,253
Other Services (25.2)	229,001	212,291	-16,710
Other Purchases of Goods & Svc from Govt Accts (25.3)	102,671	94,731	-7,940
Operation & Maintenance of Facilities (25.4)	1,292	1,292	0
Medical Care (25.6)	0	0	0
Operation and Maintenance of Equipment (25.7)	277	277	0
Subtotal Other Contractual Services:	**362,502**	**335,599**	**-26,903**
Supplies and Materials (26.0)	1,159	1,159	0
Equipment (31.0)	291	291	0
Grants, Subsidies, and Contributions (41.0)	2,987,826	2,969,830	-17,996
Insurance Claims & Indemnities (42.0)	1,355	1,355	0
Interest & Dividends (43.0)	0	0	0
Advance to Others (61.0)	0	0	0
Subtotal Non-Pay Costs	**3,365,347**	**3,320,751**	**-44,596**
Total Direct Obligations:	**$3,431,624**	**$3,386,903**	**-$44,721**
Average Cost per FTE			
Civilian FTEs	436	436	
Civilian Average Salary	$137.9	$137.3	
Percent Change	+0.50%	-0.38%	
Military FTEs	51	51	
Military Average Salary	121.0	123.1	
Percent Change	+1.90%	+1.68%	
Total SAMHSA FTEs	487	487	
Total SAMHSA Average Salary	$136.1	$135.8	
Percent Change	+0.63%	-0.19%	

1/ Personnel Compensation differs slightly from the FY 2012 President's Budget Appendix due to realignment of new staff to reimbursable. Due to review of all contracts, these are estimates and funding may shift among object classes based on the results of this review.

Substance Abuse and Mental Health Services Administration
Salaries and Expenses
(Dollars in Thousands)

Salary and Expenses 1/	FY 2011 Estimate	FY 2012 Estimate	FY 2012 +/- FY 2011
Personnel Compensation:			
Full Time Permanent (11.1)	$45,244	$45,071	-173
Other than Full-Time Permanent (11.3)	1,853	1,846	-7
Other Personnel Compensation (11.5)	972	968	-4
Military Personnel Comprensation (11.7)	4,079	4,148	+69
Special personal services payments (11.8)	105	106	+1
Subtotal Personnel Compensation:	**52,253**	**52,139**	**-114**
Civilian Personnel Benefits (12.1)	11,930	11,884	-46
Military Personnel Benefits (12.2)	2,094	2,129	+35
Benefits for Former Personnel (13.1)	0	0	0
Subtotal Pay Costs:	**66,277**	**66,152**	**-125**
Travel (21.0)	1,658	1,785	+127
Transportation of Things (22.0)	44	45	+1
Rental Payments to Others (23.2)	1	1	0
Communications, Utilities and Misc. Charges (23.3)	744	756	+12
Printing and Reproduction (24.0)	2,744	2,788	+44
Other Contractual Services:			0
Advisory and Assistance Services (25.1)	17,001	15,692	-1,309
Other Services (25.2)	224,879	208,469	-16,410
Other Purchases of Goods & Svc from Govt Accts (25.3)	25,928	23,922	-2,005
Operation & Maintenance of Facilities (25.4)	1,292	1,292	0
Medical Care (25.6)	0	0	0
Operation and Maintenance of Equipment (25.7)	277	277	0
Subtotal Other Contractual Services:	**269,376**	**249,653**	**-19,724**
Supplies and Materials (26.0)	1,159	1,159	0
Subtotal Non-Pay Costs	**275,726**	**256,187**	**-19,540**
Total, Salaries and Expenses	**$342,003**	**$322,339**	**-$19,665**
Direct FTE	**487**	**494**	**+7**

1/ Personnel Compensation differs slightly from the FY 2012 President's Budget Appendix due to realignment of new staff to reimbursable. Due to review of all contracts, these are estimates and funding may shift among object classes based on the results of this review.

Substance Abuse and Mental Health Services Administration
Detail of Full Time Equivalent (FTE)

	2010 Actual Civilian	2010 Actual Military	2010 Actual Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total
CMHS									
Direct:	78	15	93	79	17	96	79	17	96
Reimbursable:	15	7	22	14	3	17	14	3	17
Total:	93	22	115	93	20	113	93	20	113
CSAP									
Direct:	77	15	92	77	15	92	77	15	92
Reimbursable:	11	---	11	12	---	12	12	---	12
Total:	88	15	103	89	15	104	89	15	104
CSAT									
Direct:	94	11	105	93	11	104	93	11	104
Reimbursable:	1	---	1	1	---	1	1	---	1
Total:	95	11	106	94	11	105	94	11	105
OA									
Direct:	35	1	36	35	1	36	35	1	36
Reimbursable:	---	---	---	---	---	---	7	---	7
Total:	35	1	36	35	1	36	42	1	43
OAS/1									
Direct:	27	2	29	27	3	30	27	3	30
Reimbursable:	---	2	2	---	1	1	---	1	1
Total:	27	4	31	27	4	31	27	4	31
OPPB/1									
Direct:	31	2	33	31	2	33	31	2	33
Reimbursable:	1	---	1	1	---	1	1	---	1
Total:	32	2	34	32	2	34	32	2	34
OPS/1									
Direct:	93	1	94	94	2	96	94	2	96
Reimbursable:	10	1	11	10	1	11	10	1	11
Total:	103	2	105	104	3	107	104	3	107
St. Elizabeths									
Direct:	---	---	---	---	---	---	---	---	---
Reimbursable:	---	7	7	---	7	7	---	7	7
Total:	---	7	7	---	7	7	---	7	7
SAMHSA FTE Total:	**473**	**64**	**537**	**474**	**63**	**537**	**481**	**63**	**544**

/1 This table represents the organization structure prior to August 16, 2010. It does not reflect the reallocation of FTE among the new OPPI, OFR, OMTO and CBHSQ.

Substance Abuse and Mental Health Services Administration
Detail of Positions

	2010 Actual	2011 Estimate	2012 Estimate
Executive Level I	0	0	0
Executive Level II	0	0	0
Executive Level III	0	0	0
Executive Level IV	1	1	1
Executive Level V	0	0	0
Subtotal	1	1	1
Total - Exec Level Salaries	**$156,387**	**$157,169**	**$157,169**
SES	15	15	15
Subtotal	15	15	15
Total, SES salaries	**$2,572,800**	**$2,585,664**	**$2,585,664**
GM/GS-15	69	69	69
GM/GS-14	125	126	126
GM/GS-13	125	128	130
GS-12	39	40	40
GS-11	21	21	21
GS-10	3	3	3
GS-09	18	16	18
GS-08	17	17	17
GS-07	17	15	18
GS-06	10	10	10
GS-05	9	9	9
GS-04	2	2	2
GS-03	1	1	1
GS-02	1	1	1
GS-01	0	0	0
Subtotal	457	458	465
Total, GS salaries	**$49,841,591**	**$50,090,798**	**$50,090,798**
CC-08/09	1	1	1
CC-07	1	1	1
CC-06	12	13	13
CC-05	16	17	17
CC-04	19	20	20
CC-03	13	9	9
CC-02	2	2	2
CC-01	0	0	0
Subtotal	64	63	63
Total, CC salaries	**$7,421,286**	**$7,525,184**	**$7,630,537**
Total Positions	**537**	**537**	**544**
Average ES level	ES	ES	ES
Average ES salary	$156,387	$158,577	$157,169
Average SES level	SES	SES	SES
Average SES salary	$171,520	$172,378	$172,378
Average GS grade	12.4	12.5	12.5
Average GS salary	$106,956	$107,760	$107,760
Average CC level	4.5	4.6	4.6
Average CC salaries	$115,958	$119,447	$121,120

Programs Proposed for Elimination
Substance Abuse and Mental Health Services Administration
Programs Proposed for Reduction

The following table shows the programs proposed for elimination in the President's 2011 Budget request. Following the table is a brief summary of each program and the rationale for its reduction.

(Dollars in Millions)

Strategic Prevention Framework (-$111.777 million)

	FY 2011	FY 2012	FY 2011 +/- FY 2012
Strategic Prevention Framework	111.777	---	-111.777

Much of the funding from the Strategic Prevention Framework program has been redirected to the Substance Abuse – State Prevention Grant, which would provide a comprehensive, long-term funding source for the States to implement substance abuse prevention strategies.

Older Adult Programs (-$4.814 million)

	FY 2011	FY 2012	FY 2011 +/- FY 2012
Older Adult Programs	4.814	---	-4.814

The Older Adults Grant program has come to a natural end. SAMHSA encourages States and Territories to bring the service concepts to scale by utilizing their Mental Health Block Grant and Mental Health – State Prevention Grant funding to provide services.

St. Elizabeths Hospital – Environmental Remediation (-$0.795 million)

	FY 2011	FY 2012	FY 2011 +/- FY 2012
St. Elizabeths Hospital - Environmental Remediation	0.795	---	-0.795

As General Services Administration has indicated that they will not need funding from SAMHSA in FY 2012 for environmental remediation activities at the former St. Elizabeths Hospital site, there is no request for this activity.

FY 2012 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

SAMHSA Allocation Statement:

SAMHSA will use $289,931.00 of its FY 2012 budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, $21,554.00 is allocated to developmental government-wide E-Government initiatives for FY 2012. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$1,050.00
Line of Business - Grants Management	$4,313.00
Line of Business - Financial	$6,021.00
Line of Business - Budget Formulation and Execution	$4,421.00
Disaster Assistance Improvement Plan	$5,749.00
Federal Health Architecture (FHA)	$0.00
Line of Business - Geospatial	$0.00
FY 2012 Developmental E-Gov Initiatives Total	**$21,554.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF) is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and

efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business-Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

In addition, $167,473.00 is allocated to ongoing government-wide E-Government initiatives for FY 2012. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Ongoing E-Gov Initiatives*	
E-Rule Making	$9,511.00
Integrated Acquisition Environment	$45,616.00
GovBenefits	$14,163.00
Grants.Gov	$98,183.00
FY 2012 Ongoing E-Gov Initiatives Total	**$167,473.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

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SAMHSA FY 2012 Budget Structure Crosswalk

All-Purpose Table

(Dollars in Thousands)

Program Activities	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 Prevention Fund
Mental Health:				
Programs of Regional and National Significance	$361,352	$361,521	$273,342	$20,000
Children's Mental Health Services	$121,316	$121,316	$121,316	---
Protection & Advocacy	$36,380	$36,380	$36,380	---
PATH Homeless Formula Grant	$65,047	$65,047	$65,047	---
Mental Health Services Block Grant	399,735	399,735	413,645	---
PHS Evaluation Funds	21,039	21,039	21,039	---
Subtotal, Mental Health Services Block Grant	420,774	420,774	434,684	---
Subtotal, Mental Health	**1,004,869**	**1,005,038**	**930,769**	**20,000**
Substance Abuse Prevention:				
Programs of Regional and National Significance	202,040	202,209	74,582	---
Subtotal, Substance Abuse Prevention	**202,040**	**202,209**	**74,582**	**---**
Substance Abuse Treatment:				
Programs of Regional and National Significance	443,863	444,033	399,822	---
PHS Evaluation Funds	8,596	8,596	2,000	---
Subtotal	**452,459**	**452,629**	**401,822**	**---**
Prescription Drug Monitoring (NASPER)	**2,000**	**2,000**	**2,000**	**---**
Substance Abuse Block Grant	1,719,391	1,719,391	1,419,603	---
PHS Evaluation Funds	79,200	79,200	74,711	---
Subtotal, Substance Abuse Block Grant	1,798,591	1,798,591	1,494,314	---
Subtotal, Substance Abuse Treatment	**2,253,050**	**2,253,220**	**1,898,136**	**---**
TOTAL, SUBSTANCE ABUSE	**2,455,090**	**2,455,429**	**1,972,718**	**---**
Substance Abuse - State Prevention Grant	---	---	395,000	---
Behavioral Health - Tribal Prevention Grant	---	---	---	50,000
Mental Health - State Prevention Grant 1/	---	---	90,000	---
SAMHSA Agency-Wide Initiatives 2/	---	---	14,000	22,600
Performance and Quality Information Systems	---	---	12,996	---
PHS Evaluation Funds (non-add)	---	---	*12,996*	---
Public Awareness and Support	---	---	13,571	---
PHS Evaluation Funds (non-add)	---	---	*13,571*	---
Subtotal, SAMHSA-Wide Programs	**---**	**---**	**525,567**	**72,600**
Health Surveillance and Program Support	79,197	79,197	82,166	---
PHS Evaluation Funds	22,750	22,750	45,428	---
Subtotal, Health Surveillance and Program Support	**101,947**	**101,947**	**127,594**	**---**
St. Elizabeths Hospital B&F	**795**	**795**	**---**	**---**
Data Evaluation	**---**	**---**	**---**	**---**
TOTAL, SAMHSA Discretionary PL	**3,562,701**	**3,563,209**	**3,556,648**	**92,600**
Less PHS Evaluation Funds	*131,585*	*131,585*	*169,745*	---
TOTAL, SAMHSA Budget Authority	**$3,431,116**	**$3,431,624**	**$3,386,903**	**$92,600**
FTEs	**537**	**537**	**544**	

1/ Includes Project LAUNCH ($25 million) in FY 2012

2/ Includes Military Families ($10 million), Health IT ($4 million), and PPC ($22.6 million)

Center for Mental Health Services
Programs of Regional & National Significance
Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
CAPACITY:			
Co-Occurring State Incentive Grant	2,168	2,168	2,168
Seclusion & Restraint	$2,482	$2,449	$2,449
Youth Violence Prevention	94,393	94,502	94,333
National Traumatic Stress Network	40,798	40,800	11,300
Children and Family Programs	9,100	9,194	6,486
Performance Management and Coordination Activities	2,818	3,166	0
Consumer and Family Network Grants	6,223	6,236	4,966
MH System Transformation and Health Reform	29,179	29,106	10,623
Project LAUNCH	24,993	25,000	25,000
Primary and Behavioral Health Care Integration	13,987	14,000	14,000
Community Resilience and Recovery Initiative	4,979	5,000	5,000
Suicide Lifeline	5,522	5,522	5,522
GLS - Youth Suicide Prevention - States	29,617	29,738	29,738
GLS - Youth Suicide Prevention - Campus	4,972	4,975	4,975
AI/AN Suicide Prevention Initiative	2,944	2,944	2,944
Homelessness Prevention Programs	32,265	32,250	39,696
Older Adult Programs	4,810	4,814	0
Minority AIDS	9,283	9,283	9,283
Criminal and Juvenile Justice Programs	6,684	6,684	6,684
Congressional Projects	5,975	5,975	0
Subtotal, Capacity	**333,192**	**333,806**	**275,167**
SCIENCE AND SERVICE:			
GLS - Suicide Prevention Resource Center	4,957	4,957	4,957
Practice Improvement and Training	9,454	9,001	7,878
SAMHSA Health Information Network (SHIN)	2,673	2,673	0
National Registry of Evidence-based Programs and Practices (NREPP)	544	544	0
Consumer and Consumer Support Technical Assistance Centers	1,927	1,927	1,927
Minority Fellowship Program	4,279	4,279	4,279
Disaster Response	1,054	1,054	1,054
Homelessness	2,306	2,306	2,306
HIV/AIDS Education	966	974	774
Subtotal, Capacity	**28,160**	**27,715**	**23,175**
TOTAL, PRNS	**$361,352**	**$361,521**	**$298,342**

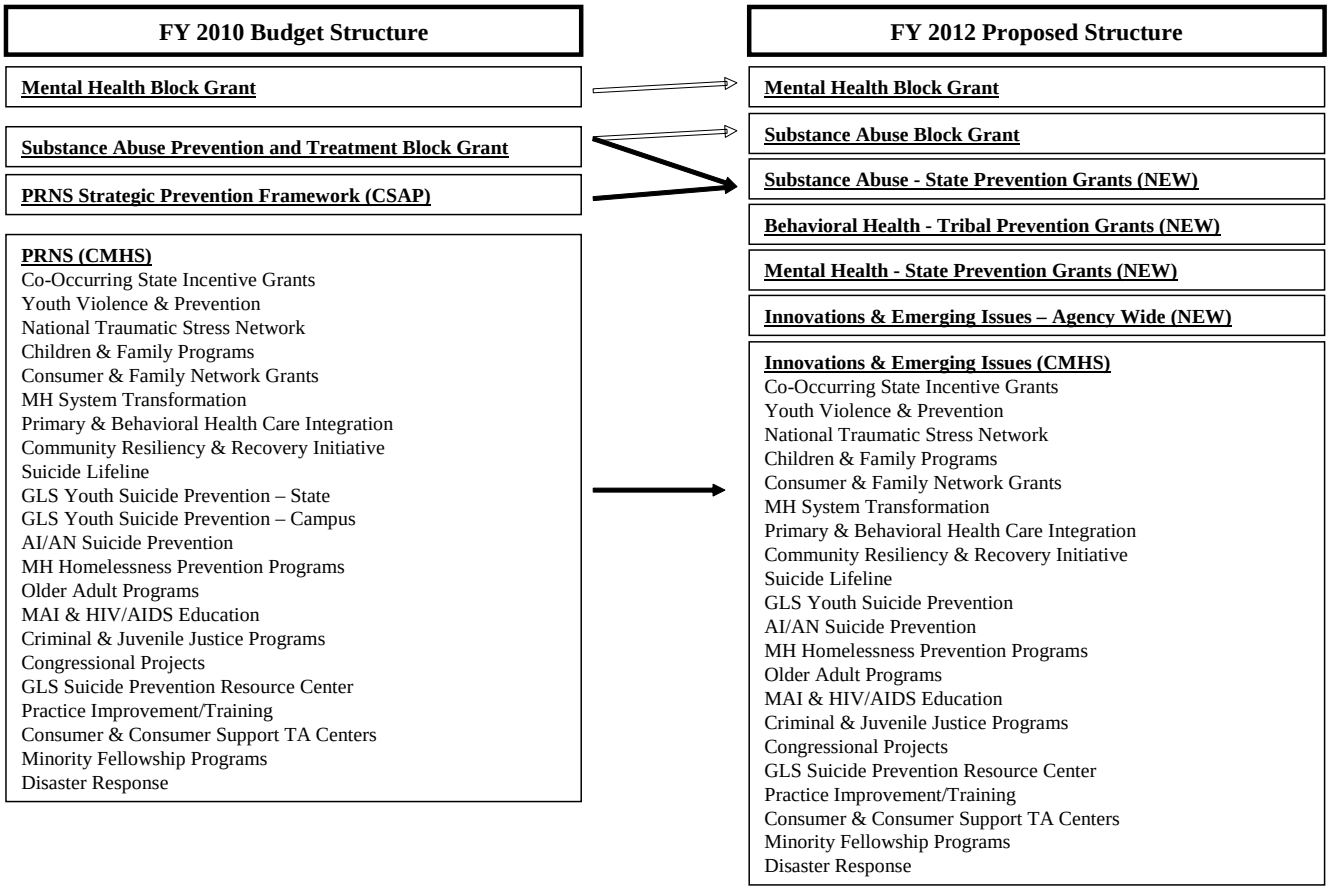
Center for Substance Abuse Prevention
Programs of Regional & National Significance
Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
CAPACITY:			
Strategic Prevention Framework	$111,705	$111,777	$0
Mandatory Drug Testing	5,202	5,206	5,206
Minority AIDS	41,385	41,385	41,385
Performance Management	6,296	6,300	0
Sober Truth on Preventing Underage Drinking (STOP Act)	7,000	7,000	7,000
Congressional Projects	3,950	3,950	0
Subtotal, Capacity	**175,538**	**175,618**	**53,591**
SCIENCE AND SERVICE:			
Fetal Alcohol Spectrum Disorder	9,820	9,821	8,000
Center for the Application of Prevention Technologies	8,367	8,511	8,511
Science and Service Program Coordination	4,845	4,789	4,409
National Registry of Evidence-based Programs and Practices	650	650	0
SAMHSA Health Information Network	2,749	2,749	0
Minority Fellowship Program	71	71	71
Subtotal, Science and Service	**26,502**	**26,591**	**20,991**
TOTAL, PRNS	**$202,040**	**$202,209**	**$74,582**

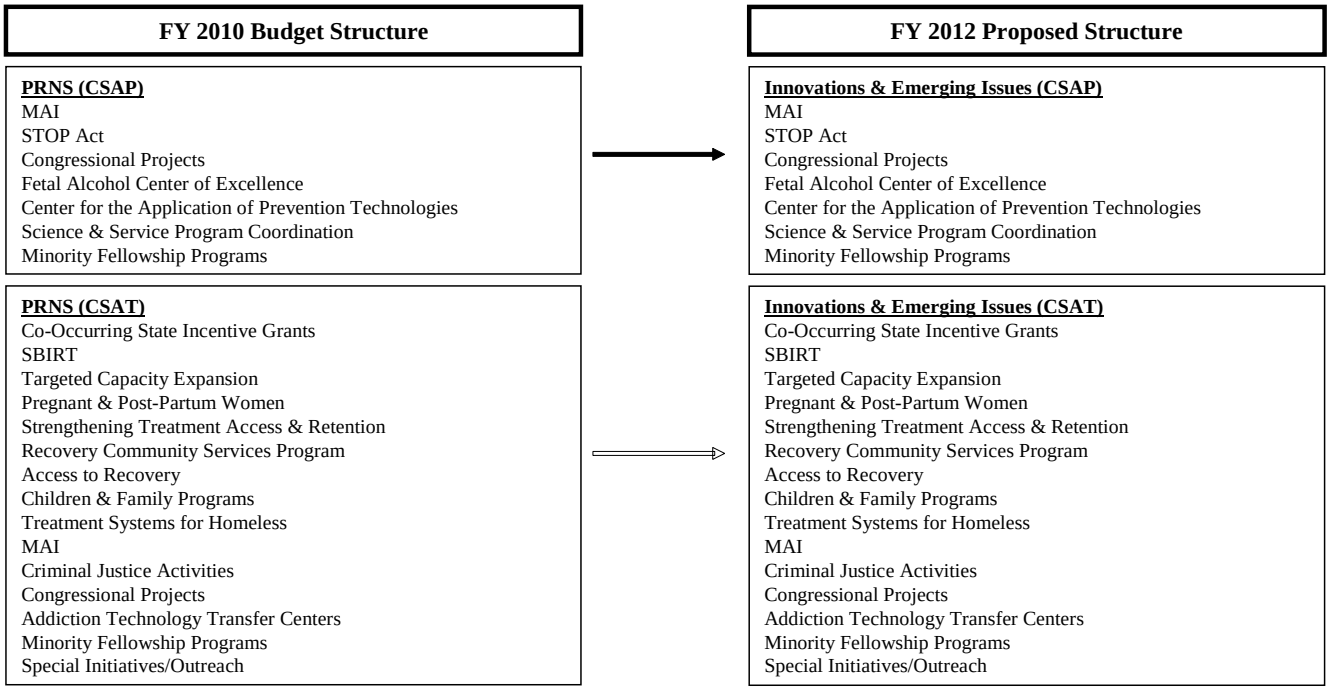
Center for Substance Abuse Treatment
Programs of Regional & National Significance
Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget
CAPACITY:			
Co-occurring State Incentive Grants (SIGs)	$4,262	$4,263	$4,263
Opioid Treatment Programs/Regulatory Activities	8,988	8,903	8,903
Screening, Brief Intervention and Referral to Treatment a/	29,106	29,106	29,106
TCE-General	29,022	28,989	17,411
Pregnant & Postpartum Women	16,000	16,000	16,000
Strengthening Treatment Access and Retention	1,773	1,775	1,675
Recovery Community Services Program	5,669	5,236	2,450
Access to Recovery	99,380	98,954	98,454
Children and Families	30,576	30,678	30,678
Treatment Systems for Homeless	42,530	42,750	47,360
Minority AIDS	65,911	65,988	65,988
Criminal Justice Activities	67,406	67,635	67,635
Treatment Drug Courts (non-add)	*43,771*	*43,882*	*43,691*
Family Dependency/Treatment Drug Courts (non-add within Drug Courts)	*5,000*	*5,000*	*5,000*
Ex-Offender Re-Entry (non-add)	*18,002*	*22,242*	*22,568*
Services Accountability b/	20,226	20,816	---
Congressional Projects	4,593	4,593	---
Subtotal, Capacity	**425,442**	**425,686**	**389,923**
SCIENCE AND SERVICE:			
Addiction Technology Transfer Centers	9,150	9,081	9,081
Minority Fellowship Program	547	547	547
Special Initiatives/Outreach c/	2,509	2,400	2,271
Information Dissemination	4,329	4,553	---
National Registry of Evidence-Based Programs & Practices	893	893	---
SAMHSA Health Information Network	4,255	4,255	---
Program Coordination and Evaluation d/	5,334	5,214	---
Subtotal, Science and Service	**27,017**	**26,943**	**11,899**
TOTAL, PRNS	**$452,459**	**$452,629**	**$401,822**

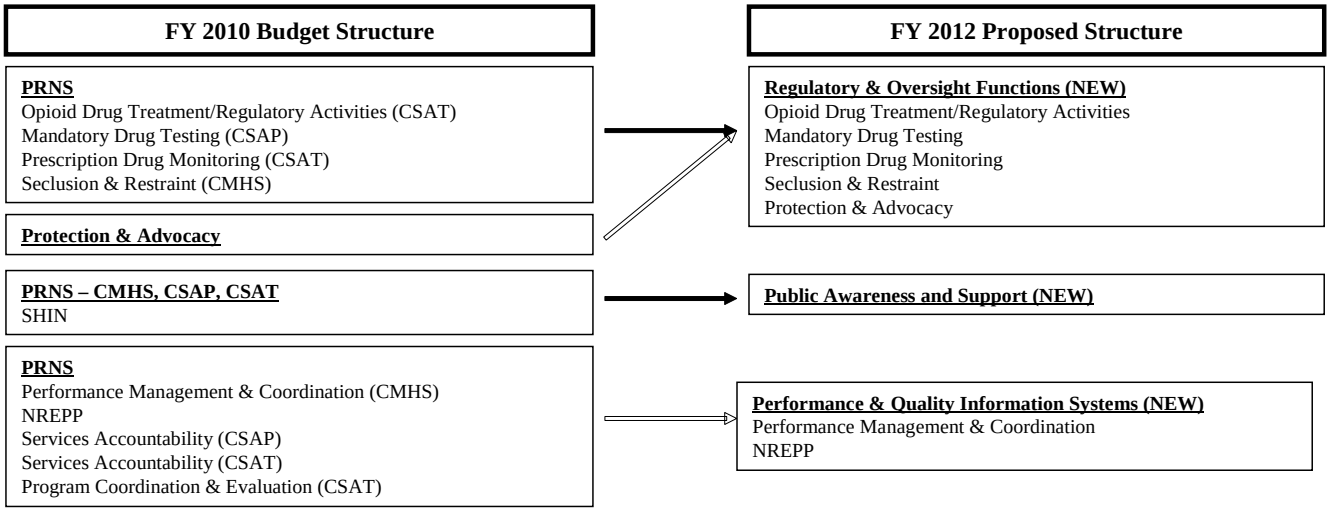
FY 2010 Compared to FY 2012



FY 2010 Compared to FY 2012 (cont.)



FY 2010 Compared to FY 2012 (cont.)



Center for Mental Health Services
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance CAPACITY	FY 2010 Actual No.	 Amount	FY 2011 Continuing Resolution No.	 Amount	FY 2012 President's Budget No.	 Amount
Co-Occurring SIG						
Grants						
Continuations	$0	$0	$0	$0	$0	$0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	1	2,006	1	2,168	1	2,168
New/Competing	0	162	0	0	0	0
Subtotal	1	2,168	1	2,168	1	2,168
Total, Co-Occurring SIG	**1**	**2,168**	**1**	**2,168**	**1**	**2,168**
Seclusion & Restraint						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	0	0	1	2,449	1	2,449
New/Competing	1	2,482	0	0	0	0
Subtotal	1	2,482	1	2,449	1	2,449
Total, Seclusion & Restraint	**1**	**2,482**	**1**	**2,449**	**1**	**2,449**
Youth Violence Prevention						
Grants						
Continuations	1	6,000	1	6,000	1	6,000
New/Competing	0	0	0	0	0	0
Subtotal	1	6,000	1	6,000	1	6,000
Contracts						
Continuations	6	83,152	6	88,402	5	87,733
New/Competing	1	5,241	1	100	1	600
Subtotal	7	88,393	7	88,502	6	88,333
Total, Youth Violence Prevention	**8**	**94,393**	**8**	**94,502**	**7**	**94,333**
National Traumatic Stress Network						
Grants						
Continuations	58	30,348	47	25,954	3	1,792
New/Competing	5	3,560	15	7,000	10	6,500
Subtotal	63	33,908	62	32,954	13	8,292
Contracts						
Continuations	3	6,516	1	6,246	1	2,125
New/Competing	0	374	1	1,600	0	883
Subtotal	3	6,890	2	7,846	1	3,008
Total, National Traumatic Stress Network	**66**	**40,798**	**64**	**40,800**	**14**	**11,300**
Children and Family Programs						
Grants						
Continuations	15	$5,530	7	$4,107	15	$5,677
New/Competing	0	747	8	2,178	0	0
Subtotal	15	6,277	15	6,285	15	5,677
Contracts						
Continuations	2	1,979	3	2,809	0	809
New/Competing	1	844	0	100	0	0
Subtotal	3	2,823	3	2,909	0	809
Total, Children and Family Programs	**18**	**$9,100**	**18**	**$9,194**	**15**	**$6,486**

Center for Mental Health Services
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Performance Management and Coordination Activities						
Grants						
Continuations	$0	$0	$0	$0	$0	$0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	2	2,803	2	3,166	0	0
New/Competing	0	15	0	0	0	0
Subtotal	2	2,818	2	3,166	0	0
Total, Perf. Mgmt. and Coordination Activities	**2**	**2,818**	**2**	**3,166**	**0**	**0**
Consumer and Family Network Grants						
Grants						
Continuations	18	1,250	79	5,178	61	3,928
New/Competing	57	3,927	0	0	0	0
Subtotal	75	5,177	79	5,178	61	3,928
Contracts						
Continuations	0	1,046	1	1,058	1	1,038
New/Competing	0	0	0	0	0	0
Subtotal	0	1,046	1	1,058	1	1,038
Total, Consumer and Family Network Grants	**75**	**6,223**	**80**	**6,236**	**62**	**4,966**
MH System Transformation and Health Reform						
Grants						
Continuations	2	4,381	42	16,460	48	10,623
New/Competing	42	16,489	6	4,500	0	0
Subtotal	44	20,870	48	20,960	48	10,623
Contracts						
Continuations	2	6,887	3	7,297	0	0
New/Competing	2	1,423	1	849	0	0
Subtotal	4	8,309	4	8,146	0	0
Total, MH Sys. Trans. and Health Reform	**48**	**29,179**	**52**	**29,106**	**48**	**10,623**
Project LAUNCH Wellness Initiative						
Grants						
Continuations	18	16,780	24	21,300	25	21,300
New/Competing	6	4,513	0	0	0	0
Subtotal	24	21,293	24	21,300	25	21,300
Contracts						
Continuations	1	3,320	1	3,500	1	3,700
New/Competing	0	380	0	200	0	0
Subtotal	1	3,700	1	3,700	1	3,700
Total, Project LAUNCH Wellness Initiative	**25**	**24,993**	**25**	**25,000**	**26**	**25,000**
Primary and Behavioral Health Care Integration						
Grants						
Continuations	13	6,449	23	12,242	23	12,200
New/Competing	10	5,887	0	0	0	0
Subtotal	23	12,336	23	12,242	23	12,200
Contracts						
Continuations	0	1,086	1	1,600	1	1,800
New/Competing	1	565	0	158	0	0
Subtotal	1	1,651	1	1,758	1	1,800
Total, PBHCI	**24**	**$13,987**	**24**	**$14,000**	**24**	**$14,000**

Center for Mental Health Services
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Community Resilience and Recovery Initiative						
Grants						
Continuations	0	$0	3	$4,163	3	$4,186
New/Competing	3	4,180	0	0	0	0
Subtotal	3	4,180	3	4,163	3	4,186
Contracts						
Continuations	0	0	1	679	1	814
New/Competing	1	799	0	158	0	0
Subtotal	1	799	1	837	1	814
Total, CRRI	**4**	**4,979**	**4**	**5,000**	**4**	**5,000**
Suicide Lifeline						
Grants						
Continuations	7	3,247	7	3,724	12	726
New/Competing	6	838	6	360	1	3,200
Subtotal	13	4,085	13	4,084	13	3,926
Contracts						
Continuations	0	1,437	1	1,338	0	1,056
New/Competing	0	0	1	100	0	540
Subtotal	0	1,437	2	1,438	0	1,596
Total, Suicide Lifeline	**13**	**5,522**	**15**	**5,522**	**13**	**5,522**
GLS - Youth Suicide Prevention - States						
Grants						
Continuations	48	23,328	18	8,896	32	15,368
New/Competing	0	0	32	15,368	19	9,120
Subtotal	48	23,328	50	24,264	51	24,488
Contracts						
Continuations	2	5,779	1	3,756	2	4,850
New/Competing	0	510	1	1,718	0	400
Subtotal	2	6,289	2	5,474	2	5,250
Total, GLS-Youth Suicide Prevention-States	**50**	**29,617**	**52**	**29,738**	**53**	**29,738**
GLS - Youth Suicide Prevention - Campus						
Grants						
Continuations	38	3,659	22	2,162	16	1,600
New/Competing	0	0	16	1,600	21	2,100
Subtotal	38	3,659	38	3,762	37	3,700
Contracts						
Continuations	1	1,313	1	963	1	1,175
New/Competing	0	0	0	250	0	100
Subtotal	1	1,313	1	1,213	1	1,275
Total, GLS-Youth Suicide Prevention-Campus	**39**	**4,972**	**39**	**4,975**	**38**	**4,975**
AI/AN Suicide Prevention Initiative						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	2	2,944	2	2,944	2	2,284
New/Competing	0	0	0	0	0	660
Subtotal	2	2,944	2	2,944	2	2,944
Total, AI/AN Suicide Prevention Initiative	**2**	**$2,944**	**2**	**$2,944**	**2**	**$2,944**

Center for Mental Health Services
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Homelessness Prevention Programs						
Grants						
Continuations	57	$21,720	61	$23,376	51	$20,308
New/Competing	5	1,999	2	800	22	9,850
Subtotal	62	23,719	63	24,176	73	30,158
Contracts						
Continuations	3	7,196	3	7,511	3	7,942
New/Competing	1	1,350	0	563	2	1,596
Subtotal	4	8,546	3	8,074	5	9,538
Total, Homelessness Prevention Programs	**66**	**32,265**	**66**	**32,250**	**78**	**39,696**
Older Adult Programs						
Grants						
Continuations	10	4,091	0	0	0	0
New/Competing	0	0	10	4,095	0	0
Subtotal	10	4,091	10	4,095	0	0
Contracts						
Continuations	1	679	0	435	0	0
New/Competing	0	40	1	284	0	0
Subtotal	1	719	1	719	0	0
Total, Older Adult Programs	**11**	**4,810**	**11**	**4,814**	**0**	**0**
Minority AIDS						
Grants						
Continuations	16	8,297	0	0	16	8,320
New/Competing	0	0	16	8,320	0	0
Subtotal	16	8,297	16	8,320	16	8,320
Contracts						
Continuations	1	986	0	0	2	963
New/Competing	0	0	2	963	0	0
Subtotal	1	986	2	963	2	963
Total, Minority AIDS	**17**	**9,283**	**18**	**9,283**	**18**	**9,283**
Criminal/Juvenile Justice Programs						
Grants						
Continuations	12	4,747	13	5,219	13	5,231
New/Competing	1	394	0	0	0	0
Subtotal	13	5,141	13	5,219	13	5,231
Contracts						
Continuations	1	1,124	1	1,465	1	1,453
New/Competing	0	419	0	0	0	0
Subtotal	1	1,543	1	1,465	1	1,453
Total, Criminal/Juvenile Justice Programs	**14**	**6,684**	**14**	**6,684**	**14**	**6,684**
Total, Congressional Projects	**25**	**5,975**	**0**	**5,975**	**0**	**0**
Subtotal, CAPACITY	**509**	**333,192**	**496**	**333,806**	**418**	**275,167**

Center for Mental Health Services
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance SCIENCE AND SERVICE	FY 2010 Actual No.	 Amount	FY 2011 Continuing Resolution No.	 Amount	FY 2012 President's Budget No.	 Amount
GLS - Suicide Prevention Resource Center						
Grants						
Continuations	0	$0	1	$4,471	1	$4,471
New/Competing	1	4,471	0	0	0	0
Subtotal	1	4,471	1	4,471	1	4,471
Contracts						
Continuations	0	0	0	486	0	486
New/Competing	0	486	0	0	0	0
Subtotal	0	486	0	486	0	486
Total, GLS - Suicide Prev. Resource Center	**1**	**4,957**	**1**	**4,957**	**1**	**4,957**
Practice Improvement and Training						
Grants						
Continuations	0	243	1	243	1	243
New/Competing	6	250	0	0	0	0
Subtotal	6	493	1	243	1	243
Contracts						
Continuations	11	8,078	10	7,870	7	6,473
New/Competing	0	883	1	888	2	1,162
Subtotal	11	8,961	11	8,758	9	7,635
Total, Information Dissemination & Training	**17**	**9,454**	**12**	**9,001**	**10**	**7,878**
SAMHSA Health Information Network (SHIN)						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	1	2,673	0	0	0	0
New/Competing	0	0	0	2,673	0	0
Subtotal	1	2,673	0	2,673	0	0
Total, SHIN	**1**	**$2,673**	**0**	**$2,673**	**0**	**$0**
National Registry of Evidence-based Programs and Practices (NREPP)						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	1	544	0	544	0	0
New/Competing	0	0	0	0	0	0
Subtotal	1	544	0	544	0	0
Total, NREPP	**1**	**$544**	**0**	**$544**	**0**	**$0**
Consumer and Consumer Support Technical Assistance Centers						
Grants						
Continuations	0	0	5	1,774	5	1,777
New/Competing	5	1,777	0	0	0	0
Subtotal	5	1,777	5	1,774	5	1,777
Contracts						
Continuations	0	0	0	153	0	150
New/Competing	0	150	0	0	0	0
Subtotal	0	150	0	153	0	150
Total, Consumer/Cons. Support TA Ctrs	**5**	**$1,927**	**5**	**$1,927**	**5**	**$1,927**

Center for Mental Health Services
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Minority Fellowship Program						
Grants						
Continuations	5	$3,605	0	$0	5	$3,455
New/Competing	0	0	5	3,455	0	0
Subtotal	5	3,605	5	3,455	5	3,455
Contracts						
Continuations	1	674	1	724	0	824
New/Competing	0	0	0	100	0	0
Subtotal	1	674	1	824	0	824
Total, Minority Fellowship Program	**6**	**4,279**	**6**	**4,279**	**5**	**4,279**
Disaster Response						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	1	1,054	1	1,054	1	1,054
New/Competing	0	0	0	0	0	0
Subtotal	1	1,054	1	1,054	1	1,054
Total, Disaster Response	**1**	**1,054**	**1**	**1,054**	**1**	**1,054**
Homelessness						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	2	2,306	1	1,118	2	2,306
New/Competing	0	0	1	1,188	0	0
Subtotal	2	2,306	2	2,306	2	2,306
Total, Homelessness	**2**	**2,306**	**2**	**2,306**	**2**	**2,306**
HIV/AIDS Education						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	3	471	4	657	4	774
New/Competing	0	495	0	317	0	0
Subtotal	3	966	4	974	4	774
Total, HIV/AIDS Education	**3**	**966**	**4**	**974**	**4**	**774**
Subtotal, SCIENCE AND SERVICE	**37**	**28,160**	**31**	**27,715**	**28**	**23,175**
TOTAL, CMHS PRNS	**546**	**$361,352**	**527**	**$361,521**	**446**	**$298,342**

Center for Substance Abuse Prevention
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual No.	FY 2010 Actual Amount	FY 2011 CR No.	FY 2011 CR Amount	FY 2012 Pres. Budget No.	FY 2012 Pres. Budget Amount
CAPACITY:						
Strategic Prevention Framework						
Grants						
Continuations	46	$76,960	41	$60,835	0	$0
New/Competing	11	12,980	12	27,118	0	0
Subtotal	57	89,940	53	87,953	0	0
Contracts						
Continuations	10	21,765	9	23,824	0	0
New	0	0	0	0	0	0
Subtotal	10	21,765	9	23,824	0	0
Total, Strategic Prevention Framework	**67**	**111,705**	**62**	**111,777**	**0**	**0**
Mandatory Drug Testing						
Contracts						
Continuations	4	4,360	7	5,206	7	5,206
New	3	842	0	0	0	0
Subtotal	7	5,202	7	5,206	7	5,206
Total, Mandatory Drug Testing	**7**	**5,202**	**7**	**5,206**	**7**	**5,206**
Minority AIDS						
Grants						
Continuations	60	20,085	125	39,430	122	38,848
New/Competing	62	18,516	0	0	0	0
Subtotal	122	38,601	125	39,430	122	38,848
Contracts						
Continuations	0	339	1	1,955	1	2,537
New	1	2,445	0	0	0	0
Subtotal	1	2,784	1	1,955	1	2,537
Total, Minority AIDS	**123**	**41,385**	**126**	**41,385**	**123**	**41,385**
Performance Management						
Contracts						
Continuations	3	6,296	3	6,300	0	0
New	0	0	0	0	0	0
Subtotal	3	6,296	3	6,300	0	0
Total, Performance Management	**3**	**6,296**	**3**	**6,300**	**0**	**0**
STOP Act						
Grants						
Continuations	99	5,005	100	5,000	100	5,000
New/Competing	0	0	0	0	0	0
Subtotal	99	5,005	100	5,000	100	5,000
Contracts						
Continuations	1	995	2	2,000	2	2,000
New	1	1,000	0	0	0	0
Subtotal	2	1,995	2	2,000	2	2,000
Total, STOP Act	**101**	**7,000**	**102**	**7,000**	**102**	**7,000**
Congressional Projects						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	12	3,950	1	3,950	0	0
Subtotal	12	3,950	1	3,950	0	0
Total, Congressional Projects	**12**	**3,950**	**1**	**3,950**	**0**	**0**
Subtotal, Capacity	**313**	**$175,538**	**301**	**$175,618**	**232**	**$53,591**

Center for Substance Abuse Prevention
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual No.	FY 2010 Actual Amount	FY 2011 CR No.	FY 2011 CR Amount	FY 2012 Pres. Budget No.	FY 2012 Pres. Budget Amount
SCIENCE AND SERVICE:						
Fetal Alcohol Center of Exellence						
Contracts						
Continuations	1	$9,820	1	$9,821	1	$8,000
New	0	0	0	0	0	0
Subtotal	1	9,820	1	9,821	1	8,000
Total, Fetal Alcohol Center of Exellence	**1**	**9,820**	**1**	**9,821**	**1**	**8,000**
Center for the Application of Prevention Technologies						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	8	200	0	0	0	0
Subtotal	8	200	0	0	0	0
Contracts						
New	0	0	0	0	0	0
Subtotal	2	8,167	2	8,511	2	8,511
Total, Center for the Application of Prevention Technologies	**10**	**8,367**	**2**	**8,511**	**2**	**8,511**
Science & Service Program Coordination						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	6	4,727	5	4,789	4	4,409
New	1	118	0	0	0	0
Subtotal	7	4,845	5	4,789	4	4,409
Total, Science & Service Program Coordination	**7**	**4,845**	**5**	**4,789**	**4**	**4,409**
NREPP						
Contracts						
Continuations	1	650	1	650	0	0
New	0	0	0	0	0	0
Subtotal	1	650	1	650	0	0
Total, NREPP	**1**	**650**	**1**	**650**	**0**	**0**
SAMHSA Health Information Network						
Contracts						
Continuations	1	2,749	1	2,749	0	0
New	0	0	0	0	0	0
Subtotal	1	2,749	1	2,749	0	0
Total, SHIN	**1**	**2,749**	**1**	**2,749**	**0**	**0**
Minority Fellowship Programs						
Grants						
Continuations	0	71	0	71	0	71
New/Competing	0	0	0	0	0	0
Subtotal	0	71	0	71	0	71
Total, Minority Fellowship Programs	**0**	**71**	**0**	**71**	**0**	**71**
Subtotal, Science and Service	**20**	**26,502**	**10**	**26,591**	**7**	**20,991**
Total, CSAP	**333**	**$202,040**	**311**	**$202,209**	**239**	**$74,582**

Center for Substance Abuse Treatment
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual No.	FY 2010 Actual Amount	FY 2011 CR No.	FY 2011 CR Amount	FY 2012 Pres. Budget No.	FY 2012 Pres. Budget Amount
CAPACITY:						
Co-occurring State Incentive Grants (SIGs)						
Grants						
Continuations	4	$1,298	2	$1,100	0	$0
New/Competing	0	0	0	0	0	0
Subtotal	4	1,298	2	1,100	0	0
Contracts						
Continuations	2	2,964	1	3,163	1	3,213
New/Competing	0	0	0	0	1	1050
Subtotal	2	2,964	1	3,163	2	4,263
Total, Co-occurring State Incentive Grants (SIGs)	**6**	**4,262**	**3**	**4,263**	**2**	**4,263**
Opioid Treatment Programs/Regulatory Activities						
Grants						
Continuations	2	1,435	1	500	2	1,000
New/Competing	1	500	1	500	0	0
Subtotal	3	1,935	2	1,000	2	1,000
Contracts						
Continuations	8	5,491	10	6,968	12	7,903
New/Competing	5	1,562	2	935	0	0
Subtotal	13	7,053	12	7,903	12	7,903
Total, Opioid Treatment Programs/Regulatory Activities	**16**	**8,988**	**14**	**8,903**	**14**	**8,903**
Screening, Brief Intervention and Referral to Treatment						
Grants						
Continuations	25	25,449	21	15,619	36	24,920
New/Competing	0	0	15	9,301	0	0
Subtotal	25	25,449	36	24,920	36	24,920
Contracts						
Continuations	0	3,657	0	4,186	0	4,186
New/Competing	0	0	0	0	0	0
Subtotal	0	3,657	0	4,186	0	4,186
Total, Screening, Brief Intervention and Referral to Treatment	**25**	**29,106**	**36**	**29,106**	**36**	**29,106**
TCE - General						
Grants						
Continuations	37	12,033	31	11,772	18	6,969
New/Competing	17	6,654	24	6,000	0	0
Subtotal	54	18,687	55	17,772	18	6,969
Contracts						
Continuations	5	8,928	7	11,217	5	10,442
New/Competing	2	1407	0	0	0	0
Subtotal	7	10,335	7	11,217	5	10,442
Total,TCE - General	**61**	**29,022**	**62**	**28,989**	**23**	**17,411**
Pregnant & Postpartum Women						
Grants						
Continuations	27	12,518	10	4,933	26	12,784
New/Competing	0	0	16	7,851	0	0
Subtotal	27	12,518	26	12,784	26	12,784
Contracts						
Continuations	1	3,482	1	3216	0	3,216
New/Competing	0	0	0	0	0	0
Subtotal	1	3,482	1	3,216	0	3,216
Total, Pregnant & Postpartum Women	**28**	**$16,000**	**27**	**$16,000**	**26**	**$16,000**

Center for Substance Abuse Treatment
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(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual No.	FY 2010 Actual Amount	FY 2011 CR No.	FY 2011 CR Amount	FY 2012 Pres. Budget No.	FY 2012 Pres. Budget Amount
Strengthening Treatment Access and Retention						
Grants						
Continuations	0	$0	0	$0	0	$0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	0	1,478	1	1,775	1	1,675
New/Competing	3	295	0	0	0	0
Subtotal	3	1,773	1	1,775	1	1,675
Total, Strengthening Treatment Access and Retention	**3**	**1,773**	**1**	**1,775**	**1**	**1,675**
Recovery Community Services Program						
Grants						
Continuations	8	2,687	6	2,150	6	2,150
New/Competing	5	1,747	8	2,686	0	0
Subtotal	13	4,434	14	4,836	6	2,150
Contracts						
Continuations	0	635	1	400	0	300
New/Competing	0	600	0	0	0	0
Subtotal	0	1235	1	400	0	300
Total, Recovery Community Services Program	**13**	**5,669**	**15**	**5,236**	**6**	**2,450**
Access to Recovery						
Grants						
Continuations	0	0	30	96,954	30	96,954
New/Competing	30	94,788	0	0	0	0
Subtotal	30	94,788	30	96,954	30	96,954
Contracts						
Continuations	0	1649	1	2,000	1	1,500
New/Competing	1	2943	0	0	0	0
Subtotal	1	4,592	1	2,000	1	1,500
Total, Access to Recovery	**31**	**99,380**	**31**	**98,954**	**31**	**98,454**
Children and Family Programs						
Grants						
Continuations	14	4,328	47	14,332	34	10,575
New/Competing	34	10,122	0	0	12	4291
Subtotal	48	14,450	47	14,332	46	14,866
Contracts						
Continuations	5	16,032	4	15,646	4	11,312
New/Competing	1	94	1	700	1	4500
Subtotal	6	16,126	5	16,346	5	15,812
Total, Children and Family Programs	**54**	**30,576**	**52**	**30,678**	**51**	**30,678**
Treatment Systems for Homeless						
Grants						
Continuations	73	27,604	73	26,407	88	34,741
New/Competing	23	7,956	15	7,281	9	4183
Subtotal	96	35,560	88	33,688	97	38,924
Contracts						
Continuations	2	6,970	2	6,562	4	8,436
New/Competing	0	0	2	2500	0	0
Subtotal	2	6,970	4	9,062	4	8,436
Total, Treatment Systems for Homeless	**98**	**$42,530**	**92**	**$42,750**	**101**	**$47,360**

Center for Substance Abuse Treatment
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Programs of Regional & National Significance	FY 2010 Actual No.	FY 2010 Actual Amount	FY 2011 CR No.	FY 2011 CR Amount	FY 2012 Pres. Budget No.	FY 2012 Pres. Budget Amount
Minority AIDS						
Grants						
Continuations	138	$62,734	123	$55,715	68	$29,016
New/Competing	0	0	11	4982	71	32081
Subtotal	138	62,734	134	60,697	139	61,097
Contracts						
Continuations	0	3,177	1	5,291	1	4,891
New/Competing	0	0	0	0	0	0
Subtotal	0	3,177	1	5,291	1	4,891
Total, Minority AIDS	**138**	**65,911**	**135**	**65,988**	**140**	**65,988**
Criminal Justice Activities						
Grants						
Continuations	99	31,888	151	49,936	105	37,588
New/Competing	86	26,497	24	9,822	65	22927
Subtotal	185	58,385	175	59,758	170	60,515
Contracts						
Continuations	5	8,600	9	7,877	9	7,120
New/Competing	6	421	0	0	0	0
Subtotal	11	9,021	9	7,877	9	7,120
Total, Criminal Justice Activities	**196**	**67,406**	**184**	**67,635**	**179**	**67,635**
Services Accountability						
Contracts						
Continuations	0	20,226	0	20,816	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	20,226	0	20,816	0	0
Total, Services Accountability	**0**	**20,226**	**0**	**20,816**	**0**	**0**
Congressional Projects						
Grants						
Continuations	0	0	0	0	0	0
New/Competing	9	4,593	0	4593	0	0
Subtotal	9	4,593	0	4593	0	0
Total, Congressional Projects	**9**	**4,593**	**0**	**4,593**	**0**	**0**
Subtotal, Capacity	**678**	**$425,442**	**652**	**$425,686**	**610**	**$389,923**

Center for Substance Abuse Treatment
Programs of Regional & National Significance
Mechanism by Summary of Activities
(Dollars in thousands)

Programs of Regional & National Significance	FY 2010 Actual No.	FY 2010 Actual Amount	FY 2011 CR No.	FY 2011 CR Amount	FY 2012 Pres. Budget No.	FY 2012 Pres. Budget Amount
SCIENCE AND SERVICE:						
Addiction Technology Transfer Centers						
Grants						
Continuations	15	$8,050	15	$8,831	0	$0
New/Competing	0	0	0	0	15	8,831
Supplements	(8)	1,100	0	0	0	0
Subtotal	15	9,150	15	8,831	15	8,831
Contracts						
Continuations	0	0	1	250	1	250
New/Competing	0	0	0	0	0	0
Subtotal	0	0	1	250	1	250
Total, Addiction Technology Transfer Centers	**15**	**9,150**	**16**	**9,081**	**16**	**9,081**
Minority Fellowship Program						
Grants						
Continuations	5	547	0	547	0	547
New/Competing	0	0	0	0	0	0
Subtotal	5	547	0	547	0	547
Total, Minority Fellowship Program	**5**	**547**	**0**	**547**	**0**	**547**
Special Initiatives/Outreach						
Grants						
Continuations	1	300	1	300	0	0
New/Competing	0	0	0	0	1	300
Subtotal	1	300	1	300	1	300
Contracts						
Continuations	5	2,022	5	2,100	5	1,971
New/Competing	1	187	0	0	0	0
Subtotal	6	2209	5	2100	5	1,971
Total, Special Initiatives/Outreach	**7**	**2,509**	**6**	**2,400**	**6**	**2,271**
Information Dissemination						
Contracts						
Continuations	1	3,894	1	4,553	0	0
New/Competing	0	435	0	0	0	0
Subtotal	1	4,329	1	4,553	0	0
Total, Information Dissemination	**1**	**4,329**	**1**	**4,553**	**0**	**0**
National Registry of Evidence-Based Programs & Practices						
Contracts						
Continuations	0	893	0	893	0	0
New/Competing	0	0	0	0	0	0
Subtotal	0	893	0	893	0	0
Total, NREPP	**0**	**893**	**0**	**893**	**0**	**0**
SAMHSA Health Information Network						
Contracts						
Continuations	1	4,255	0	0	0	0
New/Competing	0	0	0	4,255	0	0
Subtotal	1	4,255	0	4,255	0	0
Total, SAMHSA Health Information Network	**1**	**4,255**	**0**	**4,255**	**0**	**0**
Program Coordination and Evaluation						
Contracts						
Continuations	4	4,774	3	4,600	0	0
New/Competing	0	560	16	614	0	0
Supplements	0	0	0	0	0	0
Subtotal	4	5,334	19	5,214	0	0
Total, Program Coordination and Evaluation	**4**	**5,334**	**19**	**5,214**	**0**	**0**
Subtotal, Science and Service	**33**	**27,017**	**42**	**26,943**	**22**	**11,899**
Total,CSAT	**711**	**$452,459**	**694**	**$452,629**	**632**	**$401,822**

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Affordable Care Act Prevention and Public Health Fund
(Dollars in Thousands)

ACA Prevention Fund	FY 2010	FY 2011	FY 2012
Primary and Behavioral Health Care Integration 1/	$20,000	$35,000	$20,000
Garrett Lee Smith Youth Suicide Prevention	---	10,000	---
Health Surveillance	---	18,000	---
Screening, Brief Intervention, & Referral to Treatment	---	25,000	---
Prevention Prepared Communities	---	---	22,600
Behavioral Health - Tribal Prevention Grants	---	---	50,000
Total, ACA Prevention Fund	**$20,000**	**$88,000**	**$92,600**

1/ Reflects ACA Prevention Fund only; $14 million for PBCHI is funded out of Budget Authority

Behavioral Health - Tribal Prevention Grants
(Dollars in Thousands)

	FY 2010	FY 2011	FY 2012
Program Level	---	---	**$50,000**
ACA Prevention Fund (non-add)	---	---	*50,000*

Authorizing Legislation .....Section 516 and 520A of the PHS Act

FY 2012 Authorization .....N/A

Allocation Method ..... Discretionary Grants

Purpose

SAMHSA proposes to introduce a new Behavioral Health - Tribal Prevention Grant (BHTPG) starting in FY 2012, focusing exclusively on promoting overall behavioral health by preventing alcohol and substance abuse and by preventing suicides in the 565 Federally-recognized Tribes. Promotion of strong emotional health is an important contributor to the prevention of substance abuse and some mental illnesses as well as in reducing their negative impact on Tribal communities. The BHTPG represents a significant advance in the Nation's approach to substance abuse and suicide prevention in several ways. First, it recognizes that emotional health is part of overall health and thus supports the Tribes in addressing overall health, including preventing and reducing substance abuse, suicides and mental illness, in a coordinated manner. Second, it establishes a single coordinated mental health and substance abuse program for all Federally-recognized Tribes. Third, SAMHSA will consult and work closely with Tribes and Tribal leaders to develop a comprehensive, data-driven planning process to identify and address the most serious issues in each Tribal community. Recognizing the Federal obligation to help Tribes deal with physical and behavioral health issues, SAMHSA will work in consultation with Tribes to determine the best approaches.

Bringing Substance Abuse and Suicide Prevention to Scale for all Tribes

The proposal recognizes that Tribes currently receive different levels of mental health and substance abuse prevention services. Through the BHTPG, all Tribes would be eligible for a "basic" amount of funds, with the remaining funds distributed to best serve the Tribal populations. SAMHSA will hold consultation(s) consistent with SAMHSA's Tribal Consultation Policy to determine how these funds would be best distributed to address as many of the needs of the Tribes as possible. The BHTPG provides enhanced substance abuse (including alcohol) and suicide prevention funding to the Tribes to assure that their pressing needs are being met. This effort follows the lead of the President and Congress who have emphasized the importance of emotional health, prevention, and health promotion.

Structure and Required Activities

The program will consist of grants to Tribes who chose to apply. A three-year time period will enable Tribes to develop a comprehensive plan to address the most pressing need based on treatment data as well as in consultation with SAMHSA. The plan would address the prevention of substance abuse and suicide, and will provide for coordinated services. This planning activity is one of the basic components of the Tribal Law and Order Act (TLOA) and the Indian Alcohol and Substance Abuse Act, which SAMHSA is charged to coordinate in statute. Tribes will continue to be eligible for these funds beyond the three-year time frame so long as they meet the requirements of renewal applications, provide the necessary annual reports, and show continued movement toward implementing their approved plans.

The plan will reflect the results of an assessment of need, a review of the resources and capacity within the Tribal communities, a plan for carrying out the strategy, a monitoring of the strategy as implemented, and an evaluation of the strategy to identify strengths and weaknesses. SAMHSA will review and approve the plans.

Tribes will be allowed to use set percentage (determined after consultation with Tribes) of the funds for a combination of service and service-related activities, development and dissemination of prevention messages, and provider development and linkage building to support the Tribes in achieving outcomes. Funding for infrastructure activities will enable the Tribe to build service capacity. The Tribe will present data to support how the allocation will support infrastructure and/or provision of services. In carrying out these activities, the Tribe will be required to use comprehensive, evidence-based programming, and/or proven successful programming, based on either mainstream science or proven Tribal traditions. Up to 20 percent of the grant funds may be used to fund key support and development activities, such as operation of a Tribal prevention advisory group, support for a Tribal community coalition, access to an epidemiological work group, training and technical assistance to communities, data collection and evaluation, and oversight and monitoring of activities.

Approximately 75 percent of Federally-recognized tribes have a total enrollment of 2,000 or fewer persons and a greater percentage of these tribes have limited internal capacity or infrastructure in place to implement and support needed behavioral health services. Smaller Tribes will have the opportunity to work in collaboration with other small Tribes to maximize the impact of the resources. SAMHSA will consult with the smaller Tribes to ensure that their needs are being met while reducing service overlap.

To ensure that providers in both the mental health and substance abuse fields are trained in both substance abuse and mental illness prevention and emotional health concepts and practices, Tribes will be able to use funds for coordinated workforce development, training in evidence-based practices, and the development of coordinated infrastructure and service delivery systems.

Budget Request

The FY 2012 President's Budget Request is $50 million through the Prevention and Public Health Fund of the ACA. Approximately half of the funding would be allocated as a "base

level" to Federally-recognized Tribes that make an application to receive these funds. It is anticipated that the base amount each Tribe would be eligible for is approximately $50,000, depending on the number of Tribes that apply. Larger Tribes may be eligible for additional funding based on some combination of population and need. The remaining funds will be distributed to best serve the population. The details of the funds distribution will be determined in consultation with Tribes.

Outcomes and Outputs

Behavioral Health - Tribal Prevention Grants

Table 1: Key Performance Indicators for Behavioral Health - Tribal Prevention Grants

Measure	Most Recent Result	FY 2012 Performance Target Associated with FY 2011 PB	FY 2013 Performance Target Associated with FY 2012 Request	FY 2013 Performance Target +/- FY 2012 Performance Target
2.3.92: Number of persons served (Output)	N/A	N/A	Baseline	N/A
2.3.93: Percentage of youth age 12-20 who report drinking in the past month (Outcome)	N/A	N/A	Baseline	N/A

The Behavioral Health - Tribal Prevention Grants will hold tribes accountable for achieving measurable outcomes for their citizens. Program performance measures are still being developed and will be provided at a later date.

Grant Award Table

(whole dollars)	FY 2010	FY 2011	FY 2012
Number of Awards	0	0	565
Minimum Award	$0	$0	$50,000

Primary & Behavioral Health Care Integration (PBHCI)
(Dollars in Thousands)

	FY 2010	FY 2011	FY 2012
Program Level……	**$34,000**	**$49,000**	**$34,000**
ACA Prevention Fund (non-add)……	*20,000*	*35,000*	*20,000*

Authorizing Legislation ..... Sections 520A of the Public Health Service Act

FY 2012 Authorization .....Expired

Allocation Method .....Competitive Grants

Physical health problems among people with mental illnesses and addictions impact quality of life and contribute to premature deaths, where these individuals die much earlier than the general population. While several factors contribute to this disparity, empirical findings indicate that early mortality among people with serious mental illnesses is clearly linked to the lack of access to primary care services.

In FY 2009, SAMHSA initiated the Primary and Behavioral Health Care Integration (PBHCI) Program and funded 13 PBHCI grants. PBHCI grantees began providing primary care services to consumers with serious mental illness in February 2010, and are currently engaged in a variety of activities which including developing electronic health record systems, developing data collection systems, and perhaps most importantly, providing primary care and health/wellness services. In FY 2010, SAMHSA awarded 43 additional grants, mainly funded with Affordable Care Act's Prevention funds.

The PBHCI program will provide resources to facilitate screening and referral for necessary primary care prevention and treatment needs; develop a registry/tracking system for all primary care needs; provide care management, individualized person-centered planning and coordination to increase consumer participation and follow up with all primary care screening, assessment and treatment services; provide prevention and wellness support services (including nutrition consultation, health education and literacy, tobacco cessation, peer support specialists, self-help/management programs); and develop processes for referral and follow-up for needed treatments that are not appropriately provided in a primary care setting. By building the necessary partnerships, grantees will expand their offerings of primary healthcare services for people with mental illnesses, resulting in improved health status. By making available coordinated primary care services in community-based behavioral health settings, grantees will improve the overall wellness and physical health status of people with serious mental illnesses

The PBHCI program supports the coordination and integration of primary care services into publicly-funded community behavioral health settings. The expected outcome of improved health status for people with serious mental illness and substance use disorders will be achieved by encouraging grantees to engage in necessary partnerships, expand infrastructure, and increase the availability of primary health care and wellness services to individuals with behavioral health conditions. Partnerships between primary care and behavioral health organizations are deemed

crucial to this program**.** The population of focus for this grant program is individuals with serious mental illness and SUD served in the public behavioral health system.

SAMHSA expects that people with serious mental illnesses and SUD will show improvement in their physical health status through participation in this program. This grant program supports SAMHSA's Pledge for Wellness 10 by 10 Campaign to prevent and reduce early mortality among people with mental illness by 10 years over the next 10 years. It is expected that better coordination and integration of primary and behavioral health care will lead to outcomes including improved access to primary care services; improved prevention, early identification and intervention to avoid serious health issues including chronic diseases; enhanced capacity to holistically serve those with mental and/or substance use disorders; and better overall health status of consumers.

SAMHSA is collaborating with the HHS/Assistant Secretary for Planning and Evaluation (ASPE) on the evaluation for this program, which seeks to address three main questions of interest: 1) is it possible to integrate the services provided by primary care providers and community-based behavioral health agencies; 2) does the integration of primary and behavioral health care lead to improvements in the mental and physical health of the population with serious mental illnesses and/or substance use disorders served by these integrated models; 3) which models of integrated primary and behavioral health care lead to better mental and physical health impacts for the population served.

In FY 2010, SAMHSA, in partnership with the Health Resources and Services Administration (HRSA), funded a Training and Technical Assistance Center for Primary and Behavioral Health Care Integration (TTA-PBHCI). The purpose of this program is to serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development. The TTA-PBHCI grantee will be expected to provide support in two core areas: 1) technical assistance and support to SAMHSA and HRSA grantees and 2) serve as a national technical assistance resource to the general public including generating and disseminating best practice materials from Federal partners such as HRSA, Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH) and other partners.

Budget Request

The FY 2012 President's Budget request is $20 million allocated from the ACA Prevention Fund, the same as the FY 2010 Level. The request will support 34 grant and one Training and Technical Assistance Center.

Prevention Prepared Communities
(Dollars in thousands)

	FY 2010	FY 2011	FY 2012
Program Level……	---	---	**$22,600**
ACA Prevention Fund (non-add)……	---	---	*22,600*

Authorizing Legislation ..... Section 516 of the PHS Act

FY 2012 Authorization .....Expired

Allocation Method .....Competitive Grants

The Prevention Prepared Communities program will assist States and communities in developing and implementing effective mental illness and substance abuse prevention practices, strategies, and policies that will promote the wellness of individuals age 9-25 and the communities in which they live. The program builds on scientific evidence that a common set of risk and protective factors contributes to a range of mental, physical, and behavioral problems, including substance abuse and other unhealthy behaviors. Thus, targeting risk factors and promoting protective factors can prevent substance abuse and some mental illnesses as well as other negative outcomes. The goal of Prevention Prepared Communities is to improve community and individual level wellness, and health promotion outcomes in a comprehensive, collaborative way. Performance measures will be collected at both the community and individual level. Measures will include population-based indicators of community wellness and at an individual level will include measures of positive mental health, abstinence from substance abuse, better juvenile justice outcomes and improved academic achievement.

Under this program, grantee communities will use data-based approaches to identify their predominant substance abuse and mental health issue(s), and will select and implement evidence-based strategies to target the identified risk and protective factors contributing to these issues. Evidence-based strategies may include individual- and family-focused prevention programs and practices, environmental strategies, community-wide public education campaigns, school-based curricula, and parenting, social, and life skills training Grantees will collaborate with appropriate service providers for ages 9-25 to ensure the utilization of best practices for universal, selective, and indicated populations.

Budget Request

The FY 2012 President's Budget request is $22.6 million allocated from the ACA Prevention Fund. The request will support 30 new grants and two new contracts.

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