DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2015

Substance Abuse and Mental Health Services Administration

Justification of Estimates for Appropriations Committees

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Substance Abuse and Mental Health Services Administration
SAMHSA
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As the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present SAMHSA's Budget Request for FY 2015. This request reflects the Administration's priorities and the Department's key goals for advancing the nation's behavioral health promotion and health care systems while accommodating continuing constraints on public funding at all levels.

Our nation stands at a critical crossroad. Recent tragic events and the Administration's call to action on the mental health and well-being of our citizens, have spurred critical public health investments. At the same time, our health care system is preparing for the influx of individuals now eligible and enrolling for coverage. The Mental Health Parity and Addiction Equity Act along with the Affordable Care Act also requires coverage for mental or substance use disorders to provide the same level of benefits as is provided for general medical/surgical treatment. Yet, millions of Americans do not receive the help they need. It is time for our country to address these issues, and SAMHSA must lead the way. SAMHSA's efforts to do so, including support to enhance early identification of mental and substance use disorders, grants to protect and strengthen America's children and communities, and training for existing and new behavioral health service providers, can make a difference.

Behavioral health problems contribute to early death, disability, lost productivity, and high health care costs. But if we intervene early, we can save lives and lower these costs. Despite the existence of effective treatments, it typically takes more than six years for people to receive treatment after the onset of a mental illness or substance use disorder. The FY 2015 Budget Request includes funding to help teachers and other individuals who interact with youth recognize early signs of mental illness, and to improve referrals and access to mental health services for young people ages 16-25. The FY 2015 Budget also requests new funds to create a prescription drug overdose prevention program (SPF Rx) that will help address this serious public health problem.

Many Americans with mental and/or substance use disorders are now eligible for insurance that can provide access to needed treatment services. SAMHSA's FY 2015 Budget Request includes funds to enhance the integration of substance abuse treatment services and the continuum of primary care through the new Primary Care and Addiction Services Integration (PCASI) Program. In addition, the FY 2015 Budget Request funds the Science of Changing Social Norms initiative which will help SAMHSA inform the attitudes and behaviors of Americans regarding mental and substance use disorders with the ultimate goal of reducing the impact of these conditions on individuals, families, and communities.

These are just a few examples of the work SAMHSA does every day to advance the behavioral health of the nation. Substance abuse, addictions, poor emotional health, and serious mental illnesses take a toll on everyone. These conditions cost lives and productivity, and strain families and resources in the same way as untreated physical illnesses. SAMHSA submits this budget to maintain its commitment to supporting states and communities in providing effective mental health and substance abuse programs and services.

Pamela S. Hyde, J.D.
Administrator

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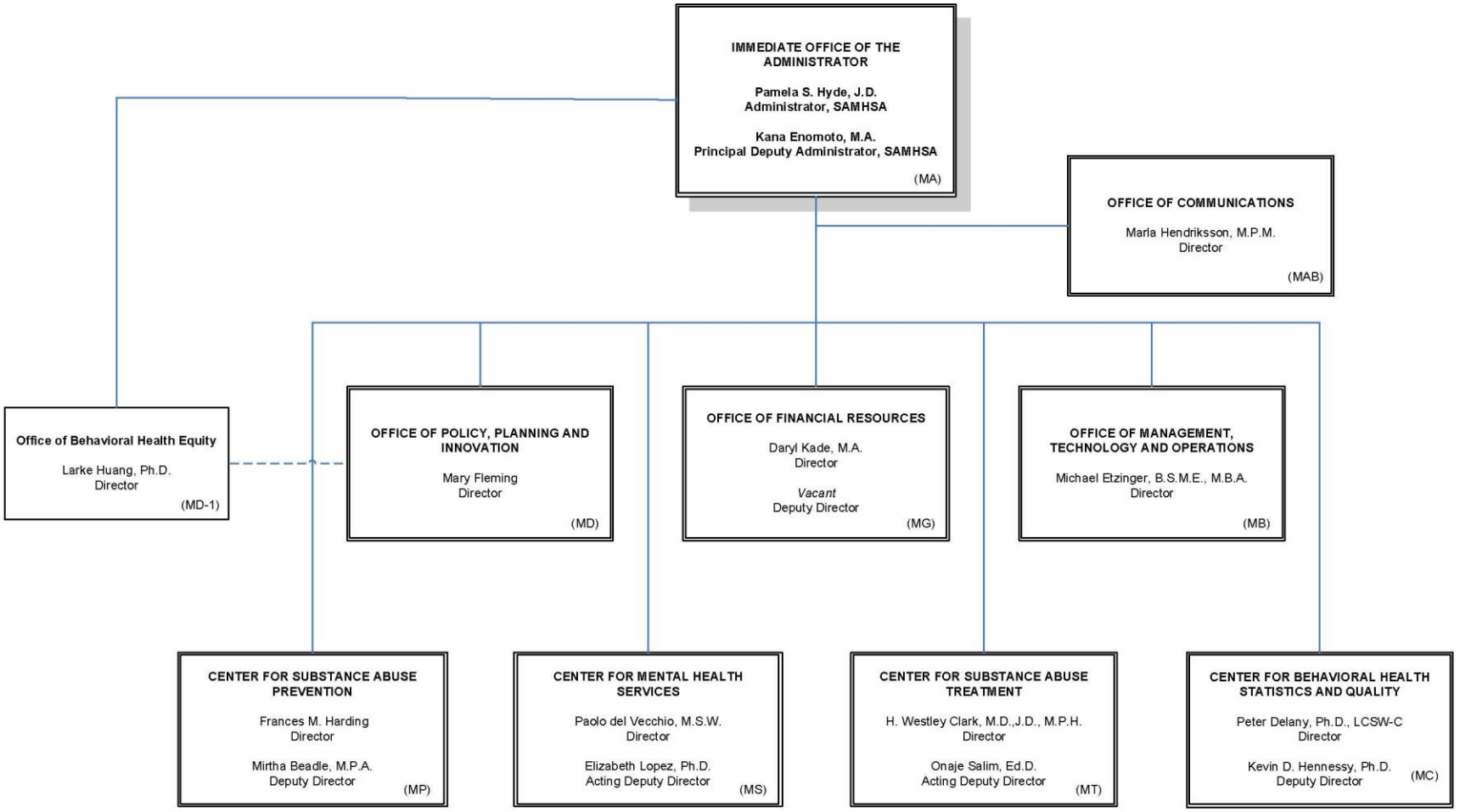
Organizational Structure:
Substance Abuse and Mental Health Services Administration (SAMHSA)



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Performance Budget Overview

Introduction

The wholeness of individuals and their families rests not on the absence of disease but on their mental and physical well-being—which includes both mental health and freedom from addiction. Prevention, treatment, and recovery support services for mental health and substance use disorders are essential components of health service systems and community-wide strategies. In addition to improving the health status of our citizens, these support services lower costs for individuals, families, businesses and governments. In fact, the presence of substance abuse and mental illness increases the cost of treating co-morbid physical diseases and results in the highest disability burden in the world. However, substance abuse, addiction, poor emotional health and mental illnesses do not just cost money, they cost lives—particularly when we do not prevent or manage them effectively. For these reasons, SAMHSA has a unique responsibility to focus the nation's health and human services agendas on these preventable and treatable problems stemming from disease, trauma, lack of access to appropriate care, and insufficient community and family supports.

Vision

SAMHSA provides leadership and devotes its resources – programs, policies, information and data, contracts and grants – toward helping the nation act on the knowledge that:

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

Mission

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA serves as a national voice on mental health and mental illness, substance abuse, and behavioral health systems of care. It coordinates behavioral health surveillance to understand better the impact of substance abuse and mental illness on children, individuals, families and the costs associated with treatment. And, SAMHSA helps to ensure dollars are invested in evidence-based and data-driven programs and initiatives that result in improved health and resilience.

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Leading Change 2.0 – SAMHSA's Proposed Six Strategic Initiatives

Behavioral health is an essential part of health service systems and effective community-wide strategies that improve health status and lower costs for families, businesses, and governments. Through practice improvement in the delivery and financing of prevention, treatment, and recovery support services, SAMHSA, with its partners, can advance behavioral health and promote the nation's health. As the driving force for its direction, SAMHSA's Strategic Plan for the last four years – *Leading Change: A Plan for SAMHSA's Roles and Actions 2011 – 2014* – outlined eight Strategic Initiatives within the concept of a public health approach and a changing health care delivery system. Since issuing the plan in 2011, SAMHSA has achieved significant successes in these strategic areas and is on track to meet its goals. Moreover, SAMHSA completed the key objectives within three of the Strategic Initiatives – Military Families; Data, Outcomes and Quality; and Public Awareness and Support – and has embedded the ongoing scope and priorities of these issue areas into programmatic and business operations across SAMHSA.

Going forward, for FY 2015 through FY 2018, SAMHSA is in the process of updating its strategic plan to align with the evolving needs of the behavioral health field, the people SAMHSA serves, and the parameters of the fiscal environment. Leading Change 2.0: A Plan for SAMHSA's Roles and Actions 2015 – 2018, to be issued in late FY 2014, will reflect SAMHSA's programmatic priorities and policy drivers including the new HHS strategic plan and the transition to full implementation of the Affordable Care Act.

SAMHSA intends to present its draft strategic plan including six Strategic Initiatives to the public for input in Spring of 2014 and issue a final plan in the Fall.

1 Prevention of Substance Abuse and Mental Illness

This Strategic Initiative focuses on the prevention of substance abuse and mental illness by maximizing opportunities to create environments where individuals, families, communities, and systems are motivated and empowered to manage their overall emotional, behavioral, and physical health. This SI will include a focus on several populations of high risk, including college students and transition age youth, especially those at risk of first episodes of mental illness or substance abuse; American Indian/Alaska Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and lesbian, gay, bisexual, and transgender individuals.

2 Health Care and Health Systems Integration

This Strategic Initiative focuses on health care and integration across systems including systems of particular importance for persons with behavioral health needs such as community health promotion, health care delivery, specialty behavioral health care, and community living needs. Integration efforts will seek to increase access to appropriate high quality prevention, treatment, recovery and wellness services and supports; reduce disparities between the availability of services for mental illness (including serious

mental illness) and substance use disorders compared with the availability of services for other medical conditions; and support coordinated care and services across systems.

3 Trauma and Justice

This Strategic Initiative focuses on trauma and justice by integrating a trauma-informed approach throughout health, behavioral health, human services, and related systems in order to reduce the harmful effects of trauma and violence on individuals, families and communities. This SI also will support the utilization of innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

4 Recovery Support

This Strategic Initiative will promote partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community.

5 Health Information Technology

This Strategic Initiative will ensure that the behavioral health system – including states, community providers, patients, peers, and prevention specialists – fully participate with the general healthcare delivery system in the adoption of health information technology (Health IT), including interoperable electronic health records (EHRs) and the use of other electronic training, assessment, treatment, monitoring, and recovery support tools, to ensure high-quality integrated health care, appropriate specialty care, improved patient/consumer engagement, and effective prevention and wellness strategies.

6 Workforce Development

This Strategic Initiative will support active strategies to strengthen the behavioral health workforce. Through technical assistance, training and focused programs, the initiative will promote an integrated, aligned, competent workforce that enhances the availability of prevention and treatment for substance abuse and mental illness, strengthens the capabilities of behavioral health professionals, and promotes the infrastructure of health systems to deliver competent, organized behavioral health services. This initiative will continually monitor and assess the needs of peers, communities, and health professionals in meeting behavioral health needs in America's transformed health promotion and health care delivery systems.

Overview of the Budget Request

The SAMHSA FY 2015 Budget Request for its Total Program Level is $3.6 billion, a decrease of $63.2 million below the FY 2014 Enacted Level. The FY 2015 Total Program Level of $3.6 billion includes $3.3 billion in Budget Authority (a decrease of $137.3 million below the FY 2014 Enacted Level), $210.7 million in PHS Evaluation Funds (an increase of $78.0 million above the FY 2014 Enacted Level), and $58.0 million in Prevention and Public Health Fund resources (a decrease of $4.0 million below the FY 2014 Enacted Level. The budget continues a $1.5 million for user fees for extraordinary data and publication requests. The FY 2015 Budget Request presents four appropriations consistent with the Consolidated Appropriations Act, 2012, and the FY 2014 Enacted Level: Mental Health, Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support.

The FY 2015 Budget Request reflects key goals for advancing the nation's behavioral health promotion, prevention, treatment, and recovery support systems while accommodating continuing constraints on public funding at all levels. At the same time, SAMHSA's Budget Request reflects the need to support an emerging and dynamic healthcare environment. The request reflects ongoing internal and external changes which have resulted in integrated data and operating structures, uniform guidance, and braided funding strategies in key discretionary programs. SAMHSA has achieved both programmatic and fiscal efficiencies through assessing its internal workforce and increasing collaboration with other federal agencies, while reducing redundancy to deliver improved program outcomes.

The FY 2015 budget continues investments to increase access to mental health services to protect children and communities, and to reduce suicide rates, with a special focus on American Indian and Alaska Native communities. The Budget Request supports the President's *Now is the Time* initiative, and lays out changes to achieve a healthier and safer nation. The Budget includes funding to improve the states' capacity to provide behavioral health services through the block grants, with a mental health set-aside dedicated to early intervention for the most serious mental illnesses, and leverages funding for competitive grant activities that will now be brought to scale through other mechanisms such as the block grants or state-level funding streams. The Budget also invests new resources to integrate primary care and addiction services and address prescription drug abuse.

As part of SAMHSA's role in the nation's mental health and substance abuse prevention and treatment systems, SAMHSA will work to target investments more strategically by:

- Targeting resources to evidence-based prevention and treatment interventions;
- Integrating Minority AIDS and related programs into the HIV Continuum of Care; and
- Decreasing negative attitudes toward seeking help for mental health and substance abuse problems, and increasing the willingness to seek help for those problems.

The FY 2015 Budget Request prioritizes essential investments which require the programmatic expertise and leadership of SAMHSA's highly trained and dedicated staff. As SAMHSA continues its commitment to be an efficient, effective steward of taxpayer dollars, it will manage resources from the Prevention and Public Health Fund, the PHS Evaluation fund, and directly appropriated Budget Authority with utmost care and integrity. Maintaining critical agency investments in FY 2015 will allow SAMHSA to build capacity in states, territories, tribes and communities to protect and promote behavioral health in America.

Programmatic Priorities to Support Strategic Initiatives

SAMHSA's Strategic Plan, Leading Change, has been the driving force in SAMHSA's strategic direction since 2011. Using a public health approach, and guided by the Affordable Care Act, SAMHSA has achieved significant success and is on track with the metrics established for the six strategic initiatives (SIs). As SAMHSA prepares for FY 2015 and beyond, the agency is retooling the strategic initiatives in light of current external drivers to better meet the needs of our stakeholders and to align with SAMHSA's vision and mission. As SAMHSA prepares for the future, the agency must continue to ensure that staff has the necessary resources and knowledge, and that SAMHSA as an organization has the infrastructure and capacity, to lead public health efforts to advance the nation's behavioral health.

In FY 2015, SAMHSA is requesting funding for the *Science of Changing Social Norms* initiative. Building on the President's effort to reduce negative attitudes and increase understanding about mental health through the *Now is the Time* initiative, this public awareness and education initiative will identify and employ science-based, data-driven methodologies to change societal and cultural norms in this important domain.

Prevention of Substance Abuse and Mental Illness

In FY 2015, SAMHSA proposes a new program, Prescription Drug Abuse and Overdose Prevention (SPF Rx), will provide funding for the prevention of prescription drug misuse and abuse in high priority age groups (including young and middle-aged adults) and populations through education and other prevention strategies. Grantees will be required to collaborate with the state's public health authority, education authority, and Medicaid authority, as well as the state's Prescription Drug Monitoring Program (PDMP) and health information exchanges (HIEs), to raise awareness of the dangers of sharing medications. It will also work with pharmaceutical and medical communities on the risks of overprescribing and on the use of PDMPs and educational materials at points of prescribing, sale, and dispensing. SAMHSA will also partner with the National Institute on Drug Abuse (NIDA) to further develop the evidence base to support these efforts.

Up to 20 other states would receive planning grants to build capacity to address prescription drug abuse and overdose prevention efforts. Funding also will be used to provide technical assistance and evaluation, and to expand work with the Office of the National Coordinator of Health Information Technology (ONC) on standards alignment for interoperability among state PDMPs and electronic health records (EHRs)/health information exchanges (HIEs) and/or any other technology efforts determined necessary for the exchange of data.

Within existing resources, SAMHSA proposes to establish the Building Behavioral Health Coalitions program to support cross-fertilization among mental health and substance abuse prevention community coalitions and/or organizations to expand their focus and activities to include a behavioral health approach. Funded activities may include, but are not limited to, bi-directional education on substance abuse prevention and mental health promotion; assessing shared community risk and protective factors, especially among youth; developing the capacity to jointly implement evidence-based programming that addresses these factors; and working with stakeholders such as health insurance companies, Marketplaces, and state Medicaid officials to promote health insurance coverage for substance abuse prevention and mental health promotion. Mental health and substance abuse funding streams will be kept separate and used for activities consistent with their funding authorities.

SAMHSA also proposes to support further implementation of the newly updated National Strategy for Suicide Prevention for a nationally coordinated, locally driven effort to bring down the tenth leading cause of death in the U.S.

In the FY 2015 Budget Request, the 20 percent Substance Abuse Prevention set aside funds are retained in the Substance Abuse Prevention and Treatment Block Grant (SABG). Funding for the Strategic Prevention Framework (SPF) is continued for additional Partnership for Success (PFS) grants to promote state-wide implementation of the SPF, an evidence-based, data-driven approach to substance abuse prevention, with a focus on underage drinking and prescription drug abuse.

Health Care and Systems Integration

In anticipation of ongoing changes and improvements brought about by the Affordable Care Act, SAMHSA continues to prepare and guide the behavioral health community through the implementation of health reform. Vulnerable populations, such as individuals who are homeless and those with co-occurring mental and substance use disorders and those with serious mental illness, continue to shape SAMHSA's educational activities as well as its outreach, eligibility, and enrollment efforts. Simultaneously, efforts to increase primary and behavioral health care integration will expand, including specific technical assistance for tribes.

As highlighted by Congress in FY 2012, the behavioral health workforce faces significant shortages with tens of thousands of new providers needed in order to maintain current service levels.

Business practices and enrollment: SAMHSA has invested significant time and resources in the behavioral health provider system to update business practices while leveraging resources to provide technical assistance and innovative collaborations. SAMHSA also has embedded health reform readiness activities regarding enrollment and billing into existing grants and initiatives. The FY 2014/2015 block grant applications have been revised, a new grants management tool has been launched, and SAMHSA project officer training continues. In addition, the FY 2015 Leading Change 2.0 Strategy will enable states to further build capacity of their workforce to manage in an insurance marketplace environment.

Primary care/substance abuse treatment integration: Building on past behavioral health integration efforts, SAMHSA is making a major investment in the bi-directional integration of substance abuse treatment services and primary care. The Primary Care and Addiction Services Integration (PCASI) grant program will address service coordination and infrastructure needs at the provider level.

Block grants: The block grant programs remain the cornerstones of SAMHSA's portfolio for implementation of health reform in FY 2015. The budget fully funds the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG) to support states in an effective transition to full implementation of the Affordable Care Act, which includes expanded coverage for mental health and substance abuse treatment services.

The FY 2015 Budget Request prioritizes essential health reform activities to ensure individuals with behavioral health needs have full access to the benefits afforded through expanded coverage. Additionally, SAMHSA stands ready to assist with critical issues related to health care insurance and behavioral health coverage. The MHBG includes a set-aside dedicated to early intervention for the most serious mental illnesses.

Trauma and Justice

Grants for Adult Trauma Screening and Brief Intervention remain a high priority in FY 2015. SAMHSA will award grants to develop or identify safe and effective tools for healthcare providers to meet the recommendation in the 2011 Institute of Medicine report *Clinical Preventive Services for Women*, recommendation for universal screening of women and adolescent girls for intimate partner violence, which includes screening for past experiences of violence and abuse. The National Child Traumatic Stress Initiative and Drug Court grant programs are close to level-funded with the FY 2014 enacted level and SAMHSA maintains its strong partnership with the Administration for Children and Families and CMS to address the HHS High-Priority Goal on improving trauma services for children and youth in child welfare.

Recovery Support

Building on lessons learned from the early iterations of the Cooperative Agreements to Benefit Homeless Individuals (CABHI) program, SAMHSA will continue this program designed to work with state and local Public Housing Authorities and state Medicaid agencies to develop systematic, cost-effective, and integrated approaches to housing that includes treatment and services for mental and substance use disorders. The program will support innovative strategies to provide needed services and supports that will help integrate individuals who experience homelessness with mental and substance use disorders into the community, assist providers in strengthening their infrastructure for delivering and sustaining housing to support recovery with integrated behavioral health and other critical services.

SAMHSA is also proposing to award a new cohort of Mental Health Transformation Grants (MHTG). The purpose of the MHTG grant program is to foster adoption and implementation of

permanent transformative changes in how public mental health services are organized, managed and delivered so that they are consumer-driven, recovery-oriented and supported through evidence-based and best practices. The new grants will expand service capacity to address the need for crisis support and response services for adults with serious mental illness (SMI) or children/youth with serious emotional disturbance (SED).

Health Information Technology

Working closely with the Office of the National Coordinator, the Centers for Medicare and Medicaid Services, the National Institutes of Health, and other public and private sector partners, SAMHSA will continue to advance standards around privacy, consent, and interoperability for behavioral health records, as well as advance comprehensive approaches to Continuity of Care Documents that fully and appropriately integrate behavioral health data.

Promoting widespread implementation of Health Information Technology (HIT) systems that support quality, integrated behavioral health care is currently one of SAMHSA's strategic initiatives. HIT has the potential to transform the healthcare system by improving the quality of care delivery, supporting patient engagement and self-management, improving the efficiency of the workforce, and expanding access to care. In FY 2011-12 SAMHSA provided supplemental funding to the Primary Behavioral Health Care Integration (PBHCI) program to help 47 grantees become meaningful users of electronic health record (EHR) technology. Ninety-three percent of these grantees successfully implemented a certified EHR system in 2012 and this technology continues to support the integration of primary and behavioral healthcare in these programs. Due to the success of the PBHCI HIT supplemental program we are requesting additional funding for the TCE program in FY 2015 to fund a similar HIT initiative among the Primary Care and Addiction Services Integration (PCASI) Program grantees. This supplemental funding will support the adoption and meaningful use of certified EHR technology which will facilitate the integration of care for patients in substance abuse treatment.

Program Increases:

<u>Primary Care and Addiction Services Integration (PCASI) (+$20.0 million)</u>
SAMHSA is requesting $20.0 million to support the development of a new initiative related to the bi-directional integration of substance abuse treatment services and primary care. The PCASI program will enable providers to offer a full array of both physical health and substance abuse services to clients. Through this program, integrated teams of professionals will be able to provide needed primary care services to individuals seeking care for their substance use disorder. In addition, healthcare providers will enhance their capacity to address substance abuse problems in the primary care setting beyond screening and referral. Grantees will establish strong partnerships between specialty substance abuse treatment providers and local community health centers. Some portion of the PCASI funds will be braided with MAI HIV funds to advance the integration of primary care, substance abuse treatment, and HIV services for critical populations in the HIV Continuum of Care grant program.

TCE-General (+$2.0 million)
The FY 2015 request for TCE-General is $15.3 million. This is an increase of $2.0 million above the FY 2014 Enacted Level. With the success of the PBHCI HIT supplemental program, SAMHSA requests an additional $2.0 million in funding for the TCE program in FY 2015 to fund the Behavioral Health Information Privacy Center of Excellence. The Center of Excellence will provide coordinated technical assistance to provider organizations, HIEs, states, consumers, and vendors to support integration of behavioral health and general healthcare through health information exchange.

Now is the Time Initiative (+$14.7 million)
The FY 2015 request for Agency-Wide Initiatives is $130.0 million. This is an increase of $14.7 million above the FY 2014 Enacted Level. The increase will support three new activities: the Science of Changing Social Norms: Building the Evidence Base and Social Media ($4.0 million) to improve the attitudes, understanding and behavior of Americans about mental and substance use disorders; Peer Professionals ($10.0 million) to strengthen the behavioral health workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16-25; and Behavioral Health Workforce Data and Development ($1.0 million) to develop a consistent data set to define and track the behavioral health workforce, a capacity which does not currently exist. This increase is offset by a $0.3 million decrease in the Minority Fellowship Program expansion activities.

Strategic Prevention Framework (+$10.0 million)
SAMHSA is requesting $10.0 million for a new program, Prescription Drug Abuse and Overdose Prevention (SPF Rx) that will provide funding for the prevention of prescription drug misuse and abuse in high priority age groups (including young and middle-aged adults) and populations through education and other prevention strategies. SAMHSA will be partnering with NIDA to further develop the evidence base to support these efforts. Funding will also be used to provide technical assistance and evaluation, and to expand work with the Office of the National Coordinator of Health Information Technology (ONC) on standards alignment on interoperability among state PDMPs and electronic health records (EHRs)/health information exchanges (HIEs) and/or any other technology efforts determined necessary for the exchange of data.

Grants for Adult Treatment, Screening, and Brief Intervention (GATSBI) (+$2.9 million)
SAMHSA requests to implement a new program line, Grants for Adult Trauma Screening and Brief Intervention in FY 2015. This request is $2.9 million to advance the knowledge base to address trauma in common health care settings, such as emergency departments, primary care, and OB/GYN. The concept and design for these grants will be developed by SAMHSA in consultation with its federal partners: ACF, CDC, NIAAA, NIDA, NIMH, and VA. An estimated four grants will be awarded with up to $600,000 per year for five years.

Suicide Prevention – National Strategy on Suicide Prevention (NSSP) (+$2.0 million)
The FY 2015 request for Suicide Prevention – National Strategy on Suicide Prevention (NSSP) is $4.0 million, an increase of $2.0 million above the FY 2014 Enacted Level. The funding assists states in further establishing evidence-based suicide prevention efforts that support the

goals and objectives of the NSSP. The requested $4.0 million will directly support the recommendations of the National Strategy released in September of 2012 and allow for a more complete implementation of the NSSP, including elements not addressed in any other national initiatives. The funding will develop and test nationwide efforts such as suicide awareness messaging, provider credentialing changes, emergency room referral processes, clinical care practice standards, practitioner training regarding depression and suicide screening techniques, and technical assistance for those community human services and health workers most likely to encounter individuals thinking about suicide. The request will support the continuation of this program.

Disaster Response (+$1.0 million)
The FY 2015 request for Disaster Response is $2.95 million. This is an increase of $1.0 million above the FY 2014 Enacted Level to continue the support of a nationally available disaster distress crisis counseling telephone line through a connection to local crisis lines throughout the country.

Minority AIDS Initiative (MAI) for Mental Health (+$7 million offset by a decrease)
The FY 2015 request for Minority AIDS is $16.3 million. This is an increase of $7.0 million above the FY 2014 Enacted Level which is offset by a shift between MAI AIDS programs with an decrease in Minority AIDS Substance Abuse Treatment. SAMHSA plans to pilot in 2014 HIV Continuum of Care grants. In FY 2015, HIV Continuum of Care will also include braided funding from MAI, PBHCI and PCASI.

Program Decreases:

Access to Recovery (-$50.0 million)
SAMHSA is proposing eliminating the Access to Recovery (ATR) program in FY 2015. Many of the clinical services provided under ATR will now be covered by public and private insurance. In addition, states have been encouraged to support recovery support services and client choice with SABG funding. States that would like to continue this activity will have support from SAMHSA in FY 2014 in incorporating lessons learned from the successful test.

Primary and Behavioral Health Care Integration (PBHCI) (-$24.0 million)
The FY 2015 request for PBHCI is $28.0 million, a decrease of $24.0 million below the FY 2014 Enacted Level. The request will continue to support integrated services between primary care services and mental health services and facilitate screening and referral for necessary primary care prevention and treatment needs. Some portion of the remaining PBHCI funds will be braided with MAI HIV funds to advance the integration of primary care, mental health services, and HIV services for critical populations in the HIV Continuum of Care grant program.

Screening, Brief Intervention and Referral to Treatment (SBIRT) (-$17.0 million)
The FY 2015 request for SBIRT is $30.0 million; all funded from PHS Evaluation Funds. This is a decrease of $17.0 million below the FY 2014 Enacted Level. SAMHSA strategically multi-year funded its 10 grants for $18.4 million in FY 2014.

Criminal Justice Activities (-$10.6 million)
The FY 2015 request for Criminal Justice Activities is $64.4 million. This is a decrease of $10.6 million below the FY 2014 Enacted Level. While funding for this program is reduced in FY 2015, this level will allow the continuations for 121 grants and fund 57 new grants.

Suicide Prevention Programs (-$10.1 million)
The FY 2015 request for Suicide Prevention Programs is $50.0 million. This is a total decrease of $10.1 million below the FY 2014 Enacted Level. These reductions include: $7.8 million from GLS – Youth Suicide Prevention – States, $1.5 million from GLS – Youth Suicide Prevention – Campus, $1.1 million from GLS-Suicide Prevention Resource Center, and $1.7 million from Suicide Lifeline. With an offsetting increase of $2.0 million for National Strategy on Suicide Prevention, this results in a net reduction of $10.1 million in Suicide Programs.
This request will continue to support selected state planning evidence-based suicide prevention efforts to support the goals and objectives of the National Strategy for Suicide Prevention.

Minority AIDS Initiative (MAI) for Substance Abuse Treatment (-$6.9 million)
The FY 2015 request for Minority AIDS is $58.9 million. This is a decrease of $6.9 million below the FY 2014 Enacted Level in CSAT which is offset by a shift between MAI AIDS programs with an increase in Mental Health. This shift will support HIV Continuum of Care grants and enable the full participation of each center. In 2015, HIV Continuum of Care will also include braided funding from MAI, PBHCI, and PCASI.

Overview of Performance

Consistent with the Government Performance and Results Modernization Act of 2010 and related legislation, SAMHSA uses performance and evaluation data to demonstrate impact. SAMHSA reduces the impact of substance abuse and mental illness in United States' communities by demonstrating that prevention works, treatment is effective, and people recover. SAMHSA promotes the health of the U.S. population by helping those with mental and substance use disorders while also supporting their families, building strong and supportive communities, and preventing costly behavioral health problems.

SAMHSA promotes efficient and effective government by defining clear roles and responsibilities, setting ambitious goals and targets, using data to review progress, coordinating across groups, and emphasizing the use of evidence to support decisions. This aids in the analysis and feedback of data in ways that contribute to improved outcomes, such as Center Performance Review Boards and similar initiatives based on the grantee continuation process.

Despite the challenges posed during times of fiscal restraint, SAMHSA demonstrated progress in each of its Strategic Initiatives (SIs) during FY 2013, including prevention of substance abuse and mental health (http://beta.samhsa.gov/about-us/strategic-initiatives). Each SI has specific action steps that link SAMHSA's programs to the current Department of Health and Human Services (HHS) budget (http://www.hhs.gov/budget/) as well as linking to HHS performance priorities (http://goals.performance.gov/agency/hhs). Examples of progress include an ongoing decrease in the percentage of middle and high school students who report current substance abuse as well as over a million suicide and crisis prevention calls answered through a network of hotlines operating nationally, day and night.

Within the FY 2014 HHS Annual Performance Report and Performance Plan, (http://www.hhs.gov/budget/fy2014/opa_040513.pdf), the services SAMHSA provides to diverse populations were highlighted, including increasing the percentage of homeless clients in substance abuse treatment who secured a permanent place to live in the community. During FY 2013, SAMHSA also continued to participate in an HHS Priority Goal to reduce cigarette smoking, a department-wide effort to increase the percentage of children receiving trauma informed services, and responded to urgent situations across the Country, such as hurricane relief. During FY 2013, SAMHSA also participated in HHS' response to 62 federally declared major disasters, including severe thunderstorm outbreaks, tornados, two hurricanes, a drought, and wildfires.

Data-Driven Performance Management

SAMHSA uses a data-driven performance management approach to foster ongoing improvements that achieve measurable impact within a reasonable time period. SAMHSA is developing a common data platform designed to streamline performance reporting and management, validate data quality, and promote evidence-based decision-making. Performance management activities are also aided by implementation of tools, such as the National Behavioral Health Quality Framework (NBHQF), which helps to integrate performance and evaluation

results with the best available evidence. The NBHQF facilitates communication with federal partners, states, networks, and non-governmental groups.

SAMHSA plays a key role in federal drug control efforts and contributes to the National Drug Control Budget. This budget provides a reliable, accurate, and transparent accounting of federal funding directed to drug control efforts, as reflected in the *National Drug Control Budget, FY 2014 Funding Highlights, released April, 2013 (*http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/fy_2014_drug_control_budget_highlights_3.pdf*).*

Since a wide array of SAMHSA's funding supports drug control efforts (including awards directly to providers), several programs focus on advancement of treatment methods and services to targeted groups, including those served by SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SABG). This formula-based funding is especially important during times of fiscal restraint for states since it fosters expansion of substance abuse treatment services, while providing maximum flexibility. For example, SAMHSA grants support the delivery of treatment while also allowing states to access funding for prevention services.

As areas of key importance, such as child trauma, continue to be emphasized, SAMHSA assures that the knowledge, infrastructure, and capacity are available to contribute to the health care reform activities associated with the Affordable Care Act. These efforts facilitate health care reform while also advancing the nation's behavioral health.

Discretionary All-Purpose Table
Substance Abuse and Mental Health Services Administration
(Dollars in Thousands)

Program Activities	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Now is the Time Presidential Initiatives				
Mental Health:				
Project AWARE	---	**$55,000**	**$55,000**	---
Project AWARE State Grants (non-add)	---	40,000	40,000	---
Mental Health First Aid (non-add)	---	15,000	15,000	---
Healthy Transitions	---	**20,000**	**20,000**	---
Health Surveillance and Program Support:				
Health Surveillance	---	---	**2,000**	**+2,000**
Science of Changing Social Norms : Building the Evidence Base (non-add).	---	---	2,000	+2,000
Public Awareness and Support	---	---	**2,000**	**+2,000**
Science of Changing Social Norms: Social Media (non-add)	---	---	2,000	+2,000
Behavioral Health Workforce	---	**40,259**	**51,000**	**+10,741**
Minority Fellowship Program Expansion (non-add)	---	5,259	5,000	-259
SAMHSA-HRSA BHWET Grant Program (non-add)	---	35,000	35,000	---
Peer Professionals (non-add)	---	---	10,000	+10,000
Behavioral Health Workforce Data and Development (non-add)	---	---	1,000	+1,000
TOTAL [1/] (information only -- amounts included below)	---	**115,259**	**130,000**	**+14,741**
Mental Health:				
Programs of Regional and National Significance	266,509	378,216	354,740	-23,476
Prevention and Public Health Fund (non-add)	---	*12,000*	*38,000*	*+26,000*
PHS Evaluation Funds (non-add)	---	---	*5,000*	*+5,000*
Children's Mental Health Services	111,430	117,315	117,315	---
Projects for Assistance in Transition from Homelessness	61,405	64,794	64,794	---
Protection and Advocacy for Individuals with Mental Illness	34,343	36,238	36,238	---
Community Mental Health Services Block Grant	436,809	483,744	483,744	---
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*21,039*	---
Total, Mental Health	**910,496**	**1,080,307**	**1,056,831**	**-23,476**
Substance Abuse Prevention:				
Programs of Regional and National Significance	175,513	175,560	185,560	+10,000
Strategic Prevention Framework Rx (non-add)	---	---	*10,000*	*+10,000*
PHS Evaluation Funds (non-add)	---	---	*16,468*	*+16,468*
Total, Substance Abuse Prevention	**175,513**	**175,560**	**185,560**	**+10,000**
Substance Abuse Treatment:				
Programs of Regional and National Significance	404,085	361,460	297,400	-64,060
Prevention and Public Health Fund (non-add)	---	*50,000*	---	*-50,000*
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*	*+28,000*
Substance Abuse Prevention and Treatment Block Grant	1,710,306	1,819,856	1,819,856	---
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	---
Total, Substance Abuse Treatment	**2,114,392**	**2,181,316**	**2,117,256**	**-64,060**
Health Surveillance and Program Support:				
Health Surveillance and Program Support:	123,419	120,157	122,157	+2,000
Prevention and Public Health Fund (non-add)	*14,733*	---	*20,000*	*+20,000*
PHS Evaluation Funds (non-add)	*27,428*	*30,428*	*29,428*	*-1,000*
Public Awareness and Support	13,545	13,571	15,571	+2,000
PHS Evaluation Funds (non-add)	---	---	*15,571*	*+15,571*
Performance and Quality Information Systems	8,803	12,996	12,996	---
PHS Evaluation Funds (non-add)	---	---	*12,996*	*+12,996*
Agency-Wide Initiatives 2/	8,293	45,695	56,000	+10,305
PHS Evaluation Funds (non-add)	---	---	*1,000*	*+1,000*
Data Request/Publications User Fees	---	1,500	1,500	---
Total, Health Surveillance/Program Support	**154,061**	**193,919**	**208,224**	**+14,305**
TOTAL, SAMHSA Discretionary PL	**3,354,461**	**3,631,102**	**3,567,871**	**-63,231**
Less PHS Evaluation Funds	*129,667*	*132,667*	*210,702*	*+78,035*
Less Prevention and Public Health Funds	*14,733*	*62,000*	*58,000*	*-4,000*
Less Data Request and Publications User Fees	---	*1,500*	*1,500*	---
TOTAL, SAMHSA Budget Authority	**$3,210,061**	**$3,434,935**	**$3,297,669**	**-$137,266**
FTEs	**608**	**655**	**655**	**---**

[1/] A total of $115 million has been enacted in FY 2014 and $130 million is requested in FY 2015 to address the behavioral health needs of transition age youth and their families in the wake of the Newtown, Connecticut tragedy at Sandy Hook Elementary School.

[2/] The Minority Fellowship Program budgets from the Mental Health, Substance Abuse Prevention and Treatment appropriations have been comparable adjusted in this table to be in line with the FY 2015 Request and are reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

*Totals may not add due to rounding.

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Summary of Change
SAMHSA

The SAMHSA FY 2015 Budget Request for its Total Program Level is $3.6 billion, a decrease of $63.2 million from the FY 2014 Enacted Level. The FY 2015 Total Program Level of $3.6 billion includes $3.3 billion in Budget Authority (a decrease of $137.3 million below the FY 2014 Enacted Level), $210.7 million in PHS Evaluation Funds (an increase of $78.0 million above the FY 2014 Enacted Level), and $58.0 million in Prevention and Public Health Fund resources (a decrease of $4.0 million below the FY 2014 Enacted Level). The budget continues to reflect $1.5 million for user fees for extraordinary data and publication requests. The FY 2015 Budget is divided among four appropriations consistent with the FY 2012 Consolidated Appropriations Act and the FY 2014 Enacted Level: (1) Mental Health, (2) Substance Abuse Prevention, (3) Substance Abuse Treatment, and (4) Health Surveillance and Program Support.

Braided Programs	**FY 2015 Request**
HIV Continuum of Care	$24,000
Mental Health: Primary and Behavioral Health Care Integration (non-add)	*3,000*
Mental Health: Minority AIDS Initiative (non-add)	*6,500*
Substance Abuse Prevention: Minority AIDS Initiative (non-add)	*3,000*
Substance Abuse Treatment: Minority AIDS Initiative (non-add)	*6,500*
Substance Abuse Treatment: Primary Care and Addiction Services Integration (non-add)	*5,000*
Building Behavioral Health Coalitions	$3,000
Mental Health: MH System Transformation and Health Reform (non-add)	*1,500*
Substance Abuse Prevention: Strategic Prevention Framework (non-add)	*1,500*
Housing and Homelessness	$14,763
Mental Health: Homelessness Prevention Program (non-add)	*5,992*
Substance Abuse Treatment: Treatment Systems for Homeless (non-add)	*8,771*

The FY 2015 Budget Request includes three new braided programs that draws on funds across the Mental Health, Substance Abuse Prevention and Substance Abuse Treatment appropriations. Any amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent. Braided programs include:

- $24 million, including $9.5 million from the Mental Health Appropriation (Primary and Behavioral Health Care Integration and Minority Aids Initiative), $3 million from the Substance Abuse Prevention Appropriation (Minority Aids Initiative), and $11.5 million from the Substance Abuse Treatment Appropriation (Minority Aids Initiative and Primary Care and Addiction Services Integration) to establishing integrated behavioral health and HIV care in addition to primary care needed by those living with or at high risk for HIV infection in minority communities heavily impacted by HIV. This program will be based on a pilot effort in 2014, which also includes a substance abuse prevention component. Please refer to HIV Continuum of Care in the Additional Item chapter.

- $3 million, including $1.5 million from the Mental Health appropriation (MH System Transformation and Health Reform) and $1.5 million from the Substance Abuse Prevention appropriation (Strategic Prevention Framework) to establish the Building Behavioral Health Coalitions program. Coalitions are ready to expand their focus and activities to include a mental health promotion, mental illness prevention, and substance abuse prevention. Funding streams will be kept separate and used for activities consistent with separate funding authorities.
- $14.7 million, including $6 million from the Mental Health appropriation (Homelessness Prevention Program) and $8.7 million from the Substance Abuse Treatment appropriation (Treatment Systems for Homeless) to support approximately 15 grants at $750,000 per year to build on lessons learned from the CABHI program and the proposed FY 2015 program.

Mental Health Appropriation

The Mental Health appropriation request is $1.057 billion, a decrease of $23.5 million from the FY 2014 Enacted Level. The request includes $992.8 million in Budget Authority (a decrease of $54.5 million from the FY 2014 Enacted Level), $26 million in PHS Evaluation Funds (an increase of $5 million from the FY 2014 Enacted Level), and $38 million in Prevention and Public Health Fund resources (an increase of $26 million from the FY 2014 Enacted Level). The following mental health priorities are requested:

- $354.7 million for Programs of Regional and National Significance (PRNS) which represents a $23.5 million decrease below the FY 2014 Enacted Level and will support the following key PRNS programs:

    - $75 million for *Now is the Time* initiative which includes $55 million for Project AWARE and $20 million for Healthy Transitions.

    - $50 million for Suicide Prevention programs, which is $10.1 million below the FY 2014 Enacted Level. These reductions include: $7.8 million from GLS – Youth Suicide Prevention – States, $1.5 million from GLS – Youth Suicide Prevention – Campus, $1.1 million from GLS-Suicide Prevention Resource Center, and $1.7 million from Suicide Lifeline. With an offsetting increase of $2 million for National Strategy on Suicide Prevention, this results in a net reduction of $10.1 million in Suicide Programs.

    - $45.7 million for the National Child Traumatic Stress Initiative, which is $0.3 million below the FY 2014 Enacted Level, to develop and promote effective community practices for children and families exposed to traumatic events.

    - $28 million for Primary and Behavioral Health Care Integration (PBHCI) and PBHCI Training and Technical Assistance, which is $24 million below the FY 2014 Enacted Level.

    - $16.3 million for Minority AIDS, which is $7 million above the FY 2014 Enacted Level, which is offset by a shift between MAI AIDS program in Treatment. SAMHSA plans to jointly award a new cohort of HIV Continuum of Care grants.

    - $3 million for Disaster Response, which is $1 million above the FY 2014 Enacted Level to continue the support of a nationally available disaster distress crisis counseling telephone line through a connection to local crisis lines throughout the country.

    - $2.9 million for Grants for Adult Treatment, Screening and Brief Intervention to implement a new program line to advance the knowledge base to address trauma in common health care settings, such as emergency departments, primary care, and OB/GYN.

- $133.8 million for all other PRNS programs, including Youth Violence Prevention $23.2 million, Children and Family Programs $6.5 million, Consumer and Family Network Grants $5 million, Project LAUNCH $34.6 million, MH System Transformation and Health Reform $10.6 million (of which, $1.5 million is braided with CSAP), Homelessness Prevention Programs $30.8 million (of which, $6.3 million is braided with CSAT), Criminal and Juvenile Justice Programs $4.3 million, Practice Improvement and Training $7.8 million, Consumer and Consumer Support TA Centers $1.9 million, Homelessness $2.3 million, HIV/AIDS Education $0.773 million, Seclusion and Restraint and Trauma $1.1 million, and Tribal Behavioral Health Grants $5 million.

- $117.3 million for Children's Mental Health Services, which is the same as the FY 2014 Enacted Level, to support the development of comprehensive, community-based systems of care.

- $64.8 million for Programs for Assistance in Transition from Homelessness (PATH) Homeless Formula Grants, which is the same as the FY 2014 Enacted Level, to continue to address critical behavioral health needs of individuals with serious mental illness and/or co-occurring substance use disorder who are experiencing homelessness or are at risk for homelessness.

- $36.2 million for Protection and Advocacy of Individuals with Mental Illness (PAIMI), which is the same as the FY 2014 Enacted Level, to support state and territorial protection and advocacy systems for individuals with serious mental illness.

- $483.7 million for the Community Mental Health Services Block Grant (MHBG), which is the same as the FY 2014 Enacted Level. The request includes a five percent set aside to focus on evidence-based practices to address the needs of individuals with early serious mental illness.

Substance Abuse Prevention Appropriation

The Substance Abuse Prevention appropriation request is $185.6 million, an increase of $10 million above the FY 2014 Enacted Level. The request includes $169.1 million in Budget Authority (a decrease of $6.5 million below the FY 2014 Enacted Level), and $16.5 million in PHS Evaluation Funds (an increase of $16.5 million from the FY 2014 Enacted Level). The following substance abuse prevention priorities are requested:

- $185.6 million, for Programs of Regional and National Significance (PRNS) which represents a $10 million increase above the FY 2014 Enacted Level and will support the following programs:

    - $119.8 million for Strategic Prevention Framework (SPF), which is an increase of $10 million above the FY 2014 Enacted Level. A new program, SPF Rx will support the Secretary's comprehensive plan to prevent prescription drug abuse and opioid-related overdose deaths.

    - $65.8 million for all other PRNS programs, maintaining the FY 2014 Enacted Level including, Mandatory Drug testing $4.9 million, Minority AIDS $41.3 million, Sober Truth on Preventing Underage Drinking (STOP) $7 million, Fetal Alcohol Spectrum Disorder $1 million, Center for the Application of Prevention Technologies (CAPT) $7.5 million, and Science and Service Program Coordination $4.1 million.

Substance Abuse Treatment Appropriation

The Substance Abuse Treatment appropriation request is $2.117 billion, a decrease of $64.1 million below the FY 2014 Enacted Level. The request includes $2.008 billion in Budget Authority (a decrease of $42 million below the FY 2014 Enacted Level), and $109.2 million in PHS Evaluation Funds (an increase of $28 million above the FY 2014 Enacted Level) and a decrease of $50 million from Prevention and Public Health Funds. The following substance abuse treatment priorities are requested:

- $297.4 million for Programs of Regional and National Significance (PRNS) which represents a $64 million decrease below the FY 2014 Enacted Level and will support the following key PRNS programs:

    - $64.4 million for Criminal Justice Activities, which is a decrease of $10.6 million from the FY 2014 Enacted Level, to continue activities that focus on diversion, alternatives to incarceration, and re-entry from incarceration for adolescents and adults with substance use disorders, and/or co-occurring substance use and mental disorders.

    - $58.9 million for Minority AIDS, which is a decrease of $6.9 million from the FY 2014 Enacted Level, which is offset by a shift between MAI AIDS program in Mental Health.

    - $30 million for Screening, Brief Intervention and Referral to Treatment (SBIRT), which is a decrease of $17 million below the FY 2014 Enacted Level and is funded with PHS Evaluation Funds instead of Budget Authority.

    - $20 million for Primary Care and Addiction Services Integration (PCASI), a new request in 2015. PCASI will enable community providers to implement primary care and substance abuse treatment integration.

    - $15.3 million for TCE-General, which is an increase of $2 million above the FY 2014 Enacted Level. Funding will go toward the implementation of Health Information Technology to support PCASI.

    - $8.1 million for Addiction Technology Transfer Centers, which is a decrease of $1 million from the FY 2014 Enacted Level to support national activities in response to regional needs by implementing evidence-based practices and supporting interventions by front-line clinicians.

    - $1 million for Strengthening Treatment Access and Retention (STAR), which is a decrease of $0.7 million from the FY 2014 Enacted Level. Funding will improve treatment access and retention of clients in treatment though the use of process improvement to ensure effective business operation practices.

- The elimination of Access to Recovery, which is a decrease of $50.0 million from the FY 2014 Enacted Level. Grants will be multi-year funded in FY 2014 for this program to support FY 2015 continuation activity. This program will be eliminated in FY 2015 as many of the clinical services provided under ATR will now be covered by public and private insurance. In addition, states have been encouraged to support recovery support services and client choice with SABG funding. States that would like to continue this activity will have support from SAMHSA in FY 2014 in incorporating lessons learned from the successful test.

- $99.7 million in all other PRNS programs remain the same as the FY 2014 Enacted Level including, Opioid Treatment $8.7 million, Pregnant and Postpartum Women $16 million, Recovery Community Services Program $2.4 million, Children and Families $29.7 million, Treatment Systems for Homeless $41.5 million, and Special Initiatives/Outreach $1.4 million.

- $1.8 billion for SABG, which is level funded from the FY 2014 Enacted Level. With many of the clinical services provided under ATR now covered by public and private insurance, SAMHSA is proposing eliminating the ATR program in the FY 2015 budget.

Health Surveillance and Program Support

The Health Surveillance and Program Support appropriation request is $208.2 million, an increase of $14.3 million above the FY 2014 Enacted Level. The request includes $127.7 million in Budget Authority (a decrease of $34.3 million below the FY 2014 Enacted Level), $59 million in PHS Evaluation Funds (an increase of $28.6 million above the FY 2014 Enacted Level), and $20 million in Prevention and Public Health Fund resources (an increase of $20 million above the FY 2014 Enacted Level). In addition, the request includes $1.5 million for Data Request and Publications User Fees. The following are key priorities:

The Health Surveillance and Program Support budget supports four activities consistent with the 2014 Enacted Level: Health Surveillance, Program Support, Performance and Quality Information Systems, Public Awareness and Support, and Agency-Wide Initiatives.

- $122.1 million for Health Surveillance and Program Support, which is $2 million above the FY 2014 Enacted Level. This includes:

    - $49.4 million for Health Surveillance, which is an increase of $2 million above the FY 2014 Enacted Level and builds on the President's effort to increase understanding about mental health through *Now is the Time* initiative. Funds will support work begun by the White House Conference on Mental Health through the collection and use of data to demonstrate evidence for effecting behavioral change at the individual, community and population levels.

    - $72.7 million for Program Support, which is the same as the FY 2014 Enacted Level. Funding supports administrative and operational costs related to the relocation of the Agency to a new building.

- $15.6 million for Public Awareness and Support, which is an increase of $2.0 million above the FY 2014 Enacted Level, builds on the effort to increase understanding about mental health through *Now is the Time* initiative. This increase will be used to support the work begun by the White House Conference on Mental Health, supporting the collection and use of data to learn if what and how we are communicating is making a positive difference.

- $13 million for Performance and Quality Information Systems, which is level funded from FY 2014 Enacted Level, to continue to support for National Registry of Evidence-Based Programs and Practices (NREPP) and Common Data Platform (CDP).

- $56 million for Agency-Wide Initiatives, which is an increase of $10.3 million above the FY 2014 Enacted Level. This includes:

    - $56 million for Behavioral Health Workforce, a net increase of $10.3 million above the FY 2014 Enacted Level to fund the Behavioral Health Workforce.

- $5 million for MFP core activities which is a decrease of $0.7 million below the FY 2014 Enacted Level. Funding provides services to support minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology.

- $51 million for *Now is the Time* initiative, which is $10.7 million above FY 2014 Enacted Level, and includes: $5 million for MFP- Youth, $10.0 million for Peer Professionals, $35 million for Behavioral Health Workforce Education and Training (BHWET), and $1.0 million Behavioral Health Workforce Data and Development.

- $1.5 million for Data Request and Publication User Fees, which is level funded from FY 2014 Enacted Level. Fees will be collected and retained for extraordinary data and publications requests.

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NOW IS THE TIME

The Administration's plan to protect our children and our communities by reducing gun violence and increasing access to mental health services.

(Dollars in thousands)

Program Activities	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Now is the Time Presidential Initiatives				
Mental Health:				
Project AWARE	**$---**	**$55,000**	**$55,000**	**$---**
Project AWARE State Grants (non-add)	---	40,000	40,000	---
Mental Health First Aid (non-add)	---	15,000	15,000	---
Healthy Transitions	---	**20,000**	**20,000**	---
Health Surveillance and Program Support:				
Health Surveillance	---	---	**2,000**	**+2,000**
Science of Changing Social Norms : Building the Evidence Base (non-add)	---	---	2,000	+2,000
Public Awareness and Support	---	---	**2,000**	**+2,000**
Science of Changing Social Norms: Social Media (non-add)	---	---	2,000	+2,000
Behavioral Health Workforce	---	**40,259**	**51,000**	**+10,741**
Minority Fellowship Program Expansion (non-add)	---	5,259	5,000	-259
SAMHSA-HRSA BHWET Grant Program (non-add)	---	35,000	35,000	---
Peer Professionals (non-add)	---	---	10,000	+10,000
Behavioral Health Workforce Data and Development (non-add)	---	---	1,000	+1,000
TOTAL	**$---**	**$115,259**	**$130,000**	**+$14,741**

The FY 2015 Budget Request reflects a continued commitment to the President's, *Now is the Time* initiative[1] to increase access to mental health services. The FY 2015 Budget includes a total of $130 million including $115 million of funding for activities begun in FY 2014 to help teachers recognize signs of mental illness in students, improve referrals and access to mental health services for young people ages 16-25, and help train approximately 5,000 more mental health professionals with a focus on serving students and young adults. The Budget Request includes increases of $15 million in funding for:

- $10 million in funding is requested for Peer Professionals which will provide support to strengthen the behavioral health workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16-25.
- $4 million in funding is requested in the HSPS appropriation to develop and test an array of messages and media to change the attitudes, understanding and behavior of Americans about mental and substance use disorders and willingness to seek help for them.
- $1 million for the Behavioral Health Workforce Data and Development component of *Now is the Time* initiative that will focus on supporting clinical internships and field placements, and certificate program completion across a range of professional and paraprofessional disciplines (some of whom may be peers) to produce a ready cohort of new behavioral health providers. This component will be managed by the Center for Behavioral Health Statistics and Quality in cooperation with HRSA, based on preliminary

[1]/ Plan can be found at: http://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf or http://www.whitehouse.gov/issues/preventing-gun-violence

work to develop a minimum data set to track the behavioral health workforce across the country.

Project AWARE

In response to the tragedy at Sandy Hook Elementary School, in FY 2015, $55 million is requested to support Project AWARE, (Advancing Wellness and Resilience in Education) to increase awareness of mental health issues and connect young people with behavioral health issues and their families with needed services. SAMHSA will partner with the Departments of Education and Justice in the development, implementation and management of this initiative to maximize coordination and avoid duplication of efforts. This initiative is expected to reach 750,000 children and youth.

Project AWARE proposes two components: Project AWARE State Grants ($40 million) build on the Safe Schools/Healthy Students State Planning and Community Pilot Program which is intended to create safe and supportive schools and communities. For more than a decade, the Safe Schools/Healthy Students Initiative has successfully decreased violence and increased the number of students receiving mental health services. Project AWARE grants will go to 20 State Education Authorities (SEAs) and in collaboration with Education and Justice, will promote comprehensive, coordinated, and integrated State efforts to make schools safer and increase access to mental health services. The SEAs will be required to partner with the State Mental Health and Law Enforcement agencies to establish Interagency State Management Teams, conduct needs assessments, develop a state plan with an evaluation mechanism, and develop the mechanisms to coordinate funding, service delivery, systems improvement, and data collection. In addition, each SEA will be required to identify three high-need Local Education Authorities (LEAs) as pilot communities that will receive sub-awards to implement comprehensive and coordinated school safety and mental health programs.

The second component, Mental Health First Aid (MHFA) ($15 million) proposes widespread dissemination of the Mental Health First Aid curriculum. MHFA-Youth prepares teachers and other individuals who work with youth to help schools and communities to understand, recognize, and respond to signs of mental illness or substance abuse in children and youth, including how to talk to adolescents and families experiencing these problems so they are more willing to seek treatment. The Budget proposes that $10 million of the Project AWARE – MHFA funds support training of teachers and a broad array of actors at the community level, including parents, law enforcement, youth and faith-based leaders. The additional $5 million proposed for MHFA will continue to support dissemination of MHFA through the 20 Project AWARE SEA grants.

Healthy Transitions

The FY 2015 Budget includes $20 million to continue the Healthy Transitions Program, which assists 16 to 25 year-olds with mental illnesses and their families in accessing and navigating behavioral health treatment systems. Compared with their peers, young adults, aged 18-25 with mental health conditions are more likely to experience homelessness, be arrested, drop out of school and be underemployed. Compared to all other chronic health conditions, mental disorders produce the greatest disability impact within this age group. Furthermore, 18-25 year-olds with

mental health conditions are significantly less likely to receive mental health services than other adults. This new demonstration grant program for states proposes new and creative approaches to provide support for transition-age youth with mental health and/or co-occurring substance abuse disorders and their families. States will take steps to expand services for these young individuals, develop family and youth networks for information sharing and peer support, and disseminate best practices for services to youth ages 16-25. The $20 million will support five-year grants to 16 states as well as new evaluation and technical assistance contracts. An estimated 5,900 individuals will be referred to mental health or related services.

Behavioral Health Workforce

The FY 2015 Budget includes the continuation of $40 million for workforce activities to help train approximately 5,000 additional professionals to work with students and young adults with mental illnesses and other behavioral health problems. The proposal continues $35 million for a jointly administered activity with HRSA to expand the Behavioral Health Workforce Education and Training (BHWET) Grant Program, and $5 million for the expansion of SAMHSA's Minority Fellowship Program as described below.

SAMHSA-HRSA Behavioral Health Workforce Education and Training (BHWET) Grant Program

In FY 2015, SAMHSA will collaborate with HRSA in expanding the Behavioral Health Workforce Education and Training (BHWET) Grant Program. This expansion will increase the clinical service capacity of the behavioral health workforce by supporting training for Master's level social workers, psychologists, marriage and family therapists, psychology doctoral interns, as well as behavioral health paraprofessionals. This effort is critical to ensure that the behavioral health workforce is able to meet the needs of high need and high demand populations, including rural, vulnerable, and underserved populations. In FY 2015, the program will continue to include an emphasis on training to address the needs of children, adolescents, and transition-age youth (ages 16-25) and their families. SAMHSA requests $35 million in FY 2015 for the SAMHSA-HRSA expansion of the BHWET grant program and will help increase the behavioral health workforce by 3,500 individuals, in addition to those below.

Minority Fellowship Program Expansion – Youth (MFP-Y) and Addiction Counselors

For FY 2015, the Minority Fellowship Program - Youth (MFP-Y) of $5 million in part provides stipends to graduate students to increase the number of culturally competent behavioral health professionals who provide direct mental health and/or co-occurring substance abuse services to underserved minority populations. MFP-Y would utilize the existing infrastructure of the MFP to expand the focus of the program to support master's level trained behavioral health providers in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing. This support would increase the number of providers who are available to provide clinical services to underserved, at-risk children, adolescents, and populations transitioning to adulthood (ages 16 – 25) in an effort to increase access to and quality of behavioral health services for this age group.

In addition, SAMHSA also will continue grants to entities providing training to Master's level addictions counselors. Because these funds are part of the President's *Now is the Time* initiative, there will be an emphasis on providing clinical services to underserved, at-risk children, adolescents, and populations transitioning to adulthood (ages 16 – 25). These grants will support graduate student stipends to increase the number of Masters level addiction counselors across the nation by approximately 300 counselors. Some portion of the funds will support evaluation and technical assistance for these new MFP grantees.

Budget Request

A total of $130 million is requested for *Now is the Time* initiative, including a $4 million increase for Science of Changing Social Norms, $10 million increase for Peer Professionals, and a $1 million increase for Behavioral Health Workforce Data and Development. These funds will be used to continue the work with HRSA to develop, for the first time, a consistent and common data set tracking the behavioral health workforce.

Science of Changing Social Norms

This Budget Request includes $4 million to support a new initiative, the Science of Changing Social Norms, to develop and test an array of messages and media designed to improve attitudes, understanding and behavior of Americans about mental and substance use disorders and the willingness to seek help for them. Building on the effort to increase understanding about mental health through the *Now is the Time* initiative launched on January 16, 2013, this public awareness and education initiative will seek to target the message resulting from the national conversation about behavioral health most effectively. A total of $2 million in Public Awareness and Support funds will employ social media strategies to support the work begun by the White House National Conference on Mental Health. The goal is to use communications science and market research to identify the most effective and evidence-based methods for decreasing negative attitudes, increasing knowledge and improving willingness to seek help for mental health and substance abuse problems to ensure outreach funds are spent where they will make the most impact. An additional $2 million in Health Surveillance funds will be used in conjunction with the Science of Changing Social Norms: Building the Evidence Base in the Center for Behavioral Health Statistics and Quality's which is essential to understand the impact of social messaging and demonstrate evidence for effecting change in social norms and behavior to reduce negative attitudes and improve people's willingness to seek help. CBHSQ's data collection component will be funded separately under Health Surveillance and Program Support.

Peer Professionals Workforce Development

In FY 2015, SAMHSA requests $10 million for the Peer Professional Workforce Development program which will provide support to strengthen the behavioral health workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16-25. Because of their lived experience with behavioral health conditions, and being able to build trust and foster connections with individuals accessing care, the entry-level providers supported by this program will play a significant role in the delivery of prevention and recovery

support services. SAMHSA plans to award up to 19 grant awards to community colleges or community college networks, states, and national organizations. These funds will provide tuition support and further establish the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education. Funding will increase the behavioral health workforce by 1,200 peer professionals.

The Behavioral Health Workforce Education and Training (BHWET) will focus on supporting clinical internships and field placements, and certificate program completion across a range of professional and paraprofessional disciplines (some of whom may be peers) to produce a ready cohort of new behavioral health providers. The Peer Professional Workforce Development program focuses exclusively on peers, or people with personal experiences with mental illness and/or substance use conditions. Peers may play roles across the spectrum of prevention, treatment and recovery/family support. The Peer Professional program will award grants to community colleges, community college networks, states, and national organizations in order to develop the training infrastructure for peer professionals nationwide.

Behavioral Health Workforce Data and Development

This Budget Request includes an additional $1 million to support Behavioral Health Workforce Data and Development. Beginning in 2014, over 62 million Americans will have expanded or first time access to coverage for services for mental and substance use disorders as a result of a combination of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act. Almost 11 million of these individuals are expected to have mild to severe mental health and/or substance abuse conditions with related treatment needs. Current data indicate that almost 90 percent of persons with substance abuse issues do not receive the services they need and over half of those with mental disorders do not receive needed treatment.

SAMHSA received $40 million in new behavioral health workforce activities in the FY 2014 Appropriation. This budget assumes continuation of those programs to develop approximately 5,000 new behavioral health clinical professionals. To ensure the existing workforce investments are responsible and well-targeted, SAMHSA's FY 2015 budget proposes $1 million to partner with HRSA on the Behavioral Health Minimum Data Set to develop consistent data collection methods to identify and track behavioral health workforce needs as well as to partner with the Department of Defense, and the Department of Veterans Affairs to inventory existing and emerging workforce issues, efforts and impacts, and develop coordinated plans.

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Appropriations Language

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

MENTAL HEALTH

For carrying out titles III, V, and XIX of the PHS Act with respect to mental health, and the Protection and Advocacy for Individuals with Mental Illness Act, **[**$1,055,347,000**]** *$992,792,000*: *Provided*, That notwithstanding section 520A(f)(2) of the PHS Act, no funds appropriated for carrying out section 520A shall be available for carrying out section 1971 of the PHS Act: *Provided further*, That in addition to amounts provided herein, **[**$21,039,000**]** *$26,039,000* shall be available under section 241 of the PHS Act *to supplement funds otherwise available for mental health activities and* to carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1920(b) activities shall not exceed 5 percent of the amounts appropriated for subpart I of part B of title XIX: *Provided further*, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated under this Act for fiscal year **[**2014**]** *2015*: *Provided further*, That **[**of the amount appropriated under this heading,$46,000,000 shall be for the National Child Traumatic Stress Initiative as described in section 582 of the PHS Act**]** *notwithstanding section 565(b)(1) of the PHS Act, technical assistance may be provided to a public entity to establish or operate a system of comprehensive community mental health services to children with a serious emotional disturbance, without regard to whether the public entity receives a grant under section 561(a) of such Act*: *Provided further*, That States shall expend at least 5 percent of the amount each receives for carrying out section 1911 of the PHS Act to support evidence-

based **[**programs that**]** *mental health prevention and treatment practices to* address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset: *Provided further*, That none of the funds provided for section 1911 of the PHS Act shall be subject to section 241 of such Act.

SUBSTANCE ABUSE TREATMENT

For carrying out titles **III[,]** *and* V**[**, and XIX**]** of the PHS Act with respect to substance abuse treatment and **[**section 1922(a) of the PHS Act**]** *title XIX of such Act* with respect to substance abuse *treatment and* prevention, **[**$2,052,661,000**]** *$2,008,056,000*: *Provided*, That in addition to amounts provided herein, **[**the following amounts**]** *$109,200,000* shall be available under section 241 of the PHS Act**[**: (1) $79,200,000**]** *to supplement funds otherwise available for substance abuse treatment activities and* to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX**[**; and (2) $2,000,000 to evaluate substance abuse treatment programs**]**: *Provided further*, That none of the funds provided for section 1921 of the PHS Act shall be subject to section 241 of such Act.

SUBSTANCE ABUSE PREVENTION

For carrying out titles III and V of the PHS Act with respect to substance abuse prevention, **[**$175,631,000**]** *$169,092,000: Provided, That in addition to amounts provided herein,*

$16,468,000 shall be available under section 241 of the PHS Act to supplement funds otherwise available for substance abuse prevention activities.

HEALTH SURVEILLANCE AND PROGRAM SUPPORT

For program support and cross-cutting activities that supplement activities funded under the headings "Mental Health", "Substance Abuse Treatment", and "Substance Abuse Prevention" in carrying out titles III, V, and XIX of the PHS Act and the Protection and Advocacy for Individuals with Mental Illness Act in the Substance Abuse and Mental Health Services Administration, **[**$151,296,000**]** *$127,729,000*: *Provided*, That in addition to amounts provided herein, **[**$30,428,000**]** *$58,995,000* shall be available under section 241 of the PHS Act to supplement funds available to carry out national surveys on drug abuse and mental health, to collect and analyze program data, and to conduct public aware ness and technical assistance activities: *Provided further*, That, in addition, fees may be collected for the costs of publications, data, data tabulations, and data analysis completed under title V of the PHS Act and provided to a public or private entity upon request, which shall be credited to this appropriation and shall remain available until expended for such purposes: *Provided further, That amounts made available in this Act for carrying out section 501(m) of the PHS Act shall remain available through September 30, 2016: Provided further*, That funds made available under this heading may be used to supplement program support funding provided under the headings "Mental Health", "Substance Abuse Treatment", and "Substance Abuse Prevention"*: Provided further, That the Administrator may transfer funds between any of the accounts of SAMHSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be*

decreased by more than 3 percent by any such transfer. (Department of Health and Human Services Appropriations Act, 2014.)

Language Analysis

Language Provision	Explanation
Provided further, That in addition to amounts provided herein, $26,039,000 shall be available under section 241 of the PHS Act to supplement funds otherwise available for mental health activities and to carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities,	Sets the amount of Public Health Service Act Evaluation Fund dollars allocated to supplement the budget authority for programs and activities authorized under title XIX as well as under titles III and V. This change would allow PHS Evaluation funds to be used to fund the Tribal Behavioral Health Grants in addition to those in the past.
Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated under this Act for fiscal year 2015:	Because all states will have received a grant under the Garrett Lee Smith Youth Suicide Prevention statewide program and the original purpose of the restriction in 520E(b)(2) has been served, this language would allow the program to continue by allowing states to receive a second grant.
Provided further, That notwithstanding section 565(b)(1) of the PHS Act, technical assistance may be provided to a public entity to establish or operate a system of comprehensive community mental health services to children with a serious emotional disturbance, without regard to whether the public entity receives a grant under section 561(a) of such Act:	The system of care model is evidence-based and effective, but currently SAMHSA may only give TA to communities with a current grant. This would allow SAMHSA to provide TA to communities whether they have a current grant or not; which would significantly leverage SAMHSA funds to establish more Systems of Care programs.

Provided further, That States shall expend at least 5 percent of the amount each receives for carrying out section 1911 of the PHS Act to support evidence-based mental health prevention and treatment practices to address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset:	States must use at least five percent of their Community Mental Health Services Block Grant award to support evidence-based mental health promotion and treatment practices with respect to individuals with early serious mental illness.
*For carrying out titles **III** and V of the PHS Act with respect to substance abuse treatment and title XIX of such Act with respect to substance abuse treatment and prevention, $2,008,056,000:*	Sets out the budget authority for the Substance Abuse Treatment appropriation.
Provided, That in addition to amounts provided herein, $109,200,000 shall be available under section 241 of the PHS Act to supplement funds otherwise available for substance abuse treatment activities and to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX	Sets the amount of Public Health Service Act Evaluation Fund dollars allocated to supplement the budget authority available for programs and activities authorized under title XIX as well as under titles III and V. This change would allow PHS Evaluation funds to be used to fund the Screening, Brief Intervention, and Referral to Treatment program.

Provided, That in addition to amounts provided herein, $16,468,000 shall be available under section 241 of the PHS Act to supplement funds otherwise available for substance abuse prevention activities.	Sets the amount of Public Health Service Act Evaluation Fund dollars allocated to supplement the budget authority available for programs and activities authorized under titles III and V. This change would allow PHS Evaluation funds to be used to fund the Center for the Application on Prevention Technologies and Strategic Prevention Framework Rx programs.
Provided further, That, in addition, fees may be collected for the costs of publications, data, data tabulations, and data analysis completed under title V of the PHS Act and provided to a public or private entity upon request, which shall be credited to this appropriation and shall remain available until expended for such purposes:	This section allows for fees to be collected for data and publications which would otherwise not be fulfilled because they incur especially onerous costs upon SAMHSA, and for those fees to be available for the same appropriation until expended.
Provided further, That amounts made available in this Act for carrying out section 501(m) of the PHS Act shall remain available through September 30, 2016:	Currently, SAMHSA's emergency authority allows it to tap certain programs up to one percent for emergency response SERG grants. SAMHSA's ability to respond to disasters which occur at the end of the year, which is hurricane season, is hampered by low available balances. To ensure programs are only tapped to the extent necessary and to ensure that SAMHSA's emergency response is agile, this proviso would allow funds tapped to be carried over one additional year, and only for the same purpose.

Provided further, That the Administrator may transfer funds between any of the accounts of SAMHSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.	Establishes a permissive authority to transfer a small portion of funds between any of the SAMHSA accounts in order to ensure that multiple accounts are not a barrier to the efficient administration of the agency, or appropriate responsiveness to emerging issues with congressional notification.

Amounts Available for Obligation

	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS, Ag, or, Interior)	3,347,973,348	3,434,935,000	3,297,669,000
Across-the-board reductions (L/HHS, Ag, or Interior)	(6,695,950)	-	-
Subtotal, Appropriation (L/HHS, Ag, or Interior)	3,341,277,398	3,434,935,000	3,297,669,000
Sequestration	(168,423,147)		-
Subtotal, adjusted appropriation	(168,423,147)	-	-
Transfer to the Department	(699,673)	-	-
Transfer from the Department	37,906,000	-	-
Transfer from the Prevention and Public Health Funds	14,733,000	62,000,000	58,000,000
Subtotal, adjusted general fund discr. appropriation	51,939,327	62,000,000	58,000,000
Total, Discretionary Appropriation	3,224,793,578	3,496,935,000	3,355,669,000
Offsetting collections from:			
Federal Source	129,667,000	132,667,000	210,702,000
Data Request and publications User Fees	-	1,500,000	1,500,000
Unobligated balance, start of year	175,390	175,390	175,890
Unobligated balance, end of year	175,390	175,890	173,890
Total obligations	3,354,460,578	3,631,102,000	3,567,871,000

Summary of Changes

2014	
Total estimated budget authority	3,434,935,000
(Obligations)	3,434,935,000
2015	
Total estimated budget authority	3,297,669,000
(Obligations)	3,297,669,000
Net Change	**-$137,266,000**

	FY 2015 PB FTE	FY 2015 PB BA	FY 2015 +/- FY 2014 FTE	FY 2015 +/- FY 2014 BA
Increases:	**655**			
A. Built-in:				
1. Annualization of 2015 Commissioned Corps pay costs	---	$ 44,225	---	+$44,225
2. Increase for January 2015 pay raise	---	635,295	---	+635,295
3. Increase in rental payments to GSA	---	3,709,158	---	+3,709,158
Subtotal, Built-in Increases	---	**4,388,678**	---	**+4,388,678**
B. Program:				
1. Agency Wide Initiatives	---	55,000,000	---	+9,305,000
Subtotal, Program Increases	---	**55,000,000**	---	**+9,305,000**
Total Increases	---	**59,388,678**	---	**+13,693,678**
Decreases:				
A. Built-in:				
1. Absorption of built increases	---	---	---	-4,388,678
Subtotal, Built-in Decreases	---	---	---	**-4,388,678**
B. Program:				
1. Mental Health PRNS	---	311,740,000	---	-54,476,000
2. Substance Abuse Prevention PRNS	---	169,092,000	---	-6,468,000
3. Substance Abuse Treatment PRNS	---	267,400,000	---	-42,060,000
4. Program Support	---	72,729,000	---	-17,000,000
5. PAS	---	---	---	-13,571,000
6. PQIS	---	---	---	-12,996,000
Subtotal, Program Increases	---	**820,961,000**	---	**-146,571,000**
Total Decreases	---	---	---	**-150,959,678**
Net Change, Discretionary Budget Authority	**655**	---	---	**-$137,266,000**

Budget Authority by Activity

Program Activities	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
1. Mental Health:				
Programs of Regional and National Significance	266,509	378,216	354,740	-23,476
Prevention and Public Health Fund (non-add)	---	*12,000*	*38,000*	*+26,000*
PHS Evaluation Funds (non-add)	---	---	*5,000*	*+5,000*
Children's Mental Health Services	111,430	117,315	117,315	---
Projects for Assistance in Transition from Homelessness	61,405	64,794	64,794	---
Protection and Advocacy for Individuals with Mental Illness	34,343	36,238	36,238	---
Community Mental Health Services Block Grant	436,809	483,744	483,744	---
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*21,039*	---
Total, Mental Health	**910,496**	**1,080,307**	**1,056,831**	**-23,476**
2. Substance Abuse Prevention:				
Programs of Regional and National Significance	175,513	175,560	185,560	+10,000
Strategic Prevention Framework Rx (non-add)	---	---	*10,000*	*+10,000*
PHS Evaluation Funds (non-add)	---	---	*16,468*	*+16,468*
Total, Substance Abuse Prevention	**175,513**	**175,560**	**185,560**	**+10,000**
3. Substance Abuse Treatment:				
Programs of Regional and National Significance	404,085	361,460	297,400	-64,060
Prevention and Public Health Fund (non-add)	---	*50,000*	---	*-50,000*
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*	*+28,000*
Substance Abuse Prevention and Treatment Block Grant	1,710,306	1,819,856	1,819,856	---
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	---
Total, Substance Abuse Treatment	**2,114,392**	**2,181,316**	**2,117,256**	**-64,060**
4. Health Surveillance and Program Support:				
Health Surveillance and Program Support:	123,419	120,157	122,157	+2,000
Prevention and Public Health Fund (non-add)	*14,733*	---	*20,000*	*+20,000*
PHS Evaluation Funds (non-add)	*27,428*	*30,428*	*29,428*	*-1,000*
Public Awareness and Support	13,545	13,571	15,571	+2,000
PHS Evaluation Funds (non-add)	---	---	*15,571*	*+15,571*
Performance and Quality Information Systems	8,803	12,996	12,996	---
PHS Evaluation Funds (non-add)	---	---	*12,996*	*+12,996*
Agency-Wide Initiatives 1/	8,293	45,695	56,000	+10,305
PHS Evaluation Funds (non-add)	---	---	*1,000*	*+1,000*
Data Request/Publications User Fees	---	1,500	1,500	---
Total, Health Surveillance/Program Support	**154,061**	**193,919**	**208,224**	**+14,305**
TOTAL, SAMHSA Discretionary PL	**3,354,461**	**3,631,102**	**3,567,871**	**-63,231**
Less PHS Evaluation Funds	*129,667*	*132,667*	*210,702*	*+78,035*
Less Prevention and Public Health Funds	*14,733*	*62,000*	*58,000*	*-4,000*
Less Data Request and Publications User Fees	---	*1,500*	*1,500*	---
TOTAL, SAMHSA Budget Authority	**$3,210,061**	**$3,434,935**	**$3,297,669**	**-$137,266**
FTEs	**608**	**655**	**655**	**---**

[1/] The Minority Fellowship Program budgets from the Mental Health, Substance Abuse Prevention and Treatment appropriations have been comparable adjusted in this table to be in line with the FY 2015 Request and are reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

*Totals may not add due to rounding.

Authorizing Legislation

Program Description/PHS Act:	FY 2014 Amount Authorized	FY 2014 Enacted	FY 2015 Amount Authorized	FY 2015 President's Budget
Grants for the Benefit of Homeless Individuals				
Sec. 506……	Expired	$41,488,000	Expired	$41,488,000
Residential Treatment Programs for Pregnant and Postpartum Women				
Sec. 508……	Expired	$15,970,000	Expired	$15,970,000
Priority Substance Abuse Treatment Needs of Regional and National Significance				
Sec. 509*……	Expired	$222,324,000	Expired	$173,764,000
Substance Abuse Treatment Services for Children and Adolescents				
Sec. 514*……	Expired	$29,678,000	Expired	$29,678,000
Priority Substance Abuse Prevention Needs of Regional and National Significance				
Sec. 516*……	Expired	$167,560,000	Expired	$161,092,000
Programs to Reduce Underage Drinking				
Sec. 519B*……	Expired	$ 7,000,000	Expired	$ 7,000,000
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	$1,000,000	Expired	$1,000,000
Priority Mental Health Needs of Regional and National Significance				
Sec. 520A*……	Expired	$203,080,000	Expired	$216,632,000
Youth Interagency Research, Training, and Technical Assistance Centers				
Sec. 520C*……	Expired	$5,000,000	Expired	$4,298,000
Suicide Prevention for Children and Youth				
Sec. 520E*……	Expired	$29,700,000	Expired	$23,363,000
Sec. 520E2*……	Expired	$5,000,000	Expired	$797,000
Grants for Jail Diversion Programs				
Sec. 520G*……	Expired	$4,280,000	Expired	$4,280,000
Awards for Co-locating Primary and Specialty Care in Community-based Mental Health Settings				
Sec. 520K*……	SSAN	$50,000,000	Expired	0
PATH Grants to States				
Sec. 535(a)……	Expired	$64,794,000	Expired	$64,794,000

SSAN = Such Sums as Necessary

Authorizing Legislation

Program Description/PHS Act:	FY 2014 Amount Authorized	FY 2014 Enacted	FY 2015 Amount Authorized	FY 2015 President's Budget
Community Mental Health Services for Children with Serious Emotional Disturbances Sec. 565 (f)……	Expired	$117,315,000	Expired	$117,315,000
Children and Violence Program Sec. 581*……	Expired	$23,156,000	Expired	$23,156,000
Grants for Persons who Experience Violence Related Stress Sec. 582 **……	Expired	$46,000,000	Expired	$45,714,000
Community Mental Health Services Block Grants Sec. 1920(a)……	Expired	$462,705,000	Expired	$462,705,000
Substance Abuse Prevention and Treatment Block Grants Sec. 1935(a)……	Expired	$1,740,656,000	Expired	$1,740,656,000
Other Legislation/Program Description				
Protection and Advocacy for Individuals with Mental Illness Act P.L. 99-319, Sec. 117……	Expired	$36,238,000	Expired	$36,238,000
Health Surveillance and Program Support				
Program Management, Sec. 501……	Indefinite	$71,569,000	Indefinite	$71,569,000
P.L. 98-621……	Indefinite	$1,160,000	Indefinite	$1,160,000
Total, Program Management……	Indefinite	$72,729,000	Indefinite	$72,729,000
Heath Surveillance…….	Indefinite	$17,000,000	Indefinite	0
Public Awareness and Support (FY12)…	Indefinite	$13,571,000	Indefinite	0
PQIS(FY12)…….	Indefinite	$12,996,000	Indefinite	0
Agency-Wide Initiatives……	Indefinite	$45,695,000	Indefinite	$55,000,000
Indian Health Care Improvement Reauthorization and Extension Act of 2009 Substance Abuse and Mental Health Services Administration Grants Sec. 724 ……..	SSAN	0	SSAN	0
Indian Youth Life Skills Development Demonstration Program Sec. 726……..	$1,000,000	0	$1,000,000	0
TOTAL, SAMHSA Budget Authority……	$1,000,000	$3,434,935,000	0	$3,297,669,000

* 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.

Appropriations History

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
FY 2006					
General Fund Appropriation:					
Base	$3,336,023,000	$3,352,047,000	$3,398,086,000	$3,237,813,000	
P.L. 109-149					
Rescission (P.L. 109-359)	0	0	0	-$1,681,000	1/
Transfers (Section 202)	0	0	0	-$2,201,000	
Subtotal	$3,336,023,000	$3,352,047,000	$3,398,086,000	$3,233,931,000	
FY 2007					
General Fund Appropriation:					
Base	$3,260,001,000	$3,326,341,772	$3,326,341,772	$1,211,654,381	2/
P.L. 109-383					
Continuing Resolution	0	0	0	$3,326,341,772	3/
Subtotal	$3,260,001,000	$3,326,341,772	$3,326,341,772	$4,537,996,153	
FY 2008					
General Fund Appropriation:					
Base	$3,167,589,000	$3,393,841,000	$3,404,798,000	$3,291,543,000	
P.L. 110-161					
Rescission (P.L. 110-161)	0	0	0	-$57,503,000	4/
Subtotal	$3,167,589,000	$3,393,841,000	$3,404,798,000	$3,234,040,000	
FY 2009					
General Fund Appropriation:					
Base	$3,024,967,000	$3,303,265,000	$3,257,647,000	$3,334,906,000	
P.L. 111-8					
Subtotal	$3,024,967,000	$3,303,265,000	$3,257,647,000	$3,334,906,000	
FY 2010					
General Fund Appropriation:					
Base	$ 3,393,882,000	$ 3,429,782,000	$3,419,438,000	$ 3,431,116,000	5/
P.L. 111-117					
Subtotal	$ 3,393,882,000	$ 3,429,782,000	$ 3,419,438,000	$ 3,431,116,000	

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
FY 2011					
General Fund Appropriation:					
Base	$ 3,541,362,000	$ 3,565,360,000	$ 3,576,184,000	$3,386,311,000	
P.L. 112-10					
Subtotal	$ 3,541,362,000	$ 3,565,360,000	$ 3,576,184,000	$ 3,386,311,000	
FY 2012					
General Fund Appropriation:					
Base	$ 3,386,903,000	$ 3,096,914,000	$ 3,354,637,000	$3,347,020,000	6/
P.L. 112-74					
Subtotal	$ 3,386,903,000	$ 3,096,914,000	$ 3,354,637,000	$ 3,347,020,000	
FY 2013					
General Fund Appropriation:					
Base	$ 3,151,508,000	$ -	$ 3,472,213,000	$ 3,172,154,778	7/
S.R. 112-176					
Subtotal	$ 3,151,508,000	$ -	$ 3,472,213,000	$ 3,172,154,778	
FY 2014					
General Fund Appropriation:					
Base	$ 3,347,951,097	$ -	$ 3,529,944,000	$ 3,434,935,000	8/
S.R. 113-071					
Subtotal	$ 3,347,951,097	$ -	$ 3,529,944,000	$ 3,434,935,000	
FY 2015					
General Fund Appropriation:					
Base	$ 3,297,669,000				
Subtotal	$ 3,297,669,000				

1/ Reflects Section 202 transfer to CMS.

2/ Reflects Continuing Resolution through February 15, 2007.

3/ Reflects the whole year appropriation

4/ Reflects a 1.7 percent across-the-board Rescission from the P.L. 110-161.

5/ Reflects a $508 thousand transfer to HHS

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

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

8/ Reflects the whole year appropriation

Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2014
Grants for the Benefit of Homeless Individuals Sec. 506	2003	$ 50,000,000	$ 16,700,000	$41,488,000
Residential Treatment Programs for Pregnant and Postpartum Women Sec. 508	2003	SSAN	$0	$15,970,000
Priority Substance Abuse Treatment Needs of Regional and National Significance Sec. 509*	2003	$ 300,000,000	$ 322,994,000	$222,324,000
Substance Abuse Treatment Services for Children and Adolescents Sec. 514*	2003	$ 40,000,000	$ 20,000,000	$29,678,000
Priority Substance Abuse Prevention Needs of Regional and National Significance Sec. 516*	2003	$ 300,000,000	$ 138,399,000	$174,560,000
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	$1,000,000
Priority Mental Health Needs of Regional and National Significance Sec. 520A*	2003	$ 300,000,000	$ 94,289,000	$253,080,000
Youth Interagency Research, Training, and Technical Assistance Centers Sec. 520C*	2007	$ 5,000,000	$ 3,960,000	$5,000,000
Suicide Prevention for Children and Youth Sec. 520E (GLS - State Grants)	2007	$ 30,000,000	$ 17,829,000	$ 29,700,000
Sec. 520E2 (GLS-Campus Grants)	2007	$ 5,000,000	$ 4,950,000	$5,000,000
Grants for Jail Diversion Programs Sec. 520G*	2003	$ 10,000,000	$ 6,043,000	$4,280,000
PATH Grants to States Sec. 535(a)	2003	$ 75,000,000	$ 46,855,000	$ 64,794,000
Community Mental Health Services for Children with Serious Emotional Disturbances Sec. 565 (f)	2003	$ 100,000,000	$ 96,694,000	$117,315,000
Children and Violence Program Sec. 581*	2003	$ 100,000,000	$ 83,035,000	$ 23,156,000
Grants for Persons who Experience Violence Related Stress Sec. 582 *	2003	$ 50,000,000	$ 20,000,000	$ 46,000,000
Community Mental Health Services Block Grants Sec. 1920(a)	2003	$ 450,000,000	$ 433,000,000	$462,705,000
Substance Abuse Prevention and Treatment Block Grants Sec. 1935(a)	2003	$ 2,000,000,000	$ 1,785,000,000	$1,740,656,000
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	$ 36,238,000
TOTAL, SAMHSA Budget Authority		$ 4,222,500,000	$ 3,142,664,000	$ 3,272,944,000

*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.

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SAMHSA/Programs of Regional and National Significance
Mental Health Services
(Dollars in thousands)

Programs of Regional & National Significance	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
CAPACITY				
Seclusion and Restraint and Trauma	$2,121	$1,150	$1,149	-$1
Youth Violence Prevention	21,945	23,156	23,156	---
Project AWARE	---	55,000	55,000	---
Project AWARE State Grants (non-add)	---	*40,000*	*40,000*	---
Mental Health First Aid (non-add)	---	*15,000*	*15,000*	---
Healthy Transitions	---	20,000	20,000	---
National Child Traumatic Stress Initiative	43,322	46,000	45,714	-286
Children and Family Programs	6,461	6,474	6,474	---
Consumer and Family Network Grants	6,140	4,966	4,966	---
Project LAUNCH	32,829	34,640	34,640	---
MH System Transformation and Health Reform	10,448	10,582	10,582	---
Primary and Behavioral Health Care Integration	28,641	50,000	26,004	-23,996
Prevention & Public Health Fund (non-add)	---	---	*7,909*	*+7,909*
Suicide Prevention	55,532	60,150	50,046	-10,104
National Strategy for Suicide Prevention (non-add)	---	*2,000*	*4,000*	*+2,000*
Prevention & Public Health Fund (non-add)	---	*2,000*	---	*-2,000*
Suicide Lifeline (non-add)	*6,085*	*7,212*	*5,512*	*-1,700*
Prevention & Public Health Fund (non-add)	---	*1,700*	*862*	*-838*
GLS- Youth Suicide Prevention - States (non-add)	*32,448*	*35,500*	*27,682*	*-7,818*
Prevention & Public Health Fund (non-add)	---	*5,800*	*4,319*	*-1,481*
GLS- Youth Suicide Prevention - Campus (non-add)	*8,875*	*6,500*	*4,966*	*-1,534*
Prevention & Public Health Fund (non-add)	---	*1,500*	*4,169*	*+2,669*
GLS - Suicide Prevention Resource Center (non-add)	*5,339*	*6,000*	*4,948*	*-1,052*
Prevention & Public Health Fund (non-add)	---	*1,000*	*650*	*-350*
AI/AN Suicide Prevention Initiative (non-add)	*2,785*	*2,938*	*2,938*	---
Tribal Behavioral Health Grants	---	5,000	5,000	---
PHS Evaluation Funds (non-add)	---	---	5,000	*+5,000*
Homelessness Prevention Programs	29,162	30,772	30,772	---
Minority AIDS	8,781	9,247	16,270	+7,023
Grants for Adult Trauma Screening & Brief Intervention	---	---	2,896	+2,896
Criminal and Juvenile Justice Programs	5,877	4,280	4,280	---
Subtotal, Capacity	**$251,259**	**$361,417**	**$336,949**	**-$24,468**

Programs of Regional & National Significance	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
SCIENCE AND SERVICE				
Practice Improvement and Training	7,413	7,847	7,847	---
Consumer and Consumer Supporter Technical Assistance Centers	1,875	1,923	1,923	---
Primary and Behavioral Health Care Integration TTA	1,992	1,996	1,996	---
Prevention & Public Health Fund (non-add)	---	---	*1,996*	*+1,996*
Disaster Response	997	1,958	2,950	+992
Homelessness	2,181	2,302	2,302	---
HIV/AIDS Education	791	773	773	---
Subtotal, Science and Service	**$15,249**	**$16,799**	**$17,791**	**+$992**
TOTAL, PRNS[1/ 2]	**$266,509**	**$378,216**	**$354,740**	**-$23,476**

1/ The PRNS FY 2014 total includes $12,000,000 and 2015 Request total includes $38,000,000 funded by the Prevention and Public Health Fund.

2/ In the FY 2015 Request, the CMHS Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

* Totals may not add due to rounding.

Authorizing Legislation ..... Sections 501, 506, 520A, 520C, 520E, 520E (2), 520G, 520K, 516, 581, and 582 of the Public Health Service Act

FY 2015 Authorization ..... Expired

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

Program Description and Accomplishments

Seclusion and Restraint and Trauma

People die as a result of seclusion and restraint practices, countless others are injured, and many are secondarily traumatized by coercive practices. Children with emotional and behavioral problems are more frequently subjected to restraints in schools than students with other disabilities, often leading to serious physical injuries and emotional trauma for the students and the staff. Coercive practices such as seclusion and restraint impede recovery and well-being. Trauma-informed approaches to care have been developed and implemented to reduce or eliminate the use of coercive practices across identified service settings.

This program area supports states/tribes and communities in their efforts to implement best practices to reduce and ultimately eliminate the use of restraints and seclusion in institutional- and community-based settings that provide services for individuals with mental and co-occurring substance use disorders. While this initiative includes a focus on the mental health delivery system, it also includes other service sectors such as criminal justice, schools, and child welfare that may use coercive practices with people who have mental and/or co-occurring substance use disorders. SAMHSA's vision for this initiative is to facilitate the implementation of evidence-

based strategies for preventing and reducing the use of seclusion and restraint and implementing trauma-informed care, an approach that reduces the use and harmful effects of coercive practices.

Population surveys and clinical studies have documented the association between experiences of trauma and mental and substance use disorders. Accordingly, investments have been made in the development and dissemination of effective trauma-specific treatments. Studies of trauma survivors, behavioral health consumers, and practitioners in behavioral health settings have similarly documented the manner in which many service settings can be secondarily traumatizing for the people seeking services and interfere with positive treatment outcomes.

In FY 2010, SAMHSA awarded a three-year contract to establish the National Technical Assistance Center: Promoting Alternatives to Seclusion and Restraint Through Trauma-Informed Practices. The purpose of this center is to disseminate, train, and implement programs supported by available evidence to provide trauma-informed care with the goal of reducing and, ultimately, preventing the use of seclusion, restraint, and other coercive practices in service systems and treatment agencies that serve children, youth, and adults with mental and/or co-occurring substance use disorders. Recipients of the training are publicly funded systems, organizations and service delivery personnel who intersect with people who have mental illnesses. This contract also supports SAMHSA's efforts in developing a standard definition and measures of individual and community trauma and develops criteria and measures for trauma-informed care that can be used with a range of health and human service programs.

Recent evidence of the effectiveness of this training includes reduced use of seclusion and restraint in facilities where the training has taken place as well as reduced incidents of violence where these trauma-informed strategies have been employed.

In FY 2013, SAMHSA awarded a new contract to support the continuation of these activities, a training institute, and to further refine the criteria for implementing and evaluating a trauma-informed approach in multiple service sectors towards the prevention, reduction, and elimination of coercive practices.

In FY 2014, SAMHSA plans to continue support of this contract.

Youth Violence Prevention

Youth violence remains a public health problem in the United States. The 2011 Youth Risk Behavior Surveillance-US reports that in 2011, approximately 12 percent of high school students reported being in a physical fight in the 12 months before the survey. Almost six percent of high school students in 2011 reported taking a gun, knife, or club to school in the 30 days before the survey. An estimated 20.1 percent of high school students reported being bullied on school property in 2011.

The Safe Schools/Healthy Students (SS/HS) Initiative is a discretionary grant program that seeks to create healthy learning environments which help students thrive, succeed in school, and build healthy relationships. From 1999 through 2012, this program was jointly administered by SAMHSA, the Department of Education (ED), and the Department of Justice (DOJ). In addition

to the cross-federal partnership with Justice through the SS/HS Initiative, SAMHSA has also supported the Justice-led National Forum on Youth Violence Prevention. The Forum aims to build a national conversation about youth and gang violence to increase awareness, drive action, and build local capacity to more effectively address youth violence. It models a new kind of federal and local collaboration, encouraging its members to change the way they do business by sharing common challenges and promising strategies, through comprehensive planning and coordinated action. Since inception in 2010, ten cities have been supported through this Initiative. SAMHSA has provided federal staff support as well as providing technical assistance support through the National Center for Mental Health Promotion and Youth Violence Prevention.

The SS/HS initiative implements an enhanced, coordinated, and comprehensive plan of activities, programs, and services that promote healthy childhood development, prevent violence, and prevent alcohol and drug abuse. Grantees are required to develop local strategic plans that address 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 all agencies concerned with the welfare of children and families could collaborate on an ongoing basis.

As a result of the SS/HS initiative implemented in local educational authorities (LEAs), more than 90 percent of school staff saw reduced violence on school grounds and almost 80 percent reported that SS/HS had reduced violence in their communities. Children and adolescents participating in the SS/HS grant program experienced a 47.1 percent increase in access to school-based mental health service and a 29.8 percent increase in receipt of community-based mental health services. Nearly 90 percent of school staff stated that they were better able to detect mental health problems in their students and more than 80 percent of school staff reported that they saw reductions in alcohol and other drug use among their students.

In FY 2012, SAMHSA supported the final cohort of SS/HS grants in collaboration with ED. SAMHSA also utilized funding in FY 2012 to realign technical assistance activities to meet the needs of grantees and the field, and to evaluate the performance of the existing program. SAMHSA transferred $2.2 million to ED to help finance technical assistance to improve the school climate for learning; including, but not limited to, bullying prevention. In addition, SAMHSA awarded 3rd, 4th, and final year funding for 21 Implementing Evidence-Based Prevention Practices in Schools grants which will come to an end in FY 2014.

In FY 2013, SAMHSA provided funds for the Safe Schools/Healthy Students State Planning, Local Education Agency and Local Community grant program (SS/HS State program). This grant program builds on the investments in the SS/HS Initiative through state and community level partnerships among education, behavioral health, and criminal justice systems that promote systems integration and policy change and sustainable policies, infrastructure, services, and supports. The SS/HS State Program is supported with SAMHSA funds only and is intended to

create safe and supportive schools and communities. In addition, SAMHSA awarded the new Resource Center for Mental Health Promotion and Youth Violence Prevention.

In FY 2014, SAMHSA plans to continue support of these efforts.

Project AWARE

In response to the tragedy at Sandy Hook Elementary School, in FY 2014, SAMHSA plans to utilize $55 million to support Project AWARE, (Advancing Wellness and Resilience in Education) to increase awareness of mental health issues and connect young people with behavioral health issues and their families with needed services. SAMHSA will partner with the Departments of Education and Justice in the development, implementation and management of this initiative to maximize coordination and avoid duplication of efforts.

Project AWARE proposes two components: Project AWARE State Grants ($40 million) build on the Safe Schools/Healthy Students State Program which is intended to create safe and supportive schools and communities. For more than a decade, the Safe Schools/Healthy Students Initiative has successfully decreased violence and increased the number of students receiving mental health services. Project AWARE grants will go to 20 State Education Authorities (SEAs), and in collaboration with Education and Justice will promote comprehensive, coordinated, and integrated State efforts to make schools safer and increase access to mental health services. The SEAs will be required to partner with the State Mental Health and Law Enforcement agencies to establish Interagency State Management Teams, conduct needs assessments, develop a state plan with an evaluation mechanism, and develop the mechanisms to coordinate funding, service delivery, systems improvement, and data collection. In addition, each SEA will be required to identify three high-need Local Education Agencies (LEAs) as communities that will receive sub-awards to implement comprehensive and coordinated school safety and mental health programs.

The second component, Mental Health First Aid (MHFA) ($15 million) proposes widespread dissemination of the Mental Health First Aid curriculum. MHFA-Youth prepares teachers and other individuals who work with youth to help schools and communities to understand, recognize, and respond to signs of mental illness or substance abuse in children and youth, including how to talk to adolescents and families experiencing these problems so they are more willing to seek treatment. The Budget proposes that $10 million of the Project AWARE – MHFA funds support training of teachers and a broad array of actors at the community level, including parents, law enforcement, youth and faith-based leaders. The additional $5 million proposed for MHFA will continue to support dissemination of MHFA through the 20 Project AWARE SEA grants.

A target of 750,000 students served is an achievable goal for first year of program implementation from these two components.

Healthy Transitions

The FY 2014 Budget includes $20 million for a new Healthy Transitions Program, which assists 16 to 25 year-olds with mental illnesses and their families to access and navigate behavioral health treatment systems. Compared with their peers, young adults, aged 18-25 with mental health conditions are more likely to experience homelessness, be arrested, drop out of school and be underemployed. Compared to all other chronic health conditions, mental disorders produce the greatest disability burden within this age group. Furthermore, 18-25 year-olds with mental health conditions are significantly less likely to receive mental health services than other adults. This new demonstration grant program for states proposes new and creative approaches to provide support for transition-age youth with mental health and/or co-occurring substance abuse disorders and their families. States will take steps to expand services for these young individuals, develop family and youth networks for information sharing and peer support, and disseminate best practices for services to youth ages 16-25. The $20 million will support five-year grants to 16 states as well as new evaluation and technical assistance contracts. An estimated 5,900 individuals will be referred to mental health or related services.

National Child Traumatic Stress Initiative

Established in 2000, the purpose of the National Child Traumatic Stress Initiative (NCTSI) is to improve behavioral health treatment, services, and interventions for children and adolescents exposed to traumatic events. The NCTSI has provided funding for a national network of grantees known as the National Child Traumatic Stress Network (NCTSN) to develop and promote effective community practices for children and adolescents exposed to a wide array of traumatic events. The NCTSN has grown from a collaborative Network of 17 to over 165 funded and affiliate centers located nationwide in university, hospital, and diverse community-based organizations, with thousands of national and local partners. The NCTSN mission is to raise the standard of care and improve access to services for traumatized children, their families, and communities. Coordinated by the SAMHSA funded National Center for Child Traumatic Stress (NCCTS), Network members and partners work together within and across diverse settings, including a wide variety of governmental and non-governmental organizations. The Network offers training, support, and resources to providers who work with children and families exposed to a wide range of traumatic experiences, including physical and sexual abuse; domestic, school, and community violence; natural disasters, terrorism, or military family challenges; and life-threatening injury and illness.

The NCTSN provides training and technical support on intervention approaches to reduce the mental, emotional, and behavioral effects of traumatic events on children/adolescents and their families. By working with established systems of care including public health, mental health, education, law enforcement, child welfare, juvenile justice, and military family service systems, the NCTSN ensures that there is a comprehensive trauma-informed continuum of accessible care. It also raises public awareness of the scope and serious impact of child traumatic stress on the safety and healthy development of America's children and youth as well as advances a broad range of effective services and interventions by creating trauma-informed developmentally and culturally appropriate programs that improve the standard of care. Finally, the NCTSN fosters a

community dedicated to collaboration within and beyond the network to ensure that widely shared knowledge and skills become a sustainable national resource.

The NCTSN is composed of three types of centers:

> The National Center for Child Traumatic Stress - (Category I) develops and maintains the collaborative network structure, supports resource development and dissemination, and coordinates the Network's national child trauma education and training efforts. It promotes further product development, learning collaborations, and system change efforts in systems across the country.
>
> The Treatment and Service Adaptation (TSA) Centers - (Category II) provide national expertise and assume responsibility in the Network for specific areas of trauma, such as specific types of traumatic events, population groups, and service systems; and support the development and adaptation of effective trauma treatments and services for children, adolescents and their families that can be implemented throughout the nation. The TSAs are comprised of nationally-recognized experts in child and adolescent trauma who have developed evidence-based interventions to treat children who have experienced a range of traumas including neglect, physical abuse, sexual abuse, medical trauma, school violence, war, refugee status, and disasters.
>
> The Community Treatment and Services (CTS) Centers - (Category III) are primarily community service providers across multiple child-serving systems service programs that implement and evaluate effective treatment and services in community settings and youth serving service systems and collaborate with other NCTSN centers on clinical issues, service approaches, policy, financing, and training issues.

Data collected during FY 2013 shows that the current grantees in the NCTSN have provided trauma treatment to more than 24,478 children, adolescents and family members. The previously collected NCTSN Core Data Set includes outcome data from more than 7,000 clinical cases in which 43 percent of cases demonstrated significant improvements. This database of clinical characteristics, trauma exposure, and treatment outcomes includes more than 18,000 cases and follow-up data on approximately 50 percent of these cases.

The NCTSN continues to be a principal source of child trauma training for our nation. In FY 2013 the NCTSN grantee sites provided training to over 170,000 individuals. The Network has developed resources for child/adolescent trauma on the NCTSN website, which receives an average of 2,500 visits a day. During this same time period 45 new resources were developed. In addition, site products such as fact sheets and toolkits were downloaded more than 70,000 times. A Learning Center website has also been developed that provides access to 195 expert webinars on trauma topics. In addition, the Network has developed 26 intensive learning collaboratives, and various online certification programs that offer continuing education credits free of charge.

In FY 2013, SAMHSA provided continuation support for a cohort of 78 NCTSI grants, (one Category I, 21 Category II and 56 Category III) with an increased focus on effective implementation and dissemination strategies for maximizing the uptake of trauma interventions,

enhanced learning networks, and strong linking of child trauma in the child welfare and juvenile justice systems.

In FY 2014, the NCTSI will build on the robust work of the NCTSN and improve and enhance the capacity of the NCTSI to deliver effective interventions and core practices developed by the NCTSN to children and youth in need.

Children and Family Programs

The Children and Family Programs provide support for the Circles of Care grant program. This program provides services and support to children and youth with and at risk for mental health conditions and their families. Initially funded in 1998, the Circles of Care Program is a three year program that promotes the elimination of mental health disparities by providing tribal and Alaskan Native communities with tools and resources to build their own culturally competent systems of care model for children's mental health. The program also increases capacity and community readiness to address the mental health issues of children and families.

In FY 2013, SAMHSA awarded the final year of funding for the six Circles of Care and seven State/Community Partnerships to Integrate Services and Supports for Youth and Young Adults 16-25 with Serious Mental Health Conditions and their Families grants. In FY 2014, SAMHSA plans to award a new cohort of Circles of Care grants.

Consumer and Family Network Programs

The Consumer and Family Network Programs supports SAMHSA's Recovery Support Strategic Initiative by promoting consumer, family, and youth meaningful participation in the development of policies, programs, and quality assurance activities related to mental health systems reform across America.

The Statewide Consumer Network Program focuses on the needs of adult mental health consumers 18-years and older by strengthening the capacities of state-wide consumer-run organizations to be catalysts for transforming the mental health and related systems in their states. It establishes sustainable mechanisms for integrating the consumer voice in state mental health and allied systems to (1) expand service system capacity, (2) support policy and program development, and (3) enhance peer support. This program promotes skill development with an emphasis on leadership and business management as well as coalition/partnership-building and economic empowerment as part of the recovery process for consumers. In FY 2011, SAMHSA funded 31 Statewide Consumer Network continuation grants for four years.

In FY 2013, SAMHSA awarded 15 new grants to support emphasis on integrated care and assist in planning for implementation of health reform and provide continuation funding to 11 grants and a technical assistance contract. In FY 2014, SAMHSA plans to support continuation grants and contracts for this program.

The Statewide Family Network Program is a three year program that provides education and training to increase family organizations' capacity for policy and service development by 1)

strengthening organizational relationships and business management skills, 2) fostering leadership skills among families of children and adolescents with serious emotional disturbances, and 3) identifying and addressing the technical assistance needs of children and adolescents with serious emotional disturbances and their families. The Statewide Family Network Program focuses on families: parents; the primary caregivers of children; youth; and young adults. In this case, 'young adults' refers to individuals generally up to age 18, up to age 21 if they have an Individual Education Plan, or up to age 26 if they are transitioning to the adult mental health system.

In FY 2013, SAMHSA awarded 29 new grants to support emphasis on integrated care and assist in planning for implementation of health reform and provide continuation funding for six grants and a technical assistance contract. In FY 2014, SAMHSA plans to support continuation grants and contract of the program.

In addition, in FY 2014, SAMHSA expects to provide support for the Statewide Peer Network Development Program for Recovery and Resiliency. In support of SAMHSA's Recovery Support Strategic Initiative, this program builds capacity for statewide consumer-run, family member-run, or addiction recovery community organizations to promote cross-service system and infrastructure development that is recovery-focused and resiliency oriented. $1 million in Substance Abuse Treatment (SAT) budget authority will be used to award new addiction recovery community statewide networks. The remaining $0.8 million will be braided between Mental Health budget authority and SAT budget authority to allow for supplemental awards for collaborative partnerships across the mental and substance use disorder fields. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent. Eligible applicants for this program will be those organizations who have an existing mental health or addiction statewide network award from SAMHSA. Up to 10 grant awards at $0.1 million will be made for addiction recovery statewide networks. Eight supplemental awards will be given at $0.1 million each.

Grantees will be expected to facilitate effective participation in state and local behavioral health services planning and health reform activities related to improving community-based services and supports for people in recovery from substance use disorders, children and youth with serious mental health conditions and their families or adult mental health consumers. The program will also address gaps in behavioral health policy as well as inform health reform implementation. In order to ensure a stronger policy voice across the behavioral health field and facilitate readiness for the implementation of health reform, a supplemental incentive award will be offered to applicants proposing to build a collaborative partnership between mental health and addictions peer-run state-wide networks and those that are mental health family-run. Additionally, partnerships with affiliate health networks will be encouraged.

Project LAUNCH

In FY 2008, Congress provided initial funding to implement the Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) Wellness Initiative. Project LAUNCH implements evidence-based practices that promote and enhance the wellness of young children by increasing grantees' capacities to develop infrastructure and implement prevention/promotion

strategies necessary to promote wellness for young children. Project LAUNCH focuses on children from birth through age eight. The goal of Project LAUNCH is to create a shared vision for the wellness of young children that drives the development of federal, state, territorial, tribal and local networks for the coordination of key child-serving systems and the integration of behavioral and physical health services.

Cumulative performance data for the program (October 2008 through September 2013) show that approximately 106,000 children and parents have been screened and assessed in diverse settings and over 22,892 families have been served in Project LAUNCH-supported home visiting and family strengthening programs. Over 38,571 community providers have been trained on social-emotional and behavioral health for young children. Nearly 67,000 individuals received evidence-based mental health services. Project LAUNCH data also indicate that nearly 2,599 new organizations are collaborating, coordinating, and sharing resources to implement prevention/promotion strategies for young children. All Project LAUNCH grantees reported improved social and academic functioning, and 78% reported decreases in problem behaviors among the targeted population.

In FY 2013, SAMHSA supported 29 continuation grants and contracts and awarded five new Project LAUNCH grants and one new contract. In FY 2014, SAMHSA plans to support Project LAUNCH continuations and contracts and award 14 new grants.

Mental Health System Transformation and Health Reform

SAMHSA supports activities that facilitate the transformation of the mental health delivery system. These efforts include the Mental Health Transformation (MHT) and the Behavioral Health Treatment Court Collaborative (BHTCC) grant programs. In FY 2010, SAMHSA awarded 20 MHT grants for five years to promote the adoption and implementation of permanent transformative changes in how communities manage and deliver mental health services. Grantees are currently implementing evidence-based or best practices that will create or expand capacity to address mental illness prevention, trauma-informed care, screening, treatment, and support services for military personnel, supported housing and supported employment. In FY 2013, grantees trained more than 7,700 mental health and related workforce personnel in specific mental-health related practices/activities as a result of the grant. Necessary changes to policies and organizational structures to support improved mental health services also will be supported along with workforce training, implementation of evidence-based practices, and improving access to quality mental health services.

In FY 2011, SAMHSA awarded 11 BHTCC grants for three years. The purpose of the BHTCC program is to help state and local courts offer treatment and recovery support instead of incarceration for individuals who are in a court system due to mental or substance use disorders and to provide more flexibility within the criminal justice system to work with other authorities and service providers to better address behavioral health needs of detainees, inmates and parolees. SAMHSA's vision of a BHTCC in the justice system is one that encourages treatment and recovery support for individuals involved in the criminal justice system with mental and substance abuse disorders and also improves public health and public safety by facilitating the transformation of the behavioral health/criminal justice system at the community level. The court

system can direct an individual into the appropriate forum, whether it is Drug Court, Veterans Court, Mental Health Court, Family Court, or another combined specialty court approach. This will be done as is appropriate for the individual and the services with which the court(s) coordinate to provide treatment and services for individuals engaged in the criminal justice system.

The BHTCC grantees have demonstrated significant accomplishment over the past year and a half. Having been built from drug courts, they have increased or expanded access for participants with mental health and/or co-occurring disorders (COD) to specialty courts and diversion opportunities. This has resulted in improved access to behavioral health services including trauma specific treatment. To accomplish this, the programs have developed new standardized assessment procedures that include court and clinical team reviews for eligibility and appropriate services to multiple courts. They have conducted cross system and discipline training, particularly Trauma Informed Care (TIC) reaching over 300 court and behavioral health staff. These accomplishments were accompanied with infrastructure changes including new cross collaboration and significant increases in the involvement of peers (persons with lived experience), and the implementation of Trauma Informed Care approaches to working with clients. Program participants are typically male, younger than 35 years old, parents, with a high school education. More than two thirds of program participants report experiencing violence and trauma. As a result of the program participants report reduced anxiety and depression and increased use of prescribed medication. They also report improved abstinence from substances, increased employment, and housing stability.

In FY 2013, SAMHSA awarded continuations for the MHT and BHTCC grants and the evaluation contract for the BHTTC program. In FY 2014, SAMHSA plans to fund continuations for the MHT grants.

In addition, in support of SAMHSA's Recovery Support Strategic Initiative, SAMHSA proposes to use a total of approximately $4.9 million in Budget Authority to establish the Transforming Lives through Supported Employment Grant Program. Based on learning from previous Mental Health Transformation grant cohorts, SAMHSA will use a total of $4.9 million (Mental Health Systems Transformation and Health Reform funds of $2.2 million and Practice Improvement and Training funds of $2.7 million) to focus the program on an existing activity: enhancing state and community capacity to provide evidence-based supported employment programs for adults and youth with serious mental illnesses/emotional disturbances. This strengthening of an existing program activity is consistent with SAMHSA's four pillars of Recovery (Health, Home, Purpose, and Community). In addition, Supported Employment was one of five allowable activities in earlier Transformation grants and has demonstrated excellent outcomes in helping individuals achieve and sustain recovery.

By having gainful employment as the target outcome and helping mental health consumers, their treatment providers, and their employers develop mutual understanding and successful relationships, Transforming Lives through Supported Employment Grants will help people with mental illnesses discover paths of self-sufficiency and recovery rather than disability and dependence. A total of up to 6 grant awards of approximately $0.85 million dollars each will be awarded for five years.

Primary & Behavioral Health Care Integration (PBHCI)

SAMHSA provided funding for the Primary & Behavioral Health Care Integration (PBHCI) program beginning in FY 2009 to address the increased rates of morbidity and mortality among adults with serious mental illness (SMI). These rates are due, in large part, to elevated incidence and prevalence of cardiovascular disease, obesity, diabetes, hypertension, and dyslipidemia in people with SMI. Increased morbidity and mortality can be attributed to a number of other issues, including inadequate physical activity and poor nutrition, smoking, side effects from atypical antipsychotic medications, and lack of access to primary health care services. Many of these health conditions are preventable through routine health promotion activities, primary care screening, monitoring, treatment, and care management/coordination strategies and/or other outreach programs at home or community sites. Physical health problems among people with SMI impact quality of life and contribute to premature death. While several factors contribute to this disparity, empirical findings indicate that early mortality among people with SMI is clearly linked to the lack of access to primary care services.

The PBHCI program supports SAMHSA's Health Reform Strategic Initiative and is comprised of competitive cooperative agreements and the PBHCI Training and Technical Assistance (TTA) Center which is co-funded with HRSA. The program supports the coordination and integration of primary care services into publicly-funded community behavioral health settings. This program is also a part of SAMHSA's Health Reform Strategic Initiative. The expected outcome of improved health status for people with SMI 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, as well as information technology entities, are deemed crucial to the success of this program. The population of focus for this grant program is individuals with SMI and/or people with co-occurring disorders served by the public mental health system. Recipients are non-profit mental health provider agencies that will use these grant funds to develop and offer primary care as well as behavioral health services in an integrated manner.

In FY 2011, $35 million was allocated from the Prevention and Public Health Fund for PBHCI to promote more integrated services between primary care services and mental health services. These funds were used to facilitate screening and referral for necessary primary care prevention and treatment needs. SAMHSA funded eight new multi-year funded PBHCI grants and 34 continuation grants with Prevention and Public Health Funds and 22 grants and one contract continuation with Budget Authority.

In FY 2012, SAMHSA supported 56 existing grants; 20 new multi-year funded grants and 10 new annually funded grants from SAMHSA Budget Authority and Prevention and Public Health Fund ($30.8 million in Budget Authority and $35 million in Prevention and Public Health Funds) as well as $1.9 million for the continuation of PBHCI Training and Technical Assistance (TTA) Center.

In FY 2013, SAMHSA awarded continuation of the program and awarded seven new grants. SAMHSA has awarded 100 PBHCI grants to date including the FY 2013 cohort.

Over 33,000 consumers were served in FY 2013, an increase of 43.5 percent over FY 2012. Improvements in all four National Outcome Measures were consistently positive as a result of this intervention. Of particular importance were the increases in measures of functioning and education/employment, demonstrating that the program supports health and productivity.

The following health indicators, as of April 2013, show improvements in program participants' physical health:

- Blood pressure: 17.4 percent of program participants showed some improvement in this biomarker. For 16.2 percent of program participants, their blood pressure improved enough that it was no longer a risk factor for hypertension.
- Blood glucose: 36.8 percent of program participants showed some improvement in this biomarker. For 10.4 percent of program participants, their blood glucose improved enough that it was no longer a risk factor for diabetes.
- HgBA1c: 40.4 percent of program participants showed some improvement in this biomarker. For 9.3 percent of program participants, their HgBA1c improved enough that it was no longer a risk factor for diabetes.
- HDL: 38 percent of program participants showed some improvement in this biomarker. For 8.9 of program participants, their HDL improved enough that it was no longer a risk factor for high cholesterol.
- LDL: 41.9 percent of program participants showed some improvement in this biomarker. For 10.7 percent of program participants, their LDL improved enough that it was no longer a risk factor for high cholesterol.
- Triglycerides: 41.1 percent of program participants showed some improvement in this biomarker. For 11.3 percent of program participants, their triglycerides improved enough it was no longer a risk factor for hyperlipidemia.

In FY 2014, SAMHSA plans to support continuation grants as well as award a new cohort of PBHCI grants and one technical assistance contract.

Suicide Prevention Programs

National Strategy for Suicide Prevention

SAMHSA supports the goals and objectives of the National Strategy for Suicide Prevention (NSSP) though several programmatic activities. The SAMHSA Suicide Prevention Resource Center provides support to the joint effort between the Office of the Surgeon General and the National Action Alliance for Suicide Prevention which has revised the NSSP to serve as the nation's blueprint for reducing suicide over the next decade. The SAMHSA supported Suicide Prevention Lifeline facilitates key NSSP objectives related to crisis intervention, follow up of high risk suicidal individuals, post discharge continuity of care, and the use of social networking to reach those at risk. Through the SAMHSA Garrett Lee Smith Suicide Prevention grant programs, states, tribes, and colleges are supported in implementing NSSP goals related to suicide prevention education and training as well as comprehensive, community-based approaches to youth suicide prevention.

In 2008, suicide became the tenth leading cause of death in the U.S. and has remained so through 2010, the most recent year for which there is available mortality data. Previously, suicide had been the eleventh leading cause of death. In 2012, SAMHSA's National Survey on Drug Use and Health reported that over 1.3 million Americans over the age of 18 attempted suicide and nine million had seriously considered it. Research, however, has shown that implementing comprehensive public health approaches that make suicide prevention a priority within health and community systems can reduce the rates of death by suicide as well as suicide attempts.

While youths have the highest rates of suicide attempts, middle aged adults have the highest number of deaths by suicide nationwide, and older adults have the highest rates of death by suicide. In 2010 more than 70 percent of the suicides in the U.S. took place among adults between ages 25-64. The nation's suicide prevention efforts must go beyond youth and address the issues of suicidal thoughts, plans, attempts, and deaths among adults. The NSSP addresses all age groups and specific populations with specific needs (e.g. military families, LGBT youth, Native American youth). The various aspects of the NSSP must be implemented to accomplish the goal of turning around the annual growth in deaths by suicide, and actually reducing that number significantly over the next few years. SAMHSA's role as both a payer and a director of standards of care throughout much of the nation's health care delivery system is key to this effort.

National Suicide Prevention Lifeline

Launched in FY 2005, the National Suicide Prevention Lifeline, 1-800-273-TALK, coordinates a network of 160 crisis centers across the United States by providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night. The Lifeline routes calls from anywhere in the country to a network of certified local crisis centers that can then link callers to local emergency, mental health, and social services resources, The Lifeline averaged 94,183 calls per month in 2013, including a peak of 104,754 calls in December. National Suicide Prevention Lifeline crisis centers across the nation are responding to people in suicidal crises. SAMHSA evaluation studies have found that when a sample of suicidal callers to the Lifeline are asked "to what extent did calling the crisis hotline stop you from killing yourself?" 69 percent respond "a lot" and 21.6 percent respond "a little". At the same time, these centers are threatened with significant cutbacks in funding from state and local governments and other sources of support.

Since FY 2007, SAMHSA has partnered with the Department of Veterans Affairs (VA) to provide and ensure that Veterans calling the Lifeline have 24/7 access to a specialized Veterans' suicide prevention hotline. In FY 2013, more than 26,943 callers per month were seamlessly connected to the Veterans crisis line. The National Suicide Prevention Lifeline is also responding to calls from active duty military and their families. 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.

In addition, in FY 2012, SAMHSA awarded a new Suicide Lifeline grant and provided continuation support for 12 National Suicide Prevention Lifeline Crisis Center grants to provide follow up to suicidal callers. Evaluation and research findings indicated that in the immediate

aftermath of suicidal crises, there is a period of heightened risk for suicide, but in this time there is a great potential for suicide prevention. Preliminary data from this program indicated that when asked by an independent evaluator, "To what extent did the counselor's calling you stop you from killing yourself?" more than 50 percent of those receiving follow-up phone contact indicated the call played a significant role in keeping them alive.

The National Suicide Prevention Lifeline uses evaluation results to document and improve program effectiveness. Evaluation results have been used to develop standards for suicide risk assessment, guidelines for callers at imminent risk for suicide, and follow up protocols for suicidal callers. In turn, these quality and performance improvement efforts have been evaluated and found to have positive impacts. Some of these outcomes have included decreases in suicidal ideation and hopelessness among callers, increased frequency of performing suicide risk assessments by crisis counselors, increased follow up of suicidal callers by crisis centers, and suicidal callers reporting such calls played a significant role in keeping them alive.

In FY 2013, SAMHSA awarded the continuation of the Suicide Lifeline grant and grants to crisis centers. In addition, 12 new crisis center grants were awarded, which will include a focus on providing follow up to suicidal people discharged from emergency rooms and inpatient units. This focus is based on current evaluation and research findings. In FY 2014, SAMHSA plans to award continuation grants and contracts as well as award a supplement to Suicide Lifeline from Prevention and Public Health Fund.

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GLS Youth Suicide Prevention

The Garrett Lee Smith (GLS) Memorial Act authorizes SAMHSA to manage two significant youth suicide prevention programs and one resource center. The GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program currently supports a total of 68 grantees which includes four multi-year funded grants in FY 2011, three multi-year funded grants in FY 2012, and 61 annually funded grants, 31 states, 29 tribes or tribal organizations, and the District of Columbia 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 82 institutions of higher education, inclusive of tribal colleges and universities, which includes five multi-year funded grants in FY 2011, 15 multi-year funded grants in FY 2012, four multi-year funded grants in FY 2013 and 58 annually funded grants, to prevent suicide and suicide attempts.

In FY 2012, through Budget Authority, SAMHSA provided support for 34 GLS state/tribal continuation grants and awarded 20 new grants. In addition, SAMHSA supported 16 GLS campus continuation grants and awarded 24 new grants.

In FY 2012, SAMHSA also received $10 million in Prevention and Public Health Fund, which supported the GLS grants, the National Suicide Prevention Lifeline, and the Suicide Prevention Resource Center. Three grants were multi-year funded for the GLS state/tribal grantees and 15 grants were multi-year funded for the campus grantees.

As of July 2013, 592,580 individuals had participated in 21,433 training events or educational seminars provided by grantees. Grantees often used their funds to provide suicide prevention trainings in their communities. The most common approach was gatekeeper training, designed to help trainees recognize suicide risk in young people, address the immediate needs of the youths, and refer youths to appropriate services. Over one third of 34.5 percent (n = 204,351) of trainees were trained through campus-sponsored trainings and educational seminars. Over half of trainees 61.0 percent (n = 361,765) participated in State-sponsored and 4.5 percent (n = 26,464) in tribal-sponsored training activities.

In FY 2013, SAMHSA provided support for the continuation of existing state/tribal and campus grantees and awarded seven new GLS State/Tribal grants and 22 GLS Campus grants.

In FY 2014, SAMHSA plans to continue support both GLS State/Tribal and GLS Campus programs and anticipates awarding 24 new GLS State/Tribal grants, 15 new GLS Campus, and one new evaluation contract.

Suicide Prevention Resource Center

In addition to programs that build suicide prevention capacity, SAMHSA also supports the Suicide Prevention Resource Center (SPRC). This program promotes the implementation of the National Strategy for Suicide Prevention and enhances the nation's mental health infrastructure by providing states, tribes, 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 SPRC also advances youth suicide prevention efforts in states, territories, tribes, and campuses as authorized through the Garrett Lee Smith (GLS) Memorial Act.

Through the SPRC, SAMHSA continues to provide support for the National Action Alliance for Suicide Prevention (NAASP), a public-private partnership to implement the National Strategy for Suicide Prevention and reduce suicide in America. The NAASP was launched on September 10, 2010, by HHS Secretary Kathleen Sebelius and the former Secretary of Defense, Robert Gates.

In FY 2011, SAMHSA received $10 million in Prevention and Public Health Fund, from which SAMHSA funded one supplement to the SPRC of $0.7 million to expand and enhance the level of support provided to the NAASP. This supplement expanded future organizational

development, partnerships, and collaborations to support the implementation of the Surgeon General's National Strategy for Suicide Prevention.

In FY 2012, SAMHSA utilized Prevention and Public Health Fund for the SPRC to help support implementation of high impact objectives identified by the National Strategy for Suicide Prevention and the NAASP and to develop, based on the experience of GLS grantees, a strategic framework to embed sustainable, comprehensive, coordinated youth suicide prevention activities in states, tribes, and colleges across the nation.

In FY 2013, SAMHSA provided support for the continuation of the SPRC grant with a reduced level of support for the NAASP as it transitions to alternate sources of funding. In FY 2014, SAMHSA plans to fund the continuation of the SPRC grant and a supplement from Prevention and Public Health Fund.

AI/AN Suicide Prevention

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 (AI/AN) youth. To date, 65 tribal communities have been provided specialized technical assistance and support in suicide prevention and related topic areas. In addition, over 9,200 community members were trained in prevention and mental health promotion in these communities.

In FY 2013, SAMHSA's CMHS AI/AN Suicide Prevention and CSAP's Native American Center for Excellence programs collaborated through braided funding to provide comprehensive, broad, focused, and/or intensive training and technical assistance to federally-recognized tribes and other American Indian/Alaska Native communities, seeking to address and prevent mental and substance use disorders, suicide, and promote mental health. Any braided amounts spent or awarded are being tracked as distinct funding streams and used for purposes consistent with legislative direction and intent. In FY 2014, SAMHSA plans to support the continuation of the jointly funded contract.

Homelessness Prevention and Housing Program

One of the goals of SAMHSA's Strategic Initiative on Recovery Support is to ensure that permanent housing and supportive services are available for individuals with mental and substance use disorders. Two programs are helping to support the goal of this Strategic Initiative. They include Services in Supportive Housing (SSH) and Grants for the Benefit of Homeless Individuals (GBHI) which are supported by both CSAT and CMHS.

Studies indicate that Permanent Supportive Housing (PSH) is effective in helping *single adults* (target population) maintain stability in housing. Performance data for the CMHS Services in Supportive Housing (SSH) program demonstrate increases in individual's perception of their overall functioning as well as decreases in serious psychological distress, use of tobacco

products, binge drinking and criminal justice system involvement and an increased retention in stable housing.

The first program, SSH, implemented in 2007, provides comprehensive services that focus on outreach, engagement, intensive case management, mental health services, substance abuse treatment, benefits support, and linkage to permanent housing. Individuals with serious mental illness and/or a co-occurring mental and substance use disorder and their families who have been continuously homeless for at least one year or have had at least four episodes of homelessness in the past three years are the population of focus. In FY 2013, the SSH program's outreach efforts resulted in 49,821 total contacts made. In FY 2012, SAMHSA provided support for 51 SSH grants. In FY 2013, SAMHSA provided support for 48 grants.

The second program, GBHI, awarded the Cooperative Agreements to Benefit Homeless Individuals (CABHI) in FY 2011 by CSAT in collaboration with CMHS. The purpose of this jointly funded program is to enhance or develop the infrastructure of states and their treatment service systems to increase capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services; permanent supportive housing; peer supports; CMHS-funded peer navigator(s); and other critical services to persons who experience chronic homelessness with substance use disorders or co-occurring substance use and mental disorders. This program builds on the success of the previous SAMHSA SSH and CSAT's Treatment for Homeless programs. As of FY 2013, there are 42 funded grants that have served 1,939 people with notable evidence of reduced experiences of depression and anxiety (62.5 percent and 66.2 percent respectively).

In FY 2013, CMHS awarded 31 jointly funded CABHI grants with CSAT. In addition, SAMHSA awarded another 11 CABHI grants, which provided grants to states with the highest prevalence of individuals who are chronically homeless.

In FY 2014, SAMHSA will work in partnership with the U.S. Interagency Council on Homelessness (USICH) to support and implement *Opening Doors: The Federal Plan to Prevent and End Homelessness.* Through both the Recovery Support and Criminal Justice and Trauma Strategic Initiatives, SAMHSA promotes collaborative leadership with other federal agencies with collaborative calls, trainings, workgroups, and expert panels to address various goals and objectives outlined in the Plan. SAMHSA accomplishes the goals and objectives outlined in the Plan by providing technical assistance to grantees and other stakeholders regarding behavioral health, homelessness, and successful interventions to prevent and end homelessness. The SAMHSA CABHI grant program aligns with the USICH goal to improve access to mainstream programs and services to reduce people's financial vulnerability to homelessness and to provide integrated primary and behavioral health care services. SAMHSA along with other HHS agencies, HUD, and VA will explore the possibility of developing criteria to incentivize demonstrated collaboration between primary and behavioral healthcare providers and homeless assistance providers.

SAMHSA proposes to use approximately $21 million in Budget Authority in working with state and local Public Housing Authorities and state Medicaid agencies to develop systematic, cost-effective, and integrated approaches to housing and behavioral health treatment and services for

mental and substance use disorders. This program will build upon lessons learned from the CABHI and the Department of Housing and Urban Development's (HUD) new Section 811 demonstration program, and will be developed by SAMHSA in collaboration with its federal partners, including HUD, Health Resources and Services Administration, Centers for Medicare and Medicaid Services, and the Interagency Council on Homelessness.

The program will support innovative strategies to increase the availability of affordable housing combined with access to and behavioral health treatment services and supports that will help integrate individuals who are homeless with substance abuse and mental health disorders into the community, and assist providers in strengthening their infrastructure for delivering and sustaining housing integrated behavioral health and other critical services to support recovery. The program also will assist providers in preparing for implementation of the Affordable Care Act by encouraging third-party billing and requiring that clients are enrolled in eligible benefit programs. Efforts will include the design and implementation of strategies that require the use of SAMHSA funds for providing supportive services to the most needy individuals who are not Medicaid-eligible (or who in the process of being enrolled), Medicaid funds for covered services, and HUD vouchers or other funding sources for housing. The FY 2014 funding will support up to 19 grant awards of approximately $1.2 million dollars each. They will be awarded for three years.

Minority AIDS

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 people living with HIV/AIDS and who have a need for mental health services. The Centers for Disease Control and Prevention (CDC) reports significantly higher rates of HIV/AIDS among people of color. African Americans accounted for 44 percent and Hispanics accounted for 20 percent of all HIV/AIDS cases diagnosed in 2009, per the most recent data available (CDC, 2011). The 2009 data also shows a significant increase of 48 percent in HIV incidence among African American Men who have Sex with Men (MSM) aged 13-29, even as overall rates remained stable. Reasons for this increase are not fully known, although the high HIV prevalence rate in African American MSM and factors such as prejudice and discrimination, limited healthcare access, and poverty may create an enabling environment for HIV (CDC 2011). Psychiatric and psychosocial complications are frequently not diagnosed or addressed 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. Over 3,900 individuals received services in FY 2012 and over 3,800 received services in FY 2013. The Mental Health Care Provider Education in HIV/AID Education program disseminates knowledge and training on the treatment of the neuropsychiatric and psychological sequelae of HIV/AIDS. The program provides training to front line providers, including psychiatrists, psychologists, social workers, primary care practitioners and medical students.

In FY 2012, SAMHSA collaborated with CDC to provide support for 11 continuation grants for the Minority AIDS Initiative Targeted Capacity Expansion: Integrated Behavioral Health/Primary Care Network Cooperative Agreements with funding provided by CMHS,

CSAT, and CSAP. This grant program facilitates the development and expansion of culturally competent and effective integrated behavioral health and primary care networks, which include HIV services, medical treatment, and the expansion of behavioral health services within racial and ethnic minority communities in 11 Metropolitan Statistical Areas and Metropolitan Divisions most impacted by HIV/AIDS. Recipients are state and city health departments from the 12 cities most impacted by HIV/AIDS. The grant fosters development of a network of care for those with behavioral health conditions who are at risk for or who have HIV/AIDS.

In FY 2013, SAMHSA provided funding for the continuation of 11 grants as well as evaluation and technical assistance contracts.

In FY 2014, SAMHSA's CMHS, CSAP, and CSAT plan to pilot HIV Continuum of Care grants which supports behavioral health screening, primary prevention, and treatment for racial/ethnic minority populations with or at high risk for mental and substance use disorders and HIV. This will include Substance Abuse (SA) primary prevention/treatment service programs, community mental health programs, and HIV integrated programs that can either co-locate or fully integrate HIV prevention and medical care services within them. Also, this program will provide SA and HIV primary prevention services in local communities served by the behavioral health program.

Criminal and Juvenile Justice Programs

Studies of people involved in the criminal justice system have found higher rates of co-occurring psychiatric and substance use disorders than the general population.[2] The number of individuals involved in the criminal justice system with mental or substance use disorders whose treatment needs are not being met by community treatment and supportive services is significant. As a result, they are at greater risk for parole or probation failure leading to re-incarceration at substantial additional governmental and societal cost. There is an ongoing need for broader implementation of effective treatment and reentry services for this high-risk, mostly nonviolent population.

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.[3] Since 2002, SAMHSA has administered the Jail Diversion Program for adults involved in the criminal justice system and has awarded grants to 51 states and communities. 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 services including primary health care, housing, and job counseling/placement.

In FY 2013, SAMHSA funded the continuation of seven grants and the evaluation and technical assistance contracts. In FY 2013, SAMHSA awarded three new grants of the Jail Diversion Program. This three-year grant program will emphasize on early diversion of individuals with behavioral health conditions at risk of being arrested. Early diversion will focus on the role of law enforcement working collaboratively with community behavioral health providers to prevent arrest and adjudication. Police will divert these individuals to behavioral health providers in the

[2] *Serious Mental Illness and Arrest*, Swartz and Lurigio, 2007
[3] *Id.*

community who will assess their needs and coordinate a comprehensive plan of treatment and supports. Performance data demonstrate that the program has had a positive impact on the welfare of participants with significant increases in housing stability and employment and with major reductions in arrests and incarcerations.

In FY 2014, and in support of SAMHSA's Recovery Support Strategic Initiative, a total of $5.4 million in Budget Authority ($2.5 million in CMHS and $2.9 million in CSAT) will fund an additional cohort of Behavioral Health Treatment Court Collaborative Grants. The purpose of this grant program is to allow local courts more flexibility to collaborate with multiple criminal justice system components and local community treatment and recovery providers to address the behavioral health needs of adults who are involved with the criminal justice system. The court collaborative will focus on diversion of adults with behavioral health problems from the criminal justice system, including alternatives to incarceration. The collaborative will allow eligible individuals to receive treatment and recovery support services as part of a court collaborative. This program will focus on connecting with individuals early in their involvement with the criminal justice system and prioritize the participation of municipal and misdemeanor courts in the collaborative. The program will support community behavioral health services for individuals with mental and/or substance disorders and will include a focus on veterans involved with the criminal justice system.

Practice Improvement and Training

SAMHSA addresses the need for disseminating key information, such as evidence-based mental health practices, to the mental health delivery system and facilitates health reform by engaging in activities that support mental health system transformation and reform. These activities include Historically Black Colleges and Universities (HBCU) – Center of Excellence and Peer Review activities, Research and Training Centers, and Recovery into Practice.

The purpose of the HBCU-Center of Excellence is to network the 103 HBCUs in the United States and promote workforce development through expanding knowledge of best practices, developing leadership, 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. There is one grant awarded for the HBCU-Center for Excellence. In FY 2013, SAMHSA provided continuation support to the grantee for the coordination and monitoring of 34 substance abuse treatment workforce development and mental health sub-award projects. In FY14, a new grant will be awarded.

In FY 2012, as part of its wellness activities, SAMHSA collaborated with the CDC on its Million Hearts Initiative by focusing on the increased risk for cardiovascular disease, hypertension, and diabetes for individuals with and at risk for mental and substance use disorders. In FY 13, SAMHSA continued its collaboration with CDC and will do so in FY 2014.

The Rehabilitation Research and Training Centers (RRTCs) are funded in partnership with the U.S. Department of Education's National Institute of Disability, Rehabilitation and Research. The RTCs develop, test, and disseminate a broad range of care models and practices that

promote and support recovery for adults with mental illnesses and support resilience and recovery among youth and young adults with serious mental health challenges. This program was first established in 1979. Currently there are two RRTCs funded for up to five years. Program outcomes include the development of new treatments and interventions, trainings, workforce development, and new products. SAMHSA plans to continue these Centers in FY 2013 and FY 2014.

Recovery into Practice is a five-year contract, funded in FY 2009, which supports the expansion and integration of recovery-oriented care delivered by mental health providers which will be accomplished through training and education, policy and analysis, and materials development. The effort collaborates amongst professional mental health disciplines to provide education and training on what recovery-oriented care is and how to implement it into practice, meet with stakeholders, establish collaborative relations with provider and consumer leaders, and conduct research and literature reviews on the current state of recovery-oriented care, knowledge, and attitudes. In FY 2013, SAMHSA funded the continuation of this contract and plans to recompete the contract in FY 2014.

Consumer and Consumer-Supporter TA Centers

The Consumer and Consumer-Supporter TA Centers is a grant program that was first funded in 1992. The purpose of Consumer and Consumer-Supported TA Centers is to provide technical assistance to facilitate the restructuring of the mental health system by promoting consumer directed approaches for adults with serious mental illnesses. Such programs maximize consumer self-determination and recovery and assist individuals with serious mental illness by decreasing their dependence on expensive social services and avoiding unnecessary or inappropriate psychiatric hospitalization. This program also improves collaboration among consumers, families, advocates, providers, and administrators and facilitates community mental health services to be more consumer-driven and family-focused.

This program also supports the annual Alternatives Conference, which provides a forum for consumers nationwide to meet, exchange information and lessons learned, and receive technical assistance on a variety of topics, such as peer support, consumer-operated services, self-help, protection and advocacy issues, empowerment, and recovery. The information and knowledge gained through attending this conference enables consumers to support effective individual treatments and services, as well as for broader managed care and service system improvements.

Performance data indicate that the program has been effective. In FY 2013, over 7,736 persons were trained and more than 1,034 consumers and family members have become involved in mental health-related planning and advocacy.

In FY 2013, SAMHSA provided support to the five continuation grants and plans to continue this support in FY 2014.

Disaster Response

Over the last 39 years, SAMHSA, in partnership with the FEMA (Federal Emergency Management Agency) has been providing Disaster Behavioral Health Response and Recovery efforts through the FEMA Crisis Counseling Assistance and Training Program (CCP).

The mission of CCP is to assist individuals and communities in recovering from challenging effects of natural and human-caused disasters through the provision of community-based outreach and psycho-educational services. The CCP supports short-term interventions that involve the counseling goals of assisting disaster survivors in understanding their current situation and reactions, mitigating stress, assisting survivors in reviewing their disaster recovery options, promoting the use or development of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies who may help survivors in their recovery process.

The CCP is administered through an interagency agreement with FEMA. On behalf of FEMA, CMHS provides technical assistance, program guidance and monitoring, as well as oversight of the CCP. States, U.S. territories and federally recognized tribes are eligible to apply for CCP grants under the Stafford Act, with a designation for Individual Assistance in the affected areas, following a Presidential disaster declaration.

SAMHSA and FEMA jointly fund a Disaster Technical Assistance Center (DTAC) that provides technical assistance, strategic planning, consultation, and logistical support. Through these services, it helps states establish state-of-the-art behavioral health readiness and response capacity through "all hazards" disaster planning to respond readily to catastrophic events and emergencies such as those resulting from bioterrorism, mass violence, natural disaster, and other traumatic incidents. SAMHSA DTAC provides consultation to review disaster plans and compiles research on new threats and how best to plan for them. Services include a wide range of technical assistance activities and products to advance state and local capacity to deliver effective behavioral health services that are well integrated with traditional public health and disaster recovery efforts.

The SAMHSA's Disaster Distress Helpline (DDH) is the first national hotline dedicated to providing year-round disaster crisis counseling. This toll-free, multilingual crisis support service is available 24/7 via telephone (1-800-985-5990) and SMS (text 'TalkWithUs' to 66746) to residents in the United States and its territories who are experiencing emotional distress related to natural or man-made disasters. In FY 2013, the Disaster Distress Helpline (DDH) received 6,436 calls and 7,848 text messages from 720 users. Four Core Regional Centers implemented trainings for 281 paid staff, interns and volunteers. The helpline established relationships with 275 local, state and national disaster relief stakeholders. The Disaster Distress Helpline website (http://disasterdistress.samhsa.gov) had 31,962 unique visits and the DDH Facebook and Twitter pages grew by 1,612 (to 3,429) and 1,521 (to 2,061) followers and likes, respectively.

When disasters strike, the role of behavioral health in recovery is immense. In 2013, SAMHSA received a total of $7.5 million in supplemental funds to assist the survivors of Hurricane Sandy recovery. Efforts focused on providing behavioral health treatment that could be funded no other

way, restoring the capability of medication assisted substance abuse treatment services in the impacted areas, ensuring the operation of the DDH, conducting resiliency training with educators, and ensuring crisis counseling services wherever Sandy survivors relocated.

Tribal Behavioral Health Grants

In FY 2014, Congress appropriated $5 million to address the high incidence of substance abuse and suicide in American Indian/Alaska Native (AI/AN) populations. The Appropriations Committee recommended that HHS use the funding for competitively awarded grants targeting tribal entities with the highest rates of suicide per capita over the past 10 years for effective and promising strategies that address the problems of substance abuse and suicide and promote mental health among AI/AN young people.

In 2010, the suicide rate among AI/AN age 8 to 24 was 14.98 per 100,000, more than twice the suicide rate for all races of the same age (7.29). Suicide is the second leading cause of death among AI/AN youth of that age group. Furthermore, AI/AN high school students report higher rates of suicidal behaviors (serious thoughts of suicide, making suicide plans, attempting suicide, and getting medical attention for a suicide attempt) than the general population of U.S. high school students. Lifetime rates of having attempted suicide are higher for AI/AN youth raised on reservations than for those raised in urban areas (17.6 percent vs. 14.3 percent), and lifetime rates of suicidal ideation were significantly higher among youth raised on reservations (32.6 percent) compared to youth raised in urban areas (21 percent).

In 2012, past month illicit drug abuse was highest among AI/AN youth ages 12-17 (12.1 percent), as is past month tobacco use (18.3 percent), compared to others in this age group. Consultation sessions with AI/AN tribal leaders in 2010, 2011, and 2012 indicated the issues of suicide and substance abuse to be the two biggest issues affected the mental health of tribal young people, and that these two issues are often experienced together among youth in tribal communities. Prescription drug abuse was also a growing concern for tribal leaders, with 4.7 percent of AI/AN youth ages 12-17 acknowledging nonmedical use of prescription drugs - and 3.0 percent acknowledging nonmedical use of pain relievers - in the past month, the highest of any group

SAMHSA will competitively award Tribal Behavioral Health Grants of up to $0.2 million to approximately 20 tribes or tribal organizations with high rates of suicide to develop and implement a plan that addresses suicide and substance abuse (including alcohol), designed to promote mental health among tribal youth. Grantees will indicate how they will incorporate evidence-based, culture-based, and practice-based strategies for tribal youth in age ranges they choose to address, up to age 24. Grantees will indicate how the strategies they choose are designed to prevent suicidal thoughts, plans and attempts among the selected tribal youth, and how they will connect promotion of positive mental health to prevention of suicide and substance abuse and how they will identify, refer, and provide assistance for tribal youth with or at risk of substance abuse and suicidal ideation, and their families. Grantees will be expected to provide or arrange for intervention and follow up with those youth who have made suicide attempts. The plan must include the development of a sustainable infrastructure.

Grantees will be required to work across tribal suicide prevention, mental health, substance abuse prevention, and substance abuse treatment programs to build positive behavioral health among youth. Using real-time surveillance data of suicide deaths and attempts, grantees will create or enhance effective systems of follow up for those identified at risk of suicide and/or substance abuse or mental health issues that could lead to suicide. With a focus on tribal traditions, interagency collaboration, early identification, community healing, and preventing future deaths by suicide, grantees will connect appropriate cultural practices, intervention services, care, and information with families, friends, schools, educational institutions, correctional systems, substance abuse programs, mental health programs, foster care systems, and other support organizations for tribal youth. Attention to the families and friends of tribal community members who recently died by suicide will be encouraged.

In addition, technical assistance will be provided to grantees through SAMHSA's Tribal Technical Assistance Center to support their ability to achieve their goals. An evaluation component will allow grantees and SAMHSA to work collaboratively to monitor progress, learn from each other, and incorporate lessons learned into enhancing the program and into national efforts to reduce suicide and substance abuse and build positive mental health among AI/AN Americans.

Funding History[1\]

Fiscal Year	Amount
FY 2011	$340,847,774
FY 2012	$315,666,472
FY 2013	$266,508,991
FY 2014	$378,216,000
FY 2015	$354,740,000

[1\]The funding history is presented on a comparable basis to previous funding levels to represent the revised budget structure and includes the PHS Evaluation Fund and Prevention and Public Health Funds.

Budget Request

The FY 2015 Budget Request is $354.7 million at the program level with $311.7 million from Budget Authority, $38 million from Prevention and Public Health Fund, and $5 million from PHS Evaluation Funds. This is an overall decrease of $23.5 million from the FY 2014 Enacted Level which includes a decrease of $54.5 million in Budget Authority, an increase of $26 million in Prevention and Public Health Funds, and an increase of $5 million in PHS Evaluation Fund. This level of funding will support the continuation of all programmatic activities and four new activities: HIV Continuum of Care, Building Behavioral Health Coalitions, CABHI and Health Information Technology, as well as a new program, Grants for Adult Trauma Screening and Brief Intervention. The request includes:

Minority AIDS Initiative and Primary and Behavioral Health Care Integration

HIV Continuum of Care Pilot

(Braided program with Substance Abuse Treatment: Minority AIDS Initiative and Primary Care and Addiction Services Integration and with Substance Abuse Prevention: Minority AIDS Initiative)

SAMHSA expects that data generated from the 2014 HIV Continuum of Care pilot grant will help to inform an expanded program proposed for 2015 to continue the co-location and integrated HIV/primary care within either substance abuse or community mental health treatment programs. Braided funds in 2015 in the amount of $24 million would be dedicated to establishing integrated behavioral health and HIV care in addition to primary care needed by those living with or at high risk for HIV infection in minority communities heavily impacted by HIV. In addition, because of the significant comorbidity of viral hepatitis with HIV infection and because viral hepatitis occurs in up to 20% of those with either substance use disorders or serious mental illness, 5% of the allocated funds will be used to provide services to prevent, screen, test and refer to treatment as clinically appropriate those at risk for or living with viral hepatitis. SAMHSA will work closely with CDC and HRSA to ensure these efforts are complimentary and not duplicative. In integrating HIV care into behavioral health settings, people living with HIV/AIDS and M/SUDs will have greater access to treatment for these conditions. Integrated care programs developed as a result of this grant program will make it possible for behavioral health and HIV care needs to be addressed in one setting. This will result in effective, person-centered, treatment that will reduce the risk of HIV transmission, improve outcomes for those living with HIV, and ultimately reduce new infections. SAMHSA's Common Data platform (CDP), now under development, will integrate substance abuse and mental health elements with HIV and Hepatitis elements to ensure a more rigorous evaluation and data analysis to inform future public health intervention decision-making that addresses the intersection of behavioral health and HIV.

Mental Health System Transformation and Health Reform

SAMHSA will continue to engage in activities that support the transformation of the mental health system in alignment with the implementation of coverage expansions for mental health and substance abuse services contained in the Affordable Care Act and Mental Health Parity and Addiction Equity Act. In FY 2015, these activities include the Mental Health Transformation Grant Program and Building Behavioral Health Coalitions; Working to Address Shared Risk and Protective Factors.

Mental Health System Transformation Grants

In support of SAMHSA's Recovery Support Strategic Initiative, SAMHSA proposes to use approximately $5.2 million to award a new cohort of Mental Health Transformation Grants (MHTG). The purpose of the MHTG grant program is to foster adoption and implementation of permanent transformative changes in how public mental health services are organized, managed and delivered so that they are consumer-driven, recovery-oriented and supported through

evidence-based and best practices. The new grants will allow applicants to expand their service capacity to address emerging needs, including the need for crisis support and response services. Specifically, the new MHTG will demonstrate the continuum of services most helpful in improving community capacity to respond to psychiatric crises and reduce the need for use of in-patient services by adults with serious mental illness (SMI) or children/youth with serious emotional disturbance (SED).

Building Behavioral Health Coalitions:
Working to Address Shared Risk and Protective Factors
(Braided program with Substance Abuse Prevention: Strategic Prevention Framework)

In support of SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, SAMHSA proposes to use $3 million in Budget Authority to establish the Building Behavioral Health Coalitions program. SAMHSA will use $1.5 million from Mental Health Appropriation's Mental Health Transformation and Health Reform funds and $1.5 million from Substance Abuse Prevention Appropriation's Strategic Prevention Framework funds to support this new initiative. The purpose of this program is to support active community coalitions and/or organizations to expand their focus and activities to include mental health promotion, mental illness prevention and substance abuse prevention. Consistent with the Institute of Medicine's 2009 report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*, this program seeks to build on the emerging evidence that a significant number of mental, emotional and substance abuse problems in young people are largely preventable, and community-based prevention can play a significant role in facilitating key prevention efforts. Evidence shows that to create emotionally healthy communities, it is important to address the shared risk factors that contribute to an array of adverse outcomes, and the protective factors that reduce the risk of these negative consequences. Risk factors include poverty, early trauma, drug/alcohol misuse, family dysfunction, poor academic performance, and peer rejection. Protective factors include good communication skills, stress mitigation, reliable support and guidance from parents and caregivers, support for high quality early learning, quality health care, healthy peer groups, social connectedness, and successful learning environments.

Mental Health Transformation and Health Reform funds will be provided to substance abuse prevention community coalitions (including, but not limited to, current and former Drug Free Communities grantees) and organizations to expand their activities to include mental health promotion and mental illness prevention, and Strategic Prevention Framework funds will be provided to coalitions and organizations with a mental health focus to expand their activities to include substance abuse prevention. Funding streams will be kept separate and used for activities consistent with separate funding authorities.

Funded activities may include but are not limited to, bi-directional education on substance abuse prevention and mental health promotion; assessing shared community risk and protective factors, especially among youth, connecting across community service systems including primary care, and developing the capacity to jointly implement evidence-based programming that addresses these factors; and working with stakeholders such as health insurance companies, Marketplaces, and state Medicaid officials to promote health insurance coverage for substance abuse prevention and mental health promotion. Grantees will be encouraged to consider best

practices and models developed through other community-level programs such as Drug Free Communities, Safe Schools/Healthy Students, and Project LAUNCH.

Homelessness Prevention Programs

Housing and Homelessness

(Braided program with Substance Abuse Treatment: Treatment Systems for Homelessness)

In FY 2015, SAMHSA proposes to use approximately $13.2 million, for new programming related to homelessness (CSAT-$8 million; CMHS-$5.2 million). This includes funding approximately 15 grants at $0.8 million per year to build on lessons learned from the CABHI and CABHI-States programs which are designed to work with state and local partners including public housing authorities, Medicaid, Veteran's Affairs, behavioral health providers and other agencies to develop systematic, cost-effective, and integrated approaches to housing that includes treatment and services for mental and substance use disorders. The program will support innovative strategies to provide needed services and supports that will help integrate individuals who are experiencing homelessness with substance abuse and mental health disorders into the community, assist providers in strengthening their infrastructure for delivering and sustaining housing to support recovery with integrated behavioral health, and other critical services. The program also will support providers in the implementation of coverage expansions for mental health and substance abuse services. The program will also support recovery residences.

Funds will also be used to support a Homelessness Health Information Sharing pilot project. This program will pilot-test automated sharing of client information within and among health care providers and social service agencies by means of electronic health records (EHRs), homeless management information systems (HMIS), and other social service information systems. The pilots will address a number of policy and technology issues including: privacy policies for protecting sensitive information, interoperability across systems, development of data collection and reporting standards for information sharing, workflow integration, etc. This initiative builds on SAMHSA's current homelessness activities in both CSAT and CMHS and will be used to explore how technology can improve systems for addressing homelessness in community-based health systems for individuals with behavioral health conditions.

Grants for Adult Trauma Screening and Brief Intervention

Consistent with the Trauma and Justice Strategic Initiative, and the Women's Preventive Services recommended by the Institute of Medicine's (IOM), in FY 2015, SAMHSA requests to implement a new $2.9 million program line, Grants for Adult Trauma Screening and Brief Intervention (GATSBI). Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war, and other adverse experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of trauma significantly impact individuals, families, and communities and create challenges for public institutions and service systems. Although many individuals who

experience a potentially traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationship among traumatic events, impaired neurodevelopment and immune system responses, and subsequent health risk behaviors resulting in chronic physical and behavioral disorders. In fact, the chronic stress that often accompanies repeated or unresolved trauma has even been linked to physically observable negative changes in brain development, including a reduction in the size of the hippocampus, the portion of the brain associated with long-term memory and spatial reasoning. With appropriate supports and intervention, individuals can overcome traumatic experiences. However, most individuals go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders, chronic physical diseases, and early death.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of individuals in the juvenile and criminal justice systems reveal high rates of mental and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Preventing exposure to potentially traumatic events and responding with early interventions and treatment for those experiencing traumatic stress may improve outcomes for these individuals and prevent prolonged involvement with the justice and child welfare systems.

Previous research has shown that there is a strong need for a public health approach to addressing trauma and adverse childhood events. According to the Adverse Childhood Experiences Study (2008), more than one in four individuals have experienced multiple adverse childhood experiences (such as sexual and emotional abuse, divorce or having a parent with a substance use disorder), which makes them more likely to have higher rates of substance abuse, depression, and suicide than others. Thus, the GATSBI program will draw upon existing and effective screening frameworks in order to identify and intervene with adults that have experienced past trauma and/or adverse events.

The GATSBI program will advance the knowledge base to address trauma in common health care settings, such as emergency departments, primary care, and OB/GYN. The concept and design for these grants will be developed by SAMHSA in consultation with its federal partners: ACF, CDC, NIAAA, NIDA, NIMH, and VA. An estimated four grants will be awarded with up to $600,000 per year for five years.

The FY 2015 Budget Request also includes an increase in the following:

- The National Strategy for Suicide Prevention request is $4 million, an increase of $2 million from the FY 2014 Enacted Level. Consistent with SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, $2 million is requested to assist states in further establishing evidence-based suicide prevention efforts that support the goals and objectives of the NSSP. The requested $2 million will directly support the recommendations of the NSSP and allow for the implementation of elements of the NSSP that are not currently being addressed in any other national initiative. This year is critical in continuing the momentum achieved during the release of the National Strategy. Some states will require assistance in developing these plans required under the block grants as well as in collaborating with Medicaid, dual eligible, and health home efforts. The $2 million will be utilized to develop and test nationwide efforts such as suicide awareness, provider credentialing changes, emergency room referral processes, clinical care practice standards, practitioner training regarding depression and suicide screening techniques, and technical assistance for those community human services and health workers most likely to encounter those who may be thinking about suicide.
- Minority AIDS Budget Request is $16.3 million, an increase of $7 million from FY 2014 Enacted Level, which is offset by a decrease to the Substance Abuse Treatment MAI to continue the support of MAI as well as HIV Continuum of Care grants.
- Disaster Response Budget Request is $2.9 million, an increase of $1 million from the FY 2014 Enacted Level to continue the support of a nationally available disaster distress crisis counseling telephone line through a connection to local crisis lines throughout the country. The need for this initiative has been documented through the Assistant Secretary for Preparedness and Response after various emergency conditions throughout the world and after U.S. disasters that did not rise to the level of presidentially declared emergencies and, therefore, did not qualify for Stafford Act Funding. In addition, funding will continue to support DTAC contract which provides consultation to review disaster plans and compiles research on new threats and how best to plan for them. Services include a wide range of technical assistance activities and products to advance state and local capacity to deliver effective behavioral health services that are well integrated with traditional public health and disaster recovery efforts.

The FY 2015 Budget Request includes level funding from the FY 2014 Enacted Level for the programs below

- Seclusion and Restraint and Trauma: Funding is requested to continue support for dissemination of trauma informed practices across multiple services settings advancing the goal of reducing and eliminating the use of seclusion, restraint, and other traumatizing practices in service systems and treatment agencies.
- Youth Violence Prevention: Funding is requested to provide continued assistance to help students thrive, succeed in school, and build healthy relationships. Funds will provide continued support for state and community level partnerships among educational, behavioral health and juvenile justice systems and promote systems integration and collaboration.

- Project AWARE: Funding is requested to support increased awareness of mental health issues and connect young people with behavioral health issues and their families with needed services. Funds will provide support for the continuation of the partnerships with the Departments of Education and Justice in the development, implementation and management of this initiative to maximize coordination and avoid duplication of efforts.
- Healthy Transitions: Funding is requested to continue support for the newly developed demonstration grant program for states. This program proposes innovative approaches to provide support for transition-age youth with mental health and/or co-occurring substance abuse disorders and their families. States will take steps to expand services for these young individuals, develop family and youth networks for information sharing and peer support, and disseminate best practices for services to youth, ages 16-25, informing state systems and other programs serving transitional-aged youth.
- Children and Family Programs: Funding is requested to continue to support Children and Family programs which provide much needed services and support to children and youth with and at risk for mental health conditions and their families.
- Consumer and Family Network Grants: Funding is requested to support SAMHSA's Recovery Support Strategic Initiative by promoting consumer, family, and youth participation in the development of policies, programs, and quality assurance activities related to mental health systems reform across America.
- Project LAUNCH: Funding is requested to continue to support, creating a shared vision for the wellness of young children that drives the development of federal, state, territorial, tribal and local networks for the coordination of key child-serving systems and the integration of behavioral and physical health services. In addition, the funding will allow Project LAUNCH to improve health outcomes for young children and coordinate with other HHS partners on early learning and other relevant services for those living in communities with highly concentrated poverty.
- MH System Transformation and Health Reform: Funding is requested to continue to support Transforming Lives through Supported Employment Grant Program to focus the program on an existing activity: enhancing state and community capacity to provide evidence-based supported employment programs for adults and youth with serious mental illnesses/emotional disturbances.
- AI/AN Suicide Prevention Initiative: Funding is requested to continue support that provides comprehensive, broad, focused, and/or intensive training and technical assistance to federally-recognized tribes and other American Indian/Alaska Native communities, seeking to address and prevent mental and substance use disorders, suicide, and promote mental health.
- Homelessness Prevention Programs: Funding is requested to continue working in partnership with the U.S. Interagency Council on Homelessness (USICH) to support and implement *Opening Doors: The Federal Plan to Prevent and End Homelessness.* Through both the Recovery Support and Criminal Justice and Trauma Strategic Initiatives, SAMHSA promotes collaborative leadership with other federal agencies with collaborative calls, trainings, workgroups, and expert panels to address various goals and objectives outlined in the Plan.
- Criminal and Juvenile Justice Programs: Funding is requested to continue the support for allowing local courts more flexibility to collaborate with multiple criminal justice system components and local community treatment and recovery providers to address the

behavioral health needs of adults who are involved with the criminal justice system. The court collaborative will focus on diversion of adults with behavioral health problems from the criminal justice system, including alternatives to incarceration.

- Practice Improvement & Training: Funding is requested to address the need for disseminating key information, such as evidence-based mental health practices, to the mental health delivery system and facilitates health reform by engaging in activities that support mental health system transformation and reform.
- Consumer and Consumer Support TA Centers: Funding is requested to continue to provide technical assistance to facilitate the restructuring of the mental health system by promoting consumer directed approaches for adults with serious mental illnesses.
- Homelessness: Funding is requested to continue to provide technical assistance on permanent supportive housing and related recovery supports to grantees. This program advances SAMHSA's Strategic Initiatives, specifically Recovery Support, as it pertains to housing and homelessness, as well as the Strategic Initiative on Trauma and Justice.
- HIV/AIDS Education: Funding is requested to continue to provide training and education activities specific to psychiatry and HIV/AIDS, prioritizing areas of highest HIV prevalence in the U.S.

The FY 2015 Budget Request includes decreases in the following:

- National Child Traumatic Stress Initiative: request is $45.7 million, a decrease of $0.3 million from the FY 2014 Enacted Level.
- Primary and Behavioral Health Care Integration request is $28 million a decrease of $24 million from the FY 2014 Enacted Level. The funding will also support Braided Program: HIV Continuum of Care to provide bi-directional integration between primary care services and substance abuse treatment/mental health services (for CSAT/CMHS) and address service coordination and infrastructure needs to providers.
- Suicide Lifeline: request is $5.5 million, a decrease of $1.7 million from FY 2014 Enacted Level.
- GLS - Youth Suicide Prevention – Campus request is $5 million, a decrease of $1.5 million from FY 2014 Enacted Level.
- The GLS - Youth Suicide Prevention – States program request is $27.7 million, a decrease of $7.8 million from the FY 2014 Enacted Level.
- GLS - Suicide Prevention Resource Center request is $4.9 million, a decrease of $1 million from FY 2014 Enacted Level.

SAMHSA/Mental Health
PRNS Mechanism Table by APT
(Dollars in thousands)

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Programs of Regional & National Significance						
Grants/Cooperative Agreements						
Continuations	425	$176,608	311	$126,218	450	$237,222
New/Competing	118	36,438	280	187,049	101	50,618
Subtotal	543	213,046	591	313,267	551	287,840
Contracts						
Continuations	26	38,847	13	37,158	35	63,172
New/Competing	6	14,617	23	27,791	---	3,728
Subtotal	32	53,463	36	64,949	35	66,900
Subtotal, PRNS [1/]	**575**	**$266,509**	**627**	**$378,216**	**586**	**$354,740**

1/ The Prevention and Public Health Funds amount to $12,000,000 in FY 2014 and $38,000,000 in the FY 2015 Request.

*Totals may not add due to rounding.

A detailed table for all grant and contract continuations and new activities can be found in the Supplementary Tables Chapter.

Key Outputs and Outcomes

Program: Youth Violence Prevention

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.2.04 Number of children served through the Youth Violence Prevention program (Outcome)	FY 2013: 952,142 Target: 2,328,500 (Target Not Met)	952,142[4]	952,142[5]	Maintain
3.2.10 Percentage of students who receive mental health services (Outcome)	FY 2013: 70.7% Target: 66% (Target Exceeded)	70.7%	70.7%	Maintain
3.2.29 Percentage of middle and high school students who have been in a physical fight on school property (Outcome)	FY 2013: 13.8 % Target: 27.0 % (Target Exceeded)	13.8 %	13.8 %	Maintain
3.2.30 Decrease the percentage of middle and high school students who report current substance abuse (Outcome)	FY 2013: 18.1 % Target: 20.0 % (Target Exceeded)	18.1 %	18.1 %	Maintain
3.2.31 Number of children (ages 0-5) screened for mental health or related interventions (Outcome)	FY 2014: Result Expected Dec 31, 2014 Target: Set Baseline (Pending)	TBD	TBD	Maintain
3.2.32 Number of organizations collaborating and sharing resources with other organizations as a result of the grant (Outcome)	FY 2014: Result Expected Dec 31, 2014 Target: Set Baseline (Pending)	TBD	TBD	Maintain

[4] Target includes children served through the Project AWARE program.

[5] Target includes children served through the Project AWARE program.

Program: National Child Traumatic Stress Initiative (NCTSI)

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.2.02a Increase the percentage of children receiving trauma informed services who report positive functioning at 6 month follow-up (Outcome)	FY 2013: 65.9% Target: 76.1% (Target Not Met)	65.9%	65.9%	Maintain
3.2.23 Unduplicated count of the number of children and adolescents receiving trauma-informed services (Outcome)	FY 2013: 2,295 Target: 3,052 (Target Not Met)	2,309	2,295	-14
3.2.24 Number of child-serving professionals trained in providing trauma-informed services (Outcome)	FY 2013: 170,201 Target: 73,992 (Target Exceeded)	171,270	170,205	-1,065

Program: Project AWARE

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.2.18 Number of children served. (Output)	FY 2015: Result Expected Dec 31, 2015 Target: 750,000 (Pending)	750,000	750,000	Maintain
3.2.19 Number of children referred to mental health or related services. (Output)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain
3.2.20 Number of organizations collaborating and sharing resources as a result of the grant. (Outcome)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain

Program: Healthy Transitions

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.2.34 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2013: 64.0 % Target: 64.0 % (Baseline)	64.0 %	64.0 %	Maintain
3.2.35 Percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2013: 36.0 % Target: 36.0 % (Baseline)	36.0 %	36.0 %	Maintain
3.2.36 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2013: 56.0 % Target: 56.0 % (Baseline)	56.0 %	56.0 %	Maintain
3.2.37 Increase the number of individuals referred to mental health or related services (Output)	FY 2013: 7,389 Target: 7,389 (Baseline)	5,911	5,911	Maintain

Program: Mental Health-Project LAUNCH

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.94 Number of persons served (Output)	FY 2013: 32,232 Target: 32,232 (Baseline)	32,232	32,232	Maintain
2.3.95 Number of persons trained in mental illness prevention or mental health promotion (Outcome)	FY 2013: 13,102 Target: 13,102 (Baseline)	13,102	13,102	Maintain
2.4.00 Number of 0-8 year old children screened for mental health or related interventions (Outcome)	FY 2013: 44,775 Target: 44,775 (Baseline)	44,775	44,775	Maintain
2.4.01 Number of 0-8 year old children referred to mental health or related interventions (Outcome)	FY 2013: 9,114 Target: 9,114 (Baseline)	9,114	9,114	Maintain

Program: Mental Health System Transformation Grants

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 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 2013: 7,751 Target: 1,488[6] (Target Exceeded)	7,736	7,736	Maintain
1.2.21 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2013: 52.1 Target: 52.1 (Baseline)	TBD	TBD	Maintain
1.2.22 Percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2013: 73.7 Target: 73.7 (Baseline)	TBD	TBD	Maintain
1.2.23 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2013: 30.7 Target: 30.7 (Baseline)	TBD	TBD	Maintain
1.2.24 Number of individuals referred to mental health or related services. (Outcome)	FY 2014: Result Expected Dec 31, 2014 Target: Set Baseline (Pending)	TBD	TBD	Maintain

[6] Target has been reduced to reflect the reduced program funding in FY 2012.

Program: Primary & Behavioral Health Care Integration (PBHCI)

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.2.40 Number of clients served (Output)	FY 2013: 33,023 Target: 33,023 (Baseline)	21,100	21,100	Maintain
3.2.41 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2013: 55.3% Target: 55.3% (Baseline)	49.9%	49.9%	Maintain
3.2.42 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2013: 21.1% Target: 21.1% (Baseline)	22.1%	22.1%	Maintain
3.2.43 Percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2013: 71.6% Target: 71.6% (Baseline)	65.7%	65.7%	Maintain
3.2.44 Percentage of adults receiving services who had positive social support at 6 month follow-up. (Outcome)	FY 2013: 68.3% Target: 68.3% (Baseline)	64.3%	64.3%	Maintain

Program: Suicide Prevention

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.59 Total number of individuals trained in youth suicide prevention (Outcome)	FY 2013: 172,876[7] Target: 35,371 (Target Exceeded)	161,000	134,000	-27,000
2.3.60 Total number of youth screened (Output)	FY 2013: 79,318 Target: 3,360 (Target Exceeded)	73,996	61,626	-12,370
2.3.61 Increase the number of calls answered by the suicide hotline (Output)	FY 2013: 1,061,204 Target: 765,638 (Target Exceeded)	989,994	824,501	-165,493
3.2.37 Increase the number of individuals referred to mental health or related services (Output)	FY 2013: 7,389 Target: 7,389 (Baseline)	5,911	5,911	Maintain

[7] Programs included are the Garrett Lee Smith Campus Suicide Prevention Program and the Garrett Lee Smith State/Tribal Suicide Prevention Program.

Program: Mental Health Homelessness Prevention Programs

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.4.01 Number of clients served (Output)	FY 2013: 4,959 Target: 5,034 (Target Not Met)	4,959	4,959	Maintain
3.4.02 Increase the percentage of adults with severe mental illness receiving homeless support services who report positive functioning at 6 month follow-up (Outcome)	FY 2013: 66.1 % Target: 63.1 % (Target Exceeded)	66.1 %	66.1 %	Maintain
3.4.03 Percentage of adults receiving services who were currently employed at 6 month follow-up (Outcome)	FY 2013: 26.0 % Target: 15.6 % (Target Exceeded)	26.0 %	26.0 %	Maintain
3.4.05 Percentage of adults receiving services who had a permanent place to live in the community at 6 month follow-up (Outcome)	FY 2013: 81.2 % Target: 74.2 % (Target Exceeded)	81.2 %	81.2 %	Maintain
3.4.06 Percentage of adults receiving services who had positive social support at 6 month follow-up (Outcome)	FY 2013: 72 % Target: 71 % (Target Exceeded)	72 %	72 %	Maintain

Program: Mental Health - Other Capacity Activities

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.2.05 Percentage of clients receiving services who report positive functioning at 6 month follow-up (Outcome)	FY 2013: 55.7 % Target: 54.0 % (Target Exceeded)	55.7 %	55.7 %	Maintain
1.2.82 Percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up (Outcome)	FY 2013: 70.5 % Target: 67.7 % (Target Exceeded)	70.5 %	70.5 %	Maintain
1.2.83 Percentage of clients receiving services who are currently employed at 6 month follow-up (Outcome)	FY 2013: 22.2 % Target: 14.0 % (Target Exceeded)	22.2 %	22.2 %	Maintain
1.2.88 Number of individuals screened for mental health or related interventions (Outcome)	FY 2013: 90,684 Target: 32,763 (Target Exceeded)	20,341	28,048[8]	+7,707

[8] Primary and Behavioral Health Care Integration, and Healthy Transitions will be reported separately for FY 2016 target.

Program: Mental Health - Science and Service Activities

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.4.06 Number of people trained by CMHS Science and Service Programs (Output)	FY 2013: 26,736 Target: 3,390 (Target Exceeded)	18,827	16,271	-2,556
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2013: 67,944[9] Target: 110,000 (Target Not Met)	110,000	110,000	Maintain

[9] Results are preliminary and will be updated in 2014.

Size of Awards

(Whole Dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	543	591	553
Average Awards	$392,349	$530,062	$520,980
Range of Awards	$15,000 - $6,000,000	$15,000 - $6,000,000	$15,000 - $6,000,000

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Children's Mental Health Services Program

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	$111,430	$117,315	$117,315	$---

Authorizing Legislation ..... Sections 561 to 565 of the Public Health Service Act
FY 2015 Authorization ..... Expired
Allocation Method ..... Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

Authorized in 1992, the Children's Mental Health Initiative (CMHI) supports the development of comprehensive, community-based systems of care for the estimated nine to thirteen percent of children and youth with serious emotional disorders (SED) and their families. A system of care (SOC) is a strategic approach to the delivery of services and supports that incorporate family-driven, youth-guided, strength-based, and culturally and linguistically competent care in order to meet the physical, intellectual, emotional, cultural, and social needs of children and youth. The SOC helps prepare children and youth for successful transition to adulthood and successful assumption of adult roles and responsibilities. These guiding principles also call for a broad array of effective services, individualized care, and coordination across child and youth-serving systems (e.g. Juvenile Justice, Child Welfare, Education, Primary Care, and Substance Abuse) and have become standards for care throughout much of the nation. A hallmark of this program is that youth and families partner with state and local providers and policy makers in service delivery, system reform planning, and decision-making. In addition to the substantial role children, youth, and families play in the care they receive, services are delivered in the least restrictive environment with evidence-supported treatments and interventions. Individualized care management ensures that planned services and supports are delivered both appropriately and effectively.

Since 1993, the CMHI program has funded 173 cooperative agreements across the country, serving more than 110,000 children, youth, and their families. Through FY 2010, cooperative agreements were funded for a total of six years, with an increasing non-federal matching requirement. The matching requirement is intended to promote sustainability of the local system of care beyond the grant period. Over 64 percent of programs funded under the CMHI have been sustained at least five-years post-federal funding. In FY 2011, SAMHSA funded 24 one-year System of Care Expansion Planning grants. The purpose of these grants was to bring systems of care to scale from a community to a statewide focus where the grantee develops a comprehensive strategic plan for improving and expanding services and supports broadly throughout a state or political subdivision of a state, tribe, or territory. In FY 2012, SAMHSA funded six additional one-year planning grants along with 16 four-year System of Care Expansion Implementation grants. The goal of these new grants was to assist states, tribes and larger geographic areas in implementing their strategic plans to expand the system of care approach to improve outcomes for children and youth with serious mental health conditions and their families. In addition, SAMHSA also supported 47 CMHI continuation grants as well as five contract continuations.

National program evaluation data reported annually to Congress indicates that CMHI systems of care are successful, resulting in many favorable outcomes for children, youth, and their families, including:

- Sustained mental health disorder improvements for participating children and youth in behavioral health outcomes after as little as six months of program participation;
- Improvements in school attendance and achievement;
- Reductions in suicide-related behaviors;
- Decreases in the use of inpatient care and reduced costs due to fewer days in residential settings; and
- Significant reductions in contacts with law enforcement.

Due to the success of this approach, SAMHSA funding ensures that grantees will continue to expand and sustain CMHI system of care values and principles, infrastructure and services throughout their states, tribes, and territories. A central focus of these efforts is linking CMHI systems of care with other child and youth-serving systems (e.g. Child Welfare, Juvenile Justice, and Education), block grant activities, and coordinating funding streams to support the SOC approach.

In FY 2013, SAMHSA awarded 11 one-year System of Care Expansion Planning grants, 15 System of Care Expansion Implementation Grants, and supported the continuation of 46 CMHI and 16 System of Care Expansion Implementation grants and five contracts.

In FY 2014, SAMHSA plans to support continuation grants and contracts as well as award a new cohort of System of Care Expansion Planning grants and System of Care Expansion Implementation Grants as well as a new contract.

Funding History

Fiscal Year	Amount
FY 2011	$117,803,000
FY 2012	$117,314,524
FY 2013	$111,430,194
FY 2014	$117,315,000
FY 2015	$117,315,000

Budget Request

The FY 2015 Budget Request is $117.3 million, which is the same level as of the FY 2014 Enacted Level. The Budget Request will support the continuation of Children's Mental Health Initiative. The request will support 66 grant and three contract continuations, as well as 37 new grants and one new contract. In addition, System of Care grantees will be encouraged to use technology-based solutions that meet their program needs, including, but not limited to: tele-mental health, technology assisted applications, technologies to support health information exchange for integration of care, electronic health records (EHRs), digital dashboards for care coordination, clinical decision support for delivery of evidence-based practices for children's

behavioral health care, and mobile technologies to improve communication with patients and caregivers and for more effective monitoring of patient status outside of the clinical setting. In addition, SAMHSA is considering opportunities within the CMHI program for in-sourcing technical expertise in the evolving children's mental health services arena.

SAMHSA/Mental Health
Mechanism Table
(Dollars in thousands)

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Children's Mental Health Services						
Grants/Cooperative Agreements						
Continuations	62	$74,163	59	$60,956	66	$65,520
New/Competing	26	17,922	43	36,284	36	35,356
Subtotal	88	92,085	102	97,240	102	100,876
Contracts						
Continuations	1	8,405	2	10,737	2	10,606
New/Competing	1	1,517	---	500	---	500
Subtotal	2	9,922	2	11,237	2	11,106
Technical Assistance	4	9,424	5	8,838	3	5,333
Report to Congress	---	---	---	---	---	---
Total, Children's Mental Health Services	**94**	**$111,430**	**109**	**$117,315**	**107**	**$117,315**

* Totals may not add due to rounding.

Key Outputs and Outcomes

Program: Children's Mental Health Services

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted Level is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.2.16 Increase the number of children with severe emotional disturbance that are receiving services from the Children's Mental Health Initiative (Output)	FY 2013: 6,610 Target: 6,457 (Target Exceeded)	6,610	6,610	Maintain
3.2.25 Percentage of children receiving services who report positive social support at 6 month follow-up (Outcome)	FY 2013: 87.6 % Target: 87.6 % (Target Met)	87.6 %	87.6 %	Maintain
3.2.26 Increase the percentage of children receiving Systems of Care mental health services who report positive functioning at 6 month follow-up (Outcome)	FY 2013: 62.7 % Target: 64.2 % (Target Not Met)	62.7 %	62.7 %	Maintain
3.2.27 Number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the program (Output)	FY 2013: 5,101 Target: 4,571 (Target Exceeded)	5,101	5,101	Maintain
3.2.28 Number of organizations that entered into formal written inter/intra-organizational agreements (e.g. MOUs/MOAs) to improve mental health-related practices/activities as a result of the grant (Output)	FY 2013: 782 Target: 928 (Target Not Met but Improved)	691	691	Maintain

Size of Awards

(Whole Dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	88	102	102
Average Awards	$1,046,418	$953,330	$988,982
Range of Awards	$330,000 - $2,000,000	$330,000 - $2,000,000	$330,000 - $2,000,000

Projects for Assistance in Transition from Homelessness

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	$61,405	$64,794	$64,794	---

Authorizing Legislation .....Section 521 of the Public Health Service Act
FY 2015 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. The PATH budget supports 56 grants to all 50 states, the District of Columbia, Puerto Rico, Guam, American Samoa, the United States Virgin Islands, and the Northern Mariana Islands as well as centralized activities such as technical assistance and evaluation. PATH funds community-based outreach, mental health, substance abuse, case management, other supportive services, and a limited set of housing services in more than 500 communities. All recipients of PATH allocations (except the territories) are required by the authorizing legislation to provide a matching contribution of $1 for every $3 of federal money received. The PATH formula calculates state allotments based on the population living in urbanized areas. This population data is updated after each census.

PATH is unique in that is specifically 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. On a single night in January 2012, it is estimated that 633,782 people were homeless in the United States. Behavioral health issues are common among this population, as are chronic physical illnesses and other disabling conditions. Almost half of people experiencing homelessness have mental health problems and/or substance use disorders. In addition, many individuals who have SMI are at risk of becoming homelessness due to their disabling conditions. 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. PATH connects members of this largely under-served population with critical services and resources to assist them in their recovery.

Grantee performance has improved over the years as evidenced by increased numbers relating to PATH program Government Performance and Results Act (GPRA) measures. Over the past five years, national PATH program data indicate increases in the number of individuals experiencing homelessness who are contacted through outreach, the number of eligible individuals who are enrolled in the PATH program, and in the percentage of enrolled PATH clients who receive community mental health services. The GPRA measures for the PATH program show improvements in the PATH program's effectiveness. PATH program results related to these measures show the number of homeless individuals contacted by the PATH program has increased from 135,007 individuals contacted in 2008 to 192,290 individuals contacted in 2012.

Of these 103,259 individuals were enrolled in the PATH program, and 68,652 of the enrolled received community mental health services.

Factors that affect performance data include changes in counting methodology for certain PATH data elements and clarification of definitions of PATH data elements. The primary external factor is the transient nature of the population that PATH seeks to serve. PATH providers encounter several challenges including staff retention, difficulty serving all clients due to funding availability, the need for increased funding, defining PATH services and programs, and lack of standardized data tracking procedures.

The need for standardized definitions is addressed through the PATH's Administrative Workgroup which is in the process of defining PATH data elements. Issues relating to retention, staff shortages, and funding are managed at the local level. PATH has implemented several activities to improve data collection and reporting.

Performance for the number of PATH providers trained on Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), Outreach, Access, and Recovery (SOAR) was not met in FY 2011, FY 2012, and FY 2013. It is important to note, however, that nearly 24,000 PATH funded providers have been trained since the initiative began. This output is important in that once trained, PATH providers are better able to assist PATH clients in applying for and getting the income benefits for which they are eligible.[10]

Training and technical assistance (TA) are ongoing and long-term TA engagements (i.e., virtual classrooms, follow-up consultation) are being implemented to ensure that PATH providers are able to use the information obtained in the training to make changes in their programs.

The ability of PATH providers to build trusting and supportive relationships that lead to consumers making meaningful contributions to agency administration and service provision is a major accomplishment. Nearly all PATH provider agencies had consumer involvement, and consumers had a range of responsibilities as peer specialists, as members of committees, assessing services received etc. PATH also presents opportunities for providers working with individuals who are homeless to connect with each other.

In FY 2012 and FY 2013 SAMHSA funded 56 grants to states and territories, as well as centralized activities such as technical assistance and evaluation. This funding and the population of focus will continue in FY 2014.

[10] Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are disability income benefits administered by the Social Security Administration (SSA) that generally also provide either Medicaid and/or Medicare health insurance to individuals who are eligible. Accessing these benefits is often a critical first step in recovery. For people, who are homeless with mental health problems that impair cognition or who are returning to the community from institutions (jails, prisons or hospitals), access to these programs can be extremely challenging. The application process for SSI/SSDI is complicated, detailed, and often difficult to navigate. Typically, about 10-15 percent of individuals who are homeless have these benefits.

Funding History

Fiscal Year	Amount
FY 2011	$64,917,000
FY 2012	$64,794,307
FY 2013	$61,405,176
FY 2014	$64,794,000
FY 2015	$64,794,000

Budget Request

The FY 2015 Budget Request is $64.8 million, which is same as the FY 2014 Enacted Level. The Budget Request will support the continuation of Projects for Assistance in Transition from Homelessness to remain the same level of the number of homeless individuals contacted which is approximately 192,000 through the PATH program.

Key Outputs and Outcomes

Program: Projects to Assist in the Transition from Homelessness

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.4.15 Increase the percentage of enrolled homeless persons in the Projects for Assistance in Transition from Homelessness (PATH) program who receive community mental health services (Outcome)	FY 2012: 66 Target: 47 (Target Exceeded)	66	66	Maintain
3.4.16 Number of homeless persons contacted (Outcome)	FY 2012: 192,290 Target: 182,000 (Target Exceeded)	191,926	191,926	Maintain
3.4.17 Percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome)	FY 2012: 58% Target: 55% (Target Exceeded)	58%	58%	Maintain
3.4.20 Increase the number of PATH (Projects for Assistance in Transition from Homelessness) providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits (Output)	FY 2013: 4,360 Target: 5,420 (Target Not Met)	4,360	4,360	Maintain

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2015 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

STATE/TERRITORY	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	$550,000	$609,000	$611,000	+2,000
Alaska	300,000	300,000	300,000	---
Arizona	1,107,000	1,341,000	1,345,000	+4,000
Arkansas	300,000	302,000	303,000	+1,000
California	8,483,000	8,761,000	8,782,000	+21,000
Colorado	910,000	1,013,000	1,016,000	+3,000
Connecticut	807,000	795,000	797,000	+2,000
Delaware	300,000	300,000	300,000	---
District Of Columbia	300,000	300,000	300,000	---
Florida	3,815,000	4,309,000	4,319,000	+10,000
Georgia	1,419,000	1,660,000	1,664,000	+4,000
Hawaii	300,000	300,000	300,000	---
Idaho	300,000	300,000	300,000	---
Illinois	2,758,000	2,689,000	2,696,000	+7,000
Indiana	966,000	1,005,000	1,008,000	+3,000
Iowa	316,000	333,000	333,000	---
Kansas	342,000	375,000	376,000	+1,000
Kentucky	444,000	466,000	467,000	+1,000
Louisiana	718,000	729,000	730,000	+1,000
Maine	300,000	300,000	300,000	---
Maryland	1,203,000	1,264,000	1,267,000	+3,000
Massachusetts	1,596,000	1,550,000	1,553,000	+3,000
Michigan	1,863,000	1,719,000	1,723,000	+4,000
Minnesota	768,000	806,000	808,000	+2,000
Mississippi	300,000	300,000	300,000	---
Missouri	875,000	888,000	891,000	+3,000
Montana	300,000	300,000	300,000	---
Nebraska	300,000	300,000	300,000	---
Nevada	475,000	612,000	614,000	+2,000
New Hampshire	300,000	300,000	300,000	---

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2015 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

STATE/TERRITORY	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	2,196,000	2,125,000	2,131,000	+6,000
New Mexico	300,000	300,000	300,000	---
New York	4,392,000	4,198,000	4,208,000	+10,000
North Carolina	1,065,000	1,371,000	1,375,000	+4,000
North Dakota	300,000	300,000	300,000	---
Ohio	$2,071,000	$1,975,000	$1,979,000	+4,000
Oklahoma	420,000	450,000	451,000	+1,000
Oregon	560,000	627,000	629,000	+2,000
Pennsylvania	2,326,000	2,353,000	2,359,000	+6,000
Rhode Island	300,000	300,000	300,000	---
South Carolina	531,000	676,000	678,000	+2,000
South Dakota	300,000	300,000	300,000	---
Tennessee	840,000	904,000	907,000	+3,000
Texas	4,191,000	4,966,000	4,978,000	+12,000
Utah	495,000	588,000	589,000	+1,000
Vermont	300,000	300,000	300,000	---
Virginia	1,335,000	1,463,000	1,467,000	+4,000
Washington	1,219,000	1,321,000	1,324,000	+3,000
West Virginia	300,000	300,000	300,000	---
Wisconsin	805,000	832,000	834,000	+2,000
Wyoming	300,000	300,000	300,000	---
American Samoa	50,000	50,000	50,000	---
Guam	50,000	50,000	50,000	---
Northern Marianas	50,000	50,000	50,000	---
Puerto Rico	985,000	886,000	888,000	+2,000
Virgin Islands	$50,000	$50,000	$50,000	---

Protection and Advocacy for Individuals with Mental Illness

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	$34,343	$36,238	$36,238	---

Authorizing Legislation ..... The PAIMI Act 42 USC 10801 et seq.
FY 2015 Authorization ..... Expired
Allocation Method ..... Formula Grants

Program Description and Accomplishments

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act of 1986 [42 USC 10801 et seq., as amended in 2000 by the Children's Health Act of 2000 [42 USC 290 ii- ii-2] extended the protections of the Developmental Disabilities Assistance Act of 1975 [as amended in 2000, 42 USC 15001 et seq.] to individuals with significant mental illness (adults) and significant emotional impairments (children/youth) at risk for abuse, neglect and rights violations while residing in public and private care and treatment facilities. The PAIMI Act authorized the same governor-designated state protection and advocacy (P&A) systems established under the DD Act of 1975 to receive PAIMI Program formula grant awards from SAMHSA. The PAIMI Program awards support legal-based advocacy services that are provided by the 57 governor-designated P&A systems located in each state, and territories, and the District of Columbia (Mayor). Each system is mandated to: 1) ensure that the rights of individuals with mental illness who are at risk for abuse, neglect and rights violations while residing in public or private care or treatment facilities; 2) protect and advocate the rights of these individuals through activities that ensure the enforcement of the Constitution and federal and state statutes; and 3) investigate incidents of abuse, neglect of individuals with mental illness.

In 2010, the results of an independent PAIMI Program evaluation concluded that individuals with significant mental health disabilities and their family members were well served by this program by providing them a voice in the exercise of their rights. The PAIMI program is highly successful in achieving client and system goals and objectives. The PAIMI Programs are highly effective in assuring that the most vulnerable individuals with mental illness, especially those residing in public and private residential care and treatment facilities are free from abuse, including inappropriate restraint and seclusion, neglect and rights violations, and receive the appropriate mental health treatment and discharge planning services they will need to facilitate their recovery and subsequent placement into an appropriate, least restrictive, community-based setting.

In 2012, the 57 state Protection and Advocacy system PAIMI Programs:

- Served 16,307 PAIMI-eligible individuals/clients: 3805 children and youth (ages 0 – 18) and 11,289 adults (ages 19 - 64), 920 adults (age 65 and older), and 23 individuals whose ages were not known. These individuals filed 18,021 complaints alleging abuse, neglect, or and/or rights violations.

- Of the closed 12,906 of these complaints, 2481 the allegation not substantiated, lacked legal merit, or was withdrawn by the client 10,525 substantiated and investigated, including 2127 abuse, 2134 neglect, and 6164 rights violation allegations.

- Resolved 85 percent of abuse, 90 percent of neglect allegations, and 87 percent of rights violations allegations and attained outcomes that resulted in positive change for the clients served, e.g: discharge into an appropriate community-based setting; discharge from a nursing facility; safer, cleaner facility environment; and reciept of appropraite medical and mental heath treatment.

The FY 2012 program funding supported various legal-based advocacy activities mandated by the PAIMI Act [42 USC at 10805]. The PAIMI Program marginal cost analysis conducted for this program estimated the average cost in FY 2012 was $2,018 per individual client served). In FY 2012 SAMHSA conducted a range of activities to ensure that the 57 PAIMI Programs within each state P&A system are monitored and fully compliant with the authorizing legislation and rules, respectively 42 USC 10801 et seq. and 42 CFR Part 51. These activities included close collaboration with the SAMHSA Division of Grants Management on annual application and program performance report criteria and reviews. Regular monthly meetings and weekly collaborations with other federal P&A program representatives are held to share information on federal monitoring activities, including site visit reports, and to coordinate P&A system technical assistance and training.

In FY 2012, SAMHSA program and grants management staff conducted on-site visits to monitor selected P&A systems. Each P&A system was assessed in the following key areas that are consistent with PAIMI Rules: governance, PAIMI Advisory Council, the administration of legal activities, and financial/fiscal management. After each site visit a report summarizing the findings and recommendations is issued. A corrective action plan is required and technical assistance is provided to all P&A systems with major compliance findings.

In FY 2013, SAMHSA continued to fund 57 grants to states and territories as well as centralized technical assistance activities and support for grantees.

In FY 2014, SAMHSA plans to continue supporting this program.

Funding History

Fiscal Year	Amount
FY 2011	$36,307,000
FY 2012	$36,238,380
FY 2013	$34,342,895
FY 2014	$36,238,000
FY 2015	$36,238,000

Budget Request

The FY 2015 Budget Request is $36.2 million, level funded from the FY 2014 Enacted Level. The Budget Request will support the continuation of Protection and Advocacy for Individuals with Mental Illness to maintain the same level of individuals served, approximately 16,000 clients and 140,000 individuals trained, educated, or reached through the program.

Key Outputs and Outcomes

Program: Protection & Advocacy

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.4.12 Number of people served by the PAIMI program (Outcome)	FY 2012: 15,955 Target: 22,325 (Target Not Met)	15,925	15,925	Maintain
3.4.19 Number attending public education/constituency training and public awareness activities (Output)	FY 2012: 139,692 Target: 92,953[11] (Target Exceeded)	139,427	139,427	Maintain
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,elimination of other barriers to personal decision-making,as a result of PAIMI involvement (Outcome)	FY 2012: 87.0 % Target: 87.0 % (Target Met)	87.0 %	87.0 %	Maintain

[11] Target was reduced to reflect most recent actual given previous two years of performance results were off nearly 30 percent and is not related to 2012 budget levels.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2015 DISCRETIONARY STATE/FORMULA GRANTS
Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA # 93.138

STATE/TERRITORY	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	$431,790	$452,480	$457,246	+4,766
Alaska	406,700	428,000	429,100	+1,100
Arizona	569,438	609,040	618,472	+9,432
Arkansas	406,700	428,000	429,100	+1,100
California	2,986,452	3,169,574	3,164,791	-4,783
Colorado	406,700	428,381	434,723	+6,342
Connecticut	406,700	428,000	429,100	+1,100
Delaware	406,700	428,000	429,100	+1,100
District Of Columbia	406,700	428,000	429,100	+1,100
Florida	1,588,303	1,680,238	1,709,038	+28,800
Georgia	859,095	909,612	919,984	+10,372
Hawaii	406,700	428,000	429,100	+1,100
Idaho	406,700	428,000	429,100	+1,100
Illinois	1,032,984	1,081,319	1,078,311	-3,008
Indiana	580,825	606,534	600,630	-5,904
Iowa	406,700	428,000	429,100	+1,100
Kansas	406,700	428,000	429,100	+1,100
Kentucky	406,700	428,000	429,100	+1,100
Louisiana	406,700	428,000	429,100	+1,100
Maine	406,700	428,000	429,100	+1,100
Maryland	433,563	457,637	457,774	+137
Massachusetts	481,952	505,220	508,248	+3,028
Michigan	875,131	911,471	905,909	-5,562
Minnesota	423,367	445,048	445,474	+426
Mississippi	406,700	428,000	429,100	+1,100
Missouri	514,052	541,644	545,747	+4,103
Montana	406,700	428,000	429,100	+1,100
Nebraska	406,700	428,000	429,100	+1,100
Nevada	406,700	428,000	429,100	+1,100
New Hampshire	406,700	428,000	429,100	+1,100

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2015 DISCRETIONARY STATE/FORMULA GRANTS
Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA # 93.138

STATE/TERRITORY	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	647,643	682,281	683,141	+860
New Mexico	406,700	428,000	429,100	+1,100
New York	1,461,310	1,522,198	1,529,647	+7,449
North Carolina	843,487	894,253	898,586	+4,333
North Dakota	406,700	428,000	429,100	+1,100
Ohio	$999,941	$1,042,233	$1,033,678	-8,555
Oklahoma	406,700	428,000	429,100	+1,100
Oregon	406,700	428,000	429,100	+1,100
Pennsylvania	1,039,800	1,088,023	1,077,471	-10,552
Rhode Island	406,700	428,000	429,100	+1,100
South Carolina	425,627	451,380	453,931	+2,551
South Dakota	406,700	428,000	429,100	+1,100
Tennessee	560,968	588,392	588,087	-305
Texas	2,143,549	2,249,157	2,260,873	+11,716
Utah	406,700	428,000	429,100	+1,100
Vermont	406,700	428,000	429,100	+1,100
Virginia	630,154	663,461	668,277	+4,816
Washington	539,338	572,901	576,348	+3,447
West Virginia	406,700	428,000	429,100	+1,100
Wisconsin	479,982	503,977	499,851	-4,126
Wyoming	406,700	428,000	429,100	+1,100
American Samoa	217,900	229,300	229,900	+600
Guam	217,900	229,300	229,900	+600
Northern Marianas	217,900	229,300	229,900	+600
Puerto Rico	545,628	566,333	553,288	-13,045
Virgin Islands	217,900	229,300	229,900	+$600
American Indian Consortium	$217,900	$229,300	$229,900	+600

Community Mental Health Services Block Grant

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Community Mental Health Services Block Grant	$436,809	$483,744	$483,744	---
PHS Evaluation Funds (non-add)	*$21,039*	*$21,039*	*$21,039*	---

Authorizing Legislation .....Section 1911 of the Public Health Service Act
FY 2015 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 MHBG 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 MHBG include services identified in SAMHSA's *Good and Modern Service System*[12] brief, including 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 currently not broadly covered under private and public insurance. The MHBG also supports and encourages states to implement proven practices demonstrated in the discretionary portfolio at SAMHSA. 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 country.

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 rely on the MHBG for delivery of critical services and for an array of non-clinical coordination and support services to strengthen their respective systems of services, for example, planning, coordination, needs assessment, quality assurance, program development, training, and evaluation.

[12] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf

The MHBG statute provides a five percent set-aside to allow 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.

In FY 2011, SAMHSA redesigned the FY 2012/2013 MHBG and SABG applications to better align with the current federal/state environments and related policy initiatives, including the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Tribal Law and Order Act (TLOA). The new design offered states the opportunity to complete a combined application for mental health and substance abuse services, submit a bi-annual versus an annual plan,[13,14] and provide information regarding their efforts to respond to various federal and state initiatives. Almost one-half of the states took advantage of this streamlined application and submitted combined plans for mental health and substance abuse services. Over 95 percent of the states provided specific information requested by SAMHSA regarding state strategies to respond to a variety of areas including primary care and behavioral health integration, recovery support services, prevention of substance use, and the promotion of emotional health. In addition, states continued to provide information on how their Block Grant funds are used to support the categories of services identified in SAMHSA's *Good and Modern Service System*[15] brief as described in the block grant application.

The FY 2014/2015 Block Grant application builds upon the FY 2012/2013 application and furthers SAMHSA's efforts to have states use and report the opportunities offered under various federal initiatives. In addition, the FY 2014/2015 Block Grant continues to allow states to submit a combined application for mental health and substance abuse services as well as a bi-annual versus an annual plan.

After the full implementation of the ACA, SAMHSA has strongly recommended that MHBG funds be directed toward four purposes: (1) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; (2) to fund priority treatment (Essential Health Benefits – EHB) and support services not covered by private and public insurance for low and moderate income individuals and that demonstrate success in improving outcomes and/or supporting recovery (non-EHB covered treatments); (3) to fund primary prevention (universal, selective, and indicated) activities and services for individuals with serious mental illness and serious emotional disturbance; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis. In addition, consistent with SAMHSA's Theory of Change, which draws a path from innovation, translation, dissemination, to implementation and finally wide scale adoption, SAMHSA will be taking advantage of the successful strategies implemented through the Access to Recovery program, by encouraging the states to utilize their Block Grants to: (1) allow recovery to be pursued through personal choice and many pathways; (2) encourage providers to manage performance and quality based on outcomes that demonstrate

[13] State Plan for Comprehensive Community Mental Health Services for Certain Individuals (Sec. 1912 of Title XIX, Part B, Subpart I of the Public Health Service (PHS) Act (42 USC § 300x-2))
[14] State Plan (Sec. 1932(b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x-32(b))
[15] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf

client successes; and (3) expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services.

Most states are currently reporting on National Outcome Measures (NOMS) for public mental health services within their state. State level outcome data for mental health are currently reported by State Mental Health Authorities. The following outcomes for all people served by the publicly funded mental health system[16] during 2012 show that:

- For the 58 states and territories that reported data in the Employment Domain, 17 percent of the mental health consumers were in competitive employment;
- For the 57 states and territories that reported data in the Housing Domain, 81 percent of the mental health consumers were living in private residences;
- For the 59 states and territories that reported data in the Access/Capacity Domain, state mental health agencies provided mental health services for 22.67 people per 1,000 population;
- For the 51 states and territories that reported data in the Retention Domain, only 9 percent of the patients returned to a state psychiatric hospital within 30 days of state hospital discharge; and
- For the 52 states and territories that reported data in the Perception of Care Domain, 71 percent of adult mental health consumers improved functioning as a direct result of the mental health services they received.

Set-aside for Evidence-based Programs That Address Needs of Individuals With Early Serious Mental Illness

Starting in FY 2014, SAMHSA will work with states required to use 5 percent set-aside of their MHBG funds to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.

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

The 5 percent set-aside of $24.2 million, allocated to states consistent with the block grant formula, will support creation of promising models that seek to address treatment of serious mental illness at an early stage through reducing symptoms and relapse rates, and preventing deterioration of cognitive function in individuals suffering from psychotic illness. The increase to the block grant in FY 2014 over the FY 2013 level will help States meet this new requirement in addition to maintaining existing services. SAMHSA is collaborating with NIMH in developing guidelines to States regarding effective programs funded by this set-aside.

[16] May reflect multiple sources of funding including, MHBG, State General Fund, Medicaid, Private Insurance, etc.

Funding History[1/]

Fiscal Year	Amount
FY 2006	$427,974,000
FY 2007	$428,256,000
FY 2008	$420,774,000
FY 2009	$420,774,000
FY 2010	$420,774,000
FY 2011	$419,933,000
FY 2012	$459,756,254
FY 2013	$436,808,709
FY 2014	$483,744,000
FY 2015	$483,744,000

[1\]The funding history includes PHS Evaluation Funds.

Budget Request

The FY 2015 Budget Request is $483.7 million, with $462.7 million from Budget Authority and $21 million from PHS Evaluation Funds. This request is the same as the FY 2014 Enacted Level. The Budget Request will support the continuation of Community Mental Health Services Block Grant.

Health Reform Implementation

As a result of the analysis and examination of the various components of the Affordable Care Act beginning in 2010, SAMHSA has undertaken a major redesign of the planning section of the application process for both the MHBG and SABG. SAMHSA is aligning the block grants to complement mental health and substance abuse coverage expansions in the Affordable Care Act, for example, implementation in which state and federal responsibility is supporting behavioral health services and supports for those otherwise unable to receive services through private and public insurance. Together, SAMHSA's block grants support the provision of services and related supports to approximately eight million individuals with mental and substance use conditions. With an estimated 11.4 million adults having a severe mental illness[17], 44.7 million adults having any mental illness[18], and another 22.1 million adults with substance use disorder[19], demand clearly outpaces the public behavioral health system's established capacity. Many of these individuals and some of the services they need will continue to be without coverage through public or private insurance mechanisms. Aligning and coordinating the SAMHSA block grants with the Affordable Care Act helps create a cohesive national service system that is responsive to potential gaps in service delivery and effectively provides needed behavioral health services across sectors and across payment sources.

[17] http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm
[18] http://www.samhsa.gov/data/2k12/NSDUH110/sr110-adult-mental-illness.htm
[19] http://www.samhsa.gov/data/NSDUH/2k10ResultsRev/NSDUHresultsRev2010.htm#Ch7

States should determine if established systems and procedures are sufficient to ensure that Block Grant funds are expended in accordance with program requirements and directed to support and not supplant health reform activities. In the Uniform Block Grant Application for FY 2014/2015, SAMHSA has strongly recommended that states use these resources to support and not supplant services that will be covered through commercial and public insurer plans. States will be asked to develop metrics or targets for their systems to measure increases in the number of individuals who become enrolled or providers that join commercial or publicly funded provider networks. The primary goals of SAMHSA's program integrity efforts are to continue to (1) promote the proper expenditure of block grant funds, (2) improve block grant program compliance nationally, and (3) demonstrate the effective use of block grant funds.

SAMHSA will provide additional guidance to the states to assist them in complying with this continuing emphasis on program integrity, will develop new and better tools for reviewing block grant application and reports, and will train SAMHSA staff in these program integrity approaches and tools. SAMHSA will be working with states to develop changes to information systems and compliance review processes to ensure increasing program integrity. This may include working closely with Medicaid and Health Insurance Exchanges to obtain information to determine if individuals and providers in their systems are enrolled. This may also include strategies to assist their providers to develop the necessary infrastructures to operate in commercial and public insurer networks. The Uniform Application along with the new set asides along with evolution of SAMHSA's block grant reporting system are all tools to assist in this process.

Key Outputs and Outcomes

Program: Mental Health Block Grant

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.11 Number of evidence-based practices (EBPs) implemented (Output)	FY 2012: 4.9 per State Target: 4.2 per State (Target Exceeded)	4.8 per State	4.5 per State	-0.36
2.3.14 Number of people served by the public mental health system (Output)	FY 2012: 7,161,659 Target: 6,300,000 (Target Exceeded)	8,249,930	8,249,930	Maintain
2.3.15 Rate of consumers (adults) reporting positively about outcomes (Outcome)	FY 2012: 71.8% Target: 72% (Target Not Met but Improved)	71.8%	71.8%	Maintain
2.3.16 Rate of family members (children/adolescents) reporting positively about outcomes (Outcome)	FY 2012: 66.3% Target: 73% (Target Not Met but Improved)	66.3%	66.1%	-0.17
2.3.81 Percentage of service population receiving any evidence-based practice (Outcome)	FY 2012: 6.2 % Target: 7.2 % (Target Not Met)	6.2 %	6.2 %	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2015 Discretionary State/Formula Grants
Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	$6,061,587	$6,713,670	$6,663,129	-$50,541
Alaska	704,026	775,287	795,224	+19,937
Arizona	9,288,329	10,564,627	10,764,162	+199,535
Arkansas	3,861,373	4,272,655	4,237,982	-34,673
California	55,061,609	62,185,567	63,247,936	+1,062,369
Colorado	6,021,813	6,829,619	6,917,175	+87,556
Connecticut	4,215,125	4,812,384	4,797,390	-14,994
Delaware	952,980	1,052,300	1,045,382	-6,918
District Of Columbia	801,063	893,917	930,079	+36,162
Florida	27,332,270	31,110,919	31,779,312	+668,393
Georgia	12,686,143	14,264,923	14,360,619	+95,696
Hawaii	2,096,651	2,352,005	2,374,475	+22,470
Idaho	2,278,593	2,554,817	2,567,359	+12,542
Illinois	15,584,077	17,322,214	17,199,945	-122,269
Indiana	7,655,345	8,547,076	8,402,340	-144,736
Iowa	3,374,363	3,735,295	3,695,279	-40,016
Kansas	3,152,560	3,492,553	3,463,095	-29,458
Kentucky	5,827,608	6,469,100	6,373,450	-95,650
Louisiana	5,151,008	5,592,499	5,526,824	-65,675
Maine	1,659,128	1,831,044	1,806,718	-24,326
Maryland	8,190,540	9,076,153	9,054,545	-21,608
Massachusetts	9,022,365	9,997,620	9,995,556	-2,064
Michigan	13,010,049	14,638,954	14,551,366	-87,588
Minnesota	6,442,510	7,127,318	7,107,025	-20,293
Mississippi	3,798,569	4,215,406	4,197,808	-17,598
Missouri	7,115,861	7,852,761	7,812,754	-40,007
Montana	1,220,293	1,364,051	1,363,037	-1,014
Nebraska	1,964,416	2,152,297	2,108,156	-44,141
Nevada	4,018,879	4,547,235	4,662,378	+115,143
New Hampshire	1,691,217	1,863,286	1,845,724	-17,562

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2015 Discretionary State/Formula Grants
Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	11,680,591	12,962,425	13,007,089	+44,664
New Mexico	2,510,107	2,809,998	2,797,905	-12,093
New York	25,474,094	28,564,852	28,305,335	-259,517
North Carolina	11,631,309	12,869,812	12,865,573	-4,239
North Dakota	765,401	826,569	818,991	-7,578
Ohio	13,708,232	15,274,428	15,112,980	-161,448
Oklahoma	4,484,357	4,974,309	4,990,212	+15,903
Oregon	5,436,315	5,988,749	5,998,120	+9,371
Pennsylvania	14,868,037	16,460,620	16,291,707	-168,913
Rhode Island	1,606,225	1,769,137	1,753,497	-15,640
South Carolina	5,955,461	6,671,692	6,672,308	+616
South Dakota	853,013	953,807	949,334	-4,473
Tennessee	7,985,574	8,833,476	8,823,748	-9,728
Texas	32,651,444	36,596,738	36,802,122	+205,384
Utah	3,128,818	3,478,559	3,498,766	+20,207
Vermont	755,783	839,604	823,049	-16,555
Virginia	10,260,781	11,406,542	11,399,971	-6,571
Washington	9,231,043	10,429,045	10,469,467	+40,422
West Virginia	2,473,008	2,715,750	2,652,970	-62,780
Wisconsin	6,641,402	7,379,783	7,292,050	-87,733
Wyoming	447,342	511,527	537,073	+25,546
American Samoa	79,029	88,385	88,510	+125
Guam	226,840	255,557	257,594	+2,037
Northern Marianas	76,701	83,532	82,789	-743
Puerto Rico	5,303,526	5,935,283	5,945,449	+10,166
Palau	50,000	50,000	50,000	---
Marshall Islands	93,748	107,574	110,310	+2,736
Micronesia	152,530	171,070	171,532	+462
Virgin Islands	$151,464	$169,385	$169,580	+195

SAMHSA
Substance Abuse Prevention
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SAMHSA/ Programs of Regional & National Significance
Substance Abuse Prevention
(Dollars in thousands)

Programs of Regional & National Significance	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
CAPACITY				
Strategic Prevention Framework	$107,902	$109,754	$119,754	$+10,000
Strategic Prevention Framework Rx (non-add)	---	---	*10,000*	*+10,000*
PHS Evaluations Funds (non-add)	---	---	*10,000*	*+10,000*
Mandatory Drug Testing	5,252	4,906	4,906	---
Minority AIDS Initiative	40,996	41,307	41,307	---
Sober Truth on Preventing Underage Drinking (STOP Act)	6,994	7,000	7,000	---
Subtotal, Capacity	**161,143**	**162,967**	**172,967**	**+10,000**
SCIENCE AND SERVICE				
Fetal Alcohol Spectrum Disorder	1,104	1,000	1,000	---
Center for the Application of Prevention Technologies (CAPT)	8,098	7,511	7,511	---
PHS Evaluations Funds (non-add)	---	---	*6,468*	*+6,468*
Science and Service Program Coordination	5,168	4,082	4,082	---
Subtotal, Science and Service	**14,369**	**12,593**	**12,593**	---
TOTAL, PRNS [1/]	**$175,513**	**$175,560**	**$185,560**	**+$10,000**

1/In FY 2013- FY 2015, the CSAP Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

Authorizing Legislation ..... Sections 516, 519B, 519D of the PHS Act
FY 2015 Authorization ..... Expired
Allocation Method ..... Competitive Grants/Cooperative Agreements/Contracts

Program Description and Accomplishments

Strategic Prevention Framework (SPF)

Partnerships for Success

The Partnerships for Success (PFS) program was initiated in FY 2009 with the goals of reducing substance abuse-related problems; preventing the onset and reducing the progression of substance abuse; strengthening prevention capacity and infrastructure at the state and community levels in support of prevention; and leveraging, redirecting and realigning state-wide funding streams for substance abuse prevention. Eligible applicants are states and territories that have completed a SPF State Incentive Grant (SPF-SIG). In FY 2009, four grants were awarded, and in FY 2010, one additional award was made. The first two cohorts incorporated an incentive award to grantees that reached or exceeded their prevention performance targets (subject to availability of funds). In FY 2012, SAMHSA supported these efforts by awarding five continuation grants. The FY 2012 data from the first cohort reporting show that 50 communities

increased the number of activities supported through collaboration and leveraging. Grantees reported implementing 888 evidence-based programs and thirty-two communities reported improvements on targeted National Outcome Measures indicators. Two of the three performance measures exceeded their targets. The vast majority of communities (88 percent) targeted alcohol use.

A new cohort of PFS grants began in FY 2012 to address two of the nation's top substance abuse prevention priorities: underage drinking among youth aged 12 to 20 and prescription drug misuse and abuse among individuals aged 12 to 25. The program is based on the premise that changes at the community level will, over time, lead to measurable changes at the state and national level. In FY 2012, SAMHSA awarded 15 new grants for three years.

In FY 2013, SAMHSA supported continuation awards for the initial cohorts established in FY 2009 and FY 2010. SAMHSA also made a new SPF SIG award to Idaho, the last state remaining to receive a SPF SIG and awarded 16 new PFS grants. In addition, SAMHSA made funds available for grantees in the first cohort who met their performance targets and were eligible for the incentive supplement.

In FY 2014, SAMHSA will award a new cohort of PFS grants. Similar to the previous cohorts, these grants will address two of the nation's top substance abuse prevention priorities: underage drinking among youth age 12-20 and prescription drug misuse and abuse among individuals age 12 to 25. The PFS program will focus on implementing the Strategic Prevention Framework to strengthen prevention capacity and infrastructure at the state, territorial, and community levels; preventing the onset and reducing the progression of substance abuse; and leveraging, redirecting, and aligning statewide funding streams and resources to focus on promoting evidence-based substance abuse prevention. Up to 34 grants will be awarded to eligible states, territories and tribes who have completed SPF-SIG. SAMHSA will also consider how best to help tribes committed to substance abuse prevention strengthen their existing service delivery systems and/or begin building the necessary infrastructure to successfully prevent substance abuse in their communities.

Of the remaining SPFSIG grantees, 88 percent reported decreases in underage drinking, 82 percent of grantees reported decreases in drug use, 29 percent reported increased perceived risk of substance use and 901 evidence-based policies, practices, and strategies were implemented. Three of these four measures exceeded their targets.

Mandatory Drug Testing

The Mandatory Drug Testing program is a critical nationwide prevention program consisting of two principal activities mandated by Executive Order and Public Law: (1) oversight of the Federal Drug-Free Workplace Program, aimed at elimination of illicit drug use in the federal workforce, with impact in the private sector workforce as well; and (2) oversight of the National Laboratory Certification Program, which certifies laboratories to conduct forensic drug testing for the federal agencies and for some federally-regulated industries.

Executive Order 12564, first signed on September 15, 1986, requires the head of each executive agency to establish a program to test for the use of illegal drugs by federal employees in sensitive positions and requires the Secretary to promulgate scientific and technical guidelines for drug testing programs. The Executive Order also requires HHS to assist the Office of Personnel Management to develop and improve training programs for federal supervisors and managers on illegal drug use.

The Supplemental Appropriations Act, 1987 (Public Law 100-71) requires HHS to: (1) certify that each federal agency has developed a plan for achieving a drug-free workplace; and (2) publish Mandatory Guidelines that establish comprehensive standards for laboratory drug testing procedures, specify the drugs for which federal employees may be tested, and establish standards and procedures for periodic review and certification of laboratories to perform drug testing for federal agencies.

The 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.

SAMHSA continued these activities in FY 2013 and will continue do so in FY 2014. In addition, the Drug Testing Advisory Board is examining the scientific basis for utilization of oral fluid and other alternative specimens to urine, and the inclusion of additional Schedule II prescription medications (e.g., oxycodone, oxymorphone, hydrocodone and hydromorphone) in the Mandatory Guidelines. Any changes in the guidelines will be based on scientific supportability. SAMHSA continues to partner with other federal agencies to ascertain the scientific evidence needed to set standards for the Mandatory Guidelines.

Minority AIDS Initiative (MAI)

Minority AIDS Initiative (MAI) supports efforts to increase access to substance abuse and HIV prevention services for the highest risk and hardest-to-serve racial and ethnic minority populations. Grantees must implement integrated, evidence-based substance abuse and HIV prevention interventions, including HIV testing, that target one or more high-risk populations such as young adults (18 to 24), African-American women, adolescents, individuals who have been released from prisons and jails within the past two years, or men having sex with men (MSM). In addition, the MAI supports partnerships between public and private nonprofit organizations to prevent and reduce the onset of substance abuse and transmission of HIV among high-risk populations.

In FY 2010, SAMHSA funded the Ready-To-Respond Initiative and the Capacity Building Initiative programs. A total of 62 grants in these cohorts will continue to be funded in FY 2014. The Ready-To-Respond Initiative, was awarded to experienced MAI grantees, and provides substance abuse and HIV prevention services to at-risk minority populations in communities disproportionately affected by HIV/AIDS. The Capacity Building Initiative focuses on using evidence-based prevention strategies and media technology to reach college students, who comprise one-third of the 18-24 year old population in the United States and are particularly at risk for substance use and HIV infection. Performance data for FY 2012 showed that almost 6,600 people received substance abuse prevention education services. Additionally, 96.8 percent

of participants rated the risk of harm from substance abuse as great. Of those participants who were non-users, 93.2 percent remained non-users of drugs and 88.4 percent remained alcohol free. During FY 2012, over 32, 975 participants were tested for HIV. SAMHSA continued to support these grants in FY 2012 and FY 2013.

In FY 2011, SAMHSA also awarded 11 grants for the MAI Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements, jointly funded with CMHS and CSAT. This grant program facilitates the development and expansion of culturally-competent and effective integrated behavioral health and primary care networks, which include HIV services and medical treatment, within racial and ethnic minority communities in the 11 Metropolitan Statistical Areas and Metropolitan Divisions most impacted by HIV/AIDS. Expected outcomes include: reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas. SAMHSA continued to support these grants in FY 2014.

In FY 2013, SAMHSA awarded a new cohort of grants for the MAI funding for Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs). The purpose of this program is to prevent and reduce substance abuse (SA) and transmission of HIV/AIDS among African-American, Hispanic/Latino, and American Indian/Alaska Natives (AI/AN) young adults (ages 18- 24) populations on campus. MSIs will partner with one or more community-based organizations (CBOs) to provide integrated SA and HIV prevention programs to African-American, Hispanic/Latino, American Indian/Alaska Native (AI/AN), and Asian American/Pacific Islander young adults (ages 18-24) in the surrounding communities. SAMHSA awarded 29 grants for three years.

In FY 2013, SAMHSA also implemented a new program, Substance Abuse and HIV/AIDS Prevention and New Media. The purpose of this program is to enhance the infrastructure capacity of community-based organizations to more effectively reach the most at-risk racial/ethnic minority populations and subpopulations using new media and emerging technologies. This program builds capacity for substance use disorders and HIV/AIDS prevention services consistent with the goals and objectives of the National HIV/AIDS Strategy and SAMHSA's Strategic Initiative #1 – Prevention of Substance Abuse and Mental Illness. SAMHSA awarded 20 grants.

SAMHSA supports the National HIV/AIDS Strategy through its grant programs, including the cross-Center Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements, the CSAT Targeted Capacity Expansion/HIV program, and the CSAP Ready-to-Respond, Capacity Building Initiative, Minority Serving Institutions in Partnership with Community Based Organizations, and Substance Abuse & HIV/AIDS Prevention & New Media programs, all described in their respective sections of this document. SAMHSA also provides training and technical assistance to its grantees to ensure they are focusing on the goals of the Strategy and collaborates with other HHS Operating Divisions involved with the Strategy to ensure a coordinated, departmental approach.

In FY 2014, SAMHSA's CMHS, CSAP, and CSAT plan to pilot HIV Continuum of Care grants which supports behavioral health screening, primary prevention, and treatment for racial/ethnic

minority populations with or at high risk for mental and substance use disorders and HIV. This will include (SA) primary prevention/treatment service programs, community mental health programs, and HIV integrated programs that can either co-locate or fully integrate HIV prevention and medical care services within them. Also, this program will provide SA and HIV primary prevention services in local communities served by the behavioral health program.

Sober Truth on Preventing Underage Drinking Act (STOP Act)

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 is the nation's first comprehensive legislation on underage drinking. One of the primary components of the Act is the STOP Act grant program, which provides additional funds to current or former grantees under the Drug Free Communities Act of 1997 to prevent and reduce alcohol use among youth age 12-20. The STOP Act grant program enables organizations to strengthen collaboration and coordination among stakeholders in order to achieve a reduction in underage drinking in their communities. Grants are limited by statute to $0.1 million per year for four years. In FY 2012, 81 new grants were awarded. In FY 2012, performance data showed that the STOP Act grant program has exceeded targets in two of the three GPRA performance measures. Almost 72 percent of coalitions reported a reduction in the past 30-day use of alcohol, 55 percent of coalitions reported an increase in perceived risk, and 58.2 percent of coalitions reported an increase in perception of parental disapproval of alcohol use (69.6 percent). In FY 2013, SAMHSA awarded 17 new grants

Another component of the STOP Act is the National Adult-Oriented Media Public Service Campaign, which educates parents regarding how to speak with their 11- through 15-year-old children about underage drinking in order to delay the onset of, and ultimately reduce, underage drinking. Nationwide, 36.6 percent of the estimated 10 million underage drinkers were provided free alcohol by adults 21 or older (2012 NSDUH). Further research continues to show 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."

The third component of the STOP Act is the federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), which provides high-level leadership from 15 federal agencies for coordinating federal efforts to prevent and reduce underage drinking. In FY 2012, the ICCPUD was reinvigorated with principals meeting from all federal agencies working to prevent underage drinking, and the launch of a webinar series featuring common messages with individualized information for the field from each involved federal agency. In 2012, the ICCPUD updated the 2007 Surgeon General's Call to Action to Prevent Underage Drinking to reflect progress over the past six years, the impact of the Affordable Care Act, and new research supporting effective prevention approaches. SAMHSA continued to support ICCPUD's activities in FY 2013. In FY 2014, SAMHSA will support 97 grant continuations and will continue to support the National-Adult-Oriented Media Campaign and ICCPUD.

Fetal Alcohol Spectrum Disorders (FASD)

The Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence (CFE) program focuses on preventing Fetal Alcohol Spectrum Disorders among women of childbearing age and improving the quality of life for individuals and families impacted by these disorders. FASD CFE uses a comprehensive approach across the lifespan to work toward reducing the number of infants exposed to alcohol prenatally, increasing the functioning of individuals who have an FASD, and addressing the challenges of individuals and families impacted by FASD.

As part of these efforts, FASD CFE has successfully established a website that provides the public with information and resources on the prevention of FASD, chartered an expert panel that provides guidance and recommendations about best practices for healthcare providers and social services, organized a Self-Advocates with FASD Network comprising young adults with a FASD and Birth Mothers Network. In addition FASD CFE partnered with the National Institute on Alcohol Abuse and Alcoholism's Interagency Coordinating Committee on FASD to advance new research and best practices on FASD, coordinated and collaborated with organizations such as the National Organization on Fetal Alcohol Syndrome to develop curricula for juvenile justice systems and certified addictions counselors, provided ongoing support to the National Association of FASD State Coordinators to integrate FASD services into existing health care systems and convened 10 "Building FASD State Systems" annual conferences to facilitate the development of comprehensive systems of care for people affected by FASD. FASD CFE also established a Native Communities Initiative to address FASD in American Indian /Alaska Native /Native Hawaiian populations.

In FY 2012, SAMHSA continued to support the FASD CFE to work toward the prevention of FASD in communities throughout the nation. In FY 2013, the CFE provided technical assistance and training to other federal and national partners to assist them in developing evidence-based prevention, intervention, and treatment approaches. Primary audiences for the FASD CFE are women of child-bearing age, persons and families affected by FASD, states, local communities, AI/AN communities, military families, other special populations, as well as health, social service, and faith-based providers who study and/or provide services for persons affected by an FASD. In 2014, the FASD CFE will continue this technical assistance.

Center for the Application of Prevention Technologies (CAPT)

The Center for the Application of Prevention Technologies (CAPT) program provides state-of-the-art training and technical assistance designed to build the capacity of SAMHSA grantees and develop the skills, knowledge, and expertise of the prevention workforce. CAPT builds capacity and promotes the development of substance abuse prevention professionals in the behavioral health field through three core strategies: (1) establishing technical assistance networks using local experts; (2) developing and delivering targeted training and technical assistance activities; and (3) using communication media such as teleconference and video conferencing, online events, and Web-based support. These activities help ensure the delivery of effective prevention programs and practices and the development of accountability systems for performance measurement and management.

During FY 2012 and FY 2013, CAPT completed a comprehensive revision and updating of its flagship Substance Abuse Prevention Skills Training, which offers participants 31 training hours toward certification as a Substance Abuse Prevention Specialist. CAPT also developed a Pacific Islander and Native American adaptation of the training for an additional six training hour credits. In FY 2012 and 2013, CAPT has continued to develop behavioral health indicators and related training and technical assistance products focused on shared risk and protective factors to promote collaboration across substance abuse and mental health disciplines within the behavioral health field.

During FY 2012, CAPT provided training to 9,041 substance abuse professionals. In addition, CAPT provided technical assistance services to 7,655 people. Over 96 percent of service recipients reported that their organization's capacity was increased as a result of the service. Almost half of the recipients reported fully implementing the training recommendations. Additional performance data for the CAPT is captured using common measures with other technical assistance activities in the Science and Service Program Coordination category. Although the CAPT funding line was reduced in FY 2014, it is co-funded with Block Grant set-aside funds. Therefore the CAPT will be fully funded in FY 2014.

Science and Service Program Coordination

The Science and Service Program Coordination category primarily encompasses contracts that provide technical assistance and training to states, tribes, communities, and grantees around substance abuse prevention. Included in the performance measurement section for this category is the former Native American Center for Excellence (NACE) and the Underage Drinking Prevention Education Initiative (UADPEI).

The purpose of NACE was to promote effective substance abuse prevention programs in tribal and urban American Indian and Alaska Native (AI/AN) communities throughout the United States. The NACE mission was to promote best practices in substance abuse prevention by disseminating information on cultural and evidence-based programs, practices, and policies and providing training and technical assistance to prevention programs and organizations serving urban and tribal Native American communities. The target audiences included the Native American SPF-Tribal Incentive Grant grantees, tribal nations and organizations, health and social service providers, federal and state level organizations, and community and faith-based providers serving Native Americans. Eighty-eight percent of recipients reported that the NACE services increased their individual capacity to provide prevention services.

NACE expanded its outreach in FY 2012 and FY 2013 through presentations at national conferences and regional events, and increased collaborative efforts with other SAMHSA initiatives and national organizations. The NACE website greatly expanded its collection of resources and dissemination of current news worthy events through daily "headlines" entries while tripling its number of visitors each month. FY 2012 and FY 2013 also brought the development of four new NACE learning communities (National Prevention Network, SPF Tribal Incentive Grant, Gathering of Native Americans, and 2-Spirit) to bring stakeholders together on conference calls or webinars to further disseminate information and support cross-

fertilization of information and ideas. Lastly, NACE expanded the frequency and reach of its national webinars.

In FY 2013, NACE was consolidated into the braided Tribal Training and Technical Assistance Center (Tribal TTA Center). The Tribal TTA Center provides comprehensive, broad, focused, and/or intensive training and technical assistance to federally-recognized tribes and other American Indian/Alaska Native communities, seeking to address and prevent mental and substance use disorders, suicide, and promote mental health. The braided amounts spent and awarded are tracked as distinct funding streams and are only to be used for purposes consistent with Congressional intent. In FY 2014, the training and technical assistance will continue.

The Underage Drinking Prevention Education Initiative (UADPEI) 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. Through this initiative, families, their children, and other youth-serving organizations have been reached through Town Hall Meetings (held in even-numbered years), technical assistance, trainings, and with a variety of tools and materials performance data shows that, collectively, the CAPT and Science and Service Program Coordination programs have exceeded their targets for customer satisfaction, and for the proportion of participants who report implementing recommendations. Efficiencies have been achieved from the growing focus on train-the-trainer models rather than training of individuals. In addition, since the Town Hall Meetings under the UADPEI contract occur biannually, numbers served expand in the years the meetings occur and contract in alternate years. Science and Service performance data for FY 2012, 15,269 people were trained and almost 9,000 received technical assistance. In FY 2014, UADPEI funding will be reduced because the town hall meetings occur every other year.

Funding History[1\]

Fiscal Year	Amount
FY 2011	$186,302,000
FY 2012	$185,884,920
FY 2013	$175,512,571
FY 2014	$175,560,000
FY 2015	$185,560,000

[1\]The funding history is presented on a comparable basis to previous funding levels to represent the revised budget structure and includes the PHS Evaluation Fund.

Budget Request

The FY 2015 Budget Request is $185.6 million at the program level with $169.1 million in Budget Authority, and $16.5 million in PHS Evaluation Fund. This is an increase of $10 million from the FY 2014 Enacted Level. The FY 2015 Budget Request continues the activities as described in the FY 2014 Enacted Level and includes an increase of $10 million for the new Strategic Prevention Framework Prescription Drug Abuse and Overdose Prevention (SPF Rx). The request includes:

Strategic Prevention Framework Prescription Drug Abuse and Overdose Prevention (SPF Rx)

According to the 2012 National Survey on Drug Use and Health (NSDUH), 2.6 percent of the U.S. population uses prescription drugs non-medically, including 4.9 million users of pain relievers, 2.1 million users of tranquilizers, 1.2 million users of stimulants, and 270,000 users of sedatives. Drug overdose death rates have increased five-fold since 1980.[20] By 2009, drug overdose deaths outnumbered deaths due to motor vehicle crashes for the first time in the U.S. Prescription drugs, especially opioid analgesics, have been increasingly involved in drug overdose deaths.[21] Opioid analgesics were involved in 30 percent of drug overdose deaths where a drug was specified in 1999, compared to nearly 60 percent in 2010. Opioid-related overdose deaths now outnumber overdose deaths involving all illicit drugs such as heroin and cocaine combined.[22] In addition to overdose deaths, emergency department visits, substance treatment admissions and economic costs associated with opioid abuse have all increased in recent years.

Rates of chronic nonmedical use of opioids are highest among 18-25 year olds, followed by 26-34 year olds, and 35-49 year olds.[23] Rates of emergency department visits due to misuse or abuse of opioids or benzodiazepines are highest among 21-29 year olds followed by 30-44 and 45-54 year olds.[24] Substance abuse treatment admissions for opioid analgesics are highest for 25-34 year olds, followed by 18-24 year olds, and 35-44 year olds.[25] Drug overdose death rates for opioids are highest among people aged 45-54 years old, followed by 35-44, 25-34, and 55-64 year olds.[26]

In FY 2015, funding is being requested for SAMHSA and CDC as part of a strategic effort to address non-medical use of prescription drugs as well as opioid overdoses, leveraging the strengths and capabilities of each agency. The two agencies are coordinating to ensure that the efforts are aligned with HHS' recently established policy and plan for prevention of Opioid-Related Overdoses and Deaths involving multiple Operating Divisions and offices.

CDC will expand its Core Violence and Injury Prevention Program to provide basic injury and violence prevention infrastructure to additional states with a high burden of prescription drug overdose. This expansion will provide additional funding and technical assistance to some current and new Core states to focus on the main drivers of the epidemic – high-risk prescribing and high-risk patients.

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[20] Warner M, Chen LH, Makuc DM, Anderson RN, Miniño AM. Drug poisoning deaths in the United States, 1980–2008. NCHS data brief, no 81. Hyattsville, MD: National Center for Health Statistics. 2011.

[21] Paulozzi L, Jones C, Mack K, Rudd R; Centers for Disease Control and Prevention (CDC). Vital signs: overdoses of prescription opioid analgesics—United States, 1999-2008. MMWR Morb Mortal Wkly Rep. 2011;60(43):1487- 1492.

[22] Centers for Disease Control and Prevention. WONDER [database]. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2013. Available at http://wonder.cdc.gov.

[23] Jones CM. Frequency of prescription pain reliever nonmedical use: 2002-2003 and 2009-2010. Arch Intern Med. 2012;172(16):1265-1267.

[24] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (July 2, 2012). *The DAWN Report: Highlights of the 2010 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits*. Rockville, MD.

[25] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *Treatment Episode Data Set (TEDS): 2000-2010. National Admissions to Substance Abuse Treatment Services.* DASIS Series S-61, HHS Publication No. (SMA) 12-4701. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

[26] CDC analysis of the 2010 Multiple Cause of Death Mortality File. 2012.

SAMHSA proposes to dedicate $10 million to a new program, the Strategic Prevention Framework Prescription Drug Abuse and Overdose Prevention (SPF Rx), that will provide funding for the prevention of prescription drug misuse and abuse in high priority age groups (including young and middle-aged adults) and the general public. SAMHSA's program will complement the CDC program by awarding grants to a state's substance abuse authority to develop a comprehensive prevention approach in collaboration with the state's public health authority, education authority, and Medicaid authority, as well as the state's Prescription Drug Monitoring Program (PDMP) and Health Information Exchange (HIE). The goal will be to raise awareness of the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing and on the use of data from PDMPs and to provide educational materials at points of prescribing, sale and dispensing. SAMHSA's program will also focus on raising community awareness and bringing prescription drug abuse prevention activities and education to schools, communities, parents, prescribers and their patients.

SAMHSA proposes to utilize $4 million to fund SAMHSA SPF Rx grantees to:

- Use the state's strategic plan to target prescription drug abuse and misuse within the state;
- Use PDMP data for prevention planning; and
- Implement evidence-based practices and/or environmental strategies aimed at reducing prescription drug abuse and misuse.

Grantees will be required to track and monitor outcomes in non-medical use of prescription medications, emergency room admissions, and deaths due to prescription drug misuse or overdoses, as well as potential shifts in use of heroin or other illicit drugs in grantee states.

SAMHSA's SPF Rx grantees will be required to use needs assessment data to determine the risk factors leading to prescription drug abuse in the state, including lack of public knowledge of the dangers of misuse of prescription drugs and easy access to prescription drugs through friends, family members, and health care professionals. Because these risk factors will likely differ across grantees, the educational activities and community awareness activities implemented by SPF Rx grantees may also differ. Activities might include media campaigns targeted at parents and focused on the safe storage of prescription drugs,[27] the publication and distribution of opioid prescribing guidelines for health care professionals,[28] and evidence-based educational programs delivered in the school setting, such as Strengthening Families.[29] SAMHSA will also partner with NIDA to further develop the evidence base to support these efforts.

SAMHSA will utilize approximately $4 million for planning grants for up to 20 other states to build capacity to address prescription drug abuse and overdose prevention efforts, in conjunction

[27] Johnson EM, Porucznik CA, Anderson JW, Rolfs RT. State level strategies for reducing prescription drug overdose deaths: Utah's prescription safety program. Pain Medicine: June 2011, Vol.12, Supp 2:S66-72.
[28] Ibid.
[29] Richard Spoth, Linda Trudeau, Chungyeol Shin, Ekaterina Ralston, Cleve Redmond, Mark Greenberg, and Mark Feinberg. Longitudinal Effects of Universal Preventive Intervention on Prescription Drug Misuse: Three Randomized Controlled Trials With Late Adolescents and Young Adults. American Journal of Public Health: April 2013, Vol. 103, No. 4, pp. 665-672.

with other state and local partners. They will utilize these funds to create partnerships with the existing prevention workforce, especially existing coalitions, to utilize PDMP, SAMHSA NSDUH, and/or commercial prescribing data to identify communities at risk and develop plans for appropriate prevention and intervention strategies. These states will be expected to produce a strategic plan focused on bringing prescription drug abuse prevention activities and education to schools, communities, and parents, and include a new focus on prescribers and their patients. These 20 states would be positioning themselves to eventually become implementation states.

Of the remaining $2 million, $1.4 million will be utilized, working in conjunction with CDC, to evaluate and provide technical assistance for funded states, and $0.6 million will be utilized to continue and expand work begun in FY 2011 with the Office of the National Coordinator of Health Information Technology (ONC) to focus on standards alignment on interoperability among state Prescription Drug Monitoring Programs (PDMPs) and electronic health records (EHRs) and HIEs and/or any other technology efforts determined necessary for the exchange of data. Additionally, grantees may identify and implement new opportunities (e.g., pilots, innovation challenges, etc.) focused on the use of EHRs and HIEs to improve clinical decision-making within and across states and to support PDMP communication and outreach activities.

SAMHSA's SPF Rx will provide funds to develop capacity and expertise in the utilization of data from the state's PDMP to identify communities by geography and population (e.g., age group) of high risk, particularly those communities that are in need of primary and secondary prevention. This will be coordinated with CDC's expansion of the Core Violence and Injury Prevention Program to include additional states with a high burden of prescription drug overdose, States will also provide technical assistance and training to the identified communities on the selection and implementation of appropriate evidence-based prevention programming using the Strategic Prevention Framework as their guide. In addition, SAMHSA's resources can be used to provide technical assistance and training on the use of SAMHSA's Opiate Overdose Prevention Tool Kit to prevent overdose deaths.

SAMHSA and CDC will coordinate to implement interventions that address the key drivers of overdose and high-risk prescribers and patients, while also implementing the foundational prevention programs required to sustain a state-wide response to this significant public health issue.

Minority AIDS Initiative

HIV Continuum of Care

(Braided program with Mental Health: Minority AIDS Initiative and Primary and Behavioral Health Care Integration and Substance Abuse Treatment: Minority AIDS Initiative and Primary Care and Addiction Services Integration)

SAMHSA expects that data generated from the 2014 HIV Continuum of Care pilot will help to inform an expanded program proposed for 2015 to continue the co-location and integrated HIV/primary care within either substance abuse or community mental health treatment programs. Braided funds in 2015 in the amount of $24 million would be dedicated to establishing integrated behavioral health and HIV care in addition to primary care needed by those living with or at high

risk for HIV infection in minority communities heavily impacted by HIV. In addition, because of the significant comorbidity of viral hepatitis with HIV infection and because viral hepatitis occurs in up to 20 percent of those with either substance use disorders or serious mental illness, 5 percent of the allocated funds will be used to provide services to prevent, screen, test and refer to treatment as clinically appropriate those at risk for or living with viral hepatitis. In integrating HIV care into behavioral health settings, people living with HIV/AIDS and M/SUDs will have greater access to treatment for these conditions. Integrated care programs developed as a result of this grant program will make it possible for behavioral health and HIV care needs to be addressed in one setting. This will result in effective, person-centered, treatment that will reduce the risk of HIV transmission, improve outcomes for those living with HIV, and ultimately reduce new infections. SAMHSA's Common Data platform (CDP), now under development, will integrate substance abuse and mental health elements with HIV and Hepatitis elements to ensure a more rigorous evaluation and data analysis to inform future public health intervention decision-making that addresses the intersection of behavioral health and HIV.

Strategic Prevention Framework

Building Behavioral Health Coalitions:
Working to Address Shared Risk and Protective Factors
(Braided program with Mental Health: MH System Transformation and Health Reform)

In support of SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, SAMHSA proposes to use $3 million in Budget Authority to establish the Building Behavioral Health Coalitions program. SAMHSA will use $1.5 million from Mental Health Appropriation's Mental Health Transformation and Health Reform funds and $1.5 million from Substance Abuse Prevention Appropriation's Strategic Prevention Framework funds to support this new initiative. The purpose of this program is to support active community coalitions and/or organizations to expand their focus and activities to include mental health promotion, mental illness prevention and substance abuse prevention. Consistent with the Institute of Medicine's 2009 report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*, this program seeks to build on the emerging evidence that a significant number of mental, emotional and substance abuse problems in young people are largely preventable and community-based prevention can play a significant role in facilitating key prevention efforts. Evidence shows that to create emotionally healthy communities, it is important to address the shared risk factors that contribute to an array of adverse outcomes, and the protective factors that reduce the risk of these negative consequences. Risk factors include poverty, early trauma, drug/alcohol misuse, family dysfunction, poor academic performance, and peer rejection. Protective factors include good communication skills, stress mitigation, reliable support and guidance from parents and caregivers, support for high quality early learning, quality health care, healthy peer groups, social connectedness, and successful learning environments.

Mental Health Transformation and Health Reform Funds will be provided to substance abuse prevention community coalitions (including, but not limited to, current and former Drug Free Communities grantees) and organizations to expand their activities to include mental health promotion and mental illness prevention, and Strategic Prevention Framework funds will be provided to coalitions and organizations with a mental health focus to expand their activities to

include substance abuse prevention. Funding streams will be kept separate and used for activities consistent with separate funding authorities.

Funded activities may include but are not limited to, bi-directional education on substance abuse prevention and mental health promotion; assessing shared community risk and protective factors, especially among youth, connecting across community service systems including primary care, and developing the capacity to jointly implement evidence-based programming that addresses these factors; and working with stakeholders such as health insurance companies, Marketplaces, and state Medicaid officials to promote health insurance coverage for substance abuse prevention and mental health promotion. Grantees will be encouraged to consider best practices and models developed through other community-level programs such as Drug Free Communities, Safe Schools/Healthy Students, and Project LAUNCH.

The FY 2015 Budget Request includes level funding from the FY 2014 Enacted Level in the following:

- Mandatory Drug Testing: Funding maintains the Federal Drug-Free Workplace Program and National Laboratory Certification Program as required by law. Both of these are critical public health and safety programs ensuring that individuals in sensitive and safety-related federal positions are not using illicit drugs, and that drug testing laboratories produce accurate results.
- Minority Aids Initiative: Funding addresses a critical public health problem and health disparity. Research has shown that there is a direct correlation between substance use (including alcohol) and HIV infection. The aim is to achieve normative and environmental changes to prevent and/or reduce substance abuse problems as risk factors for the transmission of HIV/AIDS among African-American, Hispanic/Latino, Asian American/Pacific Islander (AA/PI) and American Indian/Alaska Native (AI/AN) young adult populations (ages 18- 24) on campus. In addition, about 60 percent of youth with HIV do not know they are infected. The Minority AIDS Initiative provides life-saving prevention services, including testing.
- Sober Truth on Preventing Underage Drinking (STOP Act): Funding allows for one new grant in FY 2015.
- Fetal Alcohol Spectrum Disorder: Funding will maintain the Center for Excellence.
- Center for the Application of Prevention Technologies: Funding to provide technical assistance and workforce development to the prevention field. This is a critical function as the nation moves toward health reform and a behavioral health model.
- Science and Service Program Coordination: Funding is necessary to support SAMHSA's top strategic initiative, prevention of substance abuse and mental illness, which includes a focus on preventing underage drinking and on American Indians/Alaska Natives.

SAMHSA/ Substance Abuse Prevention
PRNS Mechanism Table by APT
(Dollars in thousands)

Programs of Regional & National	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
Grants						
Continuations	184	$83,444	205	$72,373	196	$100,915
New/Competing	63	46,119	57	56,640	125	39,139
Supplements	17	3,900	15	2,175	---	---
Subtotal	264	133,463	277	131,188	321	140,054
Contracts						
Continuations	25	30,774	22	39,535	20	33,515
New	17	11,276	7	4,837	6	11,991
Subtotal	42	42,049	29	44,372	26	45,506
Total, CSAP PRNS [1/]	**306**	**$175,513**	**306**	**$175,560**	**347**	**$185,560**

1/In the FY 2015 Request, the CSAP Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

A detailed table for all grant and contract continuations and new activities can be found in the SAMHSA Supplementary Tables Chapter.

Key Outputs and Outcomes Table
(SAMHSA)

Program: Minority AIDS Initiative

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.56 Increase the number of program participants exposed to substance abuse prevention education services (Output)	FY 2012: 6,593 Target: 1,535 (Target Exceeded)	3,000[30]	3,000	Maintain
2.3.82 Percent of program participants that rate the risk of harm from substance abuse as great (all ages) (Outcome)	FY 2012: 96.8% Target: 88% (Target Exceeded)	88%	90%	+2
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 2012: 88.4% Target: 91.2% (Target Not Met but Improved)	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 2012: 93.2% Target: 92.6% (Target Exceeded)	92.6%	92.6%	Maintain
2.3.85a Number of persons tested for HIV through the Minority AIDS Initiative prevention activities (Outcome)	FY 2012: 32,975 Target: 32,975 (Baseline)	11,066	11,066	Maintain

[30] Decrease in target from previous year is due to cohort effects and includes Cohorts IX and X.

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

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.3.01 the percentage of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades (Outcome)	FY 2012: 71.7% Target: 46.7% (Target Exceeded)	62%[31]	62%	Maintain
3.3.02 Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades (Outcome)	FY 2012: 55% Target: 63.4% (Target Not Met)	68%[32]	68%	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 2012: 58.2% Target: 56.7% (Target Exceeded)	65%[33]	65%	Maintain

[31] Change from previously reported to reflect average of FY 2011 result and FY 2014 target.

[32] Change from previously reported to reflect average of FY 2011 result and FY 2014 target.

[33] Change from previously reported to reflect average of FY 2011 result and FY 2014 target.

Program: Prevention - Science and Service Activities

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2013: 67,944[34] Target: 110,000 (Target Not Met)	110,000	110,000	Maintain
1.4.10 Prevention: Increase the number of individuals trained by SAMHSA' Science and Services Program (Output)	FY 2013: 12,086[35] Target: 37,049 (Target Not Met)	14,943[36]	17,719	+2,776
2.3.36 Percent of participants that agree or strongly agree that the training or TA provided increased their capacity to do substance abuse prevention work (Outcome)	FY 2012: 88.3% (Historical Actual)	83.8%	83.8%	Maintain
2.3.37 Percent of participants that agree or strongly agree that the training or TA provided increased their organization's capacity to do substance abuse prevention work (Outcome)	FY 2013: Result Expected Dec 31, 2014 Target: Set Baseline (Pending)	83.8%	83.8%	Maintain

[34] Results are preliminary and will be updated in 2014.

[35] FY 2013 results are preliminary and will be updated in 2014.

[36] Revised to reflect actual trends and year without Town Hall Meetings.

Program: Partnerships for Success

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.78 Number of communities who report an increase in prevention activities that are supported by collaboration and leveraging of funding streams (Output)	FY 2012: 50[37] Target: 75 (Target Not Met)	50	142[38]	+92
2.3.79 Number of EBPs implemented by sub-recipient communities (Output)	FY 2012: 888[39] Target: 300 (Target Exceeded)	950	1,850[40]	+900
2.3.80 Number of sub-recipient communities that improved on one or more targeted NOMs indicators (Outcome)	FY 2012: 32[41] Target: 30 (Target Exceeded)	50	142[42]	+92

[37] Data submitted by PFS cohort I grantees.

[38] Target increased from previous year due to substantial increase in grants and sub recipients reporting.

[39] Data submitted by PFS cohort I grantees.

[40] Target increased from previous year due to substantial increase in grants and sub recipients reporting.

[41] Data submitted by PFS cohort I grantees.

[42] Target increased from previous year due to substantial increase in grants and sub recipients reporting.

Program: Strategic Prevention Framework State Incentive Grants

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.21 Decrease underage drinking as measured by an increase in the percent of SPF SIG (Strategic Prevention Framework State Incentive Grant) states that show a decrease in 30-day use of alcohol for individuals 12 - 20 years old (Outcome)	FY 2012: 88% Target: 55.9% (Target Exceeded)	50%	50%	Maintain
2.3.23 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 (Outcome)	FY 2012: 82%[43] Target: 67.6% (Target Exceeded)	52%	52%	Maintain
2.3.25 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 (Outcome)	FY 2012: 29%[44] Target: 50% (Target Not Met but Improved)	50%	50%	Maintain
2.3.28 Number of evidence-based policies, practices, and strategies implemented (Output)	FY 2012: 901 Target: 274 (Target Exceeded)	127[45]	Discontinued	N/A

[43] NSDUH state estimates are provided for 17 of the 35 grantees, many of whom are Pacific Jurisdictions and Tribal entities.

[44] NSDUH state estimates are provided for 17 of the 35 grantees, many of whom are Pacific Jurisdictions and Tribal entities.

[45] Change from previously reported. Number of grantees reduced. Last year of funding for Cohort 5 is 2014.

Program: SPF Rx

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.3.11 Number of funded states that incorporate PDMP data into their needs assessments in developing their strategic plans (Outcome)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain
3.3.12 Number of funded states reporting reductions in opioid overdoses (Outcome)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	306	306	347
Average Awards	$573,570	$573,725	$534,074
Range of Awards	$50,000 - $2,300,000	$50,000 - $2,300,000	$50,000 - $2,300,000

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SAMHSA
Substance Abuse Treatment
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SAMHSA/Programs of Regional and National Significance
Substance Abuse Treatment
(Dollars in thousands)

Programs of Regional & National Significance	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
CAPACITY:				
Opioid Treatment Programs/Regulatory Activities	$12,421	$8,746	$8,746	---
Screening, Brief Intervention and Referral to Treatment	47,464	47,000	30,000	-17,000
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*	+28,000
TCE-General	26,516	13,256	15,256	+2,000
Pregnant & Postpartum Women	15,634	15,970	15,970	---
Strengthening Treatment Access and Retention	1,584	1,668	1,000	-668
Recovery Community Services Program	2,445	2,440	2,440	---
Access to Recovery	93,128	50,000	---	-50,000
Prevention and Public Health Fund (non-add)	---	*50,000*	---	*-50,000*
Primary Care and Addiction Services Integration	---	---	20,000	+20,000
Children and Families	29,018	29,678	29,678	---
Treatment Systems for Homeless	39,397	41,488	41,488	---
Minority AIDS	61,918	65,732	58,859	-6,873
Criminal Justice Activities	63,558	75,000	64,446	-10,554
Subtotal, Capacity	**$393,085**	**$350,978**	**$287,883**	**-$63,095**
SCIENCE AND SERVICE:				
Addiction Technology Transfer Centers	9,008	9,046	8,081	-965
Special Initiatives/Outreach	1,992	1,436	1,436	---
Subtotal, Science and Service	**$11,000**	**$10,482**	**$9,517**	-965
TOTAL, PRNS[1/]	**$404,085**	**$361,460**	**$297,400**	**-$64,060**

1/In FY 2013- FY 2015, the CSAT Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

* Totals may not add due to rounding.

Authorizing Legislation ..... Sections 506, 508, 509, 514 of the Public Health Service Act

FY 2015 Authorization ..... Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements

Program Description and Accomplishments

Opioid Drug Treatment/Regulatory Activities

SAMHSA funds a number of grants and contracts that support the regulatory efforts and monitoring activities of opioid treatment programs.

In FY 2013, SAMHSA awarded seven Cooperative Agreements for Electronic Health Record (EHR) and Prescription Drug Monitoring Program (PDMP) Data Integration grants for approximately $2.9 million. The purpose of this program is to reduce prescription drug misuse and abuse by providing healthcare providers with access to PDMP data to make sound clinical decisions without disturbing their regular clinical workflow. Providing resources to states to enable hospital emergency department EHRs, primary care facility EHRs, and retail store pharmacy dispensing systems to link electronically to PDMPs will facilitate increased utilization. Grant funds will assist states in addressing prescription drug misuse and abuse strategies by integrating their PDMP data into EHRs and other health information technology (HIT) systems. These grant funds can only be used for the purposes of integrating PDMP data into health information systems – they cannot be used to enhance or expand existing PDMPs.

In FY 2013, SAMHSA funded 15 Enhancing Opioid Treatment Program Patient Continuity of Care through Data Interoperability one-year grants. The purpose of this program is to provide resources to opioid treatment programs (OTPs) that will enable them to develop electronic health record systems that fulfill regulatory requirements, achieve certified status, and become interoperable with other patient health record systems. Additionally, SAMHSA funded nine one-year grants to support the Rapid Hepatitis C Virus Screening and Referral grants. The purpose of this program is to address the high prevalence of viral hepatitis C infection among IV drug users in selected OTPs.

As part of its regulatory responsibility, SAMHSA certifies OTPs that use methadone, buprenorphine, or buprenorphine/naloxone to treat patients with opioid dependence. SAMHSA carries out this responsibility by enforcing regulations that established an accreditation-based system, and it is accomplished in coordination with the Drug Enforcement Administration and states, territories, and the District of Columbia. SAMHSA funds the OTP Medical Education and Supporting Services project aimed at preparing OTPs to achieve accreditation, providing technical assistance and clinical training to enhance program clinical activities.

In FY 2014 SAMHSA will support the Physician Clinical Support System-Opioids (PCSS-O) through one new grant.

PCSS-O is a national mentoring network offering clinical updates, evidence-based outcomes, and training to physicians and other medical professionals in the appropriate use of opioids for the treatment of chronic pain and opioid addiction. A three-year Cooperative Agreement for the Physician Clinical Support System–Medication Assisted Treatment (PCSS-MAT) was awarded in FY 2013. The purpose of this program is to provide a national mentoring network offering clinical updates, evidence-based outcomes and training by expanding the previous focus on buprenorphine to include the other two FDA approved medications for the treatment of opioid addiction, methadone and extended release naltrexone.

All discretionary grantees are required to collect and report data on a regular and real-time basis. Data are monitored to provide information which can be used to improve service, monitor grantee performance and quality and provide recommendations for future directions. Grantee performance and outcomes data are monitored using the Services Accountability Improvement System. During the next fiscal year, data will still play an integral role in the monitoring of

grantee performance; however, the data system used for this monitoring will be switched to the Common Data Platform which will house data from all SAMHSA discretionary grantees. SAMHSA also ensures that the accreditation bodies are using sound and evidence-based approaches in accrediting OTPs through SAMHSA staff monitoring of the accrediting process and procedures.

In FY 2014, SAMHSA plans to support the continuation of two grants and six contracts as well as one new grant.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) was initiated by SAMHSA in FY 2003, using cooperative agreements to expand and enhance a 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.

The SBIRT program requires grant recipients to affect practice change throughout the spectrum of medical practice. This is achieved through implementation in all levels of primary care, including hospitals, trauma centers, health clinics, nursing homes, employee assistance programs, and school systems. Practice change also alters the educational structure of medical schools by developing and implementing SBIRT curricula as standard and permanent practice. 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 individuals with more serious problems and encourage them to obtain appropriate specialty treatment services. Funds may be used for the following services: pre/screening for substance use and co-occurring disorders; brief interventions designed with client centered, non-judgmental, motivational interviewing techniques; brief treatment including the monitoring of individuals who misuse alcohol and other drugs but are not yet dependent; referral to treatment (when indicated) for those who have a substance use disorder; and when appropriate, referral to and expansion of specialty treatment services. Since the beginning of this program, more than two million individuals have been screened. Of those, 19 percent required a brief intervention, brief treatment, or referral to specialty treatment programs.

In FY 2012, over 142,000 individuals were served by the SBIRT program. The percentage of individuals reporting abstinence at follow up tripled compared to the percentage reporting abstinence at baseline. In FY 2013, 274,873 individuals were served by the SBIRT program.

SBIRT has great future potential for promoting changes to the entire primary care medical service delivery system. Efforts are underway to identify other funding streams to help take this practice to scale. For example, new diagnostic codes have been adopted by 16 states, making it easier for doctors to get reimbursed for screening Medicaid patients. Likewise, alcohol screening is now available to Medicare beneficiaries as a preventive service without cost. In FY 2012, SAMHSA funded the continuation of 27 SBIRT grants, supported six contracts as well as three new multi-year grants funded out of the Prevention and Public Health Fund, and continued

to monitor the progress of the three FY 2011 multi-year Prevention and Public Health Fund grants.

In FY 2013, SAMHSA funded five state SBIRT grants, 14 SBIRT Medical Professional Training Program grants as well as 12 grant continuations and supported five contracts.

In FY 2014, SAMHSA plans to support nine additional (SBIRT) Medical Professional Training grants and one State SBIRT grant. The purpose of SBIRT Training is to develop and implement training programs to teach health professionals (medical residents and students of nursing, social work and counseling) the skills necessary to provide evidence-based screening, brief intervention and brief treatment and to refer patients who are at risk for a substance use disorder (SUD) to appropriate treatment. As shown by data collected from SBIRT cross-site evaluations (SBIRT Cohort I Cross-Site Evaluation Final Report, 2010), the vast majority of SBIRT service providers are nurses, social workers and counselors with the role of the physician as leading the effort through clinical work, advocacy and supervising SBIRT in medical settings. Grantees are required to use training curricula developed by the initial cohort of SAMHSA SBIRT Medical Residency grantees. The intended outcome of this program is to increase the adoption and practice of SBIRT throughout the health care delivery system. The SBIRT Training program supports the SAMHSA Health Reform Strategic Initiative to expand access to individuals vulnerable to health disparities.

The utilization of the previous cross site evaluations inform current and future SBIRT cohorts and highlights the roles of non-physicians in the actual provision of SBIRT services. The intention is to continue with a new cross site evaluation intended to show outcome measure achievement rather than process data. This will help prove the efficacy and efficiency of the SBIRT process and inform future grant design. Many grantees are also publishing information related to the outcomes achieved through the grant activities and this will help to further the acceptance of SBIRT and inform future grant proposals.

All discretionary grantees are required to collect and report data on a regular and real-time basis. Data are monitored to provide information which can be used to improve service, monitor grantee performance and quality, and provide recommendations for future directions. Grantee performance and outcomes data are monitored using the Services Accountability Improvement System

In FY 2014, SAMHSA plans to support the continuation of 22 grants, four contracts and approximately 10 new grants.

Targeted Capacity Expansion-General (TCE-General)

The Targeted Capacity Expansion (TCE-General) program was initiated in FY 1998 to help communities bridge gaps in treatment services. TCE funding supports grants 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. Since inception, TCE 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 and issues.

In FY 2011, SAMHSA funded Grants to Expand Care Coordination Through the Use of Health Information Technology (HIT) in Targeted Areas of Need. The purpose of this program is to leverage technology to enhance and/or expand the capacity of substance abuse treatment providers to serve persons in treatment who have been underserved because of lack of access to treatment in their immediate community due to transportation concerns, an inadequate number of substance abuse treatment providers in their community, and/or financial constraints. The use of HIT, including web-based services, smart phones, behavioral health electronic applications (e-apps), and telehealth will expand and enhance the ability of providers to effectively communicate with persons in treatment and to track and manage their health to ensure treatment and services are available where and when needed. Grantees will use technology to support recovery and resiliency efforts and promote wellness.

In FY 2012, SAMHSA funded 46 grant continuations and supported 13 contracts as well as six new multi-year funded HIT grants. In FY 2013, SAMHSA funded 13 TCE-Technology Assisted Care (TAC) grants, 20 TCE-Peer to Peer (TCE-PTP) grants, 30 grant continuations, and supported eight contracts. The purpose of the TCE-TAC program is to expand and/or enhance the capacity of substance abuse treatment providers to serve persons in treatment who have been underserved because of lack of access to treatment in rural areas, or in their immediate community due to transportation concerns, an inadequate number of substance abuse treatment and service providers in their community, and/or financial constraints. The use of technology, including web-based services, smart phones, and behavioral health electronic applications (e-apps), will expand and/or enhance the ability of providers to effectively communicate with persons in treatment and to track and manage their health to ensure treatment and services are available where and when needed. SAMHSA is in the process of implementing an evaluation program to analyze the impact of these technologies on the delivery of substance abuse treatment services. This will include patient and provider feedback that will be used to inform future decision making related to the program.

The TCE-PTP program's purpose is to expand and enhance service capacity through the provision of addiction peer recovery support services for those individuals with substance use disorders. It is the expectation that those with lived experience will play an integral role in the design, development, and implementation of this program. A primary program objective is to help achieve and maintain recovery and to improve the overall quality of life for those being served. This will be assessed through increased employment, housing stability, abstinence from substance use, social connectedness, and decreased criminal justice involvement.

In FY 2014, SAMHSA plans to support the continuation of 29 grants, one new TCE-PTP multi-year funded grant, and support six contracts. SAMHSA will continue to monitor the progress of the four FY 2012 multi-year funded HIT Grants and four FY 2013 TCE-PTP multi-year funded grants. It is anticipated that 3,300 clients will be served with FY 2014 funds. Outcomes including abstinence from substance use will also be tracked.

All discretionary grantees are required to collect and report data on a regular and real-time basis. Data are monitored to provide information which can be used to improve service, monitor grantee performance and quality and provide recommendations for future directions. Grantee performance and outcomes data are monitored using the Services Accountability Improvement System. During the next fiscal year, the data system used for this monitoring will be switched to the Common Data Platform which will house data from all SAMHSA discretionary grantees.

Pregnant & Postpartum Women (PPW)

As part of SAMHSA's Strategic Initiative on Trauma and Justice, the Pregnant and Postpartum Women (PPW) program has supported gender-and culturally-specific treatment service grants for pregnant, postpartum, and other parenting women. Using a family-centered trauma-informed treatment approach in residential and community settings, with women and their minor children at the center, the program has focused on the strengths and resources of the entire family. It supports sustained recovery for individual family members, coordinates with services in the community, and improves overall family functioning. The PPW program is designed to support comprehensive substance abuse prevention, treatment, and recovery support services for women, their minor children, age 17 and under children, and family members.

The PPW program provides a variety of services for women, children, and families and case management. Services for women include: outreach, engagement, pre-treatment, screening, and assessment; detoxification; substance abuse education, treatment, and relapse prevention; health care services; specialized assessment, monitoring, and referrals for education, peer support, therapeutic interventions and physical safety; mental health care including a trauma-informed system of assessments and interventions; parenting education and interventions; home management and life skills training; education, testing, counseling, and treatment of hepatitis, HIV/AIDS, other STDs, and related issues; and wraparound services. Services for children include: screenings and developmental diagnostic assessments; prevention assessments and interventions related to mental, emotional, and behavioral wellness; trauma-informed system of assessments, interventions, and social-emotional skill building services; and developmental services and therapeutic interventions. Services for families include: family-focused programs to support family strengthening including fathers; reunification; alcohol and drug education and referral services; mental health promotion and assessment, and prevention and treatment services.

In FY 2011, the PPW program funded a new cohort of grantees. In FY 2012, SAMHSA funded the continuation of 20 grants, six new grants, and support for five contracts. In FY 2013, SAMHSA funded 26 grant continuations and supported four contracts. In FY 2014, SAMHSA plans to fund 17 new grants that will build on the current PPW program. Funding will also support the continuation of six grants and five contracts.

The proposed number of clients to be served with FY 2014 funds is 966 women, 1,900 children and 1,000 other family members. Based on prior cohorts funded under the PPW program and relevant literature, the PPW program approaches service delivery from a family-centered perspective and meets the multiple individual needs of family members), including strategies to stabilize, strengthen, preserve, and reunite families. The PPW program supports comprehensive

substance abuse prevention, treatment, and recovery support services system for women, their children, and family members.

The collection of data continues to improve understanding regarding the substantial lack of access to and services for the needs of these populations of focus, particularly transitional-aged youth. Our data collection efforts will assist in the identification of gaps and needs by assessing the system of care provided by the PPW and adolescent treatment programs. As such, we intend to determine best practices and lessons learned, disseminate findings where they can be applied in other treatment modalities, guide real-time and future programmatic and policy development, and support technical assistance for this sub-population. Outcomes data are currently monitored using the Services Accountability Improvement System. During the next fiscal year, the data system used for this monitoring will be switched to the Common Data Platform which will house data from all SAMHSA discretionary grantees.

Given the availability of Medicaid and Children's Health Insurance Program (CHIP), many of the children and women served by the PPW program are eligible for these insurance options across the country. SAMHSA will consider building upon the program to advance the successful PPW model as an evidence-based approach for serving pregnant and post-partum women in need of residential substance abuse treatment.

The Affordable Care Act will further expand health insurance coverage eligibility through the expansion of Medicaid in some states and the establishment of Affordable Insurance Marketplaces in all states. The PPW program provides crucial services that are not covered under most public and private insurance. In particular the PPW program includes non-covered services and activities such as outreach, engagement, pre-treatment, substance abuse education, relapse prevention, monitoring, and referrals for education, peer support, physical safety; parenting education and interventions; home management and life skills training; education on hepatitis, HIV/AIDS, other STDs, and related issues; and wraparound services.

Strengthening Treatment Access & Retention (STAR)

During the initial phase of the STAR program, 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 (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-up effort in 2006, the STAR-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.

In FY 2010 and FY 2011, the 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. The program also conducted a learning collaborative with over 300 treatment and service providers on how to improve third-party billing practices in anticipation of the expansion in addiction treatment services coverage and health insurance affordability program eligibility under the Affordable Care Act. In FY 2012 and 2013, SAMHSA supported four contracts to continue to provide technical assistance in promoting service efficiency. In FY 2014, SAMHSA plans to support five contracts, which includes the operation of 15 provider business operations learning networks, involving an estimated 300 provider organizations. These networks will expand training to include strategic business planning, third party contracting and ensuring client eligibility and engagement in treatment.

STAR utilizes the National Institute on Drug Abuse (NIDA) research based process improvement practice to inform all business operations learning networks and organizational implementation. Treatment organizations that implement business operations practices utilize evidence-based PDSA Cycles (plan, do, study, act) as part of their improvement process. This includes collecting data before, during and following the changed that is implemented.

Recovery Community Services Program (RCSP)

SAMHSA's Strategic Initiative on Recovery Support focuses on health, home, purpose, and community. As part of the community component of this initiative, 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 advance 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, African-Americans, Latinos, rural populations, persons recently released from incarceration, the homeless, adolescents, and gay, lesbian, and transgender populations. 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 seeking recovery. 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. FY 2013 data demonstrate positive outcomes, with 84 percent of clients served reporting being abstinent at

follow-up; 32 percent reported being unemployed; 63 percent reported being housed; and 99 percent reported not being involved in the criminal justice system.

In FY 2012, SAMHSA funded the continuation of five grants and support for two contracts. In FY 2013, SAMHSA funded five grant continuations and supported two contracts.

The RCSP and TCE-PTP grant programs design and deliver peer recovery support services. Both programs use CSAT GPRA outcome data to evaluate relapse, social connectedness, housing, employment/education, and criminal justice involvement. Additionally, these grant programs are utilizing practice-based models of recovery coaching, and evidence-based practices of Wellness Recovery Action Planning (WRAP) and other wellness models of Whole Health Action Management (WHAM) as well as other EBP's that support peer recovery supports.

The RCSP and TCE-PTP are identifying peer recovery supports that promote sustained recovery and improved quality of life. These programs will support the proposed GPRA recovery measure for SAMHSA. Data is being used to evaluate the usefulness of specific recovery supports with culturally-specific populations, and to identify program models that best address the needs of individuals in recovery from addiction. The new RCSP Statewide Network Grant Program builds on evaluations of previous cohorts to move forward on strengthening the capacity of community organizations that support addiction recovery through the building of statewide networks.

In FY 2014, SAMHSA plans to support three contracts and 18 new grants ($1.4 million in CSAT and $0.4 million in CMHS) in support of the Recovery Support Strategic Initiative. These funds will be used to build capacity for statewide consumer-run, family member run, or addiction recovery community organizations to promote cross-service system and infrastructure development that is recovery-focused and resiliency oriented. Of that total, $1 million in budget authority will be used to award new addiction recovery community statewide networks.

In order to ensure a stronger policy voice across the behavioral health field and facilitate readiness for the implementation of health reform, a supplemental incentive award will be offered to applicants proposing to build a collaborative partnership among SAMHSA-funded mental health and addictions peer-run state-wide networks and those that are mental health family-run. Up to $0.8 million will be braided to allow for supplemental awards for collaborative partnerships across the mental and substance use disorder fields. Additionally, partnerships with affiliate health networks will be encouraged. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent. Eligible applicants for supplements will be those organizations who have an existing mental health (Statewide Family and Statewide Consumer Networks) or addiction statewide network award.

Up to 10 grant awards at $1 million will be made for addiction recovery statewide networks. Up to eight supplemental awards will be given at $0.1 million each. Grantees will be expected to facilitate effective participation in state and local behavioral health services planning and health reform activities related to improving community-based services and supports for people in

recovery from substance use disorders, children and youth with serious mental health conditions and their families or adult mental health consumers. The program will also address gaps in behavioral health policy as well as inform health reform planning.

All discretionary grantees are required to collect and report data on a regular and real-time basis. Data are monitored to provide information which can be used to improve service, monitor grantee performance and quality and provide recommendations for future directions. Grantee performance and outcomes data are monitored using the Services Accountability Improvement System. During the next fiscal year, the data system used for this monitoring will be switched to the Common Data Platform which will house data from all SAMHSA discretionary grantees.

Access to Recovery

Since 2004 the ATR program has served 221,607 clients through 69 grantees. In FY 2014, SAMHSA plans to award approximately five Prevention and Public Health Fund grants of up to $3 million per year for three years – these grants will be multi-year funded. The majority of services provided are expected to be recovery support not otherwise fundable through insurance mechanisms. These include services such as transportation, housing, and jobs support. Reduced in scale from past years, ATR will serve approximately 8,000 individuals per year. In FY 2014, the program will preserve the core concepts embodied in the three previous ATR cohorts, while also striving to better support provisions of the Affordable Care Act.

State and tribal ATR grants will support the provision of treatment and recovery support services to those with substance use disorders. Services payable under Medicaid and covered through essential health benefit plans, such as outpatient clinical treatment services and residential services, would, for the most part, not be allowable under this program. In order to ensure non-duplication of billing sources, providers will work with clients to link them to other usable funding sources where appropriate. For those services not covered, providers will be responsible for the provision of direct services. As was the case in the first three cohorts of ATR, states/tribes will be required to establish provider networks and develop a voucher-based mechanism to ensure client choice can be easily and freely exercised.

ATR grant funds will also support creating linkages with state health information exchanges (HIEs) to ensure coordination and non-duplication; working with non-traditional providers, such as faith-based and peer providers; working with traditional providers to ensure that proper sources of billing are being utilized for recovery support and clinical treatment services not being covered under Medicaid and other sources; and increasing availability and access to training and certification programs for non-traditional providers, such as faith-based and peer providers.

In FY 2014, the ATR program will better support the integration of third party payers, the provision of services unlikely to be covered by insurance such as supportive services like housing, and services to those who are ineligible for insurance or are unable to acquire it. ATR utilizes data from GPRA in the Services Accountability Improvement System (SAIS) system to monitor grantee performance and to support effective program operation. Data are compared across time and between programs to identify high performing programs. Grantees report at the grantee meeting their approaches to data analytics to inform future program design and

implementation opportunities. Successful ATR innovations will be communicated and new evidence shared to strengthen capacity nationwide and to inform future decision making regarding ATR models of service delivery.

Children & Family Programs

As part of SAMHSA's Trauma and Justice Strategic Initiative, adolescent treatment programs 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.

The Assertive Adolescent and Family Treatment (AAFT) grants provide adolescents 12 through 17 and their families/care givers with: a full bio-psycho-social clinical assessment, the Global Appraisal of Individual Needs (GAIN), which identifies substance use disorders, co-occurring mental health problems, mental illness, and family support and functioning; six months of substance abuse treatment and follow-up monitoring using the Assertive Community Reinforcement Approach and the Assertive Continuing Care (A-CRA/ACC) treatment interventions; urine testing; case management; and referrals to other needed community service providers. A-CRA and ACC were developed with funding from SAMHSA and the National Institute on Alcohol Abuse and Alcoholism and have proven effective in building community capacity for family-centered treatment and ensuring sustainability over time.

In FY 2012, SAMHSA funded 13 new state-based adolescent treatment grants called Cooperative Agreements for State Adolescent Treatment Enhancement and Dissemination (SAT-ED), to further the use of, and access to, effective family-centered treatment approaches through state-wide training while supporting connections between locally based treatment systems and their state, tribal, or territorial infrastructure. The services provided under this program include: evidence-based assessment and treatment interventions, outreach and other engagement strategies; recovery services and supports (e.g., peer-to-peer support, parent/family/caregiver support), youth and caregiver respite care, technology support services, therapeutic mentors, behavioral health consultation, vocational, educational and transportation services and case management and coordination services.

In addition to the adolescent treatment grant programs, SAMHSA 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 (National Center). The vast majority of children, particularly infants, who are placed in protective custody, have a parent with a substance use disorder. Thus, it is imperative that child welfare, substance abuse treatment and service providers, and the courts work efficiently together. Activities of this National Center include: in-depth technical assistance to states, forging more extensive partnerships with family drug courts, and planning greater emphasis on work with tribes. ACF grantees are able to draw upon SAMHSA technical assistance provided to the child welfare and substance abuse treatment fields, including grants awarded under an ACF grant program referred to as Regional Partnership grants.

All discretionary grantees are required to collect and report data on a regular and real-time basis. Data are monitored to provide information which can be used to improve service, monitor grantee performance and quality and provide recommendations for future directions. Grantee performance and outcomes data are monitored using the Services Accountability Improvement System. During the next fiscal year, data will still play an integral role in the monitoring of grantee performance; however, the data system used for this monitoring will be switched to the Common Data Platform which will house data from all SAMHSA discretionary grantees.

In FY 2012, the adolescent portfolio supported 32 AAFT grant continuations, six contracts and 13 new SAT-ED grants. In FY 2013, SAMHSA funded 13 SAT-ED grant continuations, supported five contracts, and funded 10 new State Youth Treatment (SYT) grants. In FY 2014, SAMHSA plans to support the continuation of 23 grants and seven contracts. SAMHSA expects to serve approximately 2,500 clients with FY 2014 funds. All outcomes, including abstinence from substance use, will also be tracked.

Treatment Systems for Homelessness

The Center for Substance Abuse Treatment (CSAT) manages two grant portfolios under its Grants for the Benefit of Homeless Individuals (GBHI) authority - Treatment for Homeless and Cooperative Agreements to Benefit Homeless Individuals (CABHI), that provide focused services to individuals with a substance use disorder or who have co-occurring substance use and mental disorders. These programs tie directly to the SAMHSA Recovery Support Strategic Initiative which focuses specifically on "home" as an integral component of one's well-being.

The Treatment for Homeless-General grants enable communities to expand and strengthen their substance abuse treatment services for individuals who are at risk for experiencing homelessness or are experiencing homelessness. The Treatment for Homeless-Services in Supportive Housing (SSH) grants seek to expand and strengthen treatment services for individuals who experience chronic homelessness using a supportive housing approach.

In FY 2011, CSAT in collaboration with CMHS, began awarding CABHI under the GBHI authority. The major goal of the program is to ensure that the most vulnerable individuals who experience chronic homelessness receive access to sustainable permanent housing, treatment, and recovery supports through mainstream funding sources. This program builds on the success of the previous Treatment for Homeless program.

In FY 2013, SAMHSA funded 71 grant continuations and supported five contracts. In addition, CSAT in collaboration with CMHS funded 11 new Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States). CABHI-States builds on the current CABHI program by adding a state infrastructure improvement approach addressing chronic homelessness to the community-based behavioral health service component for newly housed individuals who experience chronic homelessness with substance use disorders or co-occurring substance use and mental disorders.

In FY 2014, SAMHSA plans to support 34 grant continuation, five contracts and approximately 39 grant awards within a new cohort of jointly funded CSAT and CMHS CABHI-State grants and Grants for the Benefit of Homeless Individuals-Services in Supportive Housing (GBHI-

SSH). The proposed number of clients to be served with FY 2014 funding is 5,800. Outcomes including abstinence from substance use will also be tracked.

SAMHSA's homeless grant programs are designed to provide supports and services for people with mental illness and/or substance use disorders who experience homelessness or are at risk of homelessness. SAMHSA encourages grantees to work collaboratively with HUD grant programs in providing supportive services for individuals experiencing homelessness. SAMHSA homeless programs do not fund housing; therefore linkage with HUD programs is essential. SAMHSA grantees frequently work side-by-side with HUD's Permanent Supportive Housing, Section 8, Shelter plus Care, Vouchers and other programs. SAMHSA funds an array of integrated behavioral health, treatment, housing support and recovery-oriented services and supports including outreach, engagement, intensive case management, treatment for mental and/or substance abuse disorders, enrollment in mainstream benefits, employment readiness, and linkage to permanent housing.

All discretionary grantees are required to collect and report data on a regular and real-time basis. These data are used to monitor grantee performance to ensure that progress is being made toward meeting program goals and objectives. Data provided evidence of the effectiveness of the services being provided. Several key domains have been identified in order to assess the extent to which service provision is effective. These domains include abstinence from substance use, employment, housing stability, criminal justice status and social connectedness. Outcomes data are monitored using the Services Accountability Improvement System. Data are monitored to provide information which can be used to improve service quality, monitor grantee performance and provide recommendations for future direction. During the next fiscal year, data will still play an integral role in the monitoring of grantee performance; however, the data system used for this monitoring will be switched to the Common Data Platform which will house data from all SAMHSA discretionary grantees.

Minority AIDS

Minority AIDS (MAI) 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; minority men who have sex with men (MSM); 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 other medical and social services in the local community.

In FY 2012, SAMHSA's TCE/HIV program served approximately 8,000 individuals. Of these individuals, approximately 69 percent were between the ages of 25 and 54 years old. Approximately 32 percent identified themselves as Hispanic/Latino in ethnicity; 42 percent

as African-American; 27 percent White; one percent Asian, Native Hawaiian, or Pacific Islander; and seven percent as American Indian/Alaska Native.

In FY 2011, SAMHSA awarded 11 Minority AIDS Initiative Targeted Capacity Expansion (MAI-TCE) Integrated Behavioral Health/Primary Care Network Cooperative Agreements. This program is jointly funded with CMHS and CSAP and facilitates the development and expansion of culturally-competent and effective integrated behavioral health and primary care networks which includes HIV services and medical treatment within racial and ethnic minority communities in the 11 Metropolitan Statistical Areas and Metropolitan Divisions most impacted by HIV/AIDS. Expected outcomes include reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas. SAMHSA continued to support these grants in 2012 and 2013.

In FY 2012, SAMHSA funded the continuation of 76 grants and supported five contracts as well as a new cohort of 52 grants to target areas of highest need based on the most recently available HIV epidemiological data.

In FY 2013, SAMHSA funded 79 grant continuations and supported seven contracts and 35 new grants. The 35 grants support Targeted Capacity Expansion: Substance Abuse Treatment for Racial/Ethnic Minority Women at High Risk for HIV/AIDS (TCE-HIV: Minority Women). The purpose of this program is to expand substance abuse treatment and HIV services for African American, Hispanic/Latina, and other racial/ethnic minority women (ages 18 years and older), including heterosexual, lesbian, bisexual, previously incarcerated women, and their significant others, who have substance use or co-occurring substance use and mental disorders, and are living with or at risk for HIV/AIDS.

Scientific literature supports that as the incidence and prevalence of HIV/AIDS increases among racial and ethnic minority populations, the need for substance abuse and mental health treatment increases as well. Limited or a complete absence of appropriate behavioral treatment intervention services is very likely to lead to unmet behavioral health needs, adverse medical conditions, impaired quality of life, increased morbidity and mortality for this vulnerable population. To address this public health challenge, the MAI-TCE program facilitates the development and expansion of culturally competent and effective integrated behavioral health and primary care networks, which includes HIV services and medical treatment, within racial and ethnic minority communities in 11 Metropolitan Statistical Areas (MSAs) highly impacted by HIV/AIDS.

SAMHSA Services Accountability Improvement System (SAIS) data and CDC HIV prevalence data was used to identify specific minority high-risk populations that resulted in SAMHSA publishing population focused RFAs for YMSM and minority women.

By focusing on specific vulnerable populations and requiring grantees to utilize specific evidence-based interventions SAMHSA/CSAT programs can build new evidence that supports the value of simultaneous treatment of co-occurring substance abuse and HIV and the value of using evidence-based interventions for recruitment and retention of high-risk, minority populations in substance abuse treatment and antiretroviral therapy. Improved treatment

outcomes would lend itself to more rigorous evaluation and data analysis by the SAMHSA Common Data platform (CDP) to inform future public health intervention decision-making.

In FY 2014, SAMHSA plans to support the continuation of 87 grants and six contracts, and will continue to monitor the progress of the three FY 2012 multi-year funded grants. The proposed number of clients to be served with 2014 funds is 13,558. Outcomes including abstinence from substance use will also be tracked.

In FY 2014, SAMHSA's CMHS, CSAP, and CSAT plan to pilot HIV Continuum of Care grants which supports behavioral health screening, primary prevention, and treatment for racial/ethnic minority populations with or at high risk for mental and substance use disorders and HIV. This will include Substance Abuse (SA) primary prevention/treatment service programs, community mental health programs, and HIV integrated programs that can either co-locate or fully integrate HIV prevention and medical care services within them. Also, this program will provide SA and HIV primary prevention services in local communities served by the behavioral health program.

Criminal Justice Activities

Criminal Justice activities include grant programs, which focus on diversion, alternatives to incarceration, and re-entry from incarceration for adolescents and adults with substance use disorders, and/or co-occurring substance use and mental disorders. These activities comport directly with SAMHSA's Trauma and Justice Strategic Initiative efforts.

Drug 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. Funding for adult treatment drug court programs provide a variety of services, including: direct treatment or prevention services for diverse populations at risk; "wrap-around"/recovery support services designed to improve access and retention; drug testing for illicit substances required for supervision, treatment compliance, and therapeutic intervention; education support; relapse prevention and long-term management; Medication-Assisted Treatment (MAT); and HIV testing conducted in accordance with state and local requirements.

In FY 2012, SAMHSA funded the continuation of 81 drug court grants and supported eight contracts, and 54 new drug court grants. In FY 2013, SAMHSA funded the continuation of 78 drug court grants, supported three contracts, and funded 39 new drug court grants. In FY 2014, SAMHSA plans to support 92 grant continuations, two contracts, and 55 new drug court grants.

The SAMHSA Drug Court grant programs are utilizing existing evidence to support current programs and new proposals by incorporating findings from numerous studies of drug courts. There have been over 125 evaluation and research studies of the effectiveness of drug courts and several micro-analyses in addition to GAO reports on the effectiveness of treatment drug courts. SAMHSA's RFA require evidence-based practices to be used from federal inventories of such practices (NIDA, SAMHSA's NREPP). SAMHSA also has regular communications with the national drug court constituency group, the National Association of Drug Court Professionals in order to obtain and incorporate the latest findings and field expertise. Examples of SAMHSA's

drug court programs incorporating the latest "standards" for drug courts as promulgated by NADCP with the support of the Bureau of Justice Assistance, U.S. Department of Justice. Language pertaining to screening for co-occurring disorders, use of medically assisted treatments for opioid or alcohol dependent persons, and identification of behavioral health disparities have been included in the grant solicitations.

In addition to SAMHSA's drug court portfolio, the agency also supports other robust criminal justice programs. For example, the Offender Reentry 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. SAMHSA and the DOJ/BJA share a mutual interest in supporting and shaping offender re-entry-treatment services, as both agencies fund "offender reentry" programs. Formal agreements have been developed to further encourage and engage in mutual interests and activities related to criminal justice-treatment issues. ORP grantees are expected to seek out and coordinate with local federally-funded offender reentry initiatives, including the DOJ/BJA's Prisoner Reentry Initiative or "Second Chance Act" offender re-entry programs, as appropriate. Funding for ORP may be used for a variety of services, including: screening, comprehensive individual assessment for substance use and/or co-occurring mental disorders, case management, program management and referrals related to substance abuse treatment for clients; alcohol and drug treatment; wraparound services supporting the access to and retention in substance abuse treatment or to address the treatment-specific needs of clients during or following a substance abuse treatment episode; individualized services planning; drug testing; and relapse prevention and long-term management support.

The (ORP) grant program utilizes existing evidence to support current programs and new proposals by incorporating findings from numerous studies of drug courts. SAMHSA's ORP RFA requires evidence-based practices to be used from federal inventories of such practices (NIDA, SAMHSA's NREPP). SAMHSA is represented at the Attorney General's Reentry Council and in numerous inter- and intra-agency workgroups in order to obtain and incorporate the latest findings and field expertise. A federal reentry resource center has been established on the MAX electronic information forum to constantly update the 'state of the state' of offender reentry programming, research, and grant initiatives. The ORP grant solicitation contains language pertaining to Risks, Needs, and Responsivity models as part of the latest cutting edge approach to screening and assessing ex-offenders, the grant program, and the community response. Language pertaining to screening for co-occurring disorders, use of medically assisted treatments for opioid or alcohol dependent persons, and identification of behavioral health disparities has been included in the ORP grant solicitation.

In FY 2011, SAMHSA awarded grants to Develop and Expand Behavioral Health Treatment Court Collaborative (BHTCC) in collaboration with CMHS. The purpose of the BHTCC is to provide state and local criminal and dependency courts serving adults with more flexibility to collaborate with the other judicial components and local community treatment and recovery providers to better address the behavioral health needs of adults who are involved with the criminal justice system. In FY 2014 SAMHSA plans to support an additional cohort (up to 14 new grants) of BHTCC grants ($2,429,534 in CSAT and $2,969,430 in CMHS).

In FY 2012, SAMHSA created the Teen Courts grant program (TCP), of which the primary focus is preventing crimes by diverting youth with substance abuse treatment needs from deeper penetration into the traditional juvenile justice system. Funds are used to provide screening, assessment, substance abuse treatment, and recovery support services for youth involved in a TCP.

In FY 2012, in addition to drug courts, SAMHSA funded the continuation of 27 grants, supported five contracts, and funded 28 new grants.

In FY 2013, SAMHSA funded three new Early Diversion grants with CMHS, 13 Offender Reentry grants and supported five contracts. In FY 2014, and in support of SAMHSA's Trauma and Justice, a total of 5.4 million in Budget Authority ($2.5 million in CMHS and $2.9 million in CSAT) will fund an additional cohort of Behavioral Health Treatment Court Collaboratives Grants along with plans to support 41 grant continuations, nine contracts, and 15 new grants.

Addiction Technology Transfer Centers (ATTCs)

The Addiction Technology Transfer Center (ATTC) Network supports national activities and implements 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, promising practices to addiction 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 29,000 people were trained in FY 2012, exceeding the target of 20,516. In FY 2012, SAMHSA funded a new cohort of 15 grants. Ten of the new grants are geographically consistent with HHS's 10 regional offices in order to coordinate SAMHSA services, technical assistance and workforce training and development with other HHS Operating Divisions such as HRSA, CMS, ACF, and the SAMHSA Regional Administrators. The remaining five awards support one national and four focus area ATTCs. In FY 2013, SAMHSA funded the continuation of all 15 ATTC grants. Data show 36,391 people were trained in FY 2013, exceeding the target of 21,000.

All discretionary grantees are required to collect and report data on a regular and real-time basis. Data are monitored to provide information which can be used to improve service, monitor grantee performance and quality, and provide recommendations for future directions. Grantee performance and outcomes data are monitored using the Services Accountability Improvement System. During the next fiscal year, data will still play an integral role in the monitoring of grantee performance; however, the data system used for this monitoring will be switched to the Common Data Platform which will house data from all SAMHSA discretionary grantees.

In FY 2014, SAMHSA plans to support the continuation of 15 grants. The proposed number of individuals to be trained with FY 2014 funding is 20,516. Outcomes including participants who

report implementing improvements will also be tracked. By 2015, 90 percent of participants are expected to report implementing improvements in treatment methods on the basis of information and training provided by the program.

Special Initiatives/Outreach

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 105 HBCUs throughout the United States. 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 Center also supports a policy academy which focuses on workforce development, leadership development, cross-systems collaboration, cultural competency, and eliminating disparities. The Center collaborates with other HHS agencies including the HHS/Office of Minority Health (OMH) to achieve the objectives of various Executive Orders on educational excellence for minority populations.

Through this program, approximately 31 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.

In FY 2010 SAMHSA 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. In FY 2012, SAMHSA funded the continuation of one grant and supported four contracts. In FY 2013, SAMHSA funded the continuation of one grant and supported five contracts. SAMHSA plans to support three contracts and one continuation grant in FY 2014.

Funding History[1\]

Fiscal Year	Amount
FY 2011	$430,842,000
FY 2012	$428,696,822
FY 2013	$404,085,188
FY 2014	$361,460,000
FY 2015	$297,400,000

[1\]The funding history is presented on a comparable basis to previous funding levels to represent the revised budget structure and includes the PHS Evaluation Funds and Prevention and Public Health Fund.

Budget Request

The FY 2015 Budget Request is $297.4 million at the program level with $267.4 million from Budget Authority and $30 million provided by PHS Evaluation Funds. This is a decrease of $64 million in Budget Authority from the FY 2014 Enacted Level. The request includes:

The Primary Care and Addiction Services Integration (PCASI) Program

SAMHSA is requesting $20 million to support the development of a new initiative related to the integration of substance abuse treatment services and primary care. The PCASI Program would enable providers to offer a full array of both physical health and substance abuse services to clients. In conjunction with the Affordable Care Act (ACA), SAMHSA recognizes the need to emphasize the importance of integrated service delivery. Through this program, integrated teams of professionals will be able to provide needed primary care services to individuals seeking care for their substance use disorder. The purpose of this program is to establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care services in community-based substance abuse treatment settings. The goal is to improve the physical health status of adults with substance use disorders who have or are at risk for co-occurring primary care conditions and chronic diseases, with the objective of supporting the triple aim of improving the health of those with SUD; enhancing the client's experience of care (including quality, access, and reliability); and reducing/controlling the per capita cost of care. The expected outcome of improved health status for people with SUD 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 SUD. Partnerships between primary care and behavioral health organizations, as well as information technology entities, are deemed crucial to the success of this program**.**

Currently, a significant component of the overall higher cost of care for those with SUD is untreated chronic disease.[46] The likelihood that a patient seeking care for a substance use disorder will successfully complete a referral to a primary care facility is low in general but

[46] Druss, B. g., & Rosenheck. R. A. (1999). Patterns of health care costs associated with depression and substance abuse in a national sample. Psychiatric Services, 50, 214-218

greatly improved within a single visit or facility.[47] This program will not only improve the data about the success and impact of these improved referrals, but will also illuminate other benefits of integration such as improved provider knowledge and effectiveness at identifying and referring individuals in need of primary care and substance abuse treatment.

The demand for substance use disorder prevention, intervention, treatment, and recovery services after the implementation of the ACA will far exceed the current capacity and a focused effort through the states to address this shortage will be critical. As described above, the PCASI program provides the structure and infrastructure necessary to support the integrated service delivery. Together, these two programs will perform synergistically, with the process and performance outcomes building on each other.

Substance use disorders can cause physical health problems and/or exacerbate existing physical health problems. For example, several cardiovascular complications are closely related to cocaine use. They include chest pain syndromes, heart attacks, heart failure, strokes, aortic dissection, and fatal and nonfatal arrhythmias.[48] According to the CDC, alcohol use causes 80,000 deaths a year.[49] Alcohol use contributes to a variety of chronic health conditions including; cirrhosis, hypertension, obesity, diabetes, hepatitis, pancreatitis, cardiomyopathy, gastritis, etc…which increases morbidity and mortality. Additionally, excessive alcohol use increases the risk of cancers such as mouth, throat, and esophagus. As the result of other chronic health issues, many individuals develop substance abuse problems due to self-medication. The National Institute on Drug Abuse defines self-medication as the use of a substance to lessen the negative effects of stress, anxiety, or other mental disorders (or side effects of their pharmacotherapy). Self-medication may lead to addiction and other drug or alcohol-related problems.[50]

A continuum of preventive and health promotion services will be offered to and/or coordinated for clients within the PCASI program, where different services are offered to different categories of clients according to the severity of the condition/risk factors. Wellness programs (e.g., tobacco cessation, nutrition consultation, health education and literacy, self-help/management programs) will be offered, including interventions that involve preventive screening and assessment tools for all clients. In addition, this grant program can support the infrastructure necessary to ensure an effective coordination of services, including such tasks as necessary to expand partnerships, increase the use of an integrated electronic health record, and other such activities. Grantees will be required to bill third party insurance or utilize other funds and to only use SAMHSA grant funds for services to individuals who are ineligible for public health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan (co-pay or other cost sharing requirements are an acceptable use of SAMHSA grant funds).

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[47] Kathol, R. G., McAlpine, D., Kishi, Y., Speies, R., Meller, W., Bernhardt, T., et al. (2005). General medical and pharmacy claims expenditures in users of behavioral health services. Journal of General Internal Medicine, 20, 160-167.

[48] http://www.heart.org/HEARTORG/Conditions/Cocaine-Marijuana-and-Other-Drugs_UCM_428537_Article.jsp

[49] Jeffrey J. Sacks, MD, MPH, Jim Roeber, MSPH, Ellen E. Bouchery, MS, Katherine Gonzales, MPH, Frank J. Chaloupka, PhD, Robert D. Brewer, MD, MSPH; State Costs of Excessive Alcohol Consumption, 2006: Accessed at http://www.ajpmonline.org/webfiles/images/journals/amepre/AMEPRE_3854-stamped-081313.pdf

[50] http://www.drugabuse.gov/publications/research-reports/comorbidity-addiction-other-mental-illnesses/glossary

SAMHSA will fund a total of 34 grants at approximately $0.5 million annually for up to three years. Eligible applicants will be publicly funded community substance abuse treatment centers. To address the bi-directional nature of the integration approach emphasized by this grant program, the applicant must demonstrate they are able to offer the following core requirements; provided by qualified professionals, both substance abuse treatment and primary care services. Additional eligibility criteria include the ability to show demonstrable progress or commitment to the implementation of interoperable electronic health records.

The remaining $3 million will be used to fund technical assistance and evaluation activities to assess the clinical and cost effectiveness of these programs and other programs in the field, to ensure fidelity to implementation, and to assist with documentation and dissemination of lessons learned from the program. The success of the PBHCI program has taught SAMHSA that technical assistance must include strategies around integrated models, workforce, financing, clinical practice, and operations and administration of the PCASI grant. SAMHSA has been able to realize improved health outcomes for PBHCI clients across myriad domains, including blood pressure, tobacco use, and diabetes measures, in addition to improvement in client self-perception of overall health. The PBHCI program has created bridges between community behavioral health and primary care providers, yielding a cadre of providers able to serve the holistic health care needs of their patients.

Promoting widespread implementation of Health Information Technology (HIT) systems that support quality, integrated behavioral health care is currently one of SAMHSA's eight strategic initiatives. HIT has the potential to transform the health care system by improving the quality of care delivery, supporting patient engagement and self-management, improving the efficiency of the workforce, and expanding access to care. In FY 2011-2012, SAMHSA provided supplemental funding to our Primary & Behavioral Health Care Integration (PBHCI) program to help 4 grantees become meaningful users of electronic health record (EHR) technology. Of these, 93 percent successfully implemented a certified EHR system in 2012 and this technology is continuing to support the integration of primary and behavioral healthcare in these programs. Due to the success of the PBHCI HIT supplemental program, SAMHSA is requesting an additional $2 million in funding for the Targeted Capacity Expansion-General program in FY 2015 to fund the Behavioral Health Information Privacy Center of Excellence, a similar HIT initiative, among the Primary Care and Addiction Services Integration (PCASI) program grantees. This supplemental funding will support the enhancement and adoption and meaningful use of certified EHR technology which will facilitate the integration of care for patients in substance abuse treatment to improve compliance with Federal privacy law.

In addition, the funding will support Braided Program: HIV Continuum of Care grants as provided below to provide bi-directional integration between primary care services and substance abuse treatment/mental health services (for CSAT/CMHS) and address service coordination and infrastructure needs of providers serving this vulnerable population.

TCE General

Behavioral Health Information Privacy Center of Excellence

A primary objective of SAMHSA's Health Information Technology Strategic Initiative is to promote interoperability of behavioral health priorities with primary health care. Federal privacy law (42 CFR Part 2) restricts the disclosure and re-disclosure of records pertaining to substance abuse treatment. Many state laws also limit the sharing of information related to behavioral health and other sensitive health conditions such as HIV. These regulations set detailed requirements for obtaining consent and sharing health information. Currently, within the health information technology field, specifically, most electronic health record (EHR) and health information exchange (HIE) systems do not have the capacity to manage consents, to communicate privacy related obligations, or to control the re-disclosure of select types of information. In addition, most general health care providers and technology vendors are unaware of these regulations and the legal obligations associated with receiving substance abuse treatment data. This constitutes a significant barrier to the integration of primary and behavioral health care. SAMHSA therefore requests an additional $2 million within Targeted Capacity Expansion–General to create the Behavioral Health Information Privacy Center of Excellence (COE). The COE will work to address these issues by providing coordinated technical assistance to provider organizations, HIEs, states, consumers, and vendors to support integration of behavioral health and general healthcare through health information exchange. The Center of Excellence will develop resources to support information exchange between behavioral health and general health care including tools to facilitate implementation of technologies that support compliance with 42 CFR Part 2 and similar state privacy laws and regulations. This will include the development of privacy policies, best practices and toolkits for sharing sensitive health information. In addition, the Center will work to support broad dissemination of educational resources to general medical systems on compliance with federal and state regulations when receiving protected behavioral health information.

Minority AIDS and Primary Care and Addiction Services Integration

HIV Continuum of Care

(Braided program with Mental Health: Minority Aids Initiative and Primary and Behavioral Health Care Integration and with Substance Abuse Prevention: Minority Aids Initiative)

SAMHSA expects that data generated from the 2014 HIV Continuum of Care pilot will help to inform an expanded program proposed for 2015 to continue the co-location and integrated HIV/primary care within either substance abuse or community mental health treatment programs. Braided funds in 2015 in the amount of $24 million would be dedicated to establishing integrated behavioral health and HIV care in addition to primary care needed by those living with or at high risk for HIV infection in minority communities heavily impacted by HIV. In addition, because of the significant comorbidity of viral hepatitis with HIV infection and because viral hepatitis occurs in up to 20 percent of those with either substance use disorders or serious mental illness, 5 percent of the allocated funds will be used to provide services to prevent, screen, test and refer to treatment as clinically appropriate those at risk for or living with viral hepatitis. In integrating HIV care into behavioral health settings, people living with HIV/AIDS and M/SUDs will have

greater access to treatment for these conditions. Integrated care programs developed as a result of this grant program will make it possible for behavioral health and HIV care needs to be addressed in one setting. This will result in effective, person-centered, treatment that will reduce the risk of HIV transmission, improve outcomes for those living with HIV, and ultimately reduce new infections. SAMHSA's Common Data platform (CDP), will integrate substance abuse and mental health elements with HIV and Hepatitis elements to ensure a more rigorous evaluation and data analysis to inform future public health intervention decision-making that addresses the intersection of behavioral health and HIV.

Treatment Systems for Homelessness

Housing and Homelessness

(Braided program with Mental Health: Homelessness Prevention Programs)

In FY 2015, SAMHSA proposes to use approximately $13.2 million, for new programming related to homelessness (CSAT- $8 million; CMHS- $5.2 million). This includes funding approximately 15 grants at $0.8 million per year to build on lessons learned from the CABHI and CABHI-States programs which are designed to work with state and local partners including public housing authorities, Medicaid, Veteran's Affairs, behavioral health providers and other agencies to develop systematic, cost-effective, and integrated approaches to housing that includes treatment and services for mental and substance use disorders. The program will support innovative strategies to provide needed services and supports that will help integrate individuals who are experiencing homelessness with substance abuse and mental health disorders into the community, assist providers in strengthening their infrastructure for delivering and sustaining housing to support recovery with integrated behavioral health, and other critical services, including the support of recovery residences. The program also will support providers in the implementation of coverage expansions for mental health and substance abuse services.

Funds will be used to support a Homelessness Health Information Sharing activity. This program will pilot-test automated sharing of client information within and among health care providers and social service agencies by means of electronic health records (EHRs), homeless management information systems (HMIS), and other social service information systems. The pilots will address a number of policy and technology issues including: privacy policies for protecting sensitive information, interoperability across systems, development of data collection and reporting standards for information sharing, workflow integration, etc. This initiative builds on SAMHSA's current homelessness activities in both CSAT and CMHS and will be used to explore how technology can improve systems for addressing homelessness in community-based health systems for individuals with behavioral health disorders.

By 2015, 66.4 percent of clients are expected to report being abstinent from substance use at a six-month follow up, while, 31.7 percent of clients are expected to report being employed or engaged in productive activities, and 24.6 percent of clients are expected to report a permanent place to live in the community.

The FY 2015 Budget Request includes increases in the following:

- Primary Care and Addiction Services Integration (PCASI): request is $20.0 million to support the development of a new initiative related to the integration of substance abuse treatment services and primary care. The PCASI Program would enable providers to offer a full array of both physical health and substance abuse services to clients.
- TCE General: request is $15.2 million, an increase of $2.0 million from the FY 2014 Enacted Level. Due to the success of the PBHCI Health Information Technology (HIT) supplemental program we are requesting an additional $2.0 million in funding for the TCE program in FY 2015 to fund a similar HIT initiative among the Primary Care and Addiction Services Integration (PCASI) program grantees. This supplemental funding will support the adoption and meaningful use of certified EHR technology which will facilitate the integration of care for patients in substance abuse treatment.

The FY 2015 Budget Request includes level funding from the FY 2014 Enacted Level in the following:

- Opioid Treatment Programs: Funding will support two grant continuations as well as 10 contracts. In FY 2015 SAMHSA also plans to fund a demonstration project testing the feasibility of using existing health information exchange (HIE) infrastructure to support care coordination for patients in opioid treatment programs during disasters.
- Pregnant and Postpartum Women: Funding will support 17 grant continuations five contracts, and seven new grants. Approximately 82 percent of clients are expected to achieve abstinence from substance abuse, 26 percent expected to be employed or engaged in productive activity; and 22 percent are expected to report permanent housing. Based on an in-depth review of cross-site evaluation and performance data conducted in FY2014, SAMHSA plans to build upon the program to advance the successful PPW model as an evidence-based approach for serving pregnant and post-partum women in need of residential substance abuse treatment.
- The Recovery Community Services Program: Funding will allow for the continuation of existing RCSP Statewide Networks and related contracts.
- Children and Families: Funding will support 10 grant continuations, two contracts and support a new cohort of grantees. 56 percent of clients are expected to report being abstinent from substance abuse, 80 percent are expected to be employed or engaged in productive activities; and approximately 2500 individuals would be expected to be served.
- Treatment Systems for Homeless: Funding will support all continuations as well as approximately 12 new grants.
- Special Initiatives/Outreach: Funding will support three contracts.

The FY 2015 Budget Request includes decreases in the following:

- Screening, Brief Intervention and Referral to Treatment: request is for $30.0 million a decrease of $17.0 million from FY 2014 Enacted Level. This level of funding will enable SAMHSA to support continuations.
- Strengthening Treatment Access & Retention: request is for $1 million, a decrease of $0.67 million from FY 2014 Enacted Level.
- Access to Recovery (ATR): SAMHSA is proposing eliminating the Access to Recovery program in the FY 2015 budget, a decrease of $50 million from the FY 2014 Enacted Level. Many of the clinical services provided under ATR will now be covered by public and private insurance. In addition, states have been encouraged to support recovery support services and client choice with SABG funding. States that would like to continue this activity will have support from SAMHSA in FY 2014 in incorporating lessons learned from the successful test.
- Minority AIDS Initiatives: request is for $58.9 million a decrease of $6.9 million from the FY 2014 Enacted Level which is offset by the increase in Mental Health MAI. This level will support funding of grant continuations and some new programming.
- Criminal Justice Activities: request is for $64.4 million, a decrease of $10.6 million from the FY 2014 Enacted Level. This level will support some new grants in FY 2015.
- Addiction Technology Transfer Centers: request is for $8.1 million, a decrease of $1 million. Proposed number of clients to be served in 2015 is approximately 20,516. By 2015, participants are also expected to report implementing improvements in treatment methods on the basis of information and training provided by the program.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by APT
(Dollars in thousands)

Programs of Regional National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
Grants/Cooperative Agreements:						
Continuations	399	$240,818	352	$164,077	381	$173,387
New/Competing	198	98,658	175	130,008	171	64,705
Subtotal	597	339,476	527	294,086	552	238,092
Contracts:						
Continuations	23	56,970	15	52,626	18	53,517
New/Competing	6	7,639	5	14,749	5	5,791
Subtotal	29	64,609	20	67,374	23	59,308
Total,Substance Abuse Treatment	**626**	**$404,085**	**547**	**$361,460**	**575**	**$297,400**

1/ The CSAT Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

*Totals may not add due to rounding.

A detailed table for all grant and contract continuations and new activities can be found in the SAMHSA Supplementary Table Chapter.

Key Outputs and Outcomes Tables

Program: Screening, Brief Intervention and Referral to Treatment

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.2.40 Number of clients served (Output)	FY 2013: 254,017 Target: 139,650 (Target Exceeded)	52,510	52,510	Maintain
1.2.41 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2013: 36.1% Target: 36% (Target Exceeded)	36%	36%	Maintain

Program: Access to Recovery

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.2.32 Number of clients gaining access to treatment (Output)	FY 2013: 74,309 Target: 70,750 (Target Exceeded)	11,150[51]	8,000[52]	-3,150
1.2.33 Increase the percentage of adults receiving services who had no past month substance use (Outcome)	FY 2013: 83.5% Target: 83% (Target Exceeded)	80%	80%	Maintain
1.2.35 Percentage of adults receiving services who had no/reduced involvement with the criminal justice system (Outcome)	FY 2013: 96.9% Target: 96% (Target Exceeded)	93%	93%	Maintain
1.2.36 Percentage of adults receiving services who had improved social support (Outcome)	FY 2013: 91.5% Target: 91% (Target Exceeded)	88%	88%	Maintain

[51] Decrease in target from prior years due to decrease in funding levels.

[52] Decrease in target from prior years due to decrease in funding levels. Clients are still being served due to multi-year funding grants in FY 2014.

Program: Treatment System for Homelessness (GBHI)

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/-FY 2015 Target
3.4.22 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2013: 63.5 % Target: 67.4 % (Target Not Met)	66.4 %	66.4 %	Maintain
3.4.23 Number of clients served (Output)	FY 2013: 5,375 Target: 5,800 (Target Not Met)	5,800	5,800	Maintain
3.4.24 Increase the percentage of homeless clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2013: 29 % Target: 32.7 % (Target Not Met)	31.7 %	31.7 %	Maintain
3.4.25 Increase the percentage of homeless clients receiving services who had a permanent place to live in the community (Outcome)	FY 2013: 44.9 % Target: 25.6 % (Target Exceeded)	33 %	33 %	Maintain

Program: Treatment - Science and Service Activities

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 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 2013: 79.5% Target: 90% (Target Not Met)	90%	90%	Maintain
1.4.02 Number of individuals trained per year (Output)	FY 2013: 29,122 Target: 20,516 (Target Exceeded)	20,516	20,516	Maintain
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2013: 67,944[53] Target: 110,000 (Target Not Met)	110,000	110,000	Maintain

[53] Results are preliminary and will be updated in 2014.

Program: Criminal Justice - Drug Courts

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.2.72 Percentage of adult clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2013: 59% Target: 57% (Target Exceeded)	55%	55%	Maintain
1.2.73 Percentage of adult clients receiving services who had a permanent place to live in the community (Outcome)	FY 2013: 42.4% Target: 43% (Target Not Met)	41%	41%	Maintain
1.2.74 Percentage of adult clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2013: 92.8% Target: 93% (Target Not Met)	91%	91%	Maintain
1.2.76 Percentage of adult clients receiving services who had no past month substance use (Outcome)	FY 2013: 86% Target: 73% (Target Exceeded)	71%	71%	Maintain
1.2.79 Number of adult clients served (Output)	FY 2013: 7,576 Target: 5,265 (Target Exceeded)	4,413	4,369	-44

Program: Criminal Justice – Teen Courts

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.2.89 Number of teen court clients served (Output)	FY 2013: 584 Target: 584 (Baseline)	600	600	Maintain
1.2.90 Percentage of teen court clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2013: 95.3% Target: 95.3% (Baseline)	88%	90%	+2
1.2.91 Percentage of teen court clients receiving services who had no past month substance use (Outcome)	FY 2013: 62.3% Target: 62.3% (Baseline)	86%	88%	+2

Program: Criminal Justice - Ex-Offender Re-Entry Program

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.2.80 Number of clients served (Outcome)	FY 2013: 2,149 Target: 2,912 (Target Not Met)	2,500	2,500	Maintain
1.2.81 Percentage of clients who had no past month substance use (Outcome)	FY 2013: 73% Target: 80% (Target Not Met)	80%	74%	-6
1.2.84 Percentage of clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2013: 94.7 % Target: 96 % (Target Not Met)	94.9 %	94 %	-0.9

Program: Treatment - Primary Care and Addiction Services Integration (PCASI)

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.2.52 Number of persons served (Output)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain
1.2.53 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain
1.2.54 Percentage of clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain

Program: Treatment - Other Capacity

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.2.25 Percentage of adults receiving services who had no past month substance use (Outcome)	FY 2013: 70.2% Target: 66% (Target Exceeded)	60%	58%	-2
1.2.26 Number of clients served (Output)	FY 2013: 28,692 Target: 34,784 (Target Not Met)	30,849	28,998	-1,851
1.2.27 Percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2013: 44.6% Target: 47% (Target Not Met but Improved)	45%	43%	-2
1.2.28 Percentage of adults receiving services who had a permanent place to live in the community (Outcome)	FY 2013: 49.5% Target: 49% (Target Exceeded)	47%	45%	-2
1.2.29 Percentage of adults receiving services who had no involvement with the criminal justice system (Outcome)	FY 2013: 96.5% Target: 96% (Target Exceeded)	93%	91%	-2

Size of Awards

(Whole Dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	597	527	552
Average Award	$568,637	$558,037	$431,327
Range of Awards	$300,000-$7,575,000	$300,000-$600,000	$300,000-$600,000

Substance Abuse Prevention and Treatment Block Grant
(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Substance Abuse Prevention and Treatment Block Grant.....	$1,710,306	$1,819,856	$1,819,856	---
PHS Evaluation Funds (non-add).....	*$79,200*	*$79,200*	*$79,200*	---

Authorizing Legislation ..... Sections 1921 of the Public Health Service Act
FY 2015 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 Band of Chippewa Indians of Minnesota to plan, carry out, and evaluate substance abuse prevention, 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 and Center for Substance Abuse Prevention.

All Block Grant applications must include an annual plan that contains detailed provisions for complying with each funding agreement specified in the legislation, and describe how the grantees and their respective SABG sub-recipients intend to expend the SABG. The legislation includes specific provisions and funding set-asides, such as 20 percent for primary prevention; a 5 percent HIV early intervention services set-aside; performance requirements for substance using pregnant women and women with dependent children; requirements and potential penalty reduction of the Block Grant allotment with respect to sale of tobacco products to individuals 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 prevention and treatment services while providing maximum flexibility. Services funded by the SABG include services identified in SAMHSA's *Good and Modern Service System*[54] brief as described in the block application. 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 SAMHSA's technical assistance contract. The SABG 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 two year period preceding the year for which the state is applying for a grant.

[54] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf

Of the amounts appropriated for the SABG program, 95 percent are distributed to, territories and Red Lake Band of the Chippewa Indians 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 SABG is critically important because it provides the grantees and their respective SABG sub-recipients the flexibility to respond to local and/or regional emergent issues impacting health, public health, and public safety through a consistent federal funding stream. For example, this program provides approximately 32 percent of total State Substance Abuse Agency funding, and 23 percent of total substance abuse Prevention and Public Health Funding. Because SAMHSA encourages states to focus on these populations, individuals who are currently in need of such services may fall into several categories, such as having no insurance or limited health insurance coverage for substance use disorder treatment and recovery support services, or having been mandated to enter SUD treatment through public safety and/or public welfare systems. Individuals and families without health coverage or whose health insurance benefit will not cover certain services (e.g., recovery supports) rely on services funded by the SABG. States also rely on the SABG funding for an array of non-clinical activities and services which support critical needs of their respective service systems, such as planning, coordination, needs assessment, quality assurance, program development, and evaluation.

In FY 2011, SAMHSA redesigned the FY 2012/2013 MHBG and SABG applications to better align with the current federal/state environments and related policy initiatives, including the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Tribal Law and Order Act (TLOA). The new design offered states the opportunity to complete a combined application for mental health and substance abuse services, submit a bi-annual versus an annual plan, and provide information regarding their efforts to respond to various federal and state initiatives. Almost one-half of the states took advantage of this streamlined application and submitted combined plans for mental health and substance abuse services. Over 95 percent of the states provided specific information requested by SAMHSA regarding strategies to respond to a variety of areas including primary care and behavioral health integration, recovery support services, prevention of substance use, and promotion of emotional health. States continued to provide information regarding the spending of their Block Grant funds to support services identified in SAMHSA's *Good and Modern Service System*[55] brief as described in the block grant application.

The FY 2014/2015 Block Grant application builds upon the FY 2012/2013 application and furthers SAMHSA's efforts to have states use and report the opportunities offered under various federal initiatives. In addition, the FY 2014/2015 Block Gant continues to allow states to submit a combined application for mental health and substance abuse services as well as a bi-annual versus an annual plan.

After the full implementation of the ACA, SAMHSA has strongly recommended that SABG funds be directed toward four purposes: (1) to fund priority treatment and support services for

[55] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf

individuals without insurance or for whom coverage is terminated for short periods of time; (2) to fund priority treatment (Essential Health Benefits – EHB) and support services not covered by private and public insurance for low and moderate income individuals and that demonstrate success in improving outcomes and/or supporting recovery (non-EHB covered treatments); (3) to fund primary prevention (universal, selective, and indicated) activities and services for individuals not identified as needing treatment; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis. In addition, consistent with SAMHSA's Theory of Change, which draws a path from innovation, translation, dissemination, to implementation and, finally, widescale adoption, the agency will take advantage of the successful strategies implemented through the Access to Recovery program. SAMHSA will encourage the states to utilize their Block Grants to: (1) allow recovery to be pursued through personal choice and many pathways; (2) encourage providers to manage performance based on 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 independent evaluation of the SABG program[56] 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 territories and to improve coordination of services with other state systems.

As noted below, the SABG Program has been successful in expanding treatment capacity in the latest year for which actual data are available in FY 2011[57] by supporting approximately two million[58] admissions to treatment programs receiving public funding.

Outcome data for the Block Grant program show positive results as reported through Behavioral Health Services Information System/Treatment Episode Data Set (TEDS) administered by SAMHSA's Center for Behavioral Health Statistics and Quality. In FY 2011, at discharge, clients demonstrated high abstinence rates from both illegal drug (73.4 percent) and alcohol (81.6 percent) use.

State Substance Abuse Authorities reported the following outcomes for services provided during FY 2011, the most recent year data is available:

- For the 50 states[59] and D.C that reported data in the Abstinence from Drug/Alcohol Use Domain for alcohol use, 51 of 51 identified improvements in client abstinence.
- Similarly, for the 50 states and D.C. that reported data in the Abstinence from Drug/Alcohol Use Domain for drug use, 50 of 51 identified improvements in client abstinence.
- For the 50 states and D.C. that reported data in the Employment Domain, 47 of 51 identified improvements in client employment.

[56] http://tie.samhsa.gov/SAPT2010.html#Evaluation
[57] Source: 2013 SABG Report – Tables 16-21. While this is referenced as FY 2011, the actual time period varies by State, e.g; CY 2011 (imported TEDS data); SFY 2011 (manually entered by States); SFY 2012 (manually entered by States.
[58]Source: 2013 SABG Report – Table II
[59]Source: West Virginia numbers have been included in the text, but that appear lower than expected.

- For the 50 states and D.C. that reported in the Criminal Justice Domain, 46 of 51 reported an increase in clients with no arrests based on data reported to TEDS.
- For the 49 states and D.C. that reported data in the Housing Domain, 42 of 49 identified improvements in stable housing for clients based on data reported to TEDS.

20 Percent Prevention Set-Aside

SAMHSA is responsible for managing the 20 percent prevention set-aside of the Substance Abuse Prevention and Treatment Block Grant (SABG). This is one of SAMHSA's main vehicles for supporting Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness. States use these funds to develop infrastructure and capacity specific to substance abuse prevention. Some states rely solely on the 20 percent set-aside to fund their prevention systems while others use the funds to target gaps and enhance existing program efforts. Performance results will be available in December, 2013.

In an effort to streamline the application and reporting procedures for both the SABG and the Mental Health Block Grant programs, SAMHSA has developed a uniform application and reporting process to promote consistent planning, application, assurance, and reporting dates across both block grants. States are encouraged to make prevention a top priority, taking advantage of recent science, best practices in community coordination, proven planning processes, and the science articulated by the IOM report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*[60]. SAMHSA will work with states to increase their accountability systems for prevention and to develop necessary reporting capacities.

Synar

The Synar program is the set of actions put in place by states, with the support of the federal government, to implement the requirements of the Synar Amendment. The Amendment was developed in the context of a growing body of evidence about the health problems related to tobacco use by youth, as well as evidence about the ease with which youth could purchase tobacco products through retail sources. The Synar program is a critical component of the success of youth tobacco use prevention efforts. SAMHSA is charged with overseeing states' implementation of the Synar requirements and provides technical assistance to states on both the Synar requirements and youth tobacco access issues in general.

Since the inception of the Synar program in 1996, SAMHSA has worked with states to assist them in complying with and attaining the goals of the Synar Amendment and has issued programmatic requirements and guidance documents to assist states in their efforts.

By regulation, states must achieve a retailer noncompliance rate of 20 percent or less. Since FY 2006, all 50 states, Puerto Rico, and the District of Columbia have been in compliance with the Synar requirements. In FY 2012, the most recent year available, the national weighted average retailer violation rate was 9.1 percent. FY 2013 data will be available by August 31, 2014.

[60] http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx

Funding History

Fiscal Year	Amount[1/]
FY 2006	$1,757,425,000
FY 2007	$1,758,591,000
FY 2008	$1,758,728,000
FY 2009	$1,778,591,000
FY 2010	$1,798,472,000
FY 2011	$1,782,528,000
FY 2012	$1,800,331,901
FY 2013	$1,710,306,376
FY 2014	$1,819,856,000
FY 2015	$1,819,856,000

[1/]The funding history includes PHS Evaluation Funds.

Budget Request

A total of $1.8 billion is requested, reflecting the same level funding from the FY 2014 Enacted Level. The FY 2015 request for the SABG includes recognition of new coverage for some limited services for SUDs in some states, mostly after an addiction is already diagnosed. SAMHSA's FY 2015 budget also recognizes the increased demand for services likely to be created by additional coverage options.

In addition, the most recent versions of the uniform SABG and Mental Health Block Grant (MHBG) application, and related investments in technical assistance, have called upon states to make particular efforts. These include ensuring that the providers they work with are administratively prepared to bill third-party sources of coverage, and are doing so for enrolled clients. In particular, a five-year multi-million dollar training and technical assistance effort was launched in FY 2012 for training community behavioral health providers on third-party contracting and billing practices in partnership with state-level mental health and substance abuse officials.

As public and private health insurance expand coverage of substance abuse treatment, SABG funding will focus upon the provision of effective non-covered prevention and intervention services that support health outcomes.

Health Reform Implementation

As a result of the analysis and examination of the various components of the Affordable Care Act beginning in 2010, SAMHSA has undertaken a major redesign of the planning section of the application process for both the MHBG and SABG. SAMHSA is aligning the block grants to complement mental health and substance abuse coverage expansions in the Affordable Care Act and the Mental Health Parity and Addiction Equity Act support individuals otherwise unable to receive services through public and private insurance. Together, SAMHSA's block grants

support the provision of services and related supports to approximately eight million individuals with mental and substance use conditions. With an estimated 11.4 million adults having a severe mental illness,[61] 44.7 million adults having any mental illness,[62] and another 22.1 million adults with substance abuse disorder,[63] demand clearly outpaces the public behavioral health system's established capacity. Many of these individuals and some of the services they need will continue to be without coverage through public or private insurance mechanisms. Aligning and coordinating the SAMHSA block grants with the Affordable Care Act helps create a cohesive national service system that is responsive to potential gaps in service delivery and effectively provides needed behavioral health services across sectors and across payment sources.

States should determine if established systems and procedures are sufficient to ensure that Block Grant funds are expended in accordance with program requirements and directed to support and not supplant health reform activities. The Block Grant Application for FY 2014/2015, SAMHSA has strongly recommended that states use these resources to support and not supplant services that will be covered through commercial and public insurer plans. States will be asked to develop metrics or targets for their systems to measure increases in the number of individuals who become enrolled or providers that join commercial or publicly funded provider networks. The primary goals of SAMHSA's program integrity efforts are to continue to (1) promote the proper expenditure of block grant funds, (2) improve block grant program compliance nationally, and (3) demonstrate the effective use of block grant funds.

SAMHSA will provide additional guidance to the states to assist them in complying with this continuing emphasis on program integrity, will develop new and better tools for reviewing block grant application and reports, and will train SAMHSA staff in these program integrity approaches and tools. SAMHSA will be working with states to develop changes to information systems and compliance review processes to ensure increasing program integrity. This may include working closely with Medicaid and Health Insurance Exchanges to obtain information to determine if individuals and providers in their systems are enrolled. This may also include strategies to assist their providers to develop the necessary infrastructures to operate in commercial and public insurer networks. The Uniform Application, along with evolution of SAMHSA's block grant reporting system are tools to assist in this process.

[61] http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm
[62] http://www.samhsa.gov/data/2k12/NSDUH110/sr110-adult-mental-illness.htm
[63] http://www.samhsa.gov/data/NSDUH/2k10ResultsRev/NSDUHresultsRev2010.htm#Ch7

Key Outputs and Outcomes Table

Program: Treatment Activities

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.2.43 Number of admissions to substance abuse treatment programs receiving public funding (Output)	FY 2011: 1,909,124 Target: 1,881,515 (Target Exceeded)	1,937,960	1,880,000	-57,960
1.2.48 Percentage of clients reporting no drug use in the past month at discharge (Outcome)	FY 2012: 73.4% Target: 70% (Target Exceeded)	74%	74%	Maintain
1.2.49 Percentage of clients reporting no alcohol use in the past month at discharge (Outcome)	FY 2012: 81.6% Target: 75% (Target Exceeded)	78%	78%	Maintain
1.2.50 Percentage of clients reporting being employed/in school at discharge (Outcome)	FY 2012: 37.1% Target: 43% (Target Not Met but Improved)	43%	43%	Maintain
1.2.51 Percentage of clients reporting no involvement with the Criminal Justice System (Outcome)	FY 2012: 91.1% Target: 89% (Target Exceeded)	92%	92%	Maintain
1.2.85 Percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2012: 92.1% Target: 92% (Target Exceeded)	92%	92%	Maintain

Program: Synar Amendment

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.49 Number of States (including Puerto Rico) whose retail sales violations is at or below 20% (Outcome)	FY 2012: 51 Target: 52 (Target Not Met)	52	52	Maintain
2.3.62 Number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% (Outcome)	FY 2012: 30 Target: 34 (Target Not Met)	34	33	-1

Program: Prevention Set-Aside

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.63 Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17) (Outcome)	FY 2012: 27% (Historical Actual)	19%	22%	+3
2.3.65 Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 12-20) (Outcome)	FY 2012: 76% Target: 52.9% (Target Exceeded)	67.5%[64]	67.5%	Maintain
2.3.67 Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 12-17) (Outcome)	FY 2012: 63% Target: 64.7% (Target Not Met but Improved)	61%	63%	+2
2.3.68 Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 18+) (Outcome)	FY 2012: 41% Target: 37.3% (Target Exceeded)	43%[65]	43%	Maintain

[64] Change from previously reported to reflect average of FY 2011 result and FY 2014 target.

[65] Change from previously reported to reflect average of FY 2011 result and FY 2014 target.

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2015 Discretionary State/Formula Grants
Substance Abuse Prevention and Treatment Block Grant Program
CFDA #93.959

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	$22,413,051	$22,926,066	$22,940,970	+14,904
Alaska	4,643,542	5,499,891	5,539,999	+40,108
Arizona	35,045,931	39,323,249	39,546,356	+223,107
Arkansas	12,531,768	13,428,775	13,437,505	+8,730
California	235,684,407	249,086,920	250,324,755	+1,237,835
Colorado	24,718,036	25,283,810	25,300,247	+16,437
Connecticut	15,987,458	17,584,936	17,596,368	+11,432
Delaware	6,316,579	6,807,911	6,824,460	+16,549
District Of Columbia	6,316,579	6,807,911	6,824,460	+16,549
Florida	94,297,122	109,951,627	110,663,333	+711,706
Georgia	47,479,959	51,074,888	51,162,247	+87,359
Hawaii	7,174,180	8,150,210	8,212,632	+62,422
Idaho	6,491,294	8,475,423	8,480,933	+5,510
Illinois	65,664,007	67,166,999	67,210,663	+43,664
Indiana	31,301,396	32,017,858	32,038,672	+20,814
Iowa	12,709,762	13,000,677	13,009,129	+8,452
Kansas	11,551,048	11,815,441	11,823,122	+7,681
Kentucky	19,420,002	20,234,141	20,247,295	+13,154
Louisiana	24,293,250	24,849,301	24,865,455	+16,154
Maine	6,316,579	6,807,911	6,824,460	+16,549
Maryland	30,053,214	33,838,777	33,860,775	+21,998
Massachusetts	32,265,047	39,563,072	39,588,791	+25,719
Michigan	54,410,714	55,656,128	55,692,309	+36,181
Minnesota	23,395,940	23,931,452	23,947,009	+15,557
Red Lake Indians	576,624	589,822	590,206	+384
Mississippi	13,399,170	13,705,865	13,714,775	+8,910
Missouri	24,582,417	26,346,394	26,363,521	+17,127
Montana	6,316,579	6,807,911	6,824,460	+16,549
Nebraska	7,417,381	7,587,158	7,592,090	+4,932
Nevada	13,015,618	16,462,188	16,698,247	+236,059
New Hampshire	6,316,579	6,807,911	6,824,460	+16,549
New Jersey	44,113,252	46,349,018	46,379,149	+30,131
New Mexico	8,437,153	9,497,415	9,503,589	+6,174
New York	108,553,857	111,038,560	111,110,745	+72,185
North Carolina	37,499,971	43,346,419	43,374,598	+28,179

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2015 Discretionary State/Formula Grants
Substance Abuse Prevention and Treatment Block Grant Program
CFDA #93.959

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
North Dakota	5,151,710	6,101,774	6,146,271	+44,497
Ohio	62,645,080	64,078,971	64,120,628	+41,657
Oklahoma	16,646,929	17,027,963	17,039,033	+11,070
Oregon	16,856,407	20,011,555	20,024,564	+13,009
Pennsylvania	55,527,829	58,681,907	58,720,055	+38,148
Rhode Island	6,316,579	7,544,696	7,549,601	+4,905
South Carolina	19,372,201	23,149,144	23,164,193	+15,049
South Dakota	4,763,897	5,642,441	5,683,588	+41,147
Tennessee	27,956,082	29,340,645	29,359,719	+19,074
Texas	127,794,281	139,747,042	139,837,890	+90,848
Utah	16,102,598	16,471,172	16,481,880	+10,708
Vermont	5,093,619	6,032,970	6,076,965	+43,995
Virginia	40,492,722	41,682,781	41,709,878	+27,097
Washington	32,870,870	37,271,989	37,296,219	+24,230
West Virginia	8,185,634	8,372,996	8,378,439	+5,443
Wisconsin	26,401,184	27,005,484	27,023,040	+17,556
Wyoming	3,309,781	3,920,161	3,948,749	+28,588
American Samoa	310,284	333,113	333,547	+434
Guam	890,619	963,165	970,731	+7,566
Northern Marianas	301,141	314,821	311,985	-2,836
Puerto Rico	20,822,658	22,369,385	22,405,135	+35,750
Palau	116,688	126,467	127,671	+1,204
Marshall Islands	368,072	405,435	415,696	+10,261
Micronesia	598,861	644,741	646,412	+1,671
Virgin Islands	$594,675	$638,392	$639,054	+662

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SAMHSA Health Surveillance and Program Support
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SAMHSA/HSPS

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Health Surveillance and Program Support

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Health Surveillance and Program Support				
Health Surveillance	$45,421	$47,428	$49,428	+$2,000
Budget Authority (non-add)	*3,260*	*17,000*	---	*-17,000*
Prevention and Public Health Fund (non-add)	*14,733*	---	*20,000*	*+20,000*
PHS Evaluation Funds (non-add)	*27,428*	*30,428*	*29,428*	*-1,000*
Program Support	77,998	72,729	72,729	---
Total, Health Surveillance and Program Support	**$123,419**	**$120,157**	**$122,157**	**+$2,000**
Data Request and Publication User Fees	**$---**	**$1,500**	**$1,500**	$---

*Totals may not add due to rounding.

Authorizing Legislation ..... Section 501 of the Public Health Service Act
FY 2015 Authorization ..... Expired
Allocation Method ..... Direct Federal/Intramural, Contracts, Other

Program Description and Accomplishments

Health Surveillance

The Health Surveillance budget supports many of the critical behavioral health data systems, national surveys, and surveillance activities for HHS undertaken by SAMHSA to support SAMHSA grantees, the field, and the public.

The National Survey on Drug Use and Health (NSDUH) serves as the nation's primary source for information on the incidence and prevalence of substance use and mental disorders and related health conditions. A new NSDUH contract was awarded in FY 2013 to finance surveys for 2014, 2015, 2016 and 2017.

In FY 2013, funding was provided for other public surveillance systems, including data collection efforts within the Community Behavioral Health Data Initiative (CDI). The goal of the CDI is to create new opportunities for cross-agency and public-private partnerships to address critical public health questions and more effectively utilize existing or declining resources. Data from this coordinated initiative is intended to be utilized in concert with data collected by other agencies such as Centers for Medicare and Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ) to more fully develop an understanding of the status of behavioral health at the regional and community level. Use of these data will allow communities to identify service and program needs specific to the local community. Moreover, the longitudinal nature of these data will allow those evaluating the effectiveness of services and policies in a community to measure the impact and outcomes of those interventions.

Specifically in FY 2013, the SAMHSA Emergency Department Surveillance Systems (SEDSS) (formerly the Drug Abuse Warning Network – DAWN was funded at $3.75 million ($2 million in Health Surveillance PHS Evaluation Funds and $1.75 million in PQIS BA). Funding was reduced in FY 2013 for SEDSS due to delays in incorporating it into the CDC/National Center for Health Statistics' (NCHS) National Hospital Care Survey (NHCS). Funding was eliminated to the National Health Interview Survey (NHIS) to accommodate sequester reductions.

In FY 2013, funding was also provided to partially support the Behavioral Health Services Information System (BHSIS) to reflect the transition of the Drug and Alcohol Services Information System (DASIS) to the BHSIS by: 1) collecting mental health treatment admissions data along with the ongoing substance abuse treatment admissions data, and 2) augmenting the treatment locator to include mental health facility level information. SAMHSA will be working closely with the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) and our state and federal partners in the development and implementation of this integration effort which includes identifying metrics for reporting. BHSIS funding was increased to $16.6 million in FY 2013 with SAMHSA's CMHS providing $7.1 million (these funds were used for the former Data Infrastructure Grant Program).

Funding was also provided in 2013 for CMHS Transformation Accountability System (TRAC), and CSAT Services Accountability Improvement System (SAIS). These data systems will be replaced with the new SAMHSA Common Data Platform (CDP).

In FY 2014, funding was appropriated for a number of activities to support a broad range of analytic work to be carried out in the CBHSQ. These activities include support for an Analytic Support Center (ASC) which undertakes a number of scientific and writing tasks on policy and practice-related topics in response to requests from SAMHSA Centers and related components, HHS agencies (CDC, AHRQ, and FDA), the Surgeon General's Office, the Office of National Drug Control Policy, and the Department of Justice. FY 2013 and FY 2014 funds $3 million for the Analytic Support and CBHSQ's Logistics contracts (formerly the National Analytic contracts).

In FY 2014, funding reflects the transition of the Drug and Alcohol Services Information System (DASIS) to the BHSIS by: 1) collecting mental health treatment admissions data along with the ongoing substance abuse treatment admissions data, and 2) augmenting the treatment locator to include mental health facility level information. In addition, through BHSIS SAMHSA will conduct coordinated substance abuse and mental health facility surveys in FY 2014. FY 2014 funding will increase to $21 million and CMHS will provide $7.5 million for BHSIS.

Funding for Grantee Data Development Technical Assistance (TA) will be provided in 2014. The funding will be used to support the development of a support contract and TA Team for an integrated approach to performance and quality data collection and reporting, including a pilot to fund regional data coordinators.

To meet the growing evaluation and data request and needs of SAMHSA, CBHSQ has proposed to phase-in taking over support for its full complement of current 78 FTEs over FY 2014, FY

2015, and FY 2016. While SAMHSA as a whole remains flat, CBHSQ proposes to hire additional FTEs to better manage its resources and plan for long-term evaluation and data projects. These FTEs include staff that will be assigned to support the Grantee Data Technical Assistance (TA) project, State data TA support, additional data collection activities across the public behavioral health surveys supported within CBHSQ, and one additional support staff.

Program Support

The Program Support budget supports the majority of SAMHSA staff who plan, direct, and administer SAMHSA programs and individuals who provide technical assistance, data collection and evaluation, and program guidance to states, mental health and substance abuse professionals, stakeholders, federal partners, and the general public. SAMHSA staffing represents a critical component of the budget. Staff positions that are not financed directly through the Health Surveillance and Program Support account provide direct state technical assistance and are funded through the Block Grant set-asides or are financed from other budget lines to perform services previously contracted out. In addition, this budget supports the Unified Financial Management System, which covers administrative activities such as human resources, information technology and the centralized services provided by HHS's Program Support Center and the department.

In FY 2015, SAMHSA projects a total of 655 FTEs across all appropriations and funding sources which reflect the impact of in source-related hiring which is fully annualized in FY 2014. SAMHSA's historical attrition factors have been applied to determine the overall anticipated FY FTE forecast.

SAMHSA applies an estimated internal administrative charge for overhead expenses to all programs, projects and activities including its Programs of Regional and National Significance, both Block Grants, Children's Mental Health Initiatives (CMHI), Projects for Assistance in Transition from Homelessness (PATH), Protection and Advocacy for Individuals with Mental Illness (PAIMI) and the Health Surveillance and Program Support appropriation. These estimates will be adjusted to reflect final operating plans during the year of execution.

SAMHSA is pursuing an agency-wide program integrity initiative to mitigate the risk of improper payments throughout our grant portfolio. Building on the SAMHSA-specific risk assessments to date, along with the department's findings across operating and staff divisions, SAMHSA is pursuing a coordinated effort to better monitor grants and respond to grant allegations. The department has identified human resources, in particular, the competencies of federal and grantee staff as putting the department's programs at risk. SAMHSA established an Office of Financial Advisory Services to address these risks.

Funding History[1\]

Fiscal Year	Amount
FY 2011	$119,789,000
FY 2012	$124,317,616
FY 2013	$123,418,779
FY 2014	$120,157,000
FY 2015	$122,157,000

[1\]The funding history is presented on a comparable basis to previous funding levels to represent the revised budget structure and includes the PHS Evaluation Funds and Prevention and Public Health Funds.

Budget Request

A total of $122.2 million is requested for Health Surveillance and Program Support, reflecting an increase of $2 million from the FY 2014 Enacted Level.

A total of $49.4 million is requested for Health Surveillance activities, reflecting a $2 million increase from the FY 2014 Enacted Level. These funds will be used to support the President's *Now is the Time* initiative. This increase will be used to support the work begun by the White House National Conference on Mental Health, supporting the collection and use of data to learn if, what, and how we are communicating is making a positive difference. Specifically, this funding will be used for a new initiative, Science of Changing Social Norms: Building the Evidence Base, to support efforts to measure and track behavioral, attitudinal, and related community data to understand the impact of social messaging and demonstrate evidence for effecting change in social norms and behavior to reduce negative attitudes and improve people's willingness to seek help for themselves and others when they experience a mental health problem. The Science of Changing Social Norms will have a second component, Social Media, funded from Public Awareness and Support.

A total of $72.7 million is requested for Program Support, level funding relative to the FY 2014 Enacted Level. The additional costs associated with fully annualizing in-sourced staffing and with extending the current building lease will be absorbed. The funding request includes costs associated with the consolidation of several Operating Divisions at 5600 Fishers Lane, including rent and associated costs. SAMHSA's move is currently scheduled for early FY 2016.

SAMHSA will be supporting 493 Direct BA FTEs funded from Program Support.

Public Awareness and Support

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Program Level	**$13,545**	**$13,571**	**$15,571**	**+$2,000**
PHS Evaluation Funds (non-add)	---	---	*15,571*	*+15,571*

Authorizing Legislation ..... Section 501, 509, 516, and 520A of the Public Health Service Act
FY 2015 Authorization ..... Expired
Allocation Method ..... Contracts

Program Description and Accomplishments

In recent years, the news coverage has been filled with increasing reports of tragic events and, as each report has unfolded, attention has focused increasingly on behavioral health and the country's behavioral health care system. Americans want to know what their government is already doing, and what more can be done to prevent similar tragedies in the future. It is estimated that almost half of all Americans will experience symptoms of a behavioral health disorder – mental illness or addiction – at some point in their lives. Half of all lifetime cases of mental illness begin by age 14 and three-fourths by age 24. It is important to identify issues early and help individuals get the treatment they need before crisis situations develop. Also, communities need to engage in prevention approaches that are effective in stopping problems from developing in the first place.

In light of the public's sustained interest and concerns about behavioral health issues, this is a critical time to raise the public's understanding of mental and substance use disorders and increase the recognition of SAMHSA's behavioral health expertise. SAMHSA's Office of Communications is charged with setting the strategic direction and policy for the agency's public awareness and communications activities. SAMHSA's communications strategy will continue to focus on four vital efforts:

- Collaborating across agencies to communicate the importance of behavioral health to our nation;
- Providing critical resources to the behavioral health workforce;
- Leveraging SAMHSA's online and social media presence to reach our existing audience efficiently and expand our reach nationally; and
- Raising awareness of SAMHSA as a leader in behavioral health data and surveillance.

In FY 2014 and FY 2015, the SAMHSA will complete a number of vital programs and activities, both internally and externally, to solidify its role as a leader of public health efforts to advance the behavioral health of the nation.

Collaborating Across Agencies

In FY 2014 and FY 2015, SAMHSA plans to continue to collaborate with other agencies to promote awareness of behavioral health. For example, SAMHSA will coordinate with the Centers for Disease Control and Prevention (CDC) to promote the Million Hearts Campaign through social marketing activities specific to blood pressure screening and control, smoking cessation, and weight loss in communities with the highest prevalence of reported cardiovascular disease among persons with behavioral health conditions. SAMHSA also will work to support MentalHealth.gov. Internally, SAMHSA's National Outreach, Public Education and Engagement Initiative (NOPEEI), provides consistent communications support for national outreach and public education initiatives across a variety of behavioral health topics.

Funding support in FY 2015 will enable SAMHSA to broaden its reach by collaborating across agencies to help people recognize mental and/or substance use disorders and seek assistance with the same urgency as any other health condition and with the expectation of recovery.

Providing Critical Resources to the Behavioral Health Workforce

SAMHSA's communications strategy ensures that the vital information and training materials produced through SAMHSA's centers and offices are available to the behavioral health workforce through the Public Engagement Platform (PEP), which manages the agency's print and online information resources. PEP provides a customer-oriented fulfillment system, including an online store, call-in contact center, warehouse, email updates, exhibit program, and strategic partnerships to fulfill the educational and training needs of the public and health services providers. SAMHSA's various channels of communication generated more than 25 million customer interactions in FY 2013.

SAMHSA also manages the Disaster Distress Helpline (DDH), with its vast network of behavioral health experts nationwide, to provide information and counseling referral to the public after tragic events. For example, the Helpline was deployed just 30 minutes after the Boston Marathon bombing, which injured hundreds of runners and spectators. Due to increased public awareness, the HHS mental health team deployed to support the city and state was able to touch the lives of over 1,000 people. SAMHSA, in support of the DDH, also disseminated more than 8,500 disaster kits in the wake of the bombing.

To further support behavioral health first responders, SAMHSA has also developed and launched a behavioral health disaster response mobile application, available on iTunes, Google Play, and the Blackberry World. Using this app, behavioral health first responders can easily access and share behavioral health resources, updated in real-time, with those most in need at the site of a disaster. The SAMHSA disaster app has the potential to reach thousands of people with vital behavioral health resources right at the time of greatest need.

SAMHSA will also collaborate with WebMD, which reaches over 3 million US healthcare providers every month, to provide critical information to both the behavioral health workforce and primary care providers. With WebMD, SAMHSA will develop a continuing medical education (CME) resource to train providers in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach to the delivery of early intervention and treatment services for

persons with substance use disorders, as well as those who are at risk of developing these disorders.

In FY 2013, SAMHSA released the Opioid Overdose Prevention Toolkit, which equips communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. The toolkit addresses issues for first responders, treatment providers, and those recovering from opioid overdose.

Funding support in FY 2015 is important for SAMHSA to continue providing quality and timely information resources, and access to emergency response networks, for the public and the behavioral health workforce.

Leveraging SAMHSA's Online Presence

The internet is the primary way the public engages with the government. SAMHSA's website and social media channels—such as Facebook, Twitter and YouTube—are critical to our efforts to engage with citizens about behavioral health. The wide reach of these online channels was demonstrated during a "Tweet up" event SAMHSA coordinated to launch National Children's Mental Health Awareness Day 2013, which reached over 20 million Twitter users in less than 12 hours, setting a record for SAMHSA and HHS. Also, in accordance with the Americans with Disabilities Act (ADA), SAMHSA has met the federal government's deadline for ensuring the Section 508 compliance of its websites. SAMHSA.gov continues to be among the highest rated of any HHS Operating or Staff Division.

In the course of prioritizing the internet as a strategic business initiative and communications asset, SAMHSA launched Project Evolve to consolidate and modernize SAMHSA's web presence. Through Project Evolve, almost 90 disparate websites created for various SAMHSA-sponsored campaigns and programs are being consolidated into one site. This consolidation will help ensure that SAMHSA speaks to the nation with a unified voice. It also helps eliminate redundant web development and maintenance efforts, resulting in lower overall costs, greater efficiency, increased effectiveness, and improved service for visitors to SAMHSA's website. Related Project Evolve activities include audience analysis, usability testing, and planning for the prioritized migration of information from other sites to a consolidated SAMHSA.gov site. In FY 2013, the agency launched a beta version of SAMHSA.gov and anticipates the completion of the website consolidation phase in FY 2016.

Raising Awareness of SAMHSA's Role as a Leader in Behavioral Health Data and Surveillance

SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) is the government's lead agency for behavioral health statistics, as designated by the Office of Management and Budget. A key goal of the agency's Public Awareness and Support efforts is to make certain that these valuable data reach the widest number of Americans, enabling them to make informed decisions about the health and wellbeing of their loved ones and themselves. SAMHSA shares this vital information through the vehicles described above—MDMS, PEP, the Web, and social media—as well as through other program operations such as the press releases issued by the Office of Communications to announce CBHSQ's latest findings, including the National Survey

on Drug Use and Health (NSDUH), and SAMHSA's first-ever Behavioral Health Barometer, which provides data about key indicators of behavioral health problems. The Barometer shows this data at the national level, and for each of the 50 states and the District of Columbia.

Budget Request

A total of $15.6 million is requested for Public Awareness and Support, an increase of $2 million from the FY 2014 Enacted Level, and shifts from Budget Authority to PHS Evaluation funds. The increase of $2 million will be used to support the President's *Now is the Time* initiative by ensuring sufficient communications infrastructure to change social norms around mental health. The goals of this data and evidence-driven communications effort are to reduce negative public attitudes and to encourage people to seek help for themselves or others when they experience a mental health problem. Funds will be placed within Public Awareness and Support so SAMHSA can continue to release timely and accurate behavioral health information to the public, the demand for which is demonstrated by the fact that, since they were released to the public, SAMHSA's publications to support Community Conversations about Mental Health have been shipped or downloaded over 23,000 times.

Specifically, this additional request of $2 million will support a new initiative, the Science of Changing Social Norms: Social Media, to develop and test an array of messages and media designed to improve attitudes, understanding and behavior of Americans about mental and substance use disorders and the willingness to seek help for them. Building on the effort to increase understanding about mental health through the *Now is the Time* initiative launched on January 16, 2013, this public awareness and education initiative will seek to target the message resulting from the national conversation about behavioral health most effectively. The $2 million will fund social media strategies to support the work begun by the White House National Conference on Mental Health. The goal is to use communications science and market research to identify the most effective and evidence-based methods for decreasing negative attitudes, increasing knowledge and improving willingness to seek help for mental health and substance abuse problems to ensure outreach funds are spent where they will make the most impact. This initiative is in conjunction with the Science of Changing Social Norms: Building the Evidence Base in the Center for Behavioral Health Statistics and Quality's which is essential to understand the impact of social messaging and demonstrate evidence for effecting change in social norms and behavior to reduce negative attitudes and improve people's willingness to seek help. CBHSQ's data collection component will be funded separately under Health Surveillance and Program Support.

Key Outputs and Outcomes Table

Program: Public Awareness and Support

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.76 Number of persons receiving prevention information indirectly from advertising, broadcast, or website (Output)	FY 2012: 1,511,158 Target: 1,250,000 (Target Exceeded)	250,000	250,000	Maintain
4.4.12 Number of individuals referred for behavioral health treatment resources. (Output)	FY 2013: 365,919 Target: 310,000 (Target Exceeded)	310,000	310,000	Maintain

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Performance and Quality Information Systems

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Program Level	**$8,803**	**$12,996**	**$12,996**	**$---**
PHS Evaluation Funds (non-add)	---	---	*12,996*	*+12,996*

Authorizing Legislation ..... Section 501, 509, 516, and 520A of the Public Health Service Act
FY 2015 Authorization ..... Expired
Allocation Method ..... Contracts

Program Description and Accomplishments

In FY 2013, PQIS funding was used to partially fund SEDSS and the C-EMS activities.

In FY 2014, funding is also requested to provide support for a new contract for the National Registry of Evidence-based Programs and Practices that will reduce the backlog of interventions accepted but not reviewed under the previous contract. NREPP, a searchable online system that provides states, communities, and tribes tools for identifying and implementing evidence-based mental health promotion, substance abuse prevention, and substance abuse and mental health treatment interventions.

Due to unanticipated delays, PQIS funding will be used for the continued implementation of SAMHSA's Common Data Platform (CDP) which will provide a uniform collection and reporting system for 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. Funding from PQIS also will fund the continuation of all three Center legacy programs (SAIS), (TRAC), and (DCAR) while the CDP is phased in.

Other SAMHSA activities related to the implementation of the Strategic Initiative on Data, Quality and Outcomes included the development of the National Behavioral Health Quality Framework, stemming from the National Quality Strategy recently released by the Agency for Healthcare Research & Quality (AHRQ) in cooperation with the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC); and coordination with Health Information Technology efforts and Meaningful Use Measures for application in electronic health records, led by ONC and CMS. These activities will be substantially completed in FY 2014 and will move to regular operations beginning in FY 2015.

Budget Request

In FY 2015, a total of $13.0 million is requested for Performance and Quality Information Systems, reflecting level funding relative to the FY 2014 Enacted Level. The increase of $13 million in PHS Evaluation funds offsets the decrease of $13 million in Budget Authority to reflect the transfer to a different source of funding. These funds will be used to continue support for the Common Data Platform, which was awarded in late FY 2013 and implemented in FY 2014, as well as provide support for the continuation of NREPP.

Key Outputs and Outcomes Table

Program: Performance and Quality Improvement Systems

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
4.4.10 Increase the combined count of webpage hits, hits to the locator, and hits to Substance Abuse and Mental Health Data Archive (SAMHDA) for SAMHSA-supported data sets (Output)	FY 2013: 2,298,464[66] Target: 1,792,523[67] (Target Exceeded)	1,882,149[68]	2,390,402	+508,253
4.4.11 Number of evidence-based programs or practices in review (Output)	FY 2013: 61[69] Target: 46 (Target Exceeded)	48	55	+7

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

[67] Reduction in target reflects a change in the data collection methodology.

[68] Reduction in target reflects a change in the data collection methodology.

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

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Agency-Wide Initiatives

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Agency-Wide Initiatives	**$8,293**	**$45,695**	**$56,000**	**+$10,305**
Military Families	2,857	---	---	---
Behavioral Health Workforce	5,436	45,695	56,000	+10,305
Minority Fellowship Program (non-add)	*5,436*	*10,695*	*10,000*	*-695*
Minority Fellowship Program - Base (non-add) 1/	*5,436*	*5,436*	*5,000*	*-436*
Minority Fellowship Program - Youth (non-add)	---	*5,259*	*5,000*	*-259*
Peer Professional Workforce Development (non-add)	---	---	*10,000*	*+10,000*
SAMHSA-HRSA BHWET Grant Program (non-add)	---	*35,000*	*35,000*	---
Behavioral Health Workforce Data and Development (non-add)	---	---	*1,000*	*+1,000*
PHS Evaluation Funds (non-add)	*$---*	*$---*	*$1,000*	*+1,000*

[1/] The Minority Fellowship Program budgets from the MH, SAP, and SAT appropriations are reflected under the Workforce initiative.

*Totals may not add due to rounding.

Authorizing Legislation ..... Section 501, 509, 516, and 520A of the Public Health Service Act
FY 2015 Authorization ..... Expired
Allocation Method ..... Discretionary Grants, Contracts

Program Description and Accomplishments

Behavioral Health Workforce

Minority Fellowship Program

As SAMHSA implements the Leading Change 2.0 Strategic Initiatives for 2015 - 2019, the new Strategic Initiative on Workforce provides the opportunity for a concerted focus on developing the behavioral health workforce. In order to increase the visibility of this issue and to manage and administer our workforce programs more efficiently, SAMHSA is moving the Minority Fellowship Programs (MFP) to an Agency-Wide Initiative. The focus on building the components of the mental health, substance use prevention and substance use treatment workforce will be maintained through a strengthened collaboration.

Through a partnership among SAMHSA's CMHS, CSAP and CSAT, the MFP program increases behavioral health practitioners' knowledge of issues related to prevention, treatment and recovery support for mental and substance use disorders among racial and ethnic minority populations. Additionally, it aims to improve the quality of mental and substance use disorder prevention and treatment delivered to ethnic minorities by providing stipends to post-graduate students. This funding will 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. Since its start in 1973, the Minority Fellowship Program has helped to enhance services to minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology, and since 2006, marriage and family therapists. These individuals often serve in key leadership positions in mental and substance use disorder services, services supervision, services research, training, and administration. In FY 2012, SAMHSA received additional funding to increase the pool of culturally competent mental health professions eligible to receive funds through this program to include professional counselors. In FY 2013 and in FY 2014, SAMHSA anticipates funding all MFP continuation grants.

Minority Fellowship Program Expansion – Youth (MFP-Y) and Addiction Counselors

The Minority Fellowship Program Expansion - Youth (MFP-Y) provides stipends to graduate students to increase the number of culturally competent behavioral health professionals who provide direct mental and/or co-occurring substance use disorder services to underserved minority populations. MFP-Y would utilize the existing infrastructure of the MFP to expand the focus of the program to support master's level trained behavioral health providers in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing. This support would increase the number of providers who are available to provide clinical services to underserved, at-risk children, adolescents, and populations transitioning to adulthood (ages 16 – 25) in an effort to increase access to, and quality of, behavioral health services for this age group.

In FY 2014, SAMHSA also will award grants to entities providing training to Master's level addictions counselors. Because these funds are part of the President's *Now is the Time* initiative, there will be an emphasis on providing clinical services to underserved, at-risk children, adolescents, and populations transitioning to adulthood (ages 16 – 25). These grants will support graduate student stipends to increase the number of Masters level addiction counselors across the nation by approximately 300 counselors. Some portion of the funds will support evaluation and technical assistance for these new MFP grantees.

SAMHSA-HRSA Behavioral Health Workforce Education and Training Grant Program

SAMHSA in collaboration with HRSA will continue the Behavioral Health Workforce Education and Training (BHWET) Grant Program, which will increase the clinical service capacity of the behavioral health workforce by supporting training for Master's level social workers, psychologists, marriage and family therapists, psychology doctoral interns, as well as behavioral health paraprofessionals. This effort is critical to ensure that the behavioral health workforce is able to meet the needs of high need and high demand populations, including rural, vulnerable, and underserved populations. In FY 2014, the program will include an emphasis on training to address the needs of children, adolescents, and transition-age youth (ages 16-25) and their families. The SAMHSA-HRSA BHWET grant program will help increase the behavioral health workforce by 3,500 individuals.

Budget Request

SAMHSA requests $56 million for Agency-Wide Initiatives reflecting an increase of $10.3 million from the FY 2014 Enacted Level.

This increase will fund:

- $56 million for Behavioral Health Workforce, which is an increase of $10.3 million above the FY 2014 Enacted Level. As described in detail below, funding increases of $1 million will fund the Behavioral Health Workforce Data and Development to develop consistent data set to define and track the behavioral workforce and $10 million will fund Peer Professional Workforce Development with an offset of a $0.7 million reduction in Minority Fellowship Program.

Peer Professional Workforce Development

In FY 2015, SAMHSA proposes to implement a program to strengthen the behavioral health workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16-25. Because of their lived experience with behavioral health conditions, and being able to build trust and foster connections with individuals accessing care, these entry-level providers play a significant role in the delivery of prevention and recovery support services. SAMHSA plans to award up to 19 grant awards to community colleges or community college networks, states, and national organizations. These funds will provide tuition support and further establish the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education. Funding will increase the behavioral health workforce by 1,200 peer professionals.

The Behavioral Health Workforce Education and Training (BHWET) will focus on supporting clinical internships and field placements, and certificate program completion across a range of professional and paraprofessional disciplines (some of whom may be peers) to produce a ready cohort of new behavioral health providers. The Peer Professional Workforce Development program focuses exclusively on peers, or people with personal experiences with mental illness and/or substance use conditions. Peers may play roles across the spectrum of prevention, treatment and recovery/family support. The Peer Professional program will award grants to community colleges, community college networks, states, and national organizations in order to develop the training infrastructure for peer professionals nationwide.

Behavioral Health Workforce Data and Development

Beginning in 2014, over 62 million Americans will have expanded or first time access to coverage for services for mental and substance use disorders as a result of a combination of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act. Almost 11 million of these individuals are expected to have mild to severe mental health and/or substance abuse conditions with related treatment needs. Current data indicate that almost 90 percent of

persons with substance abuse issues do not receive the services they need and over half of those with mental disorders do not receive needed treatment.

SAMHSA received $40 million in new behavioral health workforce activities in the FY 2014 Appropriation. This budget assumes continuation of those programs to develop approximately 5,000 new behavioral health clinical professionals. To ensure the existing workforce investments are responsible and well-targeted, SAMHSA's FY 2015 budget proposes $1 million to partner with HRSA on the Behavioral Health Minimum Data Set to develop consistent data collection methods to identify and track behavioral health workforce needs as well as to partner with the Department of Defense, and the Department of Veterans Affairs to inventory existing and emerging workforce issues, efforts and impacts, and develop coordinated plans.

SAMHSA
Center for Behavioral Health Statistics and Quality (CBHSQ)
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SAMHSA/Center for Behavioral Health Statistics and Quality (CBHSQ)

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Substance Abuse Treatment Appropriation				
Substance Abuse Block Grant (SABG) Set Aside				
PHS Evaluation Funds				
NSDUH	$40,087	$42,709	$41,012	-$1,697
Analytic Support Center (ASC) (formerly NAC)	2,563	---	1,000	+1,000
BHSIS (formerly DASIS)	13,182	---	1,291	+1,291
SAMHDA/Data Archive	1,294	1,291	1,291	---
Community Behavioral Health Data Initiative	136	7,342	7,500	+158
C-EMS (non-add)	*136*	*3,000*	---	*-3,000*
SEDSS (formerly DAWN) (non-add)	---	*4,000*	*4,500*	*+500*
PSTAR (non-add)	---	*342*	*3,000*	*+2,658*
Data Collection and Evaluation Activities	---	1,020	---	-1,020
Operations	---	270	202	-68
FTE Payroll	2,183	6,591	5,371	-1,220
Subtotal, PHS Evaluation Funds	**59,445**	**59,223**	**57,667**	**-1,556**
Budget Authority				
NSDUH	---	---	601	+601
Community Behavioral Health Data Initiative	---	458	---	-458
PSTAR (non-add)	---	*458*	---	*-458*
FTE/Operations	432	---	---	---
Subtotal, Budget Authority	**432**	**458**	**601**	**+143**
Subtotal, SABG Set Aside	**$59,877**	**$59,681**	**$58,268**	**-$1,413**
Health Surveillance and Program Support Appropriation				
Health Surveillance				
Budget Authority				
NSDUH	2,066	5,417	---	-5,417
Common Data Platform (CDP)	583	---	---	---
Grantee Data Development TA	---	5,000	---	-5,000
Analytic Support Center (ASC) (formerly NAC)	483	2,000	---	-2,000
Data Collection and Evaluation Activities	---	2,078	---	-2,078
Operations	128	2,505	---	-2,505
Subtotal, Budget Authority	**3,260**	**17,000**	**---**	**-17,000**
PHS Evaluation Funds				
NSDUH	2,536	---	---	---
NREPP	2,382	---	---	---
BHSIS (former DASIS)	3,813	21,000	17,028	-3,972
Common Data Platform (CDP)	3,854	---	---	---
CDP Legacy Program (SAIS and TRAC)	8,299	---	---	---
CBHSQ Logistics (formerly NAC)	---	1,000	1,000	---
Science of Changing Social Norms: Building the Evidence Base	---	---	2,000	+2,000
Community Behavioral Health Data Initiative	2,000	---	---	---
SEDSS (formerly DAWN) (non-add)	*2,000*	---	---	---
Data Collection and Evaluation Activities	---	3,277	1,442	-1,835
Operations	---	988	960	-28
FTE Payroll	4,544	4,163	6,998	+2,835
Subtotal, PHS Evaluation Funds	**27,428**	**30,428**	**29,428**	**-1,000**

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Prevention and Public Health Fund				
Analytic Support Center (ASC) (formerly NAC)	---	---	1,000	+1,000
CDP Legacy Program (DCAR)	3,505	---	---	---
NSDUH	10,121	---	11,113	+11,113
BHSIS (former DASIS)	---	---	2,681	+2,681
NREPP	---	---	1,600	+1,600
Community Behavioral Health Data Initiative	500	---	3,000	+3,000
C-EMS (non-add)	*500*	---	*3,000*	*+3,000*
Operations	606	---	606	+606
Subtotal, Prevention and Public Health Fund	**14,733**	**---**	**20,000**	**+20,000**
Subtotal, Health Surveillance	**45,421**	**47,428**	**49,428**	**+2,000**
Performance and Quality Information Systems (PQIS)				
Budget Authority				
NREPP	---	3,500	---	-3,500
Common Data Platform (CDP)	---	1,400	---	-1,400
CDP Legacy Program (SAIS and TRAC)	---	4,000	---	-4,000
CDP Legacy Program (DCAR)	---	3,000	---	-3,000
Community Behavioral Health Data Initiative	4,250	---	---	---
C-EMS (non-add)	*2,500*	---	---	---
SEDSS (formerly DAWN) (non-add)	*1,750*	---	---	---
Materials Development	476	---	---	---
Content Migration	2,399	---	---	---
Innovation and Logistical Services Support	1,075	---	---	---
Operations	603	1,096	---	-1,096
Subtotal, Budget Authority	**8,803**	**12,996**	**---**	**-12,996**
PHS Evaluation Funds				
NREPP	---	---	400	+400
Common Data Platform (CDP)	---	---	5,000	+5,000
Grantee Data Development TA	---	---	4,000	+4,000
Data Collection and Evaluation Activities	---	---	1,213	+1,213
Operations	---	---	2,383	+2,383
Subtotal, PHS Evaluation Funds	**---**	**---**	**12,996**	**+12,996**
Subtotal, PQIS	**8,803**	**12,996**	**12,996**	**---**
Agency-Wide Inititatives				
PHS Evaluation Funds				
Behavioral Health Workforce Data and Development	---	---	1,000	+1,000
Subtotal, Agency-Wide Initiatives	**---**	**---**	**1,000**	**+1,000**
Subtotal, Health Surveillance and Program Support	**54,225**	**60,424**	**63,424**	**+3,000**
Total, CBHSQ	**$114,102**	**$120,105**	**$121,692**	**+$1,587**

Resources by Activity
(Dollars in thousands)

Center for Behavioral Health Statistics and Quality FY 2015 CJ Breakout by Activity *(Dollars in thousands)*				
	FY 2013 Final	**FY 2014 Enacted**	**FY 2015 President's Budget**	**FY 2015 +/- FY 2014**
CBHSQ Activities				
NSDUH	$54,811	$48,126	$52,726	+$4,600
DASIS/BHSIS	16,995	21,000	21,000	---
CBHSQ Logistics and Analytic Support Center (formerly NAC)	3,046	3,000	3,000	---
SAMHDA/Data Archive	1,294	1,291	1,291	---
Common Data Platform (CDP)	4,437	1,400	5,000	+3,600
Grantee Data Development TA	---	5,000	4,000	-1,000
CDP Legacy Programs (DCAR)	3,505	3,000	---	-3,000
CDP Legacy Programs (SAIS and TRAC)	8,299	4,000	---	-4,000
NREPP	2,382	3,500	2,000	-1,500
Science of Changing Social Norms: Building the Evidence Base.	---	---	2,000	+2,000
Community Behavioral Health Data Initiative	6,886	7,800	10,500	+2,700
C-EMS (non-add)	*3,136*	*3,000*	*3,000*	---
SEDSS (formerly DAWN) (non-add)	*3,750*	*4,000*	*4,500*	*+500*
PSTAR (non-add)	---	*800*	*3,000*	*+2,200*
Behavioral Health Workforce Data and Development	---	---	1,000	+1,000
Materials Development	476	---	---	---
Content Migration	2,399	---	---	---
Innovation and Logistical Services Support	1,075	---	---	---
Data Collection and Evaluation Activities	---	6,375	2,655	-3,720
Operations	---	4,859	4,151	-708
FTE Payroll	3,824	10,754	12,369	+1,615
Total, CBHSQ	**$109,430**	**$120,105**	**$121,692**	**+$1,587**

Authorizing Legislation ..... Sections 501, 505, 1911, 1921 of the PHS Act
FY 2015 Authorization ..... Expired
Allocation Method ..... Contracts

Program Description and Accomplishments

In FY 2015, SAMHSA will focus on strengthening and streamlining efforts begun in FY 2011 to improve data, outcomes, and quality by realigning of a number of data and analytic activities within the Center for Behavioral Health Statistics and Quality (CBHSQ). By creating an integrated data strategy and a national framework for quality improvement in behavioral healthcare, CBHSQ helps inform policy, measure program impacts, and has led to improved quality of services and outcomes for individuals, families, communities, and tribal communities. This realignment improves accountability and transparency in the development and dissemination of information to support this behavioral health care transformation.

There continue to be five major functions coordinated through CBHSQ that provide significant support to SAMHSA's integrated data strategy; surveillance and data collection; evaluation; statistical and analytic support; service systems research; and performance and quality information systems. CBHSQ also supports SAMHSA's efforts to increase public access to data.

In FY 2013, CBHSQ ended or modified several contracts to achieve greater efficiency. This was the culmination of a comprehensive review of SAMHSA's contracts conducted in FY 2011 which determined that many mission-critical contracted activities would be less expensive to accomplish by-insourcing. For CBHSQ, this resulted in hiring approximately 36 positions.

To meet the growing evaluation and data request and needs of SAMHSA, CBHSQ has proposed to phase-in taking over support for its full complement of 78 FTEs over FY 2014, FY 2015, and FY 2016. This will allow CBHSQ to better manage its resources and plan for long-term evaluation and data projects. While SAMHSA as a whole remains flat, CBHSQ proposes to hire additional FTEs in response to growing responsibility for providing data support needs within the agency. These FTEs include staff that will be assigned to support the Grantee Data Technical Assistance (TA) project, State data TA support, additional data collection activities across the public behavioral health surveys supported within CBHSQ, and one additional support staff.

Surveillance and Data Collection

SAMHSA manages a number of critical behavioral health data systems for HHS that provide high quality data on the incidence and prevalence of mental and substance use disorders, the use of emergency and specialty care, and more recently local indicators of behavioral health status of communities.

National Surveillance and Data Collection

The National Survey on Drug Use and Health (NSDUH) serves as the nation's primary source for information on the incidence and prevalence of substance use and mental illness and related health conditions. A new NSDUH contract was awarded in FY 2013 that will support the 2014, 2015, 2016, and 2017 annual surveys, pending the availability of funds. NSDUH's anticipated funding in FY 2013 was $54.8 million. In FY 2014, funding for NSDUH and NSDUH-related

activities is expected to be $48.1 million. In addition to those amounts, CMHS provides approximately $1 million a year for NSDUH to support mental health related data collection.

Building on the findings from a study commissioned by SAMHSA from the National Center for Health Statistic/Centers for Disease Control (NCHS/CDC), CBHSQ will begin to develop and test methods to produce credible estimates of Serious Emotional Disturbance (SED) within the NSDUH survey framework. In addition, CBHSQ will partner with ASPE and the Institute of Medicine (IOM) to provide a comprehensive review and to make recommendations for integrating the full-range of behavioral health conditions (mental health and substance abuse) into the NSDUH. Also, in response to Congressional recommendation, SAMHSA will explore options for incorporating Puerto Rico, the U.S. Virgin Islands and U.S. Pacific jurisdictions into the NSDUH data collection efforts.

Behavioral Health Services Information System (BHSIS)
(formerly Drug Abuse Services Information System/ Behavioral Health Services Information System)

In FY 2013, SAMHSA modified the current Drug Abuse Services Information System (DASIS) contract to become the new Behavioral Health Services Information System (BHSIS). DASIS was the primary source of data on substance abuse treatment facilities and treatment admissions. One aspect of this program is the treatment locator, which is accessed more than two million times a year by individuals, families, community groups, and organizations to identify appropriate treatment services. SAMHSA will post a new up-to-date Behavioral Health Treatment Services Locator that will provide integrated, accurate, timely, and regularly updated information on mental health and substance abuse treatment facilities across the country. CBHSQ will also explore during the coming year the potential for integrating both buprenorphine providers and health center locator information into the current treatment locator efforts. The BHSIS project completed a pilot study of a new approach to integrating a mental health treatment admissions data set with its counterpart in substance abuse. The feasibility of expanding this approach to a broader group of states and the incorporation of new datasets to be made available through advances in Health Information Technology (HIT) will be studied as part of the 2013 contract modification funded by both CBHSQ and the Center for Mental Health Services (CMHS). SAMHSA will be working closely with stakeholders including NASADAD, NASMHPD, and our state partners in the development and implementation of this integration effort which includes identifying metrics for reporting. In addition, SAMHSA will conduct coordinated substance abuse and mental health facility surveys in FY 2014. Funding from CBHSQ in FY 2013 and FY 2014 provides for $17.0 million and $21.0 million respectively for BHSIS. In addition, CMHS will provide $7.1 million in FY 2013 and $7.5 million in FY 2014 for BHSIS.

Community Behavioral Health Data Initiative (CDI)

Data collected from local communities are used to deliver programs and services are an important component of a strong public health infrastructure. Much of SAMHSA's current data effort is captured and reported at the national or state level. Information on the health and behavioral health at the community level serves to identify current and emerging problems and highlight opportunities for progress that may vary from larger geographical areas. Importantly, when communities have access to surveillance data over time, prevention can happen.

Communities using data can identify what the issues may be and then direct targeted prevention efforts at the vulnerable populations in their communities. Under the new Community Behavioral Health Data Initiative (CDI) structure, SAMHSA will more closely coordinate three separate existing data efforts, the Community Early Warning and Monitoring Systems (C-EMS), SAMHSA's Emergency Department Surveillance System (SEDSS) (formerly the Drug Abuse Warning Network (DAWN)), and the Program Studies on Treatment and Recovery (PSTAR), to create new opportunities for cross-agency and public-private partnerships to address critical public health questions and more effectively utilize existing or declining resources. Data from this coordinated initiative can be combined with data from other Agencies such as CMS and AHRQ, and then be reported by regional and community type. Use of these data will allow communities to identify service and program needs specific to the local community. Moreover, the longitudinal nature of these data will allow those evaluating the effectiveness of services and policies in a community to measure the impact and outcomes of those interventions. SAMHSA will continue to examine where in-sourcing additional staff and collaborations with other agencies can support this effort while maximizing limited resources and cost-efficiencies.

The nature and approach to the collection and reporting of these community level data may change as efforts in FY 2013 and FY 2014 suggest the best methods and as the amount of available resources is known.

Community Early Warning and Monitoring System (C-EMS)

The foundation of SAMHSA's community-based work begun in the Community Early Warning and Monitoring System (C-EMS) provides the basis for community data development in FY 2014 and beyond. With federal partners, CBHSQ will further develop the data system begun in FY 2012 in collaboration with the Agency for Healthcare Research and Quality (AHRQ) of community level data collection related to emergency departments. This expanded collaboration will engage additional federal partners (United States Department of Agriculture and National Institute of Environmental Health Sciences) to apply data from resources at the local, state and national level to populate a database available to communities to develop data tables and reports for use in surveillance of the behavioral health status of local communities. Moreover, CBHSQ will consider developing data toolkits with survey measures and instructions in the use of these measures, as well as technical assistance in sampling and survey deployment, to assist communities interested in conducting local behavioral/public health surveillance. These data may be uploaded to a community behavioral health database that SAMHSA and contributing communities may use to understand community behavioral health needs and changes over time. In FY 2013, CBHSQ provided $2.5 million and plans to provide $3.0 million in FY 2014 to expand their current IAA with United States Department of Agriculture (USDA)/National Institute of Food and Agriculture (NIFA) to develop and collect community-level data through their cooperative extension programs.

SAMHSA's Emergency Department Surveillance System (SEDSS)

Emergency Department (ED) data remains an important component of public health data because it provides a picture of the most urgent health, and more specifically behavioral health issues in the community. ED data is an excellent tool for monitoring trends in mental and substance use

disorders and related conditions, and when examined across the nation, provides important surveillance for targeting emerging behavioral health issues. As the SAMHSA Emergency Department Surveillance System (SEDSS) transitions to a more community specific face, ED data can provide a summary of visits by patients with mental health conditions, domestic violence, substance use problems, and trauma. In FY 2012, SAMHSA partnered with the National Center for Health Statistics (NCHS)/CDC through an Interagency Agreement (IAA) to integrate components of the Drug Abuse Warning Network (DAWN) data collection into the emergency department (ED) component of the National Hospital Care Survey (NHCS). DAWN served as the nation's public health surveillance system that monitored drug abuse related ED visits. By collaborating with NCHS, SAMHSA has an opportunity to understand more comprehensively the nature and course of behavioral health presentations to EDs. Thus, SAMHSA's Emergency Department Surveillance System (SEDSS), which will replace the Drug Abuse Warning Network (DAWN), will collect ED visit information on both mental and substance use disorders. The development of the SEDSS started when CBHSQ provided $5 million to NCHS in FY 2012 for planning and development. CBHSQ added $3.8 million to the activity in FY 2013 for continued development and to expand the implementation in FY 2014 will add another $4.0 million to the IAA to fully implement data collection efforts. As SEDSS continues, SAMHSA will also consider collaboration with CMS hospital data efforts to increase participation or maximize resources.

Program Studies on Treatment and Recovery (PSTAR)

With the implementation of health reform, behavioral health and primary care service networks can expect significant changes in terms of how the mix of services are financed, changes in the locus of behavioral health and primary care services, and an increase in certain populations with mental and substance use disorders that had not previously been treated in primary care and behavioral health specialty programs (e.g., veterans, youth involved in the criminal justice system, and individuals with co-occurring mental health, substance use, and physical health conditions).

It is likely that in changing the health care financing landscape, the care delivery network will expand into new settings including proprietary, private, and quasi-public partnerships. As well, lines between for profit and not-for-profit may blur. Because of these and other changes that will occur, there is an expectation of greater diversity among those seeking care. In FY 2014, SAMHSA expects to award a new contract that will monitor the impact of organizational, financing, and management strategies as they change or impact the population of individuals requiring behavioral health care. Of special interest is furthering an understanding of how these local variations impact special populations of interest (e.g., veterans, minorities, individuals with co-occurring conditions).

It is expected that PSTAR will become a public health resource that works in concert with the other data initiatives under the Community Behavioral Health Data Initiative as well as the National Survey of Drug Use and Health, other facility data systems, and ongoing analytic projects within the Center for Behavioral Health Statistics and Quality to respond to critical questions related to health reform implementation, parity, program effectiveness, financing, and access. In FY 2014, CBHSQ will provide $0.8 million for planning and development activities.

Data Collection and Evaluation Activities

In FY 2014, CBHSQ will provide $6.4 million in funding for data collection and evaluation activities, including an evaluation of the Primary Behavioral Health Care Integration (PBHCI) program, pilot implementation of a data room for use by agency research staff to access confidential data in a secure environment, and a pilot study to collect behavioral health data from electronic health records.

Evaluation

Consistent with the Administration's increased emphasis on the use of rigorous and independent program evaluation to determine if programs achieve intended outcomes at a reasonable cost, SAMHSA will continue to support the systematic collection of data to assess its investments in discretionary and block grant programs. The evaluation policy was finalized in early 2012. In late 2012, CBHSQ conducted a review of all evaluation activities. This process helped SAMHSA identify current evaluations which could be enhanced or improved with support from in-house evaluation expertise. For all new program activity in which an evaluation is proposed, CBHSQ meets with program staff and the SAMHSA Evaluation Team (SET) to gather information about planned evaluation activities, program objectives, and budget estimates for evaluation. During this period, CBHSQ reviews the planned grant or contract language to ensure there is sufficient description of evaluation and data collection plans. CBHSQ's roles vary, and may include: 1) conducting an evaluation; 2) co-directing an evaluation using a contractor to gather data and assist with report writing; or 3) serving as a consultant as needed on evaluations that are directed by an originating Center within SAMHSA. CBHSQ has been actively engaged in evaluation design and implementation in FY 2013. In FY 2014, CBHSQ will continue implementation of the evaluation guidance and begin providing training in evaluation design to relevant SAMHSA staff.

Through its evaluation guidance, SAMHSA proposes to expand its efforts to improve the quality of information on behavioral health investments by:

- providing uniform standards for evaluations;
- supporting rigorous evaluation designs;
- building a cadre of trained evaluators to oversee evaluations;
- providing a structure to assess environmental contexts that promote or impede program effectiveness;
- allowing for designs that enable adaptation and adjustments in the implementation process;
- producing timely results for decision makers; and
- creating an accessible, central repository for information related to SAMHSA evaluations.

Statistical and Analytic Support

Funding is requested for a number of activities to support a broad range of analytic work to be carried out in the CBHSQ. These activities include support for an Analytic Support Center (ASC) which undertakes a number of scientific and writing tasks on policy and practice-related topics in response to requests from SAMHSA Centers and related components, HHS agencies (CDC, AHRQ, and FDA), the Surgeon General's Office, the Office of National Drug Control Policy, and the Department of Justice. FY 2013 and FY 2014 funds $3.0 million for the Analytic Support and CBHSQ's Logistics contracts (formerly the National Analytic contracts).

Funding will also support the ongoing Substance Abuse and Mental Health Data Archive (SAMHDA) which serves as SAMHSA's primary repository for public access data files. Funding for SAMHDA in both FY 2013 and FY 2014 was $1.3 million. SAMHDA provides free access and on-line analytic tools to the public. Resources will also be used to sustain a program for providing limited public access to files restricted for privacy or other reasons, serving to expand the use and application of data collected under the survey contracts.

Finally, funding will be utilized to continue the support of positions focused on analyzing and reporting on data collected within CBHSQ, SAMHSA and HHS, as well as identifying and analyzing information from other data sets that may help inform the work of SAMHSA. Staff will also respond to requests for data and explanations of existing data points, prepare internal reports, support SAMHSA staff in the development of materials that require statistical information, and prepare short reports, data spotlights, and manuscripts for publication. These staff support data needs by serving on workgroups that require data analysis as part of their function and will prepare data requests for departmental activities. Particularly important is the inclusion of a new Health Economics and Financing Team that will focus on studies related to cost and financing trends as health care delivery models change over the next several years. Some of these positions have been created by in-sourcing tasks that are most appropriately done by federal staff, are less expensive than contract staff and/or are mission critical and thus improve SAMHSA's capacity to respond to data and information needs relevant to SAMHSA's mission.

The SAMHSA appropriations language in FY 2014 included authority to collect fees to offset the cost of publications or analyses of these data that would otherwise not be done within existing SAMHSA resources and which are requested by proprietary or other private or public entities that are interested in additional data analyses that SAMHSA's Data Request and Publication User Fees could provide if funds were available.

Services Systems Research

Building on efforts begun in FY 2011, and continued through FY 2014, SAMHSA proposes to continue to build its practice-based service systems research program which complements efforts in its sister agencies of National Institutes of Health (NIH), AHRQ, and CDC in FY 2014 and FY 2015. This will provide pilot data for full-scale research proposals to NIH or other practice settings in which to test models being developed through these agencies' research efforts. The program will focus on critical gaps in knowledge about prevention, wellness, treatment, and

recovery services for individuals, families, and communities at risk for or suffering from mental illnesses, addictions, and related chronic conditions. Of particular interest to SAMHSA are issues of quality, cost, access to, and outcomes of behavioral health services both in the primary and specialty care service sectors. Significant attention will be given to developing analyses that enhance understanding of the economic and cost implications of changes in health insurance access for behavioral health care within the larger SAMHSA analytic agenda coordinated through CBHSQ. A team of health economists and health services researchers are specifically focused on cost and finance studies related to behavioral health.

Performance and Quality Information Systems

Continued funding is requested for performance and quality information systems to phase in the implementation of SAMHSA's Common Data Platform (CDP), which was awarded in late FY 2013. The CDP will provide a uniform collection and reporting system providing SAMHSA management and staff with the ability to analyze programs at various levels (state, program, community, etc.); provide each Center with tailored information about the progress and activities of grantees; and provide data to grantees to support them in the efficient and effective implementation of projects.

During 2013 and 2014, SAMHSA will be working closely with NASADAD, NASMHD, and state partners to identify, refine, and test measures that, where possible, build upon current efforts within states. Moving forward, SAMHSA is committed to harmonizing measures across data collection programs in a way that reduces burden, increases the quality of data collected, and provides necessary information to measure performance and manage grants. CBHSQ staff has worked closely with the HHS Measures Policy Council and the National Quality Forum to ensure that SAMHSA expertise informs the field of behavioral health quality measure alignment, development, and implementation. These efforts will continue in the rapidly changing measures environment.

Funding is also requested for the continuation of the National Registry of Evidence-based Programs and Practices (NREPP), a searchable online system that supports states, communities, and tribes in identifying and implementing evidence-based mental health promotion, substance abuse prevention, and substance abuse and mental health treatment interventions. This registry is comprised of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. Moreover, the registry assists the public in identifying scientifically based approaches to preventing and treating mental and/or substance use disorders that can be readily disseminated to the field. This program is one way that SAMHSA is working to improve access to information on tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field. FY 2013 and FY 2014 provided for $2.4 million and $3.5 million respectively for NREPP.

Resource Summary

A total of $121.7 million is provided for CBHSQ, reflecting a $1.6 million increase above the FY 2014 Enacted Level. The FY 2015 resources of $121.7 million includes $57.7 million in Substance Abuse Prevention and Treatment Block Grant Set Aside (SABG-SA) PHS Evaluation Funds (a decrease of $1.5 million below FY 2014 Enacted Level), $0.6 million in SABG-SA Budget Authority (an increase of $0.1 million above FY 2014 Enacted Level), $0 in Health Surveillance and Program Support (HSPS) Budget Authority (a decrease of $17.0 million below FY 2014 Enacted Level), $29.4 million in HSPS PHS Evaluation Funds (a decrease of $1.0 million below FY 2014 Enacted Level), $20.0 million in Prevention and Public Health Fund (an increase of $20 million above the FY 2014 Enacted Level), $13.0 million in Performance and Quality Information Systems (PQIS) PHS Evaluation Funds (which includes a decrease of $13.0 million in PQIS BA funds, but a $13.0 million increase in PQIS PHS Evaluation Funds for a net level funding from the FY 2014 Enacted Level), and $1.0 million in Agency-wide PHS Evaluation Funds (an increase of $1.0 million above the FY 2014 Enacted Level).

Modules in NSDUH

CBHSQ will explore optimal strategies to obtain data on recovery, trauma, and serious emotional disturbance among children which may include the use of topical modules, as part of the NSDUH. These data are important as they fill critical data gaps in these major areas of concern associated with behavioral health. CBHSQ will support part of this effort with $2 million in FY 2015.

Trauma and Recovery Modules

CBHSQ will identify the best way to use NSDUH to address gaps in this important behavioral health national surveillance system. Once the conceptual, definitional, and operational aspects of trauma and recovery are determined, substantive areas of interest will be defined. These substantive areas will be translated into brief questionnaire modules that will be refined through a process of testing to include cognitive interviews and field tests. A plan for collecting the data, including a potential inclusion of questions in the NSDUH, should be ready for fielding by FY 2017 or FY 2018. While these modules are defined, CBHSQ will identify additional opportunities to provide empirical data related to trauma and recovery.

Serious Emotional Disturbance

SAMHSA's authorization stipulates that the agency provide estimates of Serious Emotional Disturbance (SED) among children. A pilot study done jointly by SAMHSA, National Institute of Mental Health (NIMH), and the Centers for Disease Control (CDC), using CDC's National Health Interview Survey (NHIS) yielded important preliminary results that will guide future development. Using lessons learned from the NHIS SED pilot study, SAMHSA will extend the initial development of definitions and procedures, taking into account new mental disorder criteria specified in the Diagnostic and Statistical Manual – Fifth Edition (DSM-5). This will entail the development of a valid diagnostic clinical interview tool for children, determination of

an operational definition of serious emotional disturbance, and development of new sampling and interview techniques for NSDUH.

Behavioral Health Workforce Data and Development

The President's *Now is the Time* Initiative, released in January 2013, proposed $50 million in new behavioral health workforce activities in SAMHSA's FY 2014. The FY 2014 Enacted level was $40 million. The FY 2015 Budget includes all of the investments in the FY 2014 Enacted budget, and $11 million in new investments. In total, the $51 million for workforce investments will result in approximately 5,000 new behavioral health clinical professionals. To ensure the existing workforce investments are responsible and well-targeted, the overall increase of $11 million within SAMHSA for workforce activities includes $1 million within CBHSQ to partner with HRSA on the Behavioral Health Minimum Data Set to develop consistent data collection methods to identify and track behavioral health workforce needs as well as to partner with the Department of Defense, and the Department of Veterans Affairs to inventory existing and emerging workforce issues, efforts and impacts, and develop coordinated plans.

Because of the current lack of consistent and complete data, HRSA and SAMHSA began a minimum data set project in 2012 and 2013 to define and track the behavioral health service needs and workforce in the country. However, this effort needs additional support to continue and complete its goals. In FY 2015, SAMHSA proposes to work with HRSA to develop a consistent and common data set and to develop clear goals and objectives to meet the national behavioral health workforce needs in America.

Ensuring coordinated workforce strategies will benefit the specialty behavioral health sector as well as VA and DOD's total workforce availability in the future. In FY 2015, SAMHSA requests $1.0 million to work with HRSA, DOD, and VA to track existing and emerging workforce trends, to inventory activities in public and private sectors, produce analysis of potential efforts and impacts, and proposals regarding creative actions for FY 2016 and beyond to address the critical behavioral health workforce needs of America.

Science of Changing Social Norms - Building the Evidence Base: $2 million, an increase of $2 million in support of the President's *Now is the Time* initiative to develop and test an array of messages and media designed to improve attitudes, understanding and behavior of Americans about mental and substance use disorders and willingness to seek help for them. This increase will be used to support the work begun by the White House National Conference on Mental Health, supporting the collection and use of data to learn if what and how we are communicating is making a positive difference. The increase funding represents the addition of this program that will support efforts to measure and track behavioral, attitudinal, and related community data to inform how we understand the impact of exposure to social messaging and demonstrate evidence for effecting behavioral change at the individual, community, and population levels. The data collection component of this effort will be led through SAMHSA's Center for Behavioral Health Statistics and Quality and will be included in the CDI.

Major increases from the FY 2014 Enacted Level include the following activities:

- NSDUH: $52.7 million, an increase of $4.6 million. The increase funding represents survey technology purchases and the addition of the trauma, recovery, and serious and emotional disturbance among children modules that will be added to the NSDUH.
- CDI: $10.5 million, an increase of $2.7 million. This increase supports the development and integration of the C-EMS, SEDSS, and PSTAR data collection programs (total does not include the Science of Changing Social Norms costs mentioned above).
- CDP: $5 million, an increase of $3.6 million from FY 2014 Enacted Level. The decrease to CDP in FY 2013 was due to the contract total cost coming in lower than expected. In FY 2014, due to a protest to the contract, the award of this contract was delayed until early 2014 and used FY 2013 funds. In FY 2014, this savings will be used to continue to fund the CDP-related Legacy programs. In FY 2015, the overall savings on the cost of the project, mentioned above, will be used to fund additional activities under the CDI and Grantee Data TA activities and to fund additional FTE's for a data technical assistance team.

Major decreases in funding from the FY 2014 Enacted Level include the following activities:

- NREPP: $2 million, a $1.5 million decrease. The NREPP backlog will be handled in FY 2014 and a normal schedule resumes in FY 2015.
- Grantee Data Development Technical Assistance: $4 million, a $1.0 million decrease. The initial ramping up of TA activities around development and implementation of measures, will taper off in year two, as states and grantees become familiar with the system and efficiencies are gained through lessons-learned.
- CDP Legacy - DCAR: $0, a decrease of $3.0 million from FY 2014 Enacted Level. Due to the later than expected start date of the CDP (due to protest) the phasing out of legacy system and implementation of the CDP are happening in FY 2014. CDP Legacy systems will still be funded in FY 2014 at prorated amounts and will be phased out fully in FY 2015.
- CDP Legacy – SAIS and TRAC: $0, a decrease of $4.0 million from FY 2014 Enacted Level. Due to the later than expected start date of the CDP (due to protest) the phasing out of legacy system and implementation of the CDP are happening in FY 2014. CDP Legacy systems will continue to be funded in FY 2014 at prorated amounts and will be phased out fully in FY 2015.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services
(Dollars in thousands)

RESOURCE SUMMARY

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Drug Resources by Decision Unit and Function			
Substance Abuse Prevention Programs of Regional and National Significance			
Prevention[1/]	175,513	175,560	185,560
Total, SAP PRNS	**$175,513**	**$175,560**	**$185,560**
Substance Abuse Treatment Programs of Regional and National Significance			
Treatment[2/]	404,085	361,460	297,400
Total, SAT PRNS	**$404,085**	**$361,460**	**$297,400**
Substance Abuse Prevention and Treatment Block Grant			
Prevention[3/]	342,061	363,971	363,971
Treatment[3/]	1,368,245	1,455,885	1,455,885
Total, SABG	**$1,710,306**	**$1,819,856**	**$1,819,856**
Health Surveillance and Program Support			
Prevention [4]	21,105	24,337	21,265
Treatment [4]	84,420	97,349	103,339
Total, HSPS	**$105,525**	**$121,686**	**$124,604**
Total Funding	**$2,395,429**	**$2,478,562**	**$2,427,420**
Drug Resources Personnel Summary			
Total FTEs (direct only)	**526**	**555**	**546**
Drug Resources as a Percent of Budget			
Total Agency Budget	**$3,354,461**	**$3,631,102**	**$3,567,871**
Drug Resources Percentage	**71.4%**	**68.3%**	**68.0%**

Footnotes

[1] Includes funding from the Substance Abuse Prevention PRNS.

[2] Includes funding from the Substance Abuse Treatment PRNS.

[3] The Substance Abuse Prevention and Treatment Block Grant is split 20% to the prevention function and 80% to the treatment function.

[4] The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health /Substance Abuse as follows: Program Support, Health Surveillance and PQIS are split the same percentage split as between MH/SA appropriations. PAS, Agency-wide, and Data Request and Publication User Fees are split 50/50 between MH/SA. The subsequent Substance Abuse amounts are then divided into 20% for Prevention and 80% for Treatment.

Drug Budget Split between Prevention and Treatment FY 2013 - FY 2015

(Dollars in thousands)

Substance Abuse Prevention	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Substance Abuse Prevention PRNS			
Strategic Prevention Framework	107,902	109,754	119,754
SPF Rx(PHS Evaluation Funds)(non-add)			*10,000*
Mandatory Drug Testing	5,252	4,906	4,906
Minority AIDS Initiative	40,996	41,307	41,307
Minority Fellowship Program	---	---	---
STOP Act	6,994	7,000	7,000
Fetal Alcohol Syndrome	1,104	1,000	1,000
Center for the Application of Prevention Technologies	8,098	7,511	7,511
PHS Evaluation Funds (non-add)	---	---	*6,468*
Science and Service Program Coordination	5,168	4,082	4,082
Total, Substance Abuse Prevention PRNS	**$175,513**	**$175,560**	**$185,560**
Substance Abuse Prevention and Treatment Block Grant	342,061	363,971	363,971
PHS Evaluation Funds (non-add)	15,840	15,840	15,840
Total, Substance Abuse Block Grant	**$342,061**	**$363,971**	**$363,971**
Health Surveillance and Program Support			
Health Surveillance	*6,500*	*6,504*	*6,776*
Prevention and Public Health Fund (non-add)	*2,108*	---	*2,742*
PHS Evaluation Funds (non-add)	*3,925*	*4,173*	*4,034*
Program Support	11,162	9,974	9,970
Public Awareness and Support	1,355	1,357	1,557
PHS Evaluation Funds (non-add)	---	---	*1,557*
Performance and Quality Information Systems	1,260	1,782	1,782
PHS Evaluation Funds (non-add)	---	---	*1,782*
Agency Wide Initiatives	829	4,570	1,031
Data Request/Publication User Fees	---	150	150
Total, Substance Abuse Prevention HSPS	**$21,105**	**$24,337**	**$21,265**
Total, Substance Abuse Prevention	**$538,679**	**$563,868**	**$570,796**

Substance Abuse Treatment	FY 2013 Enacted	FY 2014 Enacted	FY 2015 President's Budget
Substance Abuse Treatment PRNS			
Opioid Treatment Programs/Regulatory Activities	8,421	8,746	8,746
PDMP HER Integration and Interoperability Expansion	4,000		
Screening, Brief Intervention and Referral to Treatment	47,464	47,000	30,000
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*
TCE - General	26,516	13,256	15,256
Pregnant & Postpartum Women	15,634	15,970	15,970
Strengthening Treatment Access and Retention	1,584	1,668	1,000
Recovery Community Services Program	2,445	2,440	2,440
Access to Recovery	93,128	50,000	---
Prevention and Public Health Fund (non-add)	---	*50,000*	---
Primary Care and Addiction Services Integration (PCASI)	---	---	20,000
Children and Family Programs	29,018	29,678	29,678
Treatment Systems for Homeless	39,397	41,488	41,488
Minority AIDS	61,918	65,732	58,859
Criminal Justice Activities	63,558	75,000	64,446
Addiction Technology Transfer Centers	9,008	9,046	8,081
Special Initiatives/Outreach	1,992	1,436	1,436
Total, Substance Abuse Treatment PRNS	**$404,085**	**$361,460**	**$297,400**
Substance Abuse Prevention and Treatment Block Grant	1,368,245	1,455,885	1,455,885
PHS Evaluation Funds (non-add)	63,360	63,360	63,360
Total, Substance Abuse Block Grant	**$1,368,245**	**$1,455,885**	**$1,455,885**
Health Surveillance and Program Support			
Health Surveillance	*25,999*	*26,017*	*27,104*
Prevention and Public Health Fund (non-add)	*8,433*	---	*10,967*
PHS Evaluation Funds (non-add)	*15,700*	*16,692*	*16,137*
Program Support	44,646	39,896	39,881
Public Awareness and Support	5,418	5,428	6,228
PHS Evaluation Funds (non-add)	---	---	*6,228*
Performance and Quality Information Systems	5,039	7,129	7,126
PHS Evaluation Funds (non-add)	---	---	*7,126*
Agency Wide Initiatives	3,317	18,278	22,400
Data Request/Publication User Fees	---	600	600
Total, Substance Abuse Treatment HSPS	**$84,420**	**$97,349**	**$103,339**
Total, Substance Abuse Treatment	**$1,856,750**	**$1,914,694**	**$1,856,624**

MISSION

The Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA supports the *President's National Drug Control Strategy* through a broad range of programs focusing on prevention, treatment and recovery from substance abuse. Major programs for FY 2015 will include the Substance Abuse Prevention and Treatment Block Grant, competitive grant programs reflecting Programs of Regional and National Significance (PRNS) and Health Surveillance and Program Support. These programs are administered through SAMHSA's Centers for Substance Abuse Prevention (CSAP) and Substance Abuse Treatment (CSAT) as well as through SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) and the Office of Communications.

METHODOLOGY

SAMHSA distributes drug control funding into two functions: prevention and treatment. Both functions include a portion from the Health Surveillance and Program Support (HSPS) appropriation.

In FY 2014, the HSPS portion of the drug budget was split as follows. Since the Performance Awareness and Support (PAS) and Performance and Quality Information Systems (PQIS) programs represented the consolidation of funding from existing CSAT, CSAP and Center for Mental Health Services (CMHS) programs, 50 and 70 percents, respectively, of funding for these activities were included in the drug budget representing the substance abuse portion between substance abuse and mental health for the entire agency. The 50 and 70 percents were then divided 20 percent/80 percent into the two functions, prevention and treatment, respectively. The Health Surveillance and Program Support activities within the HSPS appropriation were split first between mental health and substance abuse (as determined by each activity) and then the substance abuse portion was split 20 percent/80 percent between prevention and treatment. Agency-wide programs were evenly split between mental health and substance abuse and then the substance abuse portion was split the same 20 percent and 80 percent for prevention and treatment.

In FY 2015, the proportion of the Health Surveillance and Program Support account attributed to the Drug Budget has used updated calculations as follows:

- The Health Surveillance, Program Support, and PQIS portions of the HSPS appropriation are first split into Mental Health and Substance Abuse using the same percentages splits as between the Mental Health and Substance Abuse (Prevention and Treatment) appropriation amounts.

    - The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

- The PAS and Agency-wide portions of the HSPS appropriation are first divided evenly between Mental Health and Substance Abuse.

    - The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

Also included in the prevention function are the funds in the Substance Abuse Prevention appropriation, including the Substance Abuse Prevention Programs of Regional and National Significance and 20 percent of the Substance Abuse Prevention and Treatment Block Grant funds from the Substance Abuse Treatment appropriation.

Also included in the treatment function are the funds in the Substance Abuse Treatment appropriation, including the Substance Abuse Treatment Programs of Regional and National Significance and 80 percent of the Substance Abuse Prevention and Treatment Block Grant funds.

BUDGET SUMMARY

In FY 2015, SAMHSA requests a total of $2.427 billion for drug control activities, which is a decrease of $51.1 million from the FY 2014 Enacted Level. The Budget directs resources to activities that have demonstrated improved health outcomes and that increase service capacity. SAMHSA has three major drug-related decision units: Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support. Each decision unit is discussed below:

Substance Abuse Prevention

Substance Abuse Prevention Programs of Regional and National Significance
Total FY 2015 Request: $185.6 million
(Reflects $10 million increase from FY 2014 Enacted Level)

The Substance Abuse Prevention Programs of Regional and National Significance (PRNS) support states and communities in carrying out an array of activities to improve the quality and availability of services in priority areas.

The FY 2015 President's Budget request for SAMHSA Substance Abuse Prevention PRNS includes $185.6 million which covers seven programmatic activities, a decrease of $10 million from the FY 2014 Enacted Level. The request includes: $119.8 million for Strategic Prevention Framework; $41.3 million for Minority AIDS; $1.0 million for the Fetal Alcohol Spectrum Disorders (FASD) contract; $7.5 million to continue provision of technical assistance to maximize effectiveness through the Centers for the Application of Prevention Technologies; $4.9 million for Mandatory Drug Testing; $7.0 million for other Sober Truth on Preventing Underage Drinking; and $4.1 million for Science and Service Program Coordination.

Strategic Prevention Framework
Total FY 2015 Request: $119.8 million
(Reflects $10 million increase from FY 2014 Enacted Level)

Partnerships for Success

The Partnerships for Success (PFS) program was initiated in FY 2009 with the goals of reducing substance abuse-related problems; preventing the onset and reducing the progression of substance abuse; strengthening prevention capacity and infrastructure at the state and community levels in support of prevention; and leveraging, redirecting and realigning state-wide funding streams for substance abuse prevention. Eligible applicants are states and territories that have completed a SPF State Incentive Grant (SPF-SIG). In FY 2009, four grants were awarded, and in FY 2010, one additional award was made. The first two cohorts incorporated an incentive award to grantees that reached or exceeded their prevention performance targets (subject to availability of funds). In FY 2012, SAMHSA supported these efforts by awarding five continuation grants. The FY 2012 data from the first cohort reporting show that 50 communities increased the number of activities supported through collaboration and leveraging. Grantees reported implementing 888 evidence-based programs and thirty-two communities reported improvements on targeted National Outcome Measures indicators. Two of the three performance measures exceeded their targets. The vast majority of communities (88 percent) targeted alcohol use.

A new cohort of PFS grants began in FY 2012 to address two of the nation's top substance abuse prevention priorities: underage drinking among youth aged 12 to 20 and prescription drug misuse and abuse among individuals aged 12 to 25. The program is based on the premise that changes at the community level will, over time, lead to measurable changes at the state and national level. In FY 2012, SAMHSA awarded 15 new grants for three years.

In FY 2013, SAMHSA supported continuation awards for the initial cohorts established in FY 2009 and FY 2010. SAMHSA also made a new SPF SIG award to Idaho, the last state remaining to receive a SPF SIG and awarded 16 new PFS grants. In addition, SAMHSA made funds available for grantees in the first cohort who met their performance targets and were eligible for the incentive supplement.

In FY 2014, SAMHSA will award a new cohort of PFS grants. Similar to the previous cohorts, these grants will address two of the nation's top substance abuse prevention priorities: underage drinking among youth age 12-20 and prescription drug misuse and abuse among individuals age 12 to 25. The PFS program will focus on implementing the Strategic Prevention Framework to strengthen prevention capacity and infrastructure at the state, territorial, and community levels; preventing the onset and reducing the progression of substance abuse; and leveraging, redirecting, and aligning statewide funding streams and resources to focus on promoting evidence-based substance abuse prevention. Up to 34 grants will be awarded to eligible states, territories and tribes who have completed SPF-SIG. SAMHSA will also consider how best to help tribes committed to substance abuse prevention strengthen their existing service delivery systems and/or begin building the necessary infrastructure to successfully prevent substance abuse in their communities.

Of the remaining SPFSIG grantees, 88 percent reported decreases in underage drinking, 82 percent of grantees reported decreases in drug use, 29 percent reported increased perceived risk of substance use and 901 evidence-based policies, practices, and strategies were implemented. Three of these four measures exceeded their targets.

In FY 2015, funding will support the continuation of grants and contracts as well as award a new cohort of PFS grants. Funding will also support the new activities mentioned below.

Building Behavioral Health Coalitions:
Working to Address Shared Risk and Protective Factors
(Braided program with Mental Health: MH System Transformation and Health Reform)

In FY 2015, in support of SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, SAMHSA proposes to use $3 million in Budget Authority to establish the Building Behavioral Health Coalitions program. SAMHSA will use $1.5 million from Mental Health Appropriation's Mental Health Transformation and Health Reform funds and $1.5 million from Substance Abuse Prevention Appropriation's Strategic Prevention Framework funds to support this new initiative. The purpose of this program is to support active community coalitions and/or organizations to expand their focus and activities to include mental health promotion, mental illness prevention and substance abuse prevention. Consistent with the Institute of Medicine's 2009 report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*, this program seeks to build on the emerging evidence that a significant number of mental, emotional and substance abuse problems in young people are largely preventable and community-based prevention can play a significant role in facilitating key prevention efforts. Evidence shows that to create emotionally healthy communities, it is important to address the shared risk factors that contribute to an array of adverse outcomes, and the protective factors that reduce the risk of these negative consequences. Risk factors include poverty, early trauma, drug/alcohol misuse, family dysfunction, poor academic performance, and peer rejection. Protective factors include good communication skills, stress mitigation, reliable support and guidance from parents and caregivers, support for high quality early learning, quality health care, healthy peer groups, social connectedness, and successful learning environments.

Mental Health Transformation and Health Reform Funds will be provided to substance abuse prevention community coalitions (including, but not limited to, current and former Drug Free Communities grantees) and organizations to expand their activities to include mental health promotion and mental illness prevention, and Strategic Prevention Framework funds will be provided to coalitions and organizations with a mental health focus to expand their activities to include substance abuse prevention. Funding streams will be kept separate and used for activities consistent with separate funding authorities.

Funded activities may include but are not limited to, bi-directional education on substance abuse prevention and mental health promotion; assessing shared community risk and protective factors, especially among youth, connecting across community service systems including primary care, and developing the capacity to jointly implement evidence-based programming that addresses these factors; and working with stakeholders such as health insurance companies, Marketplaces, and state Medicaid officials to promote health insurance coverage for substance

abuse prevention and mental health . Grantees will be encouraged to consider best practices and models developed through other community-level programs such as Drug Free Communities, Safe Schools/Healthy Students, and Project LAUNCH.

Strategic Prevention Framework Prescription Drug Abuse and Overdose Prevention (SPF Rx)

According to the 2012 National Survey on Drug Use and Health (NSDUH), 2.6 percent of the U.S. population uses prescription drugs non-medically, including 4.9 million users of pain relievers, 2.1 million users of tranquilizers, 1.2 million users of stimulants, and 270,000 users of sedatives. Drug overdose death rates have increased five-fold since 1980.[70] By 2009, drug overdose deaths outnumbered deaths due to motor vehicle crashes for the first time in the U.S. Prescription drugs, especially opioid analgesics, have been increasingly involved in drug overdose deaths.[71] Opioid analgesics were involved in 30 percent of drug overdose deaths where a drug was specified in 1999, compared to nearly 60 percent in 2010. Opioid-related overdose deaths now outnumber overdose deaths involving all illicit drugs such as heroin and cocaine combined.[72] In addition to overdose deaths, emergency department visits, substance treatment admissions and economic costs associated with opioid abuse have all increased in recent years.

Rates of chronic nonmedical use of opioids are highest among 18-25 year olds, followed by 26-34 year olds, and 35-49 year olds.[73] Rates of emergency department visits due to misuse or abuse of opioids or benzodiazepines are highest among 21-29 year olds followed by 30-44 and 45-54 year olds.[74] Substance abuse treatment admissions for opioid analgesics are highest for 25-34 year olds, followed by 18-24 year olds, and 35-44 year olds.[75] Drug overdose death rates for opioids are highest among people aged 45-54 years old, followed by 35-44, 25-34, and 55-64 year olds.[76]

In FY 2015, funding is being requested for SAMHSA and CDC as part of a strategic effort to address non-medical use of prescription drugs as well as opioid overdoses, leveraging the strengths and capabilities of each agency. The two agencies are coordinating to ensure that the efforts are aligned with HHS' recently established policy and plan for prevention of Opioid-Related Overdoses and Deaths involving multiple Operating Divisions and offices.

CDC will expand its Core Violence and Injury Prevention Program to provide basic injury and violence prevention infrastructure to additional states with a high burden of prescription drug

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[70] Warner M, Chen LH, Makuc DM, Anderson RN, Miniño AM. Drug poisoning deaths in the United States, 1980–2008. NCHS data brief, no 81. Hyattsville, MD: National Center for Health Statistics. 2011.

[71] Paulozzi L, Jones C, Mack K, Rudd R; Centers for Disease Control and Prevention (CDC). Vital signs: overdoses of prescription opioid analgesics—United States, 1999-2008. MMWR Morb Mortal Wkly Rep. 2011;60(43):1487- 1492.

[72] Centers for Disease Control and Prevention. WONDER [database]. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2013. Available at http://wonder.cdc.gov.

[73] Jones CM. Frequency of prescription pain reliever nonmedical use: 2002-2003 and 2009-2010. Arch Intern Med. 2012;172(16):1265-1267.

[74] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (July 2, 2012). **The DAWN Report: Highlights of the 2010 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits**. Rockville, MD.

[75] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. **Treatment Episode Data Set (TEDS): 2000-2010. National Admissions to Substance Abuse Treatment Services.** DASIS Series S-61, HHS Publication No. (SMA) 12-4701. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

[76] CDC analysis of the 2010 Multiple Cause of Death Mortality File. 2012.

overdose. This expansion will provide additional funding and technical assistance to some current and new Core states to focus on the main drivers of the epidemic – high-risk prescribing and high-risk patients.

SAMHSA proposes to dedicate $10 million to a new program, the Strategic Prevention Framework Prescription Drug Abuse and Overdose Prevention (SPF Rx), that will provide funding for the prevention of prescription drug misuse and abuse in high priority age groups (including young and middle-aged adults) and the general public. SAMHSA's program will complement the CDC program by awarding grants to a state's substance abuse authority to develop a comprehensive prevention approach in collaboration with the state's public health authority, education authority, and Medicaid authority, as well as the state's Prescription Drug Monitoring Program (PDMP) and Health Information Exchange (HIE). The goal will be to raise awareness of the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing and on the use of data from PDMPs and to provide educational materials at points of prescribing, sale and dispensing. SAMHSA's program will also focus on raising community awareness and bringing prescription drug abuse prevention activities and education to schools, communities, parents, prescribers and their patients.

SAMHSA proposes to utilize $4 million to fund SAMHSA SPF Rx grantees to:

- Use the state's strategic plan to target prescription drug abuse and misuse within the state;
- Use PDMP data for prevention planning; and
- Implement evidence-based practices and/or environmental strategies aimed at reducing prescription drug abuse and misuse.

Grantees will be required to track and monitor outcomes in non-medical use of prescription medications, emergency room admissions, and deaths due to prescription drug misuse or overdoses, as well as potential shifts in use of heroin or other illicit drugs in grantee states.

SAMHSA's SPF Rx grantees will be required to use needs assessment data to determine the risk factors leading to prescription drug abuse in the state, including lack of public knowledge of the dangers of misuse of prescription drugs and easy access to prescription drugs through friends, family members, and health care professionals. Because these risk factors will likely differ across grantees, the educational activities and community awareness activities implemented by SPF Rx grantees may also differ. Activities might include media campaigns targeted at parents and focused on the safe storage of prescription drugs,[77] the publication and distribution of opioid prescribing guidelines for health care professionals,[78] and evidence-based educational programs delivered in the school setting, such as Strengthening Families.[i] SAMHSA will also partner with NIDA to further develop the evidence base to support these efforts.

SAMHSA will utilize approximately $4 million for planning grants for up to 20 other states to build capacity to address prescription drug abuse and overdose prevention efforts, in conjunction with other state and local partners. They will utilize these funds to create partnerships with the existing prevention workforce, especially existing coalitions, to utilize PDMP, SAMHSA

[77] Johnson EM, Porucznik CA, Anderson JW, Rolfs RT. State level strategies for reducing prescription drug overdose deaths: Utah's prescription safety program. Pain Medicine: June 2011, Vol.12, Supp 2:S66-72.
[78] Ibid.

NSDUH, and/or commercial prescribing data to identify communities at risk and develop plans for appropriate prevention and intervention strategies. These states will be expected to produce a strategic plan focused on bringing prescription drug abuse prevention activities and education to schools, communities, and parents, and include a new focus on prescribers and their patients. These 20 states would be positioning themselves to eventually become implementation states.

Of the remaining $2 million, $1.4 million will be utilized, working in conjunction with CDC, to evaluate and provide technical assistance for funded states, and $0.6 million will be utilized to continue and expand work begun in FY 2011 with the Office of the National Coordinator of Health Information Technology (ONC) to focus on standards alignment on interoperability among state Prescription Drug Monitoring Programs (PDMPs) and electronic health records (EHRs) and HIEs and/or any other technology efforts determined necessary for the exchange of data. Additionally, grantees may identify and implement new opportunities (e.g., pilots, innovation challenges, etc.) focused on the use of EHRs and HIEs to improve clinical decision-making within and across states and to support PDMP communication and outreach activities.

SAMHSA's SPF Rx will provide funds to develop capacity and expertise in the utilization of data from the state's PDMP to identify communities by geography and population (e.g., age group) of high risk, particularly those communities that are in need of primary and secondary prevention. This will be coordinated with CDC's expansion of the Core Violence and Injury Prevention Program to include additional states with a high burden of prescription drug overdose, States will also provide technical assistance and training to the identified communities on the selection and implementation of appropriate evidence-based prevention programming using the Strategic Prevention Framework as their guide. In addition, SAMHSA's resources can be used to provide technical assistance and training on the use of SAMHSA's Opiate Overdose Prevention Tool Kit to prevent overdose deaths.

SAMHSA and CDC will coordinate to implement interventions that address the key drivers of overdose and high-risk prescribers and patients, while also implementing the foundational prevention programs required to sustain a state-wide response to this significant public health issue.

Minority AIDS Initiative
Total FY 2015 Request: $41.3 million
(Reflects level funding from FY 2014 Enacted Level)

Minority AIDS Initiative (MAI) supports efforts to increase access to substance abuse and HIV prevention services for the highest risk and hardest-to-serve racial and ethnic minority populations. Grantees must implement integrated, evidence-based substance abuse and HIV prevention interventions, including HIV testing, that target one or more high-risk populations such as young adults (18 to 24), African-American women, adolescents, individuals who have been released from prisons and jails within the past two years, or men having sex with men (MSM). In addition, the MAI supports partnerships between public and private nonprofit organizations to prevent and reduce the onset of substance abuse and transmission of HIV among high-risk populations.

In FY 2010, SAMHSA funded the Ready-To-Respond Initiative and the Capacity Building Initiative programs. A total of 62 grants in these cohorts will continue to be funded in FY 2014. The Ready-To-Respond Initiative, was awarded to experienced MAI grantees, and provides substance abuse and HIV prevention services to at-risk minority populations in communities disproportionately affected by HIV/AIDS. The Capacity Building Initiative focuses on using evidence-based prevention strategies and media technology to reach college students, who comprise one-third of the 18-24 year old population in the United States and are particularly at risk for substance use and HIV infection. Performance data for FY 2012 showed that almost 6,600 people received substance abuse prevention education services. Additionally, 96.8 percent of participants rated the risk of harm from substance abuse as great. Of those participants who were non-users, 93.2 percent remained non-users of drugs and 88.4 percent remained alcohol free. During FY 2012, over 32, 975 participants were tested for HIV. SAMHSA continued to support these grants in FY 2012 and FY 2013.

In FY 2011, SAMHSA also awarded 11 grants for the MAI Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements, jointly funded with CMHS and CSAT. This grant program facilitates the development and expansion of culturally-competent and effective integrated behavioral health and primary care networks, which include HIV services and medical treatment, within racial and ethnic minority communities in the 11 Metropolitan Statistical Areas and Metropolitan Divisions most impacted by HIV/AIDS. Expected outcomes include: reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas. SAMHSA continued to support these grants in FY 2014.

In FY 2013, SAMHSA awarded a new cohort of grants for the MAI funding for Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs). The purpose of this program is to prevent and reduce substance abuse (SA) and transmission of HIV/AIDS among African-American, Hispanic/Latino, and American Indian/Alaska Natives (AI/AN) young adults (ages 18- 24) populations on campus. MSIs will partner with one or more community-based organizations (CBOs) to provide integrated SA and HIV prevention programs to African-American, Hispanic/Latino, American Indian/Alaska Native (AI/AN), and Asian American/Pacific Islander young adults (ages 18-24) in the surrounding communities. SAMHSA awarded 29 grants for three years.

In FY 2013, SAMHSA also implemented a new program, Substance Abuse and HIV/AIDS Prevention and New Media. The purpose of this program is to enhance the infrastructure capacity of community-based organizations to more effectively reach the most at-risk racial/ethnic populations and subpopulations using new media and emerging technologies. This program builds capacity for substance use disorders and HIV/AIDS prevention services consistent with the goals and objectives of the National HIV/AIDS Strategy and SAMHSA's Strategic Initiative #1 – Prevention of Substance Abuse and Mental Illness. SAMHSA awarded 20 grants.

SAMHSA supports the National HIV/AIDS Strategy through its grant programs, including the cross-Center Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements, the CSAT Targeted Capacity Expansion/HIV program, and the CSAP

Ready-to-Respond, Capacity Building Initiative, Minority Serving Institutions in Partnership with Community Based Organizations, and Substance Abuse & HIV/AIDS Prevention & New Media programs, all described in their respective sections of this document. SAMHSA also provides training and technical assistance to its grantees to ensure they are focusing on the goals of the Strategy and collaborates with other HHS Operating Divisions involved with the Strategy to ensure a coordinated, departmental approach.

In FY 2014, SAMHSA's CMHS, CSAP, and CSAT plan to pilot HIV Continuum of Care grants which supports behavioral health screening, primary prevention, and treatment for racial/ethnic minority populations with or at high risk for mental and substance use disorders and HIV. This will include (SA) primary prevention/treatment service programs, community mental health programs, and HIV integrated programs that can either co-locate or fully integrate HIV prevention and medical care services within them. Also, this program will provide SA and HIV primary prevention services in local communities served by the behavioral health program.

In FY 2015, funding addresses a critical public health problem and health disparity. Research has shown that there is a direct correlation between substance use (including alcohol) and HIV infection. The aim is to achieve normative and environmental changes to prevent and/or reduce substance abuse problems as risk factors for the transmission of HIV/AIDS among African-American, Hispanic/Latino, Asian American/Pacific Islander (AA/PI) and American Indian/Alaska Native (AI/AN) young adult populations (ages 18- 24) on campus. In addition, about 60 percent of youth with HIV do not know they are infected. The Minority AIDS Initiative provides life-saving prevention services, including testing.

HIV Continuum of Care
(Braided program with Mental Health: Minority AIDS Initiative and Primary and Behavioral Health Care Integration and Substance Abuse Treatment: Minority AIDS Initiative and Primary Care and Addiction Services Integration)

SAMHSA expects that data generated from the 2014 HIV Continuum of Care pilot will help to inform an expanded program proposed for 2015 to continue the co-location and integrated HIV/primary care within either substance abuse or community mental health treatment programs. Braided funds would be dedicated to establishing integrated behavioral health and HIV care in addition to primary care needed by those living with or at high risk for HIV infection in minority communities heavily impacted by HIV. In addition, because of the significant comorbidity of viral hepatitis with HIV infection and because viral hepatitis occurs in up to 20 percent of those with either substance use disorders or serious mental illness, 5 percent of the allocated funds will be used to provide services to prevent, screen, test and refer to treatment as clinically appropriate those at risk for or living with viral hepatitis. In integrating HIV care into behavioral health settings, people living with HIV/AIDS and M/SUDs will have greater access to treatment for these conditions. Integrated care programs developed as a result of this grant program will make it possible for behavioral health and HIV care needs to be addressed in one setting. This will result in effective, person-centered, treatment that will reduce the risk of HIV transmission, improve outcomes for those living with HIV, and ultimately reduce new infections. SAMHSA's Common Data platform (CDP), now under development, will integrate substance abuse and mental health elements with HIV and Hepatitis elements to ensure a more rigorous evaluation

and data analysis to inform future public health intervention decision-making that addresses the intersection of behavioral health and HIV.

Fetal Alcohol Spectrum Disorder
Total FY 2015 Request: $1.0 million
(Reflects level funding from FY 2014 Enacted Level)

The Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence (CFE) program focuses on preventing Fetal Alcohol Spectrum Disorders among women of childbearing age and improving the quality of life for individuals and families impacted by these disorders. FASD CFE uses a comprehensive approach across the lifespan to work toward reducing the number of infants exposed to alcohol prenatally, increasing the functioning of individuals who have an FASD, and addressing the challenges of individuals and families impacted by FASD.

As part of these efforts, FASD CFE has successfully established a website that provides the public with information and resources on the prevention of FASD, chartered an expert panel that provides guidance and recommendations about best practices for healthcare providers and social services, organized a Self-Advocates with FASD Network comprising young adults with a FASD and Birth Mothers Network. In addition FASD CFE partnered with the National Institute on Alcohol Abuse and Alcoholism's Interagency Coordinating Committee on FASD to advance new research and best practices on FASD, coordinated and collaborated with organizations such as the National Organization on Fetal Alcohol Syndrome to develop curricula for juvenile justice systems and certified addictions counselors, provided ongoing support to the National Association of FASD State Coordinators to integrate FASD services into existing health care systems and convened 10 "Building FASD State Systems" annual conferences to facilitate the development of comprehensive systems of care for people affected by FASD. FASD CFE also established a Native Communities Initiative to address FASD in American Indian /Alaska Native /Native Hawaiian populations.

In FY 2012, SAMHSA continued to support the FASD CFE to work toward the prevention of FASD in communities throughout the nation. In FY 2013, the CFE provided technical assistance and training to other federal and national partners to assist them in developing evidence-based prevention, intervention, and treatment approaches. Primary audiences for the FASD CFE are women of child-bearing age, persons and families affected by FASD, states, local communities, AI/AN communities, military families, other special populations, as well as health, social service, and faith-based providers who study and/or provide services for persons affected by an FASD. In 2014, the FASD CFE will continue this technical assistance.

In FY 2015, Fetal Alcohol Spectrum Disorder will maintain funding for the Center for Excellence.

Center for the Application of Prevention Technologies
Total FY 2015 Request: $7.5 million
(Reflects level funding from FY 2014 Enacted Level)

The Center for the Application of Prevention Technologies (CAPT) program provides state-of-the-art training and technical assistance designed to build the capacity of SAMHSA grantees and develop the skills, knowledge, and expertise of the prevention workforce. CAPT builds capacity and promotes the development of substance abuse prevention professionals in the behavioral health field through three core strategies: (1) establishing technical assistance networks using local experts; (2) developing and delivering targeted training and technical assistance activities; and (3) using communication media such as teleconference and video conferencing, online events, and Web-based support. These activities help ensure the delivery of effective prevention programs and practices and the development of accountability systems for performance measurement and management.

During FY 2012 and FY 2013, CAPT completed a comprehensive revision and updating of its flagship Substance Abuse Prevention Skills Training, which offers participants 31 training hours toward certification as a Substance Abuse Prevention Specialist. CAPT also developed a Pacific Islander and Native American adaptation of the training for an additional six training hour credits. In FY 2012 and 2013, CAPT has continued to develop behavioral health indicators and related training and technical assistance products focused on shared risk and protective factors to promote collaboration across substance abuse and mental health disciplines within the behavioral health field.

During FY 2012, CAPT provided training to 9,041 substance abuse professionals. In addition, CAPT provided technical assistance services to 7,655 people. Over 96 percent of service recipients reported that their organization's capacity was increased as a result of the service. Almost half of the recipients reported fully implementing the training recommendations. Additional performance data for the CAPT is captured using common measures with other technical assistance activities in the Science and Service Program Coordination category. Although the CAPT funding line was reduced in FY 2014, it is co-funded with Block Grant set-aside funds. Therefore the CAPT will be fully funded in FY 2014.

In FY 2015, funding will provide technical assistance and workforce development to the prevention field. This is a critical function as the nation moves toward health reform and a behavioral health model.

Mandatory Drug Testing
Total FY 2015 Request: $4.9 million
(Reflects level funding from FY 2014 Enacted Level)

The Mandatory Drug Testing program is a critical nationwide prevention program consisting of two principal activities mandated by Executive Order and Public Law: (1) oversight of the Federal Drug-Free Workplace Program, aimed at elimination of illicit drug use in the federal workforce, with impact in the private sector workforce as well; and (2) oversight of the National Laboratory Certification Program, which certifies laboratories to conduct forensic drug testing for the federal agencies and for some federally-regulated industries.

Executive Order 12564, first signed on September 15, 1986, requires the head of each executive agency to establish a program to test for the use of illegal drugs by federal employees in sensitive

positions and requires the Secretary to promulgate scientific and technical guidelines for drug testing programs. The Executive Order also requires HHS to assist the Office of Personnel Management to develop and improve training programs for federal supervisors and managers on illegal drug use.

The Supplemental Appropriations Act, 1987 (Public Law 100-71) requires HHS to: (1) certify that each federal agency has developed a plan for achieving a drug-free workplace; and (2) publish Mandatory Guidelines that establish comprehensive standards for laboratory drug testing procedures, specify the drugs for which federal employees may be tested, and establish standards and procedures for periodic review and certification of laboratories to perform drug testing for federal agencies.

The 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.

SAMHSA continued these activities in FY 2013 and will continue do so in FY 2014. In addition, the Drug Testing Advisory Board is examining the scientific basis for utilization of oral fluid and other alternative specimens to urine, and the inclusion of additional Schedule II prescription medications (e.g., oxycodone, oxymorphone, hydrocodone and hydromorphone) in the Mandatory Guidelines. Any changes in the guidelines will be based on scientific supportability. SAMHSA continues to partner with other federal agencies to ascertain the scientific evidence needed to set standards for the Mandatory Guidelines.

In FY 2015, funding will maintain the Federal Drug-Free Workplace Program and National Laboratory Certification Program as required by law. Both of these are critical public health and safety programs ensuring that individuals in sensitive and safety-related federal positions are not using illicit drugs, and that drug testing laboratories produce accurate results.

Sober Truth on Preventing Underage Drinking (STOP Act)
Total FY 2015 Request: $7.0 million
(Reflects level funding from FY 2014 Enacted Level)

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 is the nation's first comprehensive legislation on underage drinking. One of the primary components of the Act is the STOP Act grant program, which provides additional funds to current or former grantees under the Drug Free Communities Act of 1997 to prevent and reduce alcohol use among youth age 12-20. The STOP Act grant program enables organizations to strengthen collaboration and coordination among stakeholders in order to achieve a reduction in underage drinking in their communities. Grants are limited by statute to $0.1 million per year for four years. In FY 2012, 81 new grants were awarded. In FY 2012, performance data showed that the STOP Act grant program has exceeded targets in two of the three GPRA performance measures. Almost 72 percent of coalitions reported a reduction in the past 30-day use of alcohol, 55 percent of coalitions reported an increase in perceived risk, and 58.2 percent of coalitions reported an increase in perception of parental disapproval of alcohol use (69.6 percent). In FY 2013, SAMHSA awarded 17 new grants

Another component of the STOP Act is the National Adult-Oriented Media Public Service Campaign, which educates parents regarding how to speak with their 11- through 15-year-old children about underage drinking in order to delay the onset of, and ultimately reduce, underage drinking. Nationwide, 36.6 percent of the estimated 10 million underage drinkers were provided free alcohol by adults 21 or older (2012 NSDUH). Further research continues to show 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."

The third component of the STOP Act is the federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), which provides high-level leadership from 15 federal agencies for coordinating federal efforts to prevent and reduce underage drinking. In FY 2012, the ICCPUD was reinvigorated with principals meeting from all federal agencies working to prevent underage drinking, and the launch of a webinar series featuring common messages with individualized information for the field from each involved federal agency. In 2012, the ICCPUD updated the 2007 Surgeon General's Call to Action to Prevent Underage Drinking to reflect progress over the past six years, the impact of the Affordable Care Act, and new research supporting effective prevention approaches. SAMHSA continued to support ICCPUD's activities in FY 2013. In FY 2014, SAMHSA will support 97 grant continuations and will continue to support the National-Adult-Oriented Media Campaign and ICCPUD.

In FY 2015, funding will allow for one new grant.

Science and Service Program Coordination
Total FY 2015 Request: $4.1 million
(Reflects level funding from FY 2014 Enacted Level)

The Science and Service Program Coordination category primarily encompasses contracts that provide technical assistance and training to states, tribes, communities, and grantees around substance abuse prevention. Included in the performance measurement section for this category is the former Native American Center for Excellence (NACE) and the Underage Drinking Prevention Education Initiative (UADPEI).

The purpose of NACE was to promote effective substance abuse prevention programs in tribal and urban American Indian and Alaska Native (AI/AN) communities throughout the United States. The NACE mission was to promote best practices in substance abuse prevention by disseminating information on cultural and evidence-based programs, practices, and policies and providing training and technical assistance to prevention programs and organizations serving urban and tribal Native American communities. The target audiences included the Native American SPF-Tribal Incentive Grant grantees, tribal nations and organizations, health and social service providers, federal and state level organizations, and community and faith-based providers serving Native Americans. Eighty-eight percent of recipients reported that the NACE services increased their individual capacity to provide prevention services.

NACE expanded its outreach in FY 2012 and FY 2013 through presentations at national conferences and regional events, and increased collaborative efforts with other SAMHSA initiatives and national organizations. The NACE website greatly expanded its collection of

resources and dissemination of current news worthy events through daily "headlines" entries while tripling its number of visitors each month. FY 2012 and FY 2013 also brought the development of four new NACE learning communities (National Prevention Network, SPF Tribal Incentive Grant, Gathering of Native Americans, and 2-Spirit) to bring stakeholders together on conference calls or webinars to further disseminate information and support cross-fertilization of information and ideas. Lastly, NACE expanded the frequency and reach of its national webinars.

In FY 2013, NACE was consolidated into the braided Tribal Training and Technical Assistance Center (Tribal TTA Center). The Tribal TTA Center provides comprehensive, broad, focused, and/or intensive training and technical assistance to federally-recognized tribes and other American Indian/Alaska Native communities, seeking to address and prevent mental and substance use disorders, suicide, and promote mental health. The braided amounts spent and awarded are tracked as distinct funding streams and are only to be used for purposes consistent with Congressional intent. In FY 2014, the training and technical assistance will continue.

The Underage Drinking Prevention Education Initiative (UADPEI) 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. Through this initiative, families, their children, and other youth-serving organizations have been reached through Town Hall Meetings (held in even-numbered years), technical assistance, trainings, and with a variety of tools and materials performance data shows that, collectively, the CAPT and Science and Service Program Coordination programs have exceeded their targets for customer satisfaction, and for the proportion of participants who report implementing recommendations. Efficiencies have been achieved from the growing focus on train-the-trainer models rather than training of individuals. In addition, since the Town Hall Meetings under the UADPEI contract occur biannually, numbers served expand in the years the meetings occur and contract in alternate years. Science and Service performance data for FY 2012, 15,269 people were trained and almost 9,000 received technical assistance. In FY 2014, UADPEI funding will be reduced because the town hall meetings occur every other year.

In FY 2015, funding is necessary to support SAMHSA's top strategic initiative, prevention of substance abuse and mental illness, which includes a focus on preventing underage drinking and on American Indians/Alaska Natives.

Substance Abuse Treatment

Substance Abuse Treatment Programs of Regional and National Significance
Total FY 2015 Request: $297.4 million
(Reflects $64.1 million decrease from FY 2014 Enacted Level)

The Substance Abuse Treatment Programs of Regional and National Significance (PRNS) support states and communities in carrying out an array of activities to improve the quality and availability of services in priority areas.

The FY 2015 President's Budget request for SAMHSA's Substance Abuse Treatment PRNS includes $297.4 million which covers thirteen programmatic activities, a decrease of $64.1 million from the FY 2014 Enacted Level. The request includes: $30.0 million for Screening, Brief Intervention and Referral to Treatment; $41.5 million for Treatment Systems for Homeless; $58.9 million for Minority AIDS Initiative; $64.5 million for Criminal Justice Activities of which $45.9 million will fund Drug Courts and $5.5 million for Ex-Offender Reentry; $0 for Access to Recovery, $20 million for the Primary Care and Addiction Services Integration Program; and $102.6 million for other PRNS Treatment Programs.

Screening, Brief Intervention and Referral to Treatment
FY 2015 Request: $30.0 million
(Reflects $17 million decrease from FY 2014 Enacted Level)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) was initiated by SAMHSA in FY 2003, using cooperative agreements to expand and enhance a 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.

The SBIRT program requires grant recipients to affect practice change throughout the spectrum of medical practice. This is achieved through implementation in all levels of primary care, including hospitals, trauma centers, health clinics, nursing homes, employee assistance programs, and school systems. Practice change also alters the educational structure of medical schools by developing and implementing SBIRT curricula as standard and permanent practice.
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 individuals with more serious problems and encourage them to obtain appropriate specialty treatment services. Funds may be used for the following services: pre/screening for substance use and co-occurring disorders; brief interventions designed with client centered, non-judgmental, motivational interviewing techniques; brief treatment including the monitoring of individuals who misuse alcohol and other drugs but are not yet dependent; referral to treatment (when indicated) for those who have a substance use disorder; and when appropriate, referral to and expansion of specialty treatment services. Since the beginning of this program, more than two million individuals have been screened. Of those, 19 percent required a brief intervention, brief treatment, or referral to specialty treatment programs.

In FY 2012, over 142,000 individuals were served by the SBIRT program. The percentage of individuals reporting abstinence at follow up tripled compared to the percentage reporting abstinence at baseline. In FY 2013, 274,873 individuals were served by the SBIRT program.

SBIRT has great future potential for promoting changes to the entire primary care medical service delivery system. Efforts are underway to identify other funding streams to help take this practice to scale. For example, new diagnostic codes have been adopted by 16 states, making it easier for doctors to get reimbursed for screening Medicaid patients. Likewise, alcohol screening is now available to Medicare beneficiaries as a preventive service without cost. In FY 2012, SAMHSA funded the continuation of 27 SBIRT grants, supported six contracts as well as three new multi-year grants funded out of the Prevention and Public Health Fund, and continued to monitor the progress of the three FY 2011 multi-year Prevention and Public Health Fund grants.

In FY 2013, SAMHSA funded five state SBIRT grants, 14 SBIRT Medical Professional Training Program grants as well as 12 grant continuations and supported five contracts.

In FY 2014, SAMHSA plans to support nine additional (SBIRT) Medical Professional Training grants and one State SBIRT grant. The purpose of SBIRT Training is to develop and implement training programs to teach health professionals (medical residents and students of nursing, social work and counseling) the skills necessary to provide evidence-based screening, brief intervention and brief treatment and to refer patients who are at risk for a substance use disorder (SUD) to appropriate treatment. As shown by data collected from SBIRT cross-site evaluations (SBIRT Cohort I Cross-Site Evaluation Final Report, 2010), the vast majority of SBIRT service providers are nurses, social workers and counselors with the role of the physician as leading the effort through clinical work, advocacy and supervising SBIRT in medical settings. Grantees are required to use training curricula developed by the initial cohort of SAMHSA SBIRT Medical Residency grantees. The intended outcome of this program is to increase the adoption and practice of SBIRT throughout the health care delivery system. The SBIRT Training program supports the SAMHSA Health Reform Strategic Initiative to expand access to individuals vulnerable to health disparities.

The utilization of the previous cross site evaluations inform current and future SBIRT cohorts and highlights the roles of non-physicians in the actual provision of SBIRT services. The intention is to continue with a new cross site evaluation intended to show outcome measure achievement rather than process data. This will help prove the efficacy and efficiency of the SBIRT process and inform future grant design. Many grantees are also publishing information related to the outcomes achieved through the grant activities and this will help to further the acceptance of SBIRT and inform future grant proposals.

All discretionary grantees are required to collect and report data on a regular and real-time basis. Data are monitored to provide information which can be used to improve service, monitor grantee performance and quality, and provide recommendations for future directions. Grantee performance and outcomes data are monitored using the Services Accountability Improvement System

In FY 2014, SAMHSA plans to support the continuation of 22 grants, four contracts and approximately 10 new grants.

In FY 2015, funding will enable SAMHSA to support continuations.

Treatment Drug Courts
FY 2015 Request: $45.9 million
(Reflects $6.4 million decrease from FY 2014 Enacted Level)

Drug Courts

Criminal Justice activities include grant programs, which focus on diversion, alternatives to incarceration, and re-entry from incarceration for adolescents and adults with substance use disorders, and/or co-occurring substance use and mental disorders. These activities comport directly with SAMHSA's Trauma and Justice Strategic Initiative efforts.

Drug 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. Funding for adult treatment drug court programs provide a variety of services, including: direct treatment or prevention services for diverse populations at risk; "wrap-around"/recovery support services designed to improve access and retention; drug testing for illicit substances required for supervision, treatment compliance, and therapeutic intervention; education support; relapse prevention and long-term management; Medication-Assisted Treatment (MAT); and HIV testing conducted in accordance with state and local requirements.

In FY 2012, SAMHSA funded the continuation of 81 drug court grants and supported eight contracts, and 54 new drug court grants. In FY 2013, SAMHSA funded the continuation of 78 drug court grants, supported three contracts, and funded 39 new drug court grants. In FY 2014, SAMHSA plans to support 92 grant continuations, two contracts, and 55 new drug court grants.

The SAMHSA Drug Court grant programs are utilizing existing evidence to support current programs and new proposals by incorporating findings from numerous studies of drug courts. There have been over 125 evaluation and research studies of the effectiveness of drug courts and several micro-analyses in addition to GAO reports on the effectiveness of treatment drug courts. SAMHSA's RFA require evidence-based practices to be used from federal inventories of such practices (NIDA, SAMHSA's NREPP). SAMHSA also has regular communications with the national drug court constituency group, the National Association of Drug Court Professionals in order to obtain and incorporate the latest findings and field expertise. Examples of SAMHSA's drug court programs incorporating the latest "standards" for drug courts as promulgated by NADCP with the support of the Bureau of Justice Assistance, U.S. Department of Justice. Language pertaining to screening for co-occurring disorders, use of medically assisted treatments for opioid or alcohol dependent persons, and identification of behavioral health disparities have been included in the grant solicitations.

In FY 2015, funding will support some new grants as well as the continuation on existing cohorts.

Offender Re-Entry Program
FY 2015 Request: $5.5 million
(Reflects $9.6 million decrease from FY 2014 Enacted Level)

In addition to SAMHSA's drug court portfolio, the agency also supports other robust criminal justice programs. For example, the Offender Reentry 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. SAMHSA and the DOJ/BJA share a mutual interest in supporting and shaping offender re-entry-treatment services, as both agencies fund "offender reentry" programs. Formal agreements have been developed to further encourage and engage in mutual interests and activities related to criminal justice-treatment issues. ORP grantees are expected to seek out and coordinate with local federally-funded offender reentry initiatives, including the DOJ/BJA's Prisoner Reentry Initiative or "Second Chance Act" offender re-entry programs, as appropriate. Funding for ORP may be used for a variety of services, including: screening, comprehensive individual assessment for substance use and/or co-occurring mental disorders, case management, program management and referrals related to substance abuse treatment for clients; alcohol and drug treatment; wraparound services supporting the access to and retention in substance abuse treatment or to address the treatment-specific needs of clients during or following a substance abuse treatment episode; individualized services planning; drug testing; and relapse prevention and long-term management support.

The (ORP) grant program utilizes existing evidence to support current programs and new proposals by incorporating findings from numerous studies of drug courts. SAMHSA's ORP RFA requires evidence-based practices to be used from federal inventories of such practices (NIDA, SAMHSA's NREPP). SAMHSA is represented at the Attorney General's Reentry Council and in numerous inter- and intra-agency workgroups in order to obtain and incorporate the latest findings and field expertise. A federal reentry resource center has been established on the MAX electronic information forum to constantly update the 'state of the state' of offender reentry programming, research, and grant initiatives. The ORP grant solicitation contains language pertaining to Risks, Needs, and Responsivity models as part of the latest cutting edge approach to screening and assessing ex-offenders, the grant program, and the community response. Language pertaining to screening for co-occurring disorders, use of medically assisted treatments for opioid or alcohol dependent persons, and identification of behavioral health disparities has been included in the ORP grant solicitation.

In FY 2011, SAMHSA awarded grants to Develop and Expand Behavioral Health Treatment Court Collaborative (BHTCC) in collaboration with CMHS. The purpose of the BHTCC is to provide state and local criminal and dependency courts serving adults with more flexibility to collaborate with the other judicial components and local community treatment and recovery providers to better address the behavioral health needs of adults who are involved with the criminal justice system. In FY 2014 SAMHSA plans to support an additional cohort (up to 14 new grants) of BHTCC grants ($2,429,534 in CSAT and $2,969,430 in CMHS).

In FY 2012, SAMHSA created the Teen Courts grant program (TCP), of which the primary focus is preventing crimes by diverting youth with substance abuse treatment needs from deeper penetration into the traditional juvenile justice system. Funds are used to provide screening, assessment, substance abuse treatment, and recovery support services for youth involved in a TCP.

In FY 2015, funding will support new grants as well as the continuation of existing cohorts.

Treatment Systems for Homeless Programs
FY 2015 Request: $41.5 million
(Reflects level funding from FY 2014 Enacted Level)

The Center for Substance Abuse Treatment (CSAT) manages two grant portfolios under its Grants for the Benefit of Homeless Individuals (GBHI) authority - Treatment for Homeless and Cooperative Agreements to Benefit Homeless Individuals (CABHI), that provide focused services to individuals with a substance use disorder or who have co-occurring substance use and mental disorders. These programs tie directly to the SAMHSA Recovery Support Strategic Initiative which focuses specifically on "home" as an integral component of one's well-being.

The Treatment for Homeless-General grants enable communities to expand and strengthen their substance abuse treatment services for individuals who are at risk for experiencing homelessness or are experiencing homelessness. The Treatment for Homeless-Services in Supportive Housing (SSH) grants seek to expand and strengthen treatment services for individuals who experience chronic homelessness using a supportive housing approach.

In FY 2011, CSAT in collaboration with CMHS, began awarding CABHI under the GBHI authority. The major goal of the program is to ensure that the most vulnerable individuals who experience chronic homelessness receive access to sustainable permanent housing, treatment, and recovery supports through mainstream funding sources. This program builds on the success of the previous Treatment for Homeless program.

In FY 2013, SAMHSA funded 71 grant continuations and supported five contracts. In addition, CSAT in collaboration with CMHS funded 11 new Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States). CABHI-States builds on the current CABHI program by adding a state infrastructure improvement approach addressing chronic homelessness to the community-based behavioral health service component for newly housed individuals who experience chronic homelessness with substance use disorders or co-occurring substance use and mental disorders.

In FY 2014, SAMHSA plans to support 34 grant continuation, five contracts and approximately 39 grant awards within a new cohort of jointly funded CSAT and CMHS CABHI-State grants and Grants for the Benefit of Homeless Individuals-Services in Supportive Housing (GBHI-SSH). The proposed number of clients to be served with FY 2014 funding is 5,800. Outcomes including abstinence from substance use will also be tracked.

SAMHSA's homeless grant programs are designed to provide supports and services for people with mental illness and/or substance use disorders who experience homelessness or are at risk of homelessness. SAMHSA encourages grantees to work collaboratively with HUD grant programs in providing supportive services for individuals experiencing homelessness. SAMHSA homeless programs do not fund housing; therefore linkage with HUD programs is essential. SAMHSA grantees frequently work side-by-side with HUD's Permanent Supportive Housing, Section 8, Shelter plus Care, Vouchers and other programs. SAMHSA funds an array of integrated behavioral health, treatment, housing support and recovery-oriented services and supports including outreach, engagement, intensive case management, treatment for mental and/or substance abuse disorders, enrollment in mainstream benefits, employment readiness, and linkage to permanent housing.

All discretionary grantees are required to collect and report data on a regular and real-time basis. These data are used to monitor grantee performance to ensure that progress is being made toward meeting program goals and objectives. Data provided evidence of the effectiveness of the services being provided. Several key domains have been identified in order to assess the extent to which service provision is effective. These domains include abstinence from substance use, employment, housing stability, criminal justice status and social connectedness. Outcomes data are monitored using the Services Accountability Improvement System. Data are monitored to provide information which can be used to improve service quality, monitor grantee performance and provide recommendations for future direction. During the next fiscal year, data will still play an integral role in the monitoring of grantee performance; however, the data system used for this monitoring will be switched to the Common Data Platform which will house data from all SAMHSA discretionary grantees.

In FY 2015, funding will support all continuations as well as approximately 12 new grants.

Minority AIDS Initiative
FY 2015 Request: $58.9 million
(Reflects $6.9 million decrease from FY 2014 Enacted Level)

Minority AIDS (MAI) 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; minority men who have sex with men (MSM); 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 other medical and social services in the local community.

In FY 2012, SAMHSA's TCE/HIV program served approximately 8,000 individuals. Of these individuals, approximately 69 percent were between the ages of 25 and 54 years old. Approximately 32 percent identified themselves as Hispanic/Latino in ethnicity; 42 percent as

African-American; 27 percent White; one percent Asian, Native Hawaiian, or Pacific Islander; and seven percent as American Indian/Alaska Native.

In FY 2011, SAMHSA awarded 11 Minority AIDS Initiative Targeted Capacity Expansion (MAI-TCE) Integrated Behavioral Health/Primary Care Network Cooperative Agreements. This program is jointly funded with CMHS and CSAP and facilitates the development and expansion of culturally-competent and effective integrated behavioral health and primary care networks which includes HIV services and medical treatment within racial and ethnic minority communities in the 11 Metropolitan Statistical Areas and Metropolitan Divisions most impacted by HIV/AIDS. Expected outcomes include reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas. SAMHSA continued to support these grants in 2012 and 2013.

In FY 2012, SAMHSA funded the continuation of 76 grants and supported five contracts as well as a new cohort of 52 grants to target areas of highest need based on the most recently available HIV epidemiological data.

In FY 2013, SAMHSA funded 79 grant continuations and supported seven contracts and 35 new grants. The 35 grants support Targeted Capacity Expansion: Substance Abuse Treatment for Racial/Ethnic Minority Women at High Risk for HIV/AIDS (TCE-HIV: Minority Women). The purpose of this program is to expand substance abuse treatment and HIV services for African American, Hispanic/Latina, and other racial/ethnic minority women (ages 18 years and older), including heterosexual, lesbian, bisexual, previously incarcerated women, and their significant others, who have substance use or co-occurring substance use and mental disorders, and are living with or at risk for HIV/AIDS.

Scientific literature supports that as the incidence and prevalence of HIV/AIDS increases among racial and ethnic minority populations, the need for substance abuse and mental health treatment increases as well. Limited or a complete absence of appropriate behavioral treatment intervention services is very likely to lead to unmet behavioral health needs, adverse medical conditions, impaired quality of life, increased morbidity and mortality for this vulnerable population. To address this public health challenge, the MAI-TCE program facilitates the development and expansion of culturally competent and effective integrated behavioral health and primary care networks, which includes HIV services and medical treatment, within racial and ethnic minority communities in 11 Metropolitan Statistical Areas (MSAs) highly impacted by HIV/AIDS.

SAMHSA Services Accountability Improvement System (SAIS) data and CDC HIV prevalence data was used to identify specific minority high-risk populations that resulted in SAMHSA publishing population focused RFAs for YMSM and minority women.

By focusing on specific vulnerable populations and requiring grantees to utilize specific evidence-based interventions SAMHSA/CSAT programs can build new evidence that supports the value of simultaneous treatment of co-occurring substance abuse and HIV and the value of using evidence-based interventions for recruitment and retention of high-risk, minority populations in substance abuse treatment and antiretroviral therapy. Improved treatment

outcomes would lend itself to more rigorous evaluation and data analysis by the SAMHSA Common Data platform (CDP) to inform future public health intervention decision-making.

In FY 2014, SAMHSA plans to support the continuation of 87 grants and six contracts, and will continue to monitor the progress of the three FY 2012 multi-year funded grants. The proposed number of clients to be served with 2014 funds is 13,558. Outcomes including abstinence from substance use will also be tracked.

In FY 2015, funding will support grant continuations.

HIV Continuum of Care
(Braided program with Mental Health: Minority Aids Initiative and Primary and Behavioral Health Care Integration and with Substance Abuse Prevention: Minority Aids Initiative)

In FY 2014, SAMHSA's CMHS, CSAP, and CSAT plan to pilot HIV Continuum of Care grants which supports behavioral health screening, primary prevention, and treatment for racial/ethnic minority populations with or at high risk for mental and substance use disorders and HIV. This will include Substance Abuse (SA) primary prevention/treatment service programs, community mental health programs, and HIV integrated programs that can either co-locate or fully integrate HIV prevention and medical care services within them. Also, this program will provide SA and HIV primary prevention services in local communities served by the behavioral health program.

SAMHSA expects that data generated from the 2014 HIV Continuum of Care pilot will help to inform an expanded program proposed for 2015 to continue the co-location and integrated HIV/primary care within either substance abuse or community mental health treatment programs. Braided funds would be dedicated to establishing integrated behavioral health and HIV care in addition to primary care needed by those living with or at high risk for HIV infection in minority communities heavily impacted by HIV. In addition, because of the significant comorbidity of viral hepatitis with HIV infection and because viral hepatitis occurs in up to 20 percent of those with either substance use disorders or serious mental illness, 5 percent of the allocated funds will be used to provide services to prevent, screen, test and refer to treatment as clinically appropriate those at risk for or living with viral hepatitis. In integrating HIV care into behavioral health settings, people living with HIV/AIDS and M/SUDs will have greater access to treatment for these conditions. Integrated care programs developed as a result of this grant program will make it possible for behavioral health and HIV care needs to be addressed in one setting. This will result in effective, person-centered, treatment that will reduce the risk of HIV transmission, improve outcomes for those living with HIV, and ultimately reduce new infections. SAMHSA's Common Data platform (CDP), will integrate substance abuse and mental health elements with HIV and Hepatitis elements to ensure a more rigorous evaluation and data analysis to inform future public health intervention decision-making that addresses the intersection of behavioral health and HIV.

Access to Recovery
FY 2015 Request: $0
(Reflects $50 million decrease from FY 2014 Enacted Level)

Since 2004 the ATR program has served 221,607 clients through 69 grantees. In FY 2014, SAMHSA plans to award approximately five Prevention and Public Health Fund grants of up to $3 million per year for three years – these grants will be multi-year funded. The majority of services provided are expected to be recovery support not otherwise fundable through insurance mechanisms. These include services such as transportation, housing, and jobs support. Reduced in scale from past years, ATR will serve approximately 8,000 individuals per year. In FY 2014, the program will preserve the core concepts embodied in the three previous ATR cohorts, while also striving to better support provisions of the Affordable Care Act.

State and tribal ATR grants will support the provision of treatment and recovery support services to those with substance use disorders. Services payable under Medicaid and covered through essential health benefit plans, such as outpatient clinical treatment services and residential services, would, for the most part, not be allowable under this program. In order to ensure non-duplication of billing sources, providers will work with clients to link them to other usable funding sources where appropriate. For those services not covered, providers will be responsible for the provision of direct services. As was the case in the first three cohorts of ATR, states/tribes will be required to establish provider networks and develop a voucher-based mechanism to ensure client choice can be easily and freely exercised.

ATR grant funds will also support creating linkages with state health information exchanges (HIEs) to ensure coordination and non-duplication; working with non-traditional providers, such as faith-based and peer providers; working with traditional providers to ensure that proper sources of billing are being utilized for recovery support and clinical treatment services not being covered under Medicaid and other sources; and increasing availability and access to training and certification programs for non-traditional providers, such as faith-based and peer providers.

In FY 2014, the ATR program will better support the integration of third party payers, the provision of services unlikely to be covered by insurance such as supportive services like housing, and services to those who are ineligible for insurance or are unable to acquire it. Successful ATR innovations will be communicated and new evidence shared to strengthen capacity nationwide and to inform future decision making regarding ATR models of service delivery.

SAMHSA is proposing eliminating the ATR program in FY 2015 budget, a decrease of $50 million from the FY 2014 Enacted Level. Many of the clinical services provided under ATR will now be covered by public and private insurance. In addition, states have been encouraged to support recovery support services and client choice with SABG funding. States that would like to continue this activity will have support from SAMHSA in FY 2014 in incorporating lessons learned from the successful test.

Primary Care and Addiction Services Integration
FY 2015 Request: $20 million
(Reflects $20 million increase from FY 2014 Enacted Level)

In FY 2015, SAMHSA is requesting $20 million to support the development of a new initiative related to the integration of substance abuse treatment services and primary care. The PCASI Program would enable providers to offer a full array of both physical health and substance abuse services to clients. In conjunction with the Affordable Care Act (ACA), SAMHSA recognizes the need to emphasize the importance of integrated service delivery. Through this program, integrated teams of professionals will be able to provide needed primary care services to individuals seeking care for their substance use disorder. The purpose of this program is to establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care services in community-based substance abuse treatment settings. The goal is to improve the physical health status of adults with substance use disorders who have or are at risk for co-occurring primary care conditions and chronic diseases, with the objective of supporting the triple aim of improving the health of those with SUD; enhancing the client's experience of care (including quality, access, and reliability); and reducing/controlling the per capita cost of care. The expected outcome of improved health status for people with SUD 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 SUD. Partnerships between primary care and behavioral health organizations, as well as information technology entities, are deemed crucial to the success of this program**.**

Currently, a significant component of the overall higher cost of care for those with SUD is untreated chronic disease.[79] The likelihood that a patient seeking care for a substance use disorder will successfully complete a referral to a primary care facility is low in general but greatly improved within a single visit or facility.[80] This program will not only improve the data about the success and impact of these improved referrals, but will also illuminate other benefits of integration such as improved provider knowledge and effectiveness at identifying and referring individuals in need of primary care and substance abuse treatment.

The demand for substance use disorder prevention, intervention, treatment, and recovery services after the implementation of the ACA will far exceed the current capacity and a focused effort through the states to address this shortage will be critical. As described above, the PCASI program provides the structure and infrastructure necessary to support the integrated service delivery. Together, these two programs will perform synergistically, with the process and performance outcomes building on each other.

Substance use disorders can cause physical health problems and/or exacerbate existing physical health problems. For example, several cardiovascular complications are closely related to cocaine use. They include chest pain syndromes, heart attacks, heart failure, strokes, aortic

[79] Druss, B. g., & Rosenheck. R. A. (1999). Patterns of health care costs associated with depression and substance abuse in a national sample. Psychiatric Services, 50, 214-218

[80] Kathol, R. G., McAlpine, D., Kishi, Y., Speies, R., Meller, W., Bernhardt, T., et al. (2005). General medical and pharmacy claims expenditures in users of behavioral health services. Journal of General Internal Medicine, 20, 160-167.

dissection, and fatal and nonfatal arrhythmias.[81] According to the CDC, alcohol use causes 80,000 deaths a year.[82] Alcohol use contributes to a variety of chronic health conditions including; cirrhosis, hypertension, obesity, diabetes, hepatitis, pancreatitis, cardiomyopathy, gastritis, etc…which increases morbidity and mortality. Additionally, excessive alcohol use increases the risk of cancers such as mouth, throat, and esophagus. As the result of other chronic health issues, many individuals develop substance abuse problems due to self-medication. The National Institute on Drug Abuse defines self-medication as the use of a substance to lessen the negative effects of stress, anxiety, or other mental disorders (or side effects of their pharmacotherapy). Self-medication may lead to addiction and other drug or alcohol-related problems.[83]

A continuum of preventive and health promotion services will be offered to and/or coordinated for clients within the PCASI program, where different services are offered to different categories of clients according to the severity of the condition/risk factors. Wellness programs (e.g., tobacco cessation, nutrition consultation, health education and literacy, self-help/management programs) will be offered, including interventions that involve preventive screening and assessment tools for all clients. In addition, this grant program can support the infrastructure necessary to ensure an effective coordination of services, including such tasks as necessary to expand partnerships, increase the use of an integrated electronic health record, and other such activities. Grantees will be required to bill third party insurance or utilize other funds and to only use SAMHSA grant funds for services to individuals who are ineligible for public health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan (co-pay or other cost sharing requirements are an acceptable use of SAMHSA grant funds).

SAMHSA will fund a total of 34 grants at approximately $0.5 million annually for up to three years. Eligible applicants will be publicly funded community substance abuse treatment centers. To address the bi-directional nature of the integration approach emphasized by this grant program, the applicant must demonstrate they are able to offer the following core requirements; provided by qualified professionals, both substance abuse treatment and primary care services. Additional eligibility criteria include the ability to show demonstrable progress or commitment to the implementation of interoperable electronic health records.

The remaining $3 million will be used to fund technical assistance and evaluation activities to assess the clinical and cost effectiveness of these programs and other programs in the field, to ensure fidelity to implementation, and to assist with documentation and dissemination of lessons learned from the program. The success of the PBHCI program has taught SAMHSA that technical assistance must include strategies around integrated models, workforce, financing, clinical practice, and operations and administration of the PCASI grant. SAMHSA has been able to realize improved health outcomes for PBHCI clients across myriad domains, including blood pressure, tobacco use, and diabetes measures, in addition to improvement in client self-

[81] http://www.heart.org/HEARTORG/Conditions/Cocaine-Marijuana-and-Other-Drugs_UCM_428537_Article.jsp
[82] Jeffrey J. Sacks, MD, MPH, Jim Roeber, MSPH, Ellen E. Bouchery, MS, Katherine Gonzales, MPH, Frank J. Chaloupka, PhD, Robert D. Brewer, MD, MSPH; State Costs of Excessive Alcohol Consumption, 2006: Accessed at http://www.ajpmonline.org/webfiles/images/journals/amepre/AMEPRE_3854-stamped-081313.pdf
[83] http://www.drugabuse.gov/publications/research-reports/comorbidity-addiction-other-mental-illnesses/glossary

perception of overall health. The PBHCI program has created bridges between community behavioral health and primary care providers, yielding a cadre of providers able to serve the holistic health care needs of their patients.

Promoting widespread implementation of Health Information Technology (HIT) systems that support quality, integrated behavioral health care is currently one of SAMHSA's eight strategic initiatives. HIT has the potential to transform the health care system by improving the quality of care delivery, supporting patient engagement and self-management, improving the efficiency of the workforce, and expanding access to care. In FY 2011-2012, SAMHSA provided supplemental funding to our Primary & Behavioral Health Care Integration (PBHCI) program to help 4 grantees become meaningful users of electronic health record (EHR) technology. Of these, 93 percent successfully implemented a certified EHR system in 2012 and this technology is continuing to support the integration of primary and behavioral healthcare in these programs. Due to the success of the PBHCI HIT supplemental program, SAMHSA is requesting an additional $2 million in funding for the Targeted Capacity Expansion-General program in FY 2015 to fund the Behavioral Health Information Privacy Center of Excellence, a similar HIT initiative, among the Primary Care and Addiction Services Integration (PCASI) program grantees. This supplemental funding will support the enhancement and adoption and meaningful use of certified EHR technology which will facilitate the integration of care for patients in substance abuse treatment to improve compliance with Federal privacy law.

In addition, the funding will support Braided Program: HIV Continuum of Care as provided below to provide bi-directional integration between primary care services and substance abuse treatment/mental health services (for CSAT/CMHS) and address service coordination and infrastructure needs of providers serving this vulnerable population.

Other PRNS Treatment Programs
FY 2015 Request: $102.6 million
(Reflects $29.6 million decrease from FY 2014 Enacted Level)

The FY 2015 Budget includes resources of $102.6 million for several other Treatment Capacity programs including: Strengthening Treatment Access and Retention; Children and Family Programs; Pregnant and Post-Partum Women (PPW); Recovery Community Services Program (RCSP); Special Initiatives/Outreach; Addiction Technology Transfer Centers; Opioid treatment Programs; and Targeted Capacity Expansion (TCE) General. The FY 2015 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 and service providers to achieve specific performance targets. Examples of grant awards could include supplements for treatment and service providers who are able to connect higher proportions of detoxified patients with continuing recovery-oriented treatment; or for outpatient providers who are able to successfully retain greater proportions of patients in active treatment participation for longer time periods.

Substance Abuse Prevention and Treatment Block Grant
FY 2015 Request: $1.820 billion
(Reflects level funding from FY 2014 Enacted Level)

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 Band of Chippewa Indians of Minnesota to plan, carry out, and evaluate substance abuse prevention, 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 and Center for Substance Abuse Prevention.

All Block Grant applications must include an annual plan that contains detailed provisions for complying with each funding agreement specified in the legislation, and describe how the grantees and their respective SABG sub-recipients intend to expend the SABG. The legislation includes specific provisions and funding set-asides, such as 20 percent for primary prevention; a 5 percent HIV early intervention services set-aside; performance requirements for substance using pregnant women and women with dependent children; requirements and potential penalty reduction of the Block Grant allotment with respect to sale of tobacco products to individuals 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 prevention and treatment services while providing maximum flexibility. Services funded by the SABG include services identified in SAMHSA's *Good and Modern Service System*[84] brief as described in the block application. 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 SAMHSA's technical assistance contract. The SABG 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 two year period preceding the year for which the state is applying for a grant.

Of the amounts appropriated for the SABG program, 95 percent are distributed to, territories and Red Lake Band of the Chippewa Indians 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 SABG is critically important because it provides the grantees and their respective SABG sub-recipients the flexibility to respond to local and/or regional emergent issues impacting health, public health, and public safety through a consistent federal funding stream. For example, this program provides approximately 32 percent of total State Substance Abuse Agency

[84] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf

funding, and 23 percent of total substance abuse Prevention and Public Health Funding. Because SAMHSA encourages states to focus on these populations, individuals who are currently in need of such services may fall into several categories, such as having no insurance or limited health insurance coverage for substance use disorder treatment and recovery support services, or having been mandated to enter SUD treatment through public safety and/or public welfare systems. Individuals and families without health coverage or whose health insurance benefit will not cover certain services (e.g., recovery supports) rely on services funded by the SABG. States also rely on the SABG funding for an array of non-clinical activities and services which support critical needs of their respective service systems, such as planning, coordination, needs assessment, quality assurance, program development, and evaluation.

In FY 2011, SAMHSA redesigned the FY 2012/2013 MHBG and SABG applications to better align with the current federal/state environments and related policy initiatives, including the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Tribal Law and Order Act (TLOA). The new design offered states the opportunity to complete a combined application for mental health and substance abuse services, submit a bi-annual versus an annual plan, and provide information regarding their efforts to respond to various federal and state initiatives. Almost one-half of the states took advantage of this streamlined application and submitted combined plans for mental health and substance abuse services. Over 95 percent of the states provided specific information requested by SAMHSA regarding strategies to respond to a variety of areas including primary care and behavioral health integration, recovery support services, prevention of substance use, and promotion of emotional health. States continued to provide information regarding the spending of their Block Grant funds to support services identified in SAMHSA's *Good and Modern Service System*[85] brief as described in the block grant application.

The FY 2014/2015 Block Grant application builds upon the FY 2012/2013 application and furthers SAMHSA's efforts to have states use and report the opportunities offered under various federal initiatives. In addition, the FY 2014/2015 Block Gant continues to allow states to submit a combined application for mental health and substance abuse services as well as a bi-annual versus an annual plan.

After the full implementation of the ACA, SAMHSA has strongly recommended that SABG funds be directed toward four purposes: (1) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; (2) to fund priority treatment (Essential Health Benefits – EHB) and support services not covered by private and public insurance for low and moderate income individuals and that demonstrate success in improving outcomes and/or supporting recovery (non-EHB covered treatments); (3) to fund primary prevention (universal, selective, and indicated) activities and services for individuals not identified as needing treatment; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis. In addition, consistent with SAMHSA's Theory of Change, which draws a path from innovation, translation, dissemination, to implementation and, finally, wide scale adoption, the agency will take advantage of the successful strategies implemented through the Access to Recovery

[85] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf

program. SAMHSA will encourage the states to utilize their Block Grants to: (1) allow recovery to be pursued through personal choice and many pathways; (2) encourage providers to manage performance based on 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 independent evaluation of the SABG program[86] 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 territories and to improve coordination of services with other state systems.

As noted below, the SABG Program has been successful in expanding treatment capacity in the latest year for which actual data are available in FY 2011[87] by supporting approximately two million[88] admissions to treatment programs receiving public funding.

Outcome data for the Block Grant program show positive results as reported through Behavioral Health Services Information System/Treatment Episode Data Set (TEDS) administered by SAMHSA's Center for Behavioral Health Statistics and Quality. In FY 2011, at discharge, clients demonstrated high abstinence rates from both illegal drug (73.4 percent) and alcohol (81.6 percent) use.

State Substance Abuse Authorities reported the following outcomes for services provided during FY 2011, the most recent year data is available:

- For the 50 states[89] and D.C that reported data in the Abstinence from Drug/Alcohol Use Domain for alcohol use, 51 of 51 identified improvements in client abstinence.
- Similarly, for the 50 states and D.C. that reported data in the Abstinence from Drug/Alcohol Use Domain for drug use, 50 of 51 identified improvements in client abstinence.
- For the 50 states and D.C. that reported data in the Employment Domain, 47 of 51 identified improvements in client employment.
- For the 50 states and D.C. that reported in the Criminal Justice Domain, 46 of 51 reported an increase in clients with no arrests based on data reported to TEDS.
- For the 49 states and D.C. that reported data in the Housing Domain, 42 of 49 identified improvements in stable housing for clients based on data reported to TEDS.

20 Percent Prevention Set-Aside

SAMHSA is responsible for managing the 20 percent prevention set-aside of the Substance Abuse Prevention and Treatment Block Grant (SABG). This is one of SAMHSA's main vehicles for supporting Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness. States use these funds to develop infrastructure and capacity specific to substance abuse

[86] http://tie.samhsa.gov/SAPT2010.html#Evaluation
[87] Source: 2013 SABG Report – Tables 16-21. While this is referenced as FY 2011, the actual time period varies by State, e.g; CY 2011 (imported TEDS data); SFY 2011 (manually entered by States); SFY 2012 (manually entered by States.
[88] Source: 2013 SABG Report – Table II
[89] Source: West Virginia numbers have been included in the text, but that appear lower than expected.

prevention. Some states rely solely on the 20 percent set-aside to fund their prevention systems while others use the funds to target gaps and enhance existing program efforts. Performance results will be available in December, 2013.

In an effort to streamline the application and reporting procedures for both the SABG and the Mental Health Block Grant programs, SAMHSA has developed a uniform application and reporting process to promote consistent planning, application, assurance, and reporting dates across both block grants. States are encouraged to make prevention a top priority, taking advantage of recent science, best practices in community coordination, proven planning processes, and the science articulated by the IOM report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*[90]. SAMHSA will work with states to increase their accountability systems for prevention and to develop necessary reporting capacities.

Synar

The Synar program is the set of actions put in place by states, with the support of the federal government, to implement the requirements of the Synar Amendment. The Amendment was developed in the context of a growing body of evidence about the health problems related to tobacco use by youth, as well as evidence about the ease with which youth could purchase tobacco products through retail sources. The Synar program is a critical component of the success of youth tobacco use prevention efforts. SAMHSA is charged with overseeing states' implementation of the Synar requirements and provides technical assistance to states on both the Synar requirements and youth tobacco access issues in general.

Since the inception of the Synar program in 1996, SAMHSA has worked with states to assist them in complying with and attaining the goals of the Synar Amendment and has issued programmatic requirements and guidance documents to assist states in their efforts.

By regulation, states must achieve a retailer noncompliance rate of 20 percent or less. Since FY 2006, all 50 states, Puerto Rico, and the District of Columbia have been in compliance with the Synar requirements. In FY 2012, the most recent year available, the national weighted average retailer violation rate was 9.1 percent. FY 2013 data will be available by August 31, 2014.

A total of $1.8 billion is requested in FY 2015, reflecting the same level funding from the FY 2014 Enacted Level. The FY 2015 request for the SABG includes recognition of new coverage for some limited services for SUDs in some states, mostly after an addiction is already diagnosed. SAMHSA's FY 2015 budget also recognizes the increased demand for services likely to be created by additional coverage options.

In addition, the most recent versions of the uniform SABG and Mental Health Block Grant (MHBG) application, and related investments in technical assistance, have called upon states to make particular efforts. These include ensuring that the providers they work with are administratively prepared to bill third-party sources of coverage, and are doing so for enrolled clients. In particular, a five-year multi-million dollar training and technical assistance effort was

[90] http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx

launched in FY 2012 for training community behavioral health providers on third-party contracting and billing practices in partnership with state-level mental health and substance abuse officials.

As public and private health insurance expand coverage of substance abuse treatment, SABG funding will focus upon the provision of effective non-covered prevention and intervention services that support health outcomes.

Health Reform Implementation

As a result of the analysis and examination of the various components of the Affordable Care Act beginning in 2010, SAMHSA has undertaken a major redesign of the planning section of the application process for both the MHBG and SABG. SAMHSA is aligning the block grants to complement mental health and substance abuse coverage expansions in the Affordable Care, and the Mental Health Parity and Addiction Equity Acts support individuals otherwise unable to receive services through public and private insurance. Together, SAMHSA's block grants support the provision of services and related supports to approximately eight million individuals with mental and substance use conditions. With an estimated 11.4 million adults having a severe mental illness,[91] 44.7 million adults having any mental illness,[92] and another 22.1 million adults with substance abuse disorder,[93] demand clearly outpaces the public behavioral health system's established capacity. Many of these individuals and some of the services they need will continue to be without coverage through public or private insurance mechanisms. Aligning and coordinating the SAMHSA block grants with the Affordable Care Act helps create a cohesive national service system that is responsive to potential gaps in service delivery and effectively provides needed behavioral health services across sectors and across payment sources.

States should determine if established systems and procedures are sufficient to ensure that Block Grant funds are expended in accordance with program requirements and directed to support and not supplant health reform activities. The Block Grant Application for FY 2014/2015, SAMHSA has strongly recommended that states use these resources to support and not supplant services that will be covered through commercial and public insurer plans. States will be asked to develop metrics or targets for their systems to measure increases in the number of individuals who become enrolled or providers that join commercial or publicly funded provider networks. The primary goals of SAMHSA's program integrity efforts are to continue to (1) promote the proper expenditure of block grant funds, (2) improve block grant program compliance nationally, and (3) demonstrate the effective use of block grant funds.

SAMHSA will provide additional guidance to the states to assist them in complying with this continuing emphasis on program integrity, will develop new and better tools for reviewing block grant application and reports, and will train SAMHSA staff in these program integrity approaches and tools. SAMHSA will be working with states to develop changes to information systems and compliance review processes to ensure increasing program integrity. This may include working closely with Medicaid and Health Insurance Exchanges to obtain information to

[91] http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm
[92] http://www.samhsa.gov/data/2k12/NSDUH110/sr110-adult-mental-illness.htm
[93] http://www.samhsa.gov/data/NSDUH/2k10ResultsRev/NSDUHresultsRev2010.htm#Ch7

determine if individuals and providers in their systems are enrolled. This may also include strategies to assist their providers to develop the necessary infrastructures to operate in commercial and public insurer networks. The Uniform Application, along with evolution of SAMHSA's block grant reporting system are tools to assist in this process.

Health Surveillance and Program Support

The FY 2015 Request is $124.6 million, which represents the Substance Abuse portion of the HSPS appropriation and supports staffing and activities to administer SAMHSA programs. This includes:

Health Surveillance and Program Support
FY 2015 Request: $83.7 million
(Reflects $1.3 million increase from FY 2014 Enacted Level)

Health Surveillance and Program Support provides funding for personnel costs, building and facilities, equipment, supplies, administrative costs and associated overhead to support SAMHSA programmatic activities as well as providing funding for SAMHSA national data collection and survey systems, funding to support the CDC NHIS Survey, and the data archive. This request represents the total funding available for these activities first split into Mental Health and Substance Abuse using the same percentages splits as between the Mental Health and Substance Abuse (Prevention and Treatment) appropriation amounts. The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

A total of $83.7 million is requested in FY 2015 for Health Surveillance activities. The increase in funds will be used to support the President's *Now is the Time* initiative. This increase will be used to support the work begun by the White House National Conference on Mental Health, supporting the collection and use of data to learn if, what, and how we are communicating is making a positive difference. Specifically, this funding will be used for a new initiative, Science of Changing Social Norms: Building the Evidence Base, to support efforts to measure and track behavioral, attitudinal, and related community data to understand the impact of social messaging and demonstrate evidence for effecting change in social norms and behavior to reduce negative attitudes and improve people's willingness to seek help for themselves and others when they experience a mental health problem. The Science of Changing Social Norms will have a second component, Social Media, funded from Public Awareness and Support.

Public Awareness and Support
FY 2015 Request: $7.8 million
(Reflects $1 million increase from FY 2014 Enacted Level)

Public Awareness and Support provides funding to support the unified communications approach to increase awareness of behavioral health, mental disorders and substance abuse issues. This represents the total funding available for these activities first divided evenly between Mental Health and Substance Abuse. The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

The additional request in FY 2015 will support a new initiative, the Science of Changing Social Norms: Social Media, to develop and test an array of messages and media designed to improve attitudes, understanding and behavior of Americans about mental and substance use disorders and the willingness to seek help for them. Building on the effort to increase understanding about mental health through the *Now is the Time* initiative launched on January 16, 2013, this public awareness and education initiative will seek to target the message resulting from the national conversation about behavioral health most effectively. The increase will fund social media strategies to support the work begun by the White House National Conference on Mental Health. The goal is to use communications science and market research to identify the most effective and evidence-based methods for decreasing negative attitudes, increasing knowledge and improving willingness to seek help for mental health and substance abuse problems to ensure outreach funds are spent where they will make the most impact. This initiative is in conjunction with the Science of Changing Social Norms: Building the Evidence Base in the Center for Behavioral Health Statistics and Quality's which is essential to understand the impact of social messaging and demonstrate evidence for effecting change in social norms and behavior to reduce negative attitudes and improve people's willingness to seek help. CBHSQ's data collection component will be funded separately under Health Surveillance and Program Support.

Performance and Quality Information Systems
FY 2015 Request: $8.9 million
(Reflects level funding from FY 2014 Enacted Level)

Performance and Quality Information Systems provides funding to support the Consolidated Data Platform and CDP related activities, as well as provide support for a new contract for the National Registry of Evidence-based Programs and Practices that will reduce the backlog of interventions accepted but not reviewed under the previous contract. This request represents the total funding available for these activities first split into Mental Health and Substance Abuse using the same percentages splits as between the Mental Health and Substance Abuse (Prevention and Treatment) appropriation amounts. The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

In FY 2015, these funds will be used to continue support for the Common Data Platform, which was awarded in late FY 2013 and implemented in FY 2014, as well as provide support for the continuation of NREPP.

Agency-Wide Initiatives
FY 2015 Request: $23.4 million
(Reflects $0.6 million increase from FY 2014 Enacted Level)

Agency-Wide Initiatives provides funding for across Agency initiatives such as Minority Fellowship Program which improves the quality of mental health and substance abuse prevention and treatment delivered to ethnic minorities by providing stipends to post-graduate students and other Behavioral Health Workforce programs. This represents the total funding available for these activities first divided evenly between Mental Health and Substance Abuse. The Substance

Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

In FY 2015, SAMHSA will collaborate with HRSA in expanding the Behavioral Health Workforce Education and Training (BHWET) Grant Program. This expansion will increase the clinical service capacity of the behavioral health workforce by supporting training for Master's level social workers, psychologists, marriage and family therapists, psychology doctoral interns, as well as behavioral health paraprofessionals. This effort is critical to ensure that the behavioral health workforce is able to meet the needs of high need and high demand populations, including rural, vulnerable, and underserved populations. In FY 2015, the program will continue to include an emphasis on training to address the needs of children, adolescents, and transition-age youth (ages 16-25) and their families. SAMHSA requests $35 million in FY 2015 for the SAMHSA-HRSA expansion of the BHWET grant program and will help increase the behavioral health workforce by 3,500 individuals, in addition to those below.

Peer Professional Workforce Development

In FY 2015, SAMHSA proposes to implement a program to strengthen the behavioral health workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16-25. Because of their lived experience with behavioral health conditions, and being able to build trust and foster connections with individuals accessing care, these entry-level providers play a significant role in the delivery of prevention and recovery support services. SAMHSA plans to award up to 19 grant awards to community colleges or community college networks, states, and national organizations. These funds will provide tuition support and further establish the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education. Funding will increase the behavioral health workforce by 1,200 peer professionals.

The Behavioral Health Workforce Education and Training (BHWET) will focus on supporting clinical internships and field placements, and certificate program completion across a range of professional and paraprofessional disciplines (some of whom may be peers) to produce a ready cohort of new behavioral health providers. The Peer Professional Workforce Development program focuses exclusively on peers, or people with personal experiences with mental illness and/or substance use conditions. Peers may play roles across the spectrum of prevention, treatment and recovery/family support. The Peer Professional program will award grants to community colleges, community college networks, states, and national organizations in order to develop the training infrastructure for peer professionals nationwide.

Behavioral Health Workforce Data and Development

Beginning in 2014, over 62 million Americans will have expanded or first time access to coverage for services for mental and substance use disorders as a result of a combination of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act. Almost 11 million of these individuals are expected to have mild to severe mental health and/or substance abuse conditions with related treatment needs. Current data indicate that almost 90 percent of

persons with substance abuse issues do not receive the services they need and over half of those with mental disorders do not receive needed treatment.

SAMHSA received $40 million in new behavioral health workforce activities in the FY 2014 Appropriation. This budget assumes continuation of those programs to develop approximately 5,000 new behavioral health clinical professionals. To ensure the existing workforce investments are responsible and well-targeted, SAMHSA's FY 2015 budget proposes to partner with HRSA on the Behavioral Health Minimum Data Set to develop consistent data collection methods to identify and track behavioral health workforce needs as well as to partner with the Department of Defense, and the Department of Veterans Affairs to inventory existing and emerging workforce issues, efforts and impacts, and develop coordinated plans.

Data Request and Publication User Fees
FY 2015 Request: $0.8 million
(Reflects level funding from FY 2014 Enacted Level)

In 2015, SAMHSA estimates $0.8 million in Data Request and Publication User Fees. These fees will be collected and retained for extraordinary data and publications requests. This represents the total funding estimated for these activities first divided evenly between Mental Health and Substance Abuse. The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

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[i] Richard Spoth, Linda Trudeau, Chungyeol Shin, Ekaterina Ralston, Cleve Redmond, Mark Greenberg, and Mark Feinberg. Longitudinal Effects of Universal Preventive Intervention on Prescription Drug Misuse: Three Randomized Controlled Trials With Late Adolescents and Young Adults. American Journal of Public Health: April 2013, Vol. 103, No. 4, pp. 665-672.

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SAMHSA
Prevention and Public Health Fund
Summary of the Request
(Dollars in thousands)

Prevention and Public Health Fund	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Primary and Behavioral Health Care Integration.....	$---	$---	$28,000	+$28,000
Suicide Prevention.....	---	10,000	10,000	---
Health Surveillance.....	14,733	---	20,000	+20,000
National Strategy on Suicide Prevention.....	---	2,000	---	-2,000
Access to Recovery.....	---	50,000	---	-50,000
Total, Prevention and Public Health Fund	**$14,733**	**$62,000**	**$58,000**	**-$4,000**

The FY 2015 Budget Request for the Prevention and Public Health Fund is $58 million, a decrease of $4 million from the FY 2014 Enacted Level. The FY 2015 Prevention and Public Health Fund request includes the following: $28 million for Primary and Behavioral Health Care Integration, $10 million for GLS Suicide Prevention, and $20 million for Health Surveillance.

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Primary and Behavioral Health Care Integration

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Program Level	$30,634	$51,996	$28,000	-$23,996
Prevention & Public Health Fund (non-add)	*$---*	*$---*	*$28,000*	*+$28,000*

Authorizing Legislation ..... Sections 520A and 520K of the PHS Act and Section 4002 of the Patient and Protection and Affordable Care Act

FY 2015 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

SAMHSA provided funding for the Primary & Behavioral Health Care Integration (PBHCI) program beginning in FY 2009 to address the increased rates of morbidity and mortality among adults with serious mental illness (SMI). These rates are due, in large part, to elevated incidence and prevalence of cardiovascular disease, obesity, diabetes, hypertension, and dyslipidemia in people with SMI. Increased morbidity and mortality can be attributed to a number of other issues, including inadequate physical activity and poor nutrition, smoking, side effects from atypical antipsychotic medications, and lack of access to primary health care services. Many of these health conditions are preventable through routine health promotion activities, primary care screening, monitoring, treatment, and care management/coordination strategies and/or other outreach programs at home or community sites. Physical health problems among people with SMI impact quality of life and contribute to premature death. While several factors contribute to this disparity, empirical findings indicate that early mortality among people with SMI is clearly linked to the lack of access to primary care services.

The PBHCI program supports SAMHSA's Health Reform Strategic Initiative and is comprised of competitive cooperative agreements and the PBHCI Training and Technical Assistance (TTA) Center which is co-funded with HRSA. The program supports the coordination and integration of primary care services into publicly-funded community behavioral health settings. This program is also a part of SAMHSA's Health Reform Strategic Initiative. The expected outcome of improved health status for people with SMI 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, as well as information technology entities, are deemed crucial to the success of this program. The population of focus for this grant program is individuals with SMI and/or people with co-occurring disorders served by the public mental health system. Recipients are non-profit mental health provider agencies that will use these grant funds to develop and offer primary care as well as behavioral health services in an integrated manner.

In FY 2011, $35 million was allocated from the Prevention and Public Health Fund for PBHCI to promote more integrated services between primary care services and mental health services. These funds were used to facilitate screening and referral for necessary primary care prevention and treatment needs. SAMHSA funded eight new multi-year funded PBHCI grants and 34 continuation grants with Prevention and Public Health Funds and 22 grants and one contract continuation with Budget Authority.

In FY 2012, SAMHSA supported 56 existing grants; 20 new multi-year funded grants and 10 new annually funded grants from SAMHSA Budget Authority and Prevention and Public Health Fund ($30.8 million in Budget Authority and $35 million in Prevention and Public Health Funds) as well as $1.9 million for the continuation of PBHCI Training and Technical Assistance (TTA) Center.

In FY 2013, SAMHSA awarded continuation of the program and awarded seven new grants. SAMHSA has awarded 100 PBHCI grants to date including the FY 2013 cohort.

Over 33,000 consumers were served in FY 2013, an increase of 43.5 percent over FY 2012. Improvements in all four National Outcome Measures were consistently positive as a result of this intervention. Of particular importance were the increases in measures of functioning and education/employment, demonstrating that the program supports health and productivity.

The following health indicators, as of April 2013, show improvements in program participants' physical health:

- Blood pressure: 17.4 percent of program participants showed some improvement in this biomarker. For 16.2 percent of program participants, their blood pressure improved enough that it was no longer a risk factor for hypertension.
- Blood glucose: 36.8 percent of program participants showed some improvement in this biomarker. For 10.4 percent of program participants, their blood glucose improved enough that it was no longer a risk factor for diabetes.
- HgBA1c: 40.4 percent of program participants showed some improvement in this biomarker. For 9.3 percent of program participants, their HgBA1c improved enough that it was no longer a risk factor for diabetes.
- HDL: 38 percent of program participants showed some improvement in this biomarker. For 8.9 of program participants, their HDL improved enough that it was no longer a risk factor for high cholesterol.
- LDL: 41.9 percent of program participants showed some improvement in this biomarker. For 10.7 percent of program participants, their LDL improved enough that it was no longer a risk factor for high cholesterol.
- Triglycerides: 41.1 percent of program participants showed some improvement in this biomarker. For 11.3 percent of program participants, their triglycerides improved enough it was no longer a risk factor for hyperlipidemia.

In FY 2014, SAMHSA plans to support continuation grants as well as award a new cohort of PBHCI grants and one technical assistance contract.

Budget Request

The FY 2015 Request for PBHCI Prevention and Public Health Fund is for $28 million, an increase of $28 million from the FY 2014 Enacted Level. This level of funding provides support to 34 grants and 1 contract continuation. The funding will also support Braided Program: HIV Continuum of Care to provide bi-directional integration between primary care services and substance abuse treatment/mental health services (for CSAT/CMHS) and address service coordination and infrastructure needs to providers.

Key Outputs and Outcomes

Program: Primary & Behavioral Health Care Integration (PBHCI)

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
3.2.40 Number of clients served (Output)	FY 2013: 33,023 Target: 33,023 (Baseline)	11,156	11,156	Maintain
3.2.41 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2013: 55.3% Target: 55.3% (Baseline)	49.9%	49.9%	Maintain
3.2.42 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2013: 21.1% Target: 21.1% (Baseline)	22.1%	22.1%	Maintain
3.2.43 Percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2013: 71.6% Target: 71.6% (Baseline)	65.7%	65.7%	Maintain
3.2.44 Percentage of adults receiving services who had positive social support at 6 month follow-up. (Outcome)	FY 2013: 68.3% Target: 68.3% (Baseline)	64.3%	64.3%	Maintain

Suicide Prevention

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Program Level	$52,747	$55,212	$43,108	-$12,104
Prevention & Public Health Fund (non-add)	*$---*	*$10,000*	*$10,000*	*$---*

Authorizing Legislation ..... Sections 520, 520A, 520C, and 520E of the PHS Act and Section 4002 of the Patient and Protection and Affordable Care Act

FY 2015 Authorization ..... Expired

Allocation Method ..... Competitive Grants and Contracts

Program Description and Accomplishments

GLS Youth Suicide Prevention

The Garrett Lee Smith (GLS) Memorial Act authorizes SAMHSA to manage two significant youth suicide prevention programs and one resource center. The GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program currently supports a total of 68 grantees which includes four multi-year funded grants in FY 2011, three multi-year funded grants in FY 2012, and 61 annually funded grants, 31 states, 29 tribes or tribal organizations, and the District of Columbia 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 82 institutions of higher education, inclusive of tribal colleges and universities, which includes five multi-year funded grants in FY 2011, 15 multi-year funded grants in FY 2012, four multi-year funded grants in FY 2013 and 58 annually funded grants, to prevent suicide and suicide attempts.

In FY 2012, through Budget Authority, SAMHSA provided support for 34 GLS state/tribal continuation grants and awarded 20 new grants. In addition, SAMHSA supported 16 GLS campus continuation grants and awarded 24 new grants.

In FY 2012, SAMHSA also received $10 million in Prevention and Public Health Fund, which supported the GLS grants, the National Suicide Prevention Lifeline, and the Suicide Prevention Resource Center. Three grants were multi-year funded for the GLS state/tribal grantees and 15 grants were multi-year funded for the campus grantees.

As of July 2013, 592,580 individuals had participated in 21,433 training events or educational seminars provided by grantees. Grantees often used their funds to provide suicide prevention trainings in their communities. The most common approach was gatekeeper training, designed to help trainees recognize suicide risk in young people, address the immediate needs of the youths, and refer youths to appropriate services. Over one third of 34.5 percent (n = 204,351) of trainees were trained through campus-sponsored trainings and educational seminars. Over half of

trainees 61.0 percent (n = 361,765) participated in State-sponsored and 4.5 percent (n = 26,464) in tribal-sponsored training activities.

In FY 2013, SAMHSA provided support for the continuation of existing state/tribal and campus grantees and awarded seven new GLS State/Tribal grants and 22 GLS Campus grants.

In FY 2014, SAMHSA plans to continue support both GLS State/Tribal and GLS Campus programs and anticipates awarding 24 new GLS State/Tribal grants, 15 new GLS Campus, and one new evaluation contract.

Suicide Prevention Resource Center

In addition to programs that build suicide prevention capacity, SAMHSA also supports the Suicide Prevention Resource Center (SPRC). This program promotes the implementation of the National Strategy for Suicide Prevention and enhances the nation's mental health infrastructure by providing states, tribes, 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 SPRC also advances youth suicide prevention efforts in states, territories, tribes, and campuses as authorized through the Garrett Lee Smith (GLS) Memorial Act.

Through the SPRC, SAMHSA continues to provide support for the National Action Alliance for Suicide Prevention (NAASP), a public-private partnership to implement the National Strategy for Suicide Prevention and reduce suicide in America. The NAASP was launched on September 10, 2010, by HHS Secretary Kathleen Sebelius and the former Secretary of Defense, Robert Gates.

In FY 2011, SAMHSA received $10 million in Prevention and Public Health Fund, from which SAMHSA funded one supplement to the SPRC of $0.7 million to expand and enhance the level of support provided to the NAASP. This supplement expanded future organizational development, partnerships, and collaborations to support the implementation of the Surgeon General's National Strategy for Suicide Prevention.

In FY 2012, SAMHSA utilized Prevention and Public Health Fund for the SPRC to help support implementation of high impact objectives identified by the National Strategy for Suicide Prevention and the NAASP and to develop, based on the experience of GLS grantees, a strategic framework to embed sustainable, comprehensive, coordinated youth suicide prevention activities in states, tribes, and colleges across the nation.

In FY 2013, SAMHSA provided support for the continuation of the SPRC grant with a reduced level of support for the NAASP as it transitions to alternate sources of funding. In FY 2014, SAMHSA plans to fund the continuation of the SPRC grant and a supplement from Prevention and Public Health Fund.

National Suicide Prevention Lifeline

Launched in FY 2005, the National Suicide Prevention Lifeline, 1-800-273-TALK, coordinates a network of 160 crisis centers across the United States by providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night. The Lifeline routes calls from anywhere in the country to a network of certified local crisis centers that can then link callers to local emergency, mental health, and social services resources, The Lifeline averaged 94,183 calls per month in 2013, including a peak of 104,754 calls in December. National Suicide Prevention Lifeline crisis centers across the nation are responding to people in suicidal crises. SAMHSA evaluation studies have found that when a sample of suicidal callers to the Lifeline are asked "to what extent did calling the crisis hotline stop you from killing yourself?" 69 percent respond "a lot" and 21.6 percent respond "a little". At the same time, these centers are threatened with significant cutbacks in funding from state and local governments and other sources of support.

Since FY 2007, SAMHSA has partnered with the Department of Veterans Affairs (VA) to provide and ensure that Veterans calling the Lifeline have 24/7 access to a specialized Veterans' suicide prevention hotline. In FY 2013, more than 26,943 callers per month were seamlessly connected to the Veterans crisis line. The National Suicide Prevention Lifeline is also responding to calls from active duty military and their families. 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.

In addition, in FY 2012, SAMHSA awarded a new Suicide Lifeline grant and provided continuation support for 12 National Suicide Prevention Lifeline Crisis Center grants to provide follow up to suicidal callers. Evaluation and research findings indicated that in the immediate aftermath of suicidal crises, there is a period of heightened risk for suicide, but in this time there is a great potential for suicide prevention. Preliminary data from this program indicated that when asked by an independent evaluator, "To what extent did the counselor's calling you stop you from killing yourself?" more than 50 percent of those receiving follow-up phone contact indicated the call played a significant role in keeping them alive.

The National Suicide Prevention Lifeline uses evaluation results to document and improve program effectiveness. Evaluation results have been used to develop standards for suicide risk assessment, guidelines for callers at imminent risk for suicide, and follow up protocols for suicidal callers. In turn, these quality and performance improvement efforts have been evaluated and found to have positive impacts. Some of these outcomes have included decreases in suicidal ideation and hopelessness among callers, increased frequency of performing suicide risk assessments by crisis counselors, increased follow up of suicidal callers by crisis centers, and suicidal callers reporting such calls played a significant role in keeping them alive.

In FY 2013, SAMHSA awarded the continuation of the Suicide Lifeline grant and grants to crisis centers. In addition, 12 new crisis center grants were awarded, which will include a focus on providing follow up to suicidal people discharged from emergency rooms and inpatient units. This focus is based on current evaluation and research findings. In FY 2014, SAMHSA plans to

award continuation grants and contracts as well as award a supplement to Suicide Lifeline from Prevention and Public Health Fund.

The National Suicide Prevention Lifeline uses evaluation results to document and improve program effectiveness. Evaluation results have been used to develop standards for suicide risk assessment, guidelines for callers at imminent risk for suicide, and follow up protocols for suicidal callers. In turn, these quality and performance improvement efforts have been evaluated and found to have positive impacts. Some of these outcomes have included decreases in suicidal ideation and hopelessness among callers, increased frequency of performing suicide risk assessments by crisis counselors, increased follow up of suicidal callers by crisis centers, and suicidal callers reporting such calls played a significant role in keeping them alive. To see one aspect of this outreach effort in action, visit https://www.facebook.com/800273TALK.

Budget Request

The FY 2015 Budget Request for GLS Suicide Prevention is $10 million in Prevention and Public Health Funds, the same level as FY 2014 Enacted Level. The total program level request, which includes both Budget Authority and Prevention and Public Health Funds, is $43.1 million, a decrease of $12.1 million from the FY 2014 Enacted Level.

Key Outputs and Outcomes

Program: Suicide Prevention

NOTE: SAMHSA grant awards are made late in the year. FY 2014 Enacted is reflected in FY 2015 targets. FY 2015 President's Budget is reflected in FY 2016 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
2.3.59 Total number of individuals trained in youth suicide prevention (Outcome)	FY 2013: 172,876[95] Target: 35,371 (Target Exceeded)	161,000	134,000	-27,000
2.3.60 Total number of youth screened (Output)	FY 2013: 79,318 Target: 3,360 (Target Exceeded)	73,996	61,626	-12,370
2.3.61 Increase the number of calls answered by the suicide hotline (Output)	FY 2013: 1,061,204 Target: 765,638 (Target Exceeded)	989,994	824,501	-165,493
3.2.37 Increase the number of individuals referred to mental health or related services (Output)	FY 2013: 7,389 Target: 7,389 (Baseline)	5,911	5,911	Maintain

[95] Programs included are the Garrett Lee Smith Campus Suicide Prevention Program and the Garrett Lee Smith State/Tribal Suicide Prevention Program.

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Health Surveillance

(Dollars in thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Program Level	$45,421	$47,428	$49,428	+$2,000
PHS Evaluation Funds (non-add)	*27,428*	*30,428*	*29,428*	*-1,000*
Prevention & Public Health Fund (non-add)	*$14,733*	*$---*	*$20,000*	*+$20,000*

Authorizing Legislation ..... Section 501 of the Public Health Service Act and Section 4002 of the Patient and Protection and Affordable Care Act

FY 2015 Authorization ..... Expired

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

Program Description and Accomplishments

The Health Surveillance budget supports many of the critical behavioral health data systems, national surveys, and surveillance activities for HHS undertaken by SAMHSA to support SAMHSA grantees, the field, and the public.

The National Survey on Drug Use and Health (NSDUH) serves as the nation's primary source for information on the incidence and prevalence of substance use and mental disorders and related health conditions. A new NSDUH contract was awarded in FY 2013 to finance surveys for 2014, 2015, 2016 and 2017.

In FY 2013, funding was provided for other public surveillance systems, including data collection efforts within the Community Behavioral Health Data Initiative (CDI). The goal of the CDI is to create new opportunities for cross-agency and public-private partnerships to address critical public health questions and more effectively utilize existing or declining resources. Data from this coordinated initiative is intended to be utilized in concert with data collected by other agencies such as Centers for Medicare and Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ) to more fully develop an understanding of the status of behavioral health at the regional and community level. Use of these data will allow communities to identify service and program needs specific to the local community. Moreover, the longitudinal nature of these data will allow those evaluating the effectiveness of services and policies in a community to measure the impact and outcomes of those interventions. Funding was also provided in 2013 for DCAR. This data system will be replaced with the new SAMHSA Common Data Platform

In FY 2014, no PPHF funds were provided for Health Surveillance.

Budget Request

The FY 2015 Budget Request is for $20 million in Prevention and Public Health Funds, an increase of $20.0 million from the FY 2014 Enacted Budget. The total program level request, which includes PHS Evaluation Funds and Prevention and Public Health Funds, is $49.4 million,

an increase of $2 million above the FY 2014 Enacted Budget. The Prevention and Public Health funding will support the work of NSDUH, BHSIS, Analytic Support Center, CDI, as well as, the C-EMS project.

Funding is requested for a number of activities to support a broad range of analytic work to be carried out in the CBHSQ. These activities include support for an Analytic Support Center (ASC) which undertakes a number of scientific and writing tasks on policy and practice-related topics in response to requests from SAMHSA Centers and related components, HHS agencies (CDC, AHRQ, and FDA), the Surgeon General's Office, the Office of National Drug Control Policy, and the Department of Justice. FY 2015 funds $1.0 million for the Analytic Support with PPHF funds.

A new NSDUH contract was awarded in FY 2013 that will support the 2014, 2015, 2016, and 2017 annual surveys, pending the availability of funds. In FY 2015, funding for NSDUH and NSDUH-related activities is expected to be $52.7 million, of which, $11.1 million will be funded with PPHF funds.

In FY 2013, funding was also provided to partially support the Behavioral Health Services Information System (BHSIS) to reflect the transition of the Drug and Alcohol Services Information System (DASIS) to the BHSIS by: 1) collecting mental health treatment admissions data along with the ongoing substance abuse treatment admissions data, and 2) augmenting the treatment locator to include mental health facility level information. SAMHSA will continue the transition from DASIS to BHSIS in FY 2014 by working closely with the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) and our state and federal partners in the development and implementation of this integration effort which includes identifying metrics for reporting outcomes. In FY 2015, funding for BHSIS funding is $21.0 million, $2.7 million funded with PPHF funds.

Funding is also requested for the continuation of the National Registry of Evidence-based Programs and Practices (NREPP), a searchable online system that supports states, communities, and tribes in identifying and implementing evidence-based mental health promotion, substance abuse prevention, and substance abuse and mental health treatment interventions. This registry is comprised of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. Moreover, the registry assists the public in identifying scientifically based approaches to preventing and treating mental and/or substance use disorders that can be readily disseminated to the field. This program is one way that SAMHSA is working to improve access to information on tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field. In FY 2015, PPHF funds NREPP at $1.6 million.

Under the new Community Behavioral Health Data Initiative (CDI) structure, $3.0 million is funded in 2015 with PPHF funds. Data collected from local communities are used to deliver programs and services are an important component of a strong public health infrastructure. Much of SAMHSA's current data effort is captured and reported at the national or state level. Information on the health and behavioral health at the community level serves to identify current

and emerging problems and highlight opportunities for progress that may vary from larger geographical areas. Importantly, when communities have access to surveillance data over time, prevention can happen. Communities using data can identify what the issues may be and then direct targeted prevention efforts at the vulnerable populations in their communities. SAMHSA will more closely coordinate three separate existing data efforts, the Community Early Warning and Monitoring Systems (C-EMS), SAMHSA's Emergency Department Surveillance System (SEDSS) (formerly the Drug Abuse Warning Network (DAWN)), and the Program Studies on Treatment and Recovery (PSTAR), to create new opportunities for cross-agency and public-private partnerships to address critical public health questions and more effectively utilize existing or declining resources. Data from this coordinated initiative can be combined with data from other Agencies such as CMS and AHRQ, and then be reported by regional and community type. Use of these data will allow communities to identify service and program needs specific to the local community. Moreover, the longitudinal nature of these data will allow those evaluating the effectiveness of services and policies in a community to measure the impact and outcomes of those interventions. SAMHSA will continue to examine where in-sourcing additional staff and collaborations with other agencies can support this effort while maximizing limited resources and cost-efficiencies

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Budget Authority by Object Classification Tables

Health Surveillance and Program Support

(Dollars in Thousands)

Object Class - Direct Budget Authority	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1)	46,600.458	45,670.129	(930.329)
Other than full-time permanent (11.3)	3,755.777	3,680.820	(74.956)
Other personnel compensation (11.5)	749.171	734.220	(14.952)
Military personnel (11.7)	2,993.606	3,206.787	213.181
Special personnel services payments (11.8)	40.208	41.615	1.407
Subtotal personnel compensation:	**54,139.220**	**53,333.571**	**(805.648)**
Civilian benefits (12.1)	14,084.662	14,713.191	628.530
Military benefits (12.2)	1,486.610	1,792.581	305.971
Subtotal Pay Costs:	**69,710.491**	**69,839.344**	**128.852**
Travel and transportation of persons (21.0)	853.099	853.000	(0.099)
Transportation of things (22.0)	7.000	7.000	-
Rental payments to GSA (23.1)	727.704	1,156.440	428.736
Printing and reproduction (24.0)	253.000	253.000	-
Other Contractual Services:			
Other services (25.2)	41,692.544	40,052.845	(1,639.699)
Purchase of Goods & Svcs. from Govt. Accts (25.3)	8,200.000	8,300.000	100.000
Operation and maintenance of facilities (25.4)	342.000	345.000	3.000
Research and Development Contracts (25.5)	3,043.162	3,310.372	267.210
Operation and maintenance of equipment (25.7)	86.000	86.000	-
Subtotal Other Contractual Services:	**53,363.706**	**52,094.217**	**(1,269.489)**
Supplies and materials (26.0)	203.000	203.000	-
Equipment (31.0)	365.000	365.000	-
Grants, subsidies, and contributions (41.0)	36,500.000	22,950.000	(13,550.000)
Interest and dividends (43.0)	8.000	8.000	-
Subtotal Non-Pay Costs	**92,280.508**	**77,889.656**	**(14,390.852)**
Total Direct Obligations	**161,991.000**	**147,729.000**	**(14,262.000)**

Mental Health Services

(Dollars in Thousands)

Object Class - Direct Budget Authority	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1).....	987.291	1,096.881	109.589
Other than full-time permanent (11.3).....	79.572	88.404	8.832
Other personnel compensation (11.5).....	15.872	17.634	1.762
Military personnel (11.7).....	90.715	91.622	0.907
Subtotal personnel compensation:	**1,173.451**	**1,294.541**	**121.091**
Civilian benefits (12.1).....	298.404	353.374	54.970
Military benefits (12.2).....	45.049	51.217	6.168
Subtotal Pay Costs:	**1,516.903**	**1,699.132**	**182.228**
Travel and transportation of persons (21.0).....	230.000	232.000	2.000
Rental payments to GSA (23.1).....	2,029.513	3,225.226	1,195.713
Communication, utilities, and misc. charges (23.3).....	221.000	223.000	2.000
Printing and reproduction (24.0).....	35.000	37.000	2.000
Other Contractual Services:			-
Other services (25.2)(25.9).....	44,955.701	42,000.000	(2,955.701)
Purchase of Goods & Svcs. from Govt. Accts (25.3)..	35,000.000	35,443.700	443.700
Operation and maintenance of facilities (25.4).....	230.000	235.000	5.000
Research and Development Contracts (25.5).....	868.000	870.000	2.000
Operation and maintenance of equipment (25.7).....	30.000	32.000	2.000
Subtotal Other Contractual Services:	**81,083.701**	**78,580.700**	**(2,503.001)**
Supplies and materials (26.0).....	4.500	4.750	0.250
Equipment (31.0).....	3.100	3.250	0.150
Grants, subsidies, and contributions (41.0).....	974,089.387	946,726.942	(27,362.445)
Interest and dividends (43.0).....	54.896	60.000	5.104
Subtotal Non-Pay Costs	**1,057,751.097**	**1,029,092.868**	**(28,658.229)**
Total Direct Obligations	**1,059,268.000**	**1,030,792.000**	**(28,476.000)**

Substance Abuse Prevention

(Dollars in Thousands)

Object Class - Direct Budget Authority	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1).....	---	---	---
Other than full-time permanent (11.3).....	---	---	---
Other personnel compensation (11.5).....	---	---	---
Military personnel (11.7).....	---	---	---
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	---	---	---
Civilian benefits (12.1).....	---	---	---
Military benefits (12.2).....	---	---	---
Subtotal Pay Costs:	---	---	---
Rental payments to GSA (23.1).....	842.273	1,338.509	496.236
Communication, utilities, and misc. charges (23.3).....	33.418	35.000	1.582
Printing and reproduction (24.0).....	227.460	230.000	2.540
Other Contractual Services:			
Advisory and assistance services (25.1).....	3,509.774	2,939.507	(570.267)
Other services (25.2)(25.9).....	35,951.773	29,382.793	(6,568.980)
Purchase of Goods & Svcs. from Govt. Accts (25.3)..	3,071.053	2,572.069	(498.984)
Operation and maintenance of facilities (25.4).....	64.000	66.000	2.000
Operation and maintenance of equipment (25.7).....	170.000	175.000	5.000
Subtotal Other Contractual Services:	**42,766.600**	**35,135.369**	**(7,631.231)**
Supplies and materials (26.0).....	2.431	5.000	2.569
Grants, subsidies, and contributions (41.0).....	131,687.817	132,348.122	660.305
Subtotal Non-Pay Costs	**175,560.000**	**169,092.000**	**(6,468.000)**
Total Direct Obligations	**175,560.000**	**169,092.000**	**(6,468.000)**

Substance Abuse Treatment

(Dollars in Thousands)

Object Class - Direct Budget Authority	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1).....	3,751.708	3,988.658	236.950
Other than full-time permanent (11.3).....	302.372	321.469	19.097
Other personnel compensation (11.5).....	60.315	64.124	3.809
Military personnel (11.7).....	90.715	91.622	0.907
Subtotal personnel compensation:	**4,205.109**	**4,465.873**	**260.764**
Civilian benefits (12.1).....	1,133.935	1,284.995	151.060
Military benefits (12.2).....	45.049	51.217	6.168
Subtotal Pay Costs:	**5,384.093**	**5,802.085**	**417.992**
Travel and transportation of persons (21.0).....	147.286	150.000	2.714
Rental payments to GSA (23.1).....	2,696.155	4,284.629	1,588.473
Communication, utilities, and misc. charges (23.3).....	459.000	465.000	6.000
Printing and reproduction (24.0).....	830.468	835.000	4.532
Other Contractual Services:			-
Advisory and assistance services (25.1).....	45,000.000	40,445.436	(4,554.564)
Other services (25.2)(25.9).....	75,000.000	66,183.441	(8,816.559)
Purchase of Goods & Svcs. from Govt. Accts (25.3).	17,000.000	15,933.051	(1,066.949)
Operation and maintenance of facilities (25.4).....	225.000	225.000	-
Subtotal Other Contractual Services:	**137,225.000**	**122,786.927**	**(14,438.073)**
Supplies and materials (26.0).....	18.436	25.000	6.564
Equipment (31.0).....	77.900	85.000	7.100
Grants, subsidies, and contributions (41.0).....	1,953,277.662	1,873,622.360	(79,655.302)
Subtotal Non-Pay Costs	**2,094,731.908**	**2,002,253.916**	**(92,477.992)**
Total Direct Obligations	**2,100,116.000**	**2,008,056.000**	**(92,060.000)**

Summary Direct Budget Authority

(Dollars in Thousands)

Object Class - Direct Budget Authority	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1).....	51,339.457	50,755.667	(583.789)
Other than full-time permanent (11.3).....	4,137.720	4,090.693	(47.027)
Other personnel compensation (11.5).....	825.358	815.978	(9.381)
Military personnel (11.7).....	3,175.037	3,390.032	214.995
Special personnel services payments (11.8)	40.208	41.615	1.407
Subtotal personnel compensation:	**59,517.780**	**59,093.986**	**(423.794)**
Civilian benefits (12.1).....	15,517.000	16,351.560	834.559
Military benefits (12.2).....	1,576.707	1,895.014	318.307
Subtotal Pay Costs:	**76,611.487**	**77,340.560**	**729.072**
Travel and transportation of persons (21.0).....	1,230.385	1,235.000	4.615
Transportation of things (22.0).....	7.000	7.000	-
Rental payments to GSA (23.1).....	6,295.646	10,004.803	3,709.158
Communication, utilities, and misc. charges (23.3)...	713.418	723.000	9.582
Printing and reproduction (24.0).....	1,345.928	1,355.000	9.072
Other Contractual Services:			
Advisory and assistance services (25.1).....	48,509.774	43,384.943	(5,124.831)
Other services (25.2)(25.9).....	197,600.018	177,619.079	(19,980.939)
Purch. Goods & Svcs. Govt. Accts (25.3).....	63,271.053	62,248.819	(1,022.233)
Operation and maintenance of facilities (25.4).....	861.000	871.000	10.000
Research and Development Contracts (25.5).....	3,911.162	4,180.372	269.210
Operation and maintenance of equipment (25.7).....	286.000	293.000	7.000
Subtotal Other Contractual Services:	**314,439.007**	**288,597.213**	**(25,841.794)**
Supplies and materials (26.0).....	228.368	237.750	9.382
Equipment (31.0).....	446.000	453.250	7.250
Grants, subsidies, and contributions (41.0).....	3,095,554.866	2,975,647.424	(119,907.442)
Interest and dividends (43.0).....	62.896	68.000	5.104
Subtotal Non-Pay Costs	**3,420,323.512**	**3,278,328.440**	**(141,995.072)**
Total Direct Obligations	**3,496,935.000**	**3,355,669.000**	**(141,266.000)**

Health Surveillance and Program Support

(Dollars in Thousands)

Object Class - PHS EVAL Funds	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1).....	2,953.530	4,320.301	1,366.771
Other than full-time permanent (11.3).....	319.874	467.899	148.025
Other personnel compensation (11.5).....	6.122	8.955	2.833
Military personnel (11.7).....	578.737	730.655	151.918
Subtotal personnel compensation:	**3,858.263**	**5,527.810**	**1,669.547**
Civilian benefits (12.1).....	911.708	1,409.229	497.521
Military benefits (12.2).....	306.152	408.433	102.281
Subtotal Pay Costs:	**5,076.123**	**7,345.472**	**2,269.349**
Travel and transportation of persons (21.0).....	60.000	61.333	1.333
Communication, utilities, and misc. charges (23.3).....	56.667	57.667	1.000
Printing and reproduction (24.0).....	40.917	40.375	(0.542)
Other Contractual Services:			
Advisory and assistance services (25.1).....	1,799.887	1,799.887	-
Other services (25.2)(25.9).....	21,547.853	47,842.879	26,295.026
Purchase of Goods & Svcs. from Govt. Accts (25.3)..	1,799.887	1,799.887	-
Subtotal Other Contractual Services:	**25,147.627**	**51,442.652**	**26,295.026**
Supplies and materials (26.0).....	41.667	42.500	0.833
Equipment (31.0).....	5.000	5.000	-
Grants, subsidies, and contributions (41.0).....	---	-	-
Subtotal Non-Pay Costs	**25,351.877**	**51,649.528**	**26,297.651**
Total Reimbursable Obligations	**30,428.000**	**58,995.000**	**28,567.000**

Mental Health Services

(Dollars in Thousands)

Object Class - PHS EVAL Funds	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1).....	2,036.917	1,830.767	(206.150)
Other than full-time permanent (11.3).....	220.603	66.784	(153.819)
Other personnel compensation (11.5).....	4.222	18.818	14.596
Military personnel (11.7).....	144.684	76.539	(68.145)
Subtotal personnel compensation:	**2,406.426**	**1,992.907**	**(413.519)**
Civilian benefits (12.1).....	628.764	548.084	(80.680)
Military benefits (12.2).....	76.538	39.554	(36.984)
Subtotal Pay Costs:	**3,111.729**	**2,580.546**	**(531.182)**
Travel and transportation of persons (21.0).....	60.000	61.333	1.333
Communication, utilities, and misc. charges (23.3).....	56.667	57.667	1.000
Printing and reproduction (24.0).....	127.117	143.812	16.695
Other Contractual Services:			
Other services (25.2)(25.9).....	17,636.821	19,132.020	1,495.199
Subtotal Other Contractual Services:	**17,636.821**	**19,132.020**	**1,495.199**
Supplies and materials (26.0).....	41.667	42.500	0.833
Equipment (31.0).....	5.000	5.000	-
Grants, subsidies, and contributions (41.0).....	-	4,016.122	4,016.122
Subtotal Non-Pay Costs	**17,927.271**	**23,458.454**	**5,531.183**
Total Reimbursable Obligations	**21,039.000**	**26,039.000**	**5,000.000**

Substance Abuse Prevention

(Dollars in Thousands)

Object Class - PHS EVAL Funds	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1).....	---	---	---
Other than full-time permanent (11.3).....	---	---	---
Other personnel compensation (11.5).....	---	---	---
Military personnel (11.7).....	---	---	-
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	---	---	---
Civilian benefits (12.1).....	---	---	---
Military benefits (12.2).....	---	---	---
Benefits to former personnel (13.0).....	---	---	---
Subtotal Pay Costs:	---	---	-
Other Contractual Services:			
Advisory and assistance services (25.1).....	---	---	---
Other services (25.2)(25.9).....	---	8,762.204	8,762.204
Purchase of Goods & Svcs. from Govt. Accts (25.3).	---	---	---
Operation and maintenance of facilities (25.4).....	---	---	---
Research and Development Contracts (25.5).....	---	---	---
Medical care (25.6).....	---	---	---
Operation and maintenance of equipment (25.7).....	---	---	---
Subsistence and support of persons (25.8).....	---	---	---
Subtotal Other Contractual Services:	---	**8,762.204**	**8,762.204**
Grants, subsidies, and contributions (41.0)		7,705.796	7,705.796
Subtotal Non-Pay Costs	-	**7,705.796**	**7,705.796**
Total Reimbursable Obligations	-	**16,468.000**	**16,468.000**

Substance Abuse Treatment

(Dollars in Thousands)

Object Class - PHS EVAL Funds	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1).....	916.613	720.050	(196.563)
Other than full-time permanent (11.3).....	99.271	77.983	(21.288)
Other personnel compensation (11.5).....	1.900	1.492	(0.407)
Military personnel (11.7).....	85.359	73.066	(12.294)
Subtotal personnel compensation:	**1,103.143**	**872.591**	**(230.552)**
Civilian benefits (12.1).....	282.944	234.871	(48.072)
Military benefits (12.2).....	41.368	40.843	(0.525)
Subtotal Pay Costs:	**1,427.456**	**1,148.306**	**(279.149)**
Travel and transportation of persons (21.0).....	60.000	61.333	1.333
Communication, utilities, and misc. charges (23.3).....	56.667	57.667	1.000
Printing and reproduction (24.0).....	158.966	143.812	(15.154)
Other Contractual Services:			
Advisory and assistance services (25.1).....	1,691.649	1,691.649	-
Other services (25.2)(25.9).....	75,004.947	79,532.657	4,527.711
Purchase of Goods & Svcs. from Govt. Accts (25.3).	1,691.649	1,691.649	-
Subtotal Other Contractual Services:	**78,388.245**	**82,915.955**	**4,527.711**
Supplies and materials (26.0).....	41.667	42.500	0.833
Equipment (31.0).....	5.000	5.000	-
Grants, subsidies, and contributions (41.0).....	1,062.000	24,825.430	23,763.430
Subtotal Non-Pay Costs	**79,772.544**	**108,051.698**	**28,279.154**
Total Reimbursable Obligations	**81,200.000**	**109,200.004**	**28,000.004**

Summary PHS Evaluation Funds

(Dollars in Thousands)

Object Class - PHS EVAL Funds	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Direct Obligations:			
Personnel Compensation:			
Full Time Permanent (11.1)	5,907.060	6,871.119	964.059
Other than Full-Time Permanent (11.3)	639.749	612.666	(27.083)
Other Personnel Compensation (11.5)	12.244	29.265	17.021
Military Personnel Compensation (11.7)	808.780	880.259	71.479
Subtotal Personnel Compensation:	**7,367.833**	**8,393.309**	**1,025.476**
Civilian Personnel Benefits (12.1)	1,823.417	2,192.185	368.768
Military Personnel Benefits (12.2)	424.058	488.831	64.773
Subtotal Pay Costs:	**9,615.307**	**11,074.325**	**1,459.017**
Travel (21.0)	180.000	184.000	4.000
Communications, Utilities and Misc. Charges (23.3)	170.000	173.000	3.000
Printing and Reproduction (24.0)	327.000	328.000	1.000
Other Contractual Services:			
Advisory and assistance services (25.1)	3,491.536	3,491.536	-
Other services (25.2)(25.9)	114,189.621	152,975.555	38,785.935
Purchase of Goods & Svcs. from Govt. Accts (25.3)	3,491.536	3,491.536	-
Subtotal Other Contractual Services:	**121,172.693**	**159,958.627**	**38,785.935**
Supplies and Materials (26.0)	125.000	127.500	2.500
Equipment (31.0)	15.000	15.000	-
Grants, Subsidies, and Contributions (41.0)	1,062.000	38,841.552	37,779.552
Subtotal Non-Pay Costs	**123,051.692**	**199,627.679**	**76,575.987**
Total Reimbursable:	**132,667.000**	**210,702.004**	**78,035.005**

Salaries and Expenses Table

Direct Budget Authority
(Dollars in Thousands)

Object Class	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1)	51,339.457	50,755.667	(583.789)
Other than full-time permanent (11.3)	4,137.720	4,090.693	(47.027)
Other personnel compensation (11.5)	825.358	815.978	(9.381)
Military personnel (11.7)	3,175.037	3,390.032	214.995
Special personnel services payments (11.8)	40.208	41.615	1.407
Subtotal personnel compensation	**59,517.780**	**59,093.986**	**(423.794)**
Civilian benefits (12.1)	15,517.000	16,351.560	834.559
Military benefits (12.2)	1,576.707	1,895.014	318.307
Subtotal Pay Costs:	**76,611.487**	**77,340.560**	**729.072**
Travel (21.0)	1,230.385	1,235.000	4.615
Transportation of things (22.0)	7.000	7.000	-
Communication, utilities, and misc. charges (23.3)	713.418	723.000	9.582
Printing and reproduction (24.0)	1,345.928	1,355.000	9.072
Other Contractual Services:			-
Advisory and assistance services (25.1)	48,509.774	43,384.943	(5,124.831)
Other services (25.2)	197,600.018	177,619.079	(19,980.939)
Purch. Goods & Svcs. Govt. Accts (25.3)	63,271.053	62,248.819	(1,022.233)
Operation and maintenance of facilities (25.4)	861.000	871.000	10.000
Research and Development Contracts (25.5)	3,911.162	4,180.372	269.210
Operation and maintenance of equipment (25.7)	286.000	293.000	7.000
Subtotal Other Contractual Services:	**314,439.007**	**288,597.213**	**(25,841.794)**
Supplies and materials (26.0)	228.368	237.750	9.382
Subtotal Non-Pay Costs	**317,964.105**	**292,154.963**	**(25,809.142)**
Total Salary and Expenses	**394,575.592**	**369,495.522**	**(25,080.070)**
Rental Payments to GSA (23.1)	6,295.646	10,004.803	3,709.158
Grand Total, Salaries & Expenses and Rent	**400,871.238**	**379,500.326**	**(21,370.912)**
Direct FTE	555	546	(9)

Salaries and Expenses Table

PHS Evaluation Funds

(Dollars in Thousands)

Object Class - PHS EVAL Funds	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- FY 2014
Personnel compensation:				
Full-time permanent (11.1).....	4,529.620	5,907.060	6,871.119	964.059
Other than full-time permanent (11.3).....	490.569	639.749	612.666	(27.083)
Other personnel compensation (11.5).....	9.389	12.244	29.265	17.021
Military personnel (11.7).....	535.847	808.780	880.259	71.479
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**5,565.424**	**7,367.833**	**8,393.309**	**1,025.476**
Civilian benefits (12.1).....	1,412.797	1,823.417	2,192.185	368.768
Military benefits (12.2).....	312.703	424.058	488.831	64.773
Subtotal Pay Costs:	**7,290.924**	**9,615.307**	**11,074.325**	**1,459.017**
Travel (21.0).....	33.699	180.000	184.000	4.000
Communication, utilities, and misc. charges (23.3)..	-	170.000	173.000	3.000
Printing and reproduction (24.0).....	187.865	327.000	328.000	1.000
Other Contractual Services:				
Advisory and assistance services (25.1).....	-	3,491.536	3,491.536	-
Other services (25.2).....	117,560.432	114,189.621	152,975.555	38,785.935
Purch. Goods & Svcs. Govt. Accts (25.3).....	2,679.625	3,491.536	3,491.536	-
Subtotal Other Contractual Services:	**120,240.057**	**121,172.693**	**159,958.627**	**38,785.935**
Supplies and materials (26.0).....	-	125.000	127.500	2.500
Subtotal Non-Pay Costs	**120,461.622**	**121,974.692**	**160,771.127**	**38,796.435**
Total Salary and Expenses	**127,752.546**	**131,590.000**	**171,845.452**	**40,255.452**
Rental Payments to GSA (23.1).....	539.562	-	-	-
Grand Total, Salaries & Expenses and Rent	**128,292.108**	**131,590.000**	**171,845.452**	**40,255.452**
Reimbursable FTE(1).....	52	71	79	8

(1) Does not include Other reimbursable FTE's (30) and associated Object Class Cost.

Detail of Full Time Equivalent Employee (FTE)

	2013 Actual Civilian	2013 Actual. Military	2013 Actual Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total	2015 Est. Civilian	2015 Est. Military	2015 Est. Total
CMHS									
Direct:.....	99	9	108	103	9	112	105	9	114
Reimbursable:.....	18	2	20	21	2	23	21	2	23
Total:	118	11	128	124	11	135	126	11	137
CSAP									
Direct:.....	88	9	96	92	9	101	90	9	99
Reimbursable:.....	8	3	12	12	3	15	12	3	15
Total:	96	12	108	104	12	116	102	12	114
CSAT									
Direct:.....	102	10	112	105	10	115	104	10	114
Reimbursable:.....	4	---	4	5	---	5	5	---	5
Total:	106	10	116	110	10	120	109	10	119
OC									
Direct:.....	8	---	8	11	---	11	11	---	11
Reimbursable:.....	---	---	---	---	---	---	---	---	---
Total:	8	---	8	11	---	11	11	---	11
OA									
Direct:.....	7	---	7	8	---	8	8	---	8
Reimbursable:.....	---	---	---	---	---	---	---	---	---
Total:	7	---	7	8	---	8	8	---	8
OFR									
Direct:.....	67	2	68	73	2	75	73	1	74
Reimbursable:.....	8		8	9	---	9	9	---	9
Total:	75	2	77	82	2	84	82	1	83
CBHSQ									
Direct:.....	24	2	26	25	2	27	19	5	24
Reimbursable:.....	22	5	27	33	5	38	41	6	47
Total:	46	7	53	58	7	65	60	11	71
OPPI									
Direct:.....	39	1	40	43	1	44	40	1	41
Reimbursable:.....	5	1	6	5	1	6	5	1	6
Total:	44	2	46	48	2	50	45	2	47
OMTO									
Direct:.....	58	2	60	60	2	62	59	2	61
Reimbursable:.....	---	---	---	---	---	---	---	---	---
Total:	58	2	60	60	2	62	59	2	61
St. Elizabeths									
Direct:.....	---	---	---	---	---	---	---	---	---
Reimbursable:.....	---	4	4	---	4	4	---	4	4
Total:	---	4	4	---	4	4	---	4	4
SAMHSA Totals									
Direct:.....	**492**	**34**	**526**	**520**	**35**	**555**	**509**	**37**	**546**
Reimbursable:...	**66**	**16**	**82**	**85**	**15**	**100**	**93**	**16**	**109**
Total:	**558**	**50**	**608**	**605**	**50**	**655**	**602**	**53**	**655**

FY 2014
SAMHSA staffing increases reflect annualization of resources identified to contracts that were insourced in FY 2011. Additionally SAMHSA ability to backfill vacated positions due to attrition has been impacted by higher average of retirements than normal historical attrition would indicate for future planning.

FY 2015
SAMHSA staffing levels reflect optimal staffing levels necessary to achieve budget authority management and execution. Historical attrition rates and Human Resources hiring practices are utilized in overall forecast.

Average GS Grade

FY 2011.....	13/8
FY 2012.....	13/7
FY 2013.....	13/6
FY 2014.....	13/7
FY 2015.....	13/8

Detail of Positions

	FY 2013 Actual	FY 2014 Base	FY 2015 Budget
Executive Level IV	1	1	1
Subtotal	1	1	1
Total - Exec Level Salaries	**$155,500**	**$155,500**	**$155,500**
SES	10	13	13
Subtotal	10	13	13
Total, SES salaries	**$1,651,944**	**$2,169,002**	**$2,190,692**
GM/GS-15/EE	74	79	79
GM/GS-14	141	145	145
GM/GS-13	185	190	187
GS-12	62	64	64
GS-11	21	25	25
GS-10	1	1	1
GS-09	15	16	16
GS-08	23	25	25
GS-07	18	23	23
GS-06	14	18	18
GS-05	2	5	5
GS-04	0	0	0
GS-03	0	0	0
GS-02	0	0	0
Subtotal	556	591	588
Total, GS salaries	**$57,882,322**	**$63,529,560**	**$63,851,596**
CC-08/09	1	1	1
CC-07	0	0	0
CC-06	13	13	13
CC-05	16	16	16
CC-04	16	16	16
CC-03	4	4	7
CC-02	0	0	0
Subtotal	50	50	53
Total, CC salaries	**$4,421,830**	**$4,402,266**	**$4,606,711**
Total Positions [1/]	**617**	**655**	**655**
Average ES level	ES	ES	ES
Average ES salary	$155,500	$155,500	$155,500
Average SES level	SES	SES	SES
Average SES salary	$165,194	$166,846	$168,515
Average GS grade	13.6	13.7	13.8
Average GS salary	$104,105	$107,495	$108,591
Average CC level	4.5	4.4	4.2
Average CC salaries	$88,437	$88,045	$86,919

[1/] This figure represents on-board staff.

Programs Proposed for Elimination

The following table shows the programs proposed for elimination in the President's FY 2015 Budget Request. Termination of this program allows the agency to redirect approximately $50 million from the FY 2014 Enacted Level for health programs that have a demonstrated record of success or that hold significant promise for increasing accountability and improving health outcomes. Following the table is a brief summary of the program and rationale for its elimination.

Program	FY 2014 Enacted (in Millions)
Access to Recovery	$50.0

Access to Recovery (-$50.0 million)

SAMHSA is proposing eliminating the Access to Recovery (ATR) program in FY 2015. Many of the clinical services provided under ATR will now be covered by public and private insurance. In addition, states have been encouraged to support recovery support services and client choice with SABG funding. States that would like to continue this activity will have support from SAMHSA in FY 2014 in incorporating lessons learned from the successful test.

Federal Employment Funded by the Patient Protection and Affordable Care Act

Substance Abuse Mental Health Services Administration

(Dollars in Thousands)

Program	Section	FY 2011			FY 2012			FY 2013			FY 2014			FY 2015		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
Primary and Behavioral Health Care Integration																
Discretionary																
Mandatory	4002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sucide Prevention																
Discretionary																
Mandatory	4002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Surveillance																
Discretionary																
Mandatory	4002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Physician's Comparability Allowance Worksheet

	PY 2013 (Estimates)	CY 2014 (Estimates)	BY 2015 (Estimates)
1) Number of Physicians Receiving PCAs	4	4	4
2) Number of Physicians with One-Year PCA Agreements	---	---	---
3) Number of Physicians with Multi-Year PCA Agreements	4	4	4
4) Average Annual PCA Physician Pay (without PCA payment)	$143,236	$143,236	$147,179
5) Average Annual PCA Payment	$18,000	$18,000	$18,000
6) Number of Physicians Receiving PCAs by Category (non-add)	---	---	---
Category I Clinical Position	---	---	---
Category II Research Position	---	---	---
Category III Occupational Health	---	---	---
Category IV-A Disability Evaluation	---	---	---
Category IV-B Health and Medical Admin.	4	4	4

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.	N/A
8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.	$30.000.00 - based on years of education, experience and the position held by the incumbent. Amount is required to retain the employee.
9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).	SAMHSA does not have any medical officer vacancies at this time.
10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.	We have to offer PCAs in order to be competitive with the private sector. Salaries being offered by the Government are usually lower than the candidates are making on the outside and a PCA is the only way to raise the income and make the offer attractive.
11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.	

PRNS Mechanism Tables by SLOA

SAMHSA/Mental Health
PRNS Mechanism Table by SLOA
(Dollars in thousands)

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
CAPACITY:						
Seclusion and Restraint and Trauma						
Grants						
Continuations	---	$---	---	$---	---	$---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	---	1	1,150	1	1,001
New/Competing	1	2,121	---	---	---	148
Subtotal	1	2,121	1	1,150	1	1,149
Total, S & R & T	**1**	**2,121**	**1**	**1,150**	**1**	**1,149**
Youth Violence Prevention						
Grants						
Continuations	---	---	7	15,479	7	15,621
New/Competing	7	14,237	---	---	---	---
Subtotal	7	14,237	7	15,479	7	15,621
Contracts						
Continuations	---	1,947	2	7,302	5	7,535
New/Competing	3	5,761	3	375	---	---
Subtotal	3	7,708	5	7,677	5	7,535
Total, YVP	**10**	**21,945**	**12**	**23,156**	**12**	**23,156**
Project AWARE						
Grants						
Continuations	---	---	---	---	40	51,388
New/Competing	---	---	40	51,535	---	---
Subtotal	---	---	40	51,535	40	51,388
Contracts						
Continuations	---	---	---	---	---	3,612
New/Competing	---	---	---	3,465	---	---
Subtotal	---	---	---	3,465	---	3,612
Total, Project AWARE	**---**	**---**	**40**	**55,000**	**40**	**55,000**

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
National Child Traumatic Stress Network						
Grants						
Continuations	78	40,594	78	41,681	79	42,437
New/Competing	---	---	3	1,200	---	---
Subtotal	78	40,594	81	42,881	79	42,437
Contracts						
Continuations	---	2,728	---	2,934	---	3,277
New/Competing	---	---	---	184	---	---
Subtotal	---	2,728	---	3,119	---	3,277
Total, NCTSI	**78**	**43,322**	**81**	**46,000**	**79**	**45,714**
Children and Family Programs						
Grants						
Continuations	13	4,982	---	212	11	4,830
New/Competing	---	---	11	4,563	---	---
Subtotal	13	4,982	11	4,775	11	4,830
Contracts						
Continuations	2	1,479	---	572	2	1,644
New/Competing	---	---	2	1,127	---	---
Subtotal	2	1,479	2	1,699	2	1,644
Total, CFP	**15**	**6,461**	**13**	**6,474**	**13**	**6,474**
Healthy Transitions						
Grants						
Continuations	---	---	---	---	16	15,687
New/Competing	---	---	16	15,740	---	---
Subtotal	---	---	16	15,740	16	15,687
Contracts						
Continuations	---	---	---	---	2	4,313
New/Competing	---	---	2	4,260	---	---
Subtotal	---	---	2	4,260	2	4,313
Total, Healthy Transitions	**---**	**---**	**18**	**20,000**	**18**	**20,000**
Consumer and Family Network Grants						
Grants						
Continuations	17	1,148	56	3,856	43	3,108
New/Competing	44	3,756	4	400	12	1,176
Subtotal	61	4,904	60	4,256	55	4,283
Contracts						
Continuations	1	1,237	---	710	---	683
New/Competing	---	---	---	---	---	---
Subtotal	1	1,237	---	710	---	683
Total, CFN	**62**	**6,140**	**60**	**4,966**	**55**	**4,966**

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
Project LAUNCH						
Grants/Cooperative Agreements						
Continuations	29	23,312	22	18,688	30	26,364
New/Competing	5	5,572	14	11,571	4	3,806
Subtotal	34	28,884	36	30,259	34	30,170
Contracts						
Continuations	---	1,999	1	4,151	1	4,470
New/Competing	1	1,945	---	230	---	---
Subtotal	1	3,944	1	4,381	1	4,470
Total, LAUNCH	**35**	**32,829**	**37**	**34,640**	**35**	**34,640**
MH System Transformation and Health Reform						
Grants						
Continuations	31	8,551	20	6,429	5	1,997
New/Competing	---	---	5	2,197	38	6,777
Subtotal	31	8,551	25	8,626	43	8,774
Contracts						
Continuations	2	1,897	1	1,956	1	1,808
New/Competing	---	---	---	---	---	---
Subtotal	2	1,897	1	1,956	1	1,808
Total, MH-STHR	**33**	**10,448**	**26**	**10,582**	**44**	**10,582**
Primary and Behavioral Health Care Integration						
Grants						
Continuations	52	24,179	16	6,185	34	13,266
New/Competing	7	2,793	39	40,665	---	11,030
Subtotal	59	26,972	55	46,850	34	24,296
Contracts						
Continuations	---	93	---	3,150	---	1,708
New/Competing	---	1,576	---	---	---	---
Subtotal	---	1,669	---	3,150	---	1,708
Total, PBHCI	**59**	**28,641**	**55**	**50,000**	**34**	**26,004**
National Strategy for Suicide Prevention						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	---	---	---	---	2,142
New/Competing	---	---	1	2,000	---	1,858
Subtotal	---	---	1	2,000	---	4,000
Total, NSSP	**---**	**---**	**1**	**2,000**	**---**	**4,000**

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
Suicide Lifeline						
Grants						
Continuations	7	4,059	13	4,389	12	690
New/Competing	12	890	---	1,440	1	3,700
Subtotal	19	4,948	13	5,829	13	4,390
Contracts						
Continuations	---	963	---	348	---	1,122
New/Competing	---	174	---	1,035	---	---
Subtotal	---	1,137	---	1,383	---	1,122
Total, Suicide Lifeline [1/]	**19**	**6,085**	**13**	**7,212**	**13**	**5,512**
GLS- Youth Suicide Prevention - States						
Grants						
Continuations	54	25,182	27	12,251	31	20,452
New/Competing	7	3,015	24	17,678	3	2,136
Subtotal	61	28,196	51	29,929	34	22,588
Contracts						
Continuations	1	4,127	---	2,124	1	5,094
New/Competing	---	125	1	3,447	---	---
Subtotal	1	4,252	1	5,571	1	5,094
Total, GLS-States [1/]	**62**	**32,448**	**52**	**35,500**	**35**	**27,682**
GLS- Youth Suicide Prevention - Campus						
Grants						
Continuations	40	3,776	41	3,864	33	3,208
New/Competing	22	2,959	15	1,409	6	614
Subtotal	62	6,735	56	5,273	39	3,822
Contracts						
Continuations	---	1,648	---	416	---	1,144
New/Competing	---	492	---	811	---	---
Subtotal	---	2,139	---	1,227	---	1,144
Total, GLS-Campus	**62**	**8,875**	**56**	**6,500**	**39**	**4,966**

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
GLS - Suicide Prevention Resource Center						
Grants						
Continuations	1	4,471	1	4,471	---	---
New/Competing	---	583	---	1,154	1	4,623
Subtotal	1	5,054	1	5,625	1	4,623
Contracts						
Continuations	---	285	---	315	---	---
New/Competing	---	---	---	61	---	325
Subtotal	---	285	---	375	---	325
Total, SPRC	**1**	**5,339**	**1**	**6,000**	**1**	**4,948**
AI/AN Suicide Prevention Initiative						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	521	1	2,571	1	2,677
New/Competing	1	2,264	---	367	---	261
Subtotal	1	2,785	1	2,938	1	2,938
Total, AI/AN	**1**	**2,785**	**1**	**2,938**	**1**	**2,938**
Homelessness Prevention Programs						
Grants						
Continuations	79	22,468	24	6,542	31	18,266
New/Competing	11	550	31	17,716	15	5,242
Subtotal	90	23,018	55	24,258	46	23,508
Contracts						
Continuations	2	6,145	2	4,214	3	6,514
New/Competing	---	---	1	2,300	---	750
Subtotal	2	6,145	3	6,514	3	7,264
Total, HPP	**92**	**29,162**	**58**	**30,772**	**49**	**30,772**

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
Minority AIDS						
Grants						
Continuations	11	7,257	---	---	36	7,689
New/Competing	---	83	36	7,689	12	6,111
Subtotal	11	7,340	36	7,689	48	13,800
Contracts						
Continuations	2	1,441	---	583	2	2,470
New/Competing	---	---	2	975	---	---
Subtotal	2	1,441	2	1,558	2	2,470
Total, MAI	**13**	**8,781**	**38**	**9,247**	**50**	**16,270**
Grants for Adult Trauma Screening & Brief Intervention						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	4	2,706
Subtotal	---	---	---	---	4	2,706
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	190
Subtotal	---	---	---	---	---	190
Total, GATSBI	**---**	**---**	**---**	**---**	**4**	**2,896**
Criminal and Juvenile Justice Programs						
Grants						
Continuations	7	2,754	1	394	14	2,497
New/Competing	3	2,000	14	2,497	---	---
Subtotal	10	4,754	15	2,891	14	2,497
Contracts						
Continuations	2	1,123	1	989	2	1,713
New/Competing	---	---	---	400	---	70
Subtotal	2	1,123	1	1,389	2	1,783
Total, CJJP	**12**	**5,877**	**16**	**4,280**	**16**	**4,280**
Tribal Behavoiral Health Grants						
Grants						
Continuations	---	---	---	---	20	4,016
New/Competing	---	---	20	3,885	---	---
Subtotal	---	---	20	3,885	20	4,016
Contracts						
Continuations	---	---	---	---	---	984
New/Competing	---	---	---	1,115	---	---
Subtotal	---	---	---	1,115	---	984
Total, TBHG	**---**	**---**	**20**	**5,000**	**20**	**5,000**
Subtotal, CAPACITY	**555**	**251,259**	**599**	**361,417**	**559**	**336,949**

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
SCIENCE AND SERVICE:						
Practice Improvement Training						
Grants						
Continuations	---	215	---	---	6	2,906
New/Competing	---	---	6	2,902	---	---
Subtotal	---	215	6	2,902	6	2,906
Contracts						
Continuations	8	7,039	3	2,153	9	4,941
New/Competing	---	159	7	2,792	---	---
Subtotal	8	7,198	10	4,945	9	4,941
Total, PIT	**8**	**7,413**	**16**	**7,847**	**15**	**7,847**
Consumer and Consumer Supporter Technical Assistance Centers						
Grants						
Continuations	5	1,775	5	1,777	---	---
New/Competing	---	---	---	---	5	1,797
Subtotal	5	1,775	5	1,777	5	1,797
Contracts						
Continuations	---	100	---	146	---	---
New/Competing	---	---	---	---	---	126
Subtotal	---	100	---	146	---	126
Total, CCSTAC	**5**	**1,875**	**5**	**1,923**	**5**	**1,923**
Primary and Behavioral Health Care Integration TA						
Grants						
Continuations	1	1,886	---	---	1	1,865
New/Competing	---	---	1	1,870	---	---
Subtotal	1	1,886	1	1,870	1	1,865
Contracts						
Continuations	---	106	---	---	---	131
New/Competing	---	---	---	126	---	---
Subtotal	---	106	---	126	---	131
Total, PBHCI TA	**1**	**1,992**	**1**	**1,996**	**1**	**1,996**

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
Disaster Response						
Grants						
Continuations	---	---	---	---	1	936
New/Competing	---	---	1	936	---	900
Subtotal	---	---	1	936	1	1,836
Contracts						
Continuations	1	997	---	273	1	1,114
New/Competing	---	---	1	749	---	---
Subtotal	1	997	1	1,022	1	1,114
Total, Disaster Response	**1**	**997**	**2**	**1,958**	**2**	**2,950**
Homelessness						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	2	2,181	1	1,102	1	2,302
New/Competing	---	---	---	1,200	---	---
Subtotal	2	2,181	1	2,302	1	2,302
Total, Homelessness	**2**	**2,181**	**1**	**2,302**	**1**	**2,302**
HIV/AIDS Education						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	3	791	---	---	3	773
New/Competing	---	---	3	773	---	---
Subtotal	3	791	3	773	3	773
Total, HIV/AIDS	**3**	**791**	**3**	**773**	**3**	**773**
Subtotal, SCIENCE AND SERVICE	**20**	**15,249**	**28**	**16,799**	**27**	**17,791**
TOTAL, MH PRNS	**575**	**$266,509**	**627**	**$378,216**	**586**	**$354,740**

1/In the FY 2015 Request, the Mental Health Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

SAMHSA/Substance Abuse Prevention
PRNS Mechanism Table by SLOA
(Dollars in thousands)

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
CAPACITY:						
Strategic Prevention Framework						
Grants						
Continuations	39	$60,068	28	$43,960	51	$78,272
New/Competing	17	30,981	34	47,292	85	22,007
Supplements	17	3,900	15	2,175	---	---
Subtotal	73	94,949	77	93,427	136	100,279
Contracts						
Continuations	5	7,812	10	16,077	7	16,059
New	5	5,142	1	250	3	3,415
Subtotal	10	12,953	11	16,327	10	19,475
Total, Strategic Prevention Framework	**83**	**$107,902**	**88**	**$109,754**	**146**	**$119,754**
Mandatory Drug Testing						
Contracts						
Continuations	2	2,179	2	4,065	3	4,443
New	2	3,072	2	841	1	463
Subtotal	4	5,252	4	4,906	4	4,906
Total, Mandatory Drug Testing	**4**	**$5,252**	**4**	**$4,906**	**4**	**$4,906**
Minority AIDS						
Grants						
Continuations	65	19,538	80	23,766	48	17,999
New/Competing	29	14,334	23	9,348	40	17,133
Subtotal	94	33,872	103	33,115	88	35,131
Contracts						
Continuations	12	6,716	3	7,692	3	6,176
New	3	407	2	500	---	---
Subtotal	15	7,123	5	8,192	3	6,176
Total, Minority AIDS	**109**	**$40,996**	**108**	**$41,307**	**91**	**$41,307**
Sober Truth on Preventing Underage Drinking Act						
Grants						
Continuations	80	3,838	97	4,646	97	4,643
New/Competing	17	804	---	---	---	---
Subtotal	97	4,642	97	4,646	97	4,643
Contracts						
Continuations	1	1,362	1	1,367	1	1,449
New	1	989	1	987	1	907
Subtotal	2	2,352	2	2,354	2	2,357
Total, STOP	**99**	**6,994**	**99**	**7,000**	**99**	**7,000**
Subtotal, CAPACITY	**295**	**$161,143**	**299**	**$162,967**	**340**	**$172,967**

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
SCIENCE AND SERVICE:						
Fetal Alcohol Center of Exellence						
Contracts						
Continuations	---	$508	1	$1,000	1	$1,000
New	1	595	---	---	---	---
Subtotal	1	1,104	1	1,000	1	1,000
Total, Fetal Alcohol Center of Exellence	**1**	**1,104**	**1**	**1,000**	**1**	**1,000**
Center for the Application of Prevention Technologies						
Contracts						
Continuations	1	8,098	1	7,511	---	306
New	---	---	---	---	1	7,205
Subtotal	1	8,098	1	7,511	1	7,511
Total, Center for the Application of Prevention Technologies	**1**	**8,098**	**1**	**7,511**	**1**	**7,511**
Science & Service Program Coordination						
Contracts						
Continuations	4	4,099	4	1,823	5	4,082
New	5	1,070	1	2,259	---	---
Subtotal	9	5,168	5	4,082	5	4,082
Total, Science & Service Program Coordination	**9**	**5,168**	**5**	**4,082**	**5**	**4,082**
Subtotal, SCIENCE AND SERVICE	**11**	**14,369**	**7**	**12,593**	**7**	**12,593**
Total, CSAP [1/]	**306**	**$175,513**	**306**	**$175,560**	**347**	**$185,560**

1/In the FY 2015 Request, the CSAP Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by SLOA
(Dollars in thousands)

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
CAPACITY:						
Opioid Treatment Programs/Regulatory Activities						
Grants						
Continuations	1	$500	2	$1,398	2	$2,400
New/Competing	33	5,315	1	1,000	---	---
Subtotal	34	5,815	3	2,398	2	2,400
Contracts						
Continuations	5	4,562	6	4,997	4	5,510
New/Competing	3	2,045	---	1,352	3	836
Subtotal	8	6,607	6	6,348	7	6,346
Total, Opioid Treatment Programs/Regulatory Activities	**42**	**12,421**	**9**	**8,746**	**9**	**8,746**
Screening, Brief Intervention and Referral to Treatment						
Grants						
Continuations	12	12,194	22	19,923	22	19,919
New/Competing	19	29,575	10	18,407	12	3,844
Subtotal	31	41,769	32	38,330	34	23,763
Contracts						
Continuations	1	5,238	---	4,036	1	6,237
New/Competing	---	457	1	4,634	---	---
Subtotal	1	5,695	1	8,670	1	6,237
Total, Screening, Brief Intervention and Referral to Treatment	**32**	**47,464**	**33**	**47,000**	**35**	**30,000**
TCE - General						
Grants						
Continuations	30	8,033	29	7,611	30	7,672
New/Competing	33	10,595	2	800	---	---
Subtotal	63	18,628	31	8,411	30	7,672
Contracts						
Continuations	5	6,932	1	3,338	2	4,816
New/Competing	1	956	---	1,508	2	2,769
Subtotal	6	7,889	1	4,845	4	7,584
Total, TCE - General	**69**	**26,516**	**32**	**13,256**	**34**	**15,256**

Programs of Regional & National Significance	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Pregnant & Postpartum Women						
Grants						
Continuations	26	12,579	6	3,073	17	8,884
New/Competing	---	---	17	8,884	9	4,452
Subtotal	26	12,579	23	11,957	26	13,336
Contracts						
Continuations	---	2,382	---	3,256	1	2,455
New/Competing	---	674	1	757	---	178
Subtotal	---	3,056	1	4,013	1	2,634
Total, Pregnant & Postpartum Women	**26**	**15,634**	**24**	**15,970**	**27**	**15,970**
Strengthening Treatment Access and Retention						
Contracts						
Continuations	1	1,584	---	1,585	---	1,000
New/Competing	---	---	---	83	---	---
Subtotal	1	1,584	---	1,668	---	1,000
Total, Strengthening Treatment Access and Retention	1	**1,584**	---	**1,668**	---	**1,000**
Recovery Community Services Program						
Grants						
Continuations	5	1,749	---	---	10	1,000
New/Competing	---	---	18	1,400	---	---
Subtotal	5	1,749	18	1,400	10	1,000
Contracts						
Continuations	---	696	---	530	1	921
New/Competing	---	---	1	510	---	519
Subtotal	---	696	1	1,040	1	1,440
Total, Recovery Community Services Program	**5**	**2,445**	**19**	**2,440**	**11**	**2,440**
Access to Recovery						
Grants						
Continuations	29	87,486	---	---	---	---
New/Competing	2	328	---	46,969	---	---
Subtotal	31	87,814	---	46,969	---	---
Contracts						
Continuations	---	5,314	---	3,031	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	5,314	---	3,031	---	---
Total, Access to Recovery	**31**	**93,128**	**---**	**50,000**	**---**	**---**
Primary Care and Addiction Services Integration						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	68	18,687
Subtotal	---	---	---	---	68	18,687
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	1,313
Subtotal	---	---	---	---	---	1,313
Total, Primary Care and Addiction Services Integration	---	---	---	---	**68**	**20,000**

Programs of Regional & National Significance	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Children and Family Programs						
Grants						
Continuations	13	12,818	23	21,954	10	9,112
New/Competing	10	9,103	---	---	13	13,893
Subtotal	23	21,920	23	21,954	23	23,005
Contracts						
Continuations	2	6,629	2	5,513	2	6,673
New/Competing	---	469	---	2,211	---	---
Subtotal	2	7,098	2	7,724	2	6,673
Total, Children and Family Programs	**25**	**29,018**	**25**	**29,678**	**25**	**29,678**
Treatment Systems for Homeless						
Grants						
Continuations	71	26,560	34	15,732	50	26,995
New/Competing	11	7,157	39	20,029	12	8,771
Subtotal	82	33,717	73	35,760	62	35,765
Contracts						
Continuations	2	5,680	3	5,430	2	5,723
New/Competing	---	---	1	298	---	---
Subtotal	2	5,680	4	5,728	2	5,723
Total, Treatment Systems for Homeless	**84**	**39,397**	**77**	**41,488**	**64**	**41,488**
Minority AIDS						
Grants						
Continuations	79	35,936	87	43,480	102	50,892
New/Competing	35	17,870	18	11,584	---	---
Subtotal	114	53,807	105	55,064	102	50,892
Contracts						
Continuations	2	6,608	2	10,468	2	7,967
New/Competing	1	1,503	---	200	---	---
Subtotal	3	8,112	2	10,668	2	7,967
Total, Minority AIDS	**117**	**61,918**	**107**	**65,732**	**104**	**58,859**
Criminal Justice Activities						
Grants						
Continuations	117	34,137	133	42,130	122	38,663
New/Competing	55	18,715	70	20,935	57	15,058
Subtotal	172	52,852	203	63,065	179	53,721
Contracts						
Continuations	3	10,182	1	9,648	1	10,550
New/Competing	---	524	---	2,287	---	175
Subtotal	3	10,706	1	11,935	1	10,725
Total, Criminal Justice Activities	**175**	**63,558**	**204**	**75,000**	**180**	**64,446**
Subtotal, CAPACITY	**607**	**393,085**	**530**	**350,978**	**557**	**287,883**

Programs of Regional & National Significance	FY 2013 Final No.	FY 2013 Final Amount	FY 2014 Enacted No.	FY 2014 Enacted Amount	FY 2015 President's Budget No.	FY 2015 President's Budget Amount
SCIENCE AND SERVICE:						
Addiction Technology Transfer Centers						
Grants						
Continuations	15	8,527	15	8,476	15	7,550
New/Competing	---	---	---	---	---	---
Subtotal	15	8,527	15	8,476	15	7,550
Contracts						
Continuations	---	481	---	570	---	531
New/Competing	---	---	---	---	---	---
Subtotal	---	481	---	570	---	531
Total, Addiction Technology Transfer Centers	**15**	**9,008**	**15**	**9,046**	**15**	**8,081**
Special Initiatives/Outreach						
Grants						
Continuations	1	300	1	300	1	300
New/Competing	---	---	---	---	---	---
Subtotal	1	300	1	300	1	300
Contracts						
Continuations	2	681	---	225	2	1,136
New/Competing	1	1,010	1	911	---	---
Subtotal	3	1,692	1	1,136	2	1,136
Total, Special Initiatives/Outreach	**4**	**1,992**	**2**	**1,436**	**3**	**1,436**
Subtotal, SCIENCE AND SERVICE	**19**	**11,000**	**17**	**10,482**	**18**	**9,517**
Total, CSAT PRNS [1/]	**626**	**$404,085**	**547**	**$361,460**	**575**	**$297,400**

1/In the FY 2015 Request, the CSAT Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

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Substance Abuse and Mental Health Services Administration
SIGNIFICANT ITEMS IN SENATE REPORT

FY 2015 Consolidated Senate Report Language
(Senate Report 113-71)

General Items

Item

The Committee is disappointed that the administration has continued to use the **Substance Abuse Prevention and Treatment [SAPT] Block Grant and the MHBG** as sources for program evaluation transfers pursuant to section 241 of the PHS Act. The Committee directs SAMHSA and the Department to exempt these two programs from being used as a source for PHS evaluation transfers in fiscal year 2014, as was done prior to fiscal year 2012. (Page 111)

Action taken or to be taken

Consistent with Congressional direction, the Substance Abuse Prevention and Treatment Block Grant and Mental Health Block Grant are exempt from being used as a source for PHS evaluation transfers in fiscal year 2014. The 2015 President's Budget continues this exemption in 2015.

Item

The Committee is concerned that the combined block grant application for fiscal years 2014-2015 does not make clear that, in the absence of congressional action, using funds to improve provider enrollment and billing practices is an allowable use of funds but is not a requirement. The Committee directs SAMHSA to clarify with State mental health and substance abuse authorities which block grant activities are required and which are optional. (Page 111-112)

Action taken or to be taken

The FY14-15 block grant application asked states to set-aside five percent of the MHBG for implementation of evidence-based practices and three percent of their SABG and MHBG allocations to improve provider business practices, including billings systems, and to support enrollment into health insurance for eligible individuals served in the public service system. The block grant application does not require that the states conduct this activity.

This clarification has been provided to the State mental health and substance abuse authorities in several different ways and through several mechanisms. SAMHSA had included this clarification in several conference calls and informational webinars with the state authorities, mental health block grant planners and the two national organizations, NASADAD and NASMHPD; through ongoing communication between the SAMHSA state project officers and state block grant coordinators; and in the online instructions in the web based application itself.

Item

Primary and Behavioral Healthcare Integration - The Committee provides funding for this program through budget authority rather than through transfers from the PPH Fund as requested by the administration. The Committee continues to direct SAMHSA to ensure that new Integration grants awarded for fiscal year 2014 are funded under the authorities in section 520K of the PHS Act. (Page 113)

Action taken or to be taken

In FY 2014, SAMHSA plans to fund approximately 40 new grants under section 520K of the PHS Act.

Item

Psychotropic Medications and Children - The Committee has become increasingly concerned about the safe, appropriate, and effective use of psychotropic medications and children, particularly children in foster care settings. According to a December 2012 GAO report, an alarming 18 percent of foster children are prescribed psychotropic medications, compared with 4.8 percent of privately insured children. The Committee strongly encourages SAMHSA to establish meaningful partnerships with Medicaid, the foster care program, medical specialty societies, and treatment centers to develop new strategies for treating this vulnerable population. The Committee would like an update in next year's congressional justification on the steps SAMHSA has taken to promote the most effective and appropriate treatment approaches, including the use of evidence-based psychosocial therapies instead of, or in combination with, psychotropic medications. (Page 113)

Action taken or to be taken

SAMHSA has taken a significant leadership role to address the safe, effective and appropriate use of psychotropic medication in children and youth. The agency has collaborated extensively with the Administration on Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS) to address this issue for children in foster care; has partnered with professional groups to create more stringent guidelines related to prescribing and medication oversight practices; and has worked closely with parents and youth to improve consumer decision-making with regards to the use of medications. Below reflect a number of activities and developments that SAMHSA has been engaged in to address the issue.

SAMHSA supported the American Academy of Child and Adolescent Psychiatry's (AACAP) development of guidelines on issues that community agencies should address when prescribers are considering the use of psychotropic medications. Titled, "A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents," this document provides information to community agencies about safely and effectively prescribing psychotropic medications, describes the phases in treatment when medication could be considered part of an overall treatment plan, and provides information about the use of community based alternatives that child serving systems and agencies should consider in addition to psychotropic medications. SAMHSA has also collaborated with AACAP to support a

Child and Adolescent Psychiatry Fellow at SAMHSA one day a week (20% FTE). For the past four years each Fellow has undertaken a project to improve psychiatric service delivery, connect with community agencies and organizations, and identify evidence-based treatment strategies. Perhaps one of the most significant advances SAMHSA has helped to support has been the development of a Youth Advisory Group at AACAP that provides advice, guidance and information about medication use and empowers youth to make their own informed decisions regarding using medications. One accomplishment supported through this youth group was the development and expansion of the AACAP website as a resource to youth and families. Via a simple click on the "families and youth" toolbar on the AACAP homepage, youth and families can obtain a wealth of resources that include a section on how to choose a child and adolescent psychiatrist; "Facts for Families" on a wide range of topics; a patient education section that provides information about mental health conditions; and an entire section dedicated to youth resources. Going forward, SAMHSA will be continuing its efforts to address the importance of using psychotropic medications safely and effectively in collaboration with AACAP.

In addition to the work with AACAP, SAMHSA has also supported efforts by the Center for Health Care Strategies of the Robert Wood Johnson Foundation to provide technical assistance on strategies to improve oversight of psychotropic medication use in foster children. The technical assistance has included a webinar series, "Psychotropic Medication Use among Children in Foster Care: Technical Assistance Webinar Series." As part of this series, in September of 2013, a webinar was held titled, "The Use and Financing of Non-Pharmacologic Evidence-Based Practices: Alternatives to Psychotropic Medications." Evidence-based psychosocial interventions were identified that may offer a more comprehensive and cost-effective means of addressing behavioral health and social challenges experienced by children and youth in foster care, as well as other child populations with significant behavioral health challenges. SAMHSA also supported the Center for Health Care Strategies recently released "Faces of Medicaid Analysis," which identified areas to improve behavioral health treatment, including the use of psychotropic medications and alternative approaches.

SAMHSA was also one of the sponsors of an Administration on Children Youth and Families conference and dialogue about the appropriate use of psychotropic medication for foster children. SAMHSA provided training to nearly 100 early career child and adolescent psychiatrists on community and public sector psychiatry, systems of care and youth and family engagement.

As part of SAMHSA's ongoing commitment, SAMHSA will maintain its meaningful partnerships with other federal agencies, guilds and organizations to further the important agenda to address psychotropic medication use in America's children and youth.

Item

One promising model that seeks to address serious mental illness at an early stage is called **First Episode Psychosis [FEP]**, currently being used in Canada, the United Kingdom, and Australia. This early treatment model may help reduce symptoms, reduce relapse rates, and prevent deterioration of cognitive function in individuals suffering from psychotic illness. The 5 percent set-aside will provide $24,817,000 to programs such as FEP. The Committee provides an increase to the block grant over the fiscal year 2013 level to help States meet this new

requirement without losing funding for existing services. The Committee directs SAMHSA to collaborate with NIMH in developing guidelines to States regarding effective programs funded by this set-aside. (Page 114)

Action taken or to be taken

SAMHSA supports States' efforts to address the identification and referral of individuals experiencing first episode psychosis (FEP) in order to substantially reduce the duration of untreated psychosis. SAMHSA has been involved for some time in an ongoing collaboration with NIMH directed toward the goals of the FEP model. SAMHSA staff has received training and consultation on the Recovery After an Initial Schizophrenia Episode (RAISE) project that is designed to change the identification and treatment of this illness to reduce the likelihood of long term disability and promote productive and independent lives. SAMHSA has already engaged with State Mental Health Authorities to discuss the upcoming guidance and necessary updates to each state's Block Grant Plan for FY 2014. SAMHSA will continue to work with NIMH to assure that states have access to information relating to the RAISE project and other research-based early intervention programs to address serious mental illness.

Item

Addiction Technology Transfer Centers [ATTCs] - The Committee continues to direct SAMHSA to ensure ATTCs continue to maintain a primary focus on addiction treatment and recovery services in order to strengthen the addiction workforce. (Page 116)

Action taken or to be taken

SAMHSA ensures ATTCs continue to maintain a primary focus on addiction treatment and recovery services in order to strengthen the addiction workforce. The target audience of the ATTCs includes both those members of the workforce who work in traditional substance abuse treatment settings and those members who provide services to individuals with substance use disorders in other behavioral health and primary health care locations.

Through ongoing discussions with state authorities, treatment provider associations, addiction counselors, multidisciplinary behavioral health and primary health care professionals, and faith-based and recovery community leaders, the ATTCs assess the training and development needs of those providing substance abuse treatment services in their regions. The focus of the training and technical assistance provided by the ATTCs is on increasing knowledge and improving skills in the use of evidence-based and promising treatment/recovery practices in recovery-oriented systems of care.

The ATTCs are the primary mechanisms through which SAMHSA focuses on building the addiction workforce's capacity in terms of both the number of members in the workforce and the competencies and qualifications of those members. ATTCs are located in each of the ten Department of Health and Human Services' regions. In addition to the ten regional centers, SAMHSA funds four national focus area ATTCs: the National American Indian and Alaskan

Native ATTC, the National Frontier and Rural ATTC, the National Hispanic and Latino ATTC, and the National Screening, Brief Intervention and Referral to Treatment ATTC.

Item

Addiction Workforce - The Committee notes that several studies conducted over the past decade suggest that lack of information about the addiction field and the perception that addiction counselors are not viewed as a valued profession appear to be recruitment barriers for the addiction workforce. This is particularly concerning given that the demand for substance abuse services is anticipated to increase in the coming years as a result of the ACA and the Mental Health Parity and Addictions Equity Act. The Committee strongly urges SAMHSA to work with community colleges, universities, and State substance abuse agencies to develop ways to encourage individuals to enter the addiction prevention, treatment, and recovery workforce. (Page 116)

Action taken or to be taken

SAMHSA's primary vehicle for addressing substance abuse treatment practice improvement issues is the Addiction Technology Transfer Centers (ATTC) program. The ATTCs seek to increase the numbers of individuals in the workforce and to promote the adoption of research-based treatment interventions. By increasing the science-base of the methodologies employed by the addictions treatment workforce, individuals in the substance abuse treatment workforce increase their competencies and the likelihood of preferred client outcomes. These efforts help to elevate the profession in the eyes of stakeholders to retain those in the workforce and to attract new members. The ATTCs seek to increase the number of individuals entering the addiction workforce through adoption and implementation of pre-service strategies. Thirteen of the fifteen ATTCs are situated in Universities, including one historically African American university and one Hispanic university. The ATTC staffs, located on these campuses, are faculty members who teach relevant classes in behavioral health theory and practice, and support the development of curricula that will prepare students for service in the behavioral/addiction treatment workforce. The ATTC network also has a standing committee on Pre-Service Education. This committee seeks to reach out to universities and colleges in the ten Department of Health and Human Service regions, and advocate for curriculum/course tracks in behavioral health care. The National American Indian and Alaska Native ATTC works with Tribal Universities and Colleges to ensure access to courses that will help American Indians and Alaska Natives meet certification requirements in their states and enable them to pass the necessary tests. A combination of this effort along with the efforts of the National Hispanic and Latino ATTC, the presence of the ATTC at Historically Black Colleges and Universities, and other SAMHSA initiatives reflect its focus on increasing the diversity of the behavioral health workforce.

In addition, in September 2013, SAMHSA convened two workforce meetings including: a stakeholder listening session with national organizations and guilds with the goal of developing an initial roadmap for strengthening the behavioral health workforce, and a second meeting which addressed strategies for integrating peers, paraprofessionals and community health workers in the behavioral health and broader healthcare workforce. Summary reports from each of these meetings are in final stages of development.

SAMHSA is using 2014 Minority Fellowship Program funds to support the training of addiction counselors with a focus on those planning to work with youth ages 16-25. SAMHSA is also partnering with HRSA to expand its Behavioral Health Workforce Education and Training Program to include paraprofessional workers such as recovery coaches and mental health/ addition specialists.

Further, working collaboratively with HRSA, SAMHSA will use FY 2014 funds to provide internship support for Master's level psychologists, professional counselors, social workers, marriage and family therapists, psychology doctoral interns and behavioral health paraprofessionals.

Item

Drug Treatment Courts **-** The Committee continues to direct SAMHSA to ensure that all funding appropriated for Drug Treatment Courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. The Committee expects CSAT to ensure that non-State substance abuse agency applicants for any drug treatment court grant in its portfolio continue to demonstrate extensive evidence of working directly and extensively with the corresponding State substance abuse agency in the planning, implementation, and evaluation of the grant. (Page 116)

Action taken or to be taken

SAMHSA will ensure their FY 2014 drug court grant solicitations contain language requiring funds to be used to serve people diagnosed with a substance use disorder as their primary condition. In addition, language will be included to assure all non-State substance abuse agency applicants have demonstrated evidence of working directly and extensively with the corresponding state alcohol and drug abuse agency in the planning, implementation and evaluation of the grant.

Item

Infectious Disease Testing **-** The Committee remains concerned by the high incidence of viral hepatitis and HIV among the populations that SAMHSA serves. The Committee encourages SAMHSA to continue to support hepatitis and HIV testing within its activities and to utilize rapid tests to encourage patient receipt of results. In addition, SAMHSA is encouraged to continue surveillance of these activities in order to monitor the progress of infectious diseases screening. (Page 116)

Action taken or to be taken

SAMHSA will maintain the requirement that substance abuse treatment programs which receive funding from CSAT perform HIV testing with all clients, and HIV case management of HIV positive clients who participate in SAMHSA's Minority AIDS Initiative-funded programs. SAMHSA allows grantees in certain substance abuse treatment programs to utilize up to 5

percent of their funds to provide viral hepatitis testing. For those grantees that provide hepatitis testing, SAMHSA offers technical assistance to build their capacity to provide hepatitis case management services including confirmatory testing and referral to treatment. All new CSAT Request for Applications (RFAs) will require that substance abuse treatment clients be tested for HIV and hepatitis. All new HIV Continuum of Care grants will also require hepatitis testing.

Item

Minority AIDS Initiative **-** The Committee rejects the administration request to move funds to CMHS from the Minority AIDS Initiative administered by CSAT. The Committee urges SAMHSA to focus its efforts on building capacity and outreach to individuals at risk for or with a primary substance use disorder and to improve efforts to identify such individuals to prevent the spread of HIV. (Page 116)

Action taken or to be taken

Consistent with Congressional direction, SAMHSA will maintain 2014 funding for CSAT's substance abuse treatment Minority AIDS Initiative (MAI) grant programs and focus on building capacity and outreach efforts to individuals with, or at risk of developing, a primary substance use disorder and to improve efforts to identify such individuals to prevent the spread of HIV. To support ongoing efforts, SAMHSA intends to issue a collaborative MAI program funded by CMHS, CSAT and CSAP. The primary focus will be the co-location and integration of HIV services within substance abuse primary prevention, substance abuse treatment and mental health treatment for racial/ethnic minority individuals with or at risk for mental illness, substance abuse, and HIV/AIDS. Grantees will submit separate budgets for each funding source to ensure that all funding is used in a manner consistent with the purpose for which it was appropriated.

Item

Screening, Brief Intervention, and Referral to Treatment [SBIRT] **-** The Committee provides funding for SBIRT through budget authority rather than through transfers from the PPH Fund as requested by the administration. The Committee continues to direct SAMHSA to ensure that funds provided for SBIRT are used for existing evidence-based models of providing early intervention and treatment services to those at risk of developing substance abuse disorders. (Page 116-117)

Action taken or to be taken

Screening, Brief Intervention, and Referral to Treatment (SBIRT) appropriated funds are used for programs that utilize the evidence-based SBIRT models that provide early intervention and substance abuse treatment referral to those in need. Models include use of validated substance abuse screening tools, motivational interviewing techniques that inform counseling interventions, and promotion of established referral to treatment methodologies. In addition, SBIRT funds are used to train primary care practitioners in existing SBIRT evidence-based models.

Item

Workforce Development **-** The Committee is concerned that only 50 to 55 percent of addiction counselors hold a master's degree. While 75 percent hold at least a bachelor's degree, the remainder have only a high school diploma or equivalent. The Committee urges SAMHSA to work with HRSA to ensure that programs aimed at mental health and substance use disorder professionals are available to addiction professionals seeking to move from a bachelor's level to a master's level. (Page 117)

Action taken or to be taken

SAMHSA agrees with the committee and is making significant investments in behavioral health workforce development. Efforts in 2014 include a $1.6 million investment to create the Minority Fellowship Program for Addiction Counselors (MFP-AC), which will provide additional support for the broader objective of the MFP grant. Specifically, the purpose of the MFP-AC, part of the President's *Now is the Time* Initiative, is for "increasing the number of addiction counselors with Master's level training." The MFP-AC will provide stipends to students pursuing master's degrees in addiction/substance abuse counseling. Part of the student's program must include training on addiction issues associated with transitional age youth (16-21 years old). Additionally, SAMHSA will work with HRSA using FY 2014 funds to administer an expansion of the Mental and Behavioral Health Workforce Education and Training Program to strengthen the clinical field competencies of graduate students.

Item

Programs of Regional and National Significance **-** Given that youth drug use is on the rise and perceptions of harm are waning, the Committee directs that all of the money appropriated explicitly for substance abuse prevention purposes both in CSAP's PRNS lines as well as the funding from the 20 percent prevention set-aside in the SAPT Block Grant be used only for bona fide substance abuse prevention programs and strategies and not for any other purposes. (Page 118)

Action taken or to be taken

SAMHSA agrees with the Committee and can confirm that substance abuse prevention funds in both CSAP's PRNS line and funding from the 20 percent prevention set-aside in the Substance Abuse Prevention and Treatment Block Grant (SABG) are used solely to fund substance abuse prevention programs and strategies.

Specifically, the FY 2014-2015 SABG Block Grant application states, as per statute, that "the 20% set aside funds of the SABG Block Grant must be used only for substance abuse primary prevention activities by the state." CSAP State Project Officers monitor state expenditures to confirm that states are spending at least 20% of the total SABG award on primary substance abuse prevention programs, practices and strategies. Similarly, grantees funded through CSAP's PRNS line are also required to expend grant funds on substance abuse prevention strategies and infrastructure development. CSAP Project Officers also monitor these grant expenditures to ensure that grant funds are spent appropriately and on allowable items.

While all SAMHSA prevention funds must be used by grantees to funds strategies that have a positive impact on the prevention of substance use, it is important to acknowledge that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

Item

Overdose Fatality Prevention **-** The Committee is deeply concerned about the increasing number of unintentional overdose deaths attributable to prescription and nonprescription opioids. The Committee urges SAMHSA to take steps to encourage and support the use of SAPT Block Grant funds for opioid safety education and training, with a focus on initiatives that improve access of naloxone to public health and law enforcement professionals. (Page 117)

Action taken or to be taken

SAMHSA's Opioid Overdose Prevention Toolkit (Toolkit) can serve as a foundation for such education and training. CSAT, through the SABG Technical Assistance Tracker process, will continue to stress the importance of SAMHSA's Toolkit to Single State Authorities (SSAs). The Toolkit information link was distributed on the TA Tracker list serve on August 29, 2013 to help raise awareness of overdose prevention and reversal strategies available to them through SAMHSA (http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742). CSAT also intends to send a letter to all SSAs reminding them of this valuable information and urge them to include it in their strategic planning as they furnish communities and local governments with materials on how to develop policies and practices to help prevent opioid-related overdoses and deaths. SAMHSA agrees that increasing access to naloxone or naloxone administration is an important component to addressing unintentional overdose.

Since CSAP/DWP can provide linkages with workplace employees and treatment, CSAP/DWP intends to promote SAMHSA's Opioid Overdose Prevention Toolkit through the Prevention of Prescription Drug Abuse in the Workplace (PAW) Technical Assistance contract as well as through the education of federal Medical Review Officers who interpret drug test results of donors. In addition, SAMHSA will provide a link to its Opioid Overdose Prevention Toolkit on DWP's website.

Item

Minority Fellowships **-** The Committee recommendation includes $10,695,000 for the Minority Fellowship program, a $5,000,000 increase above the fiscal year 2013 level. The Committee provides funding for this program within the three Centers as it has done in previous years, rather than in the Health Surveillance and Program Support account as requested by the administration. The Committee intends that the increase provided in CSAT for Minority Fellowship be used to increase the number of addiction counselors receiving Master's level training. (Page 119)

Action taken or to be taken

Consistent with Congressional direction, funding for Minority Fellowship Program will be expanded and is provided in all appropriations. Please refer to the Agency-Wide Initiatives in the Health Surveillance and Program Support Chapter.

Item

National Survey on Drug Use and Health [NSDUH] - The Committee is concerned about the exclusion of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands from NSDUH. The exclusion is especially troubling with respect to Puerto Rico and the U.S. Virgin Islands, which are designated as a high intensity drug trafficking area, because NSDUH is a leading evidence-based resource used to measure the effectiveness of Federal drug control policies and programs. The Committee encourages SAMHSA to consider fully incorporating each territory into the redesign of NSDUH. (Page 119)

Action taken or to be taken

SAMHSA understands the concerns over exclusion of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands from the NSDUH, especially with respect to the inclusion of Puerto Rico and the U.S Virgin Islands as designated High Intensity Drug Trafficking areas.

The redesign of the NSDUH sample was implemented in 2013, and data collection based on this new design will begin in January 2014. Thus, it will not be possible to incorporate additional data collection in these outlying areas in the current NSDUH redesign. Also, given the differences between the States and the District of Columbia and American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands, there may be substantial cultural, scientific and methodological reasons for considering a separately designed and delivered study so as not to compromise or undermine the quality and validity of current NSDUH data.

In FY 2014, SAMHSA will conduct a feasibility study that will provide options for addressing the concerns noted above. The results of the study could be ready by summer 2015 and include estimated costs and potential timelines for the implementation of various options.

Item

Overdose Prevention - The Committee notes that accidental deaths from overdose, particularly from prescription drugs such as opioids, are on the rise and have become the leading cause of preventable death for individuals under the age of 65 in the United States. The Committee is concerned that many healthcare professionals, treatment providers and at-risk populations are unaware of overdose prevention and reversal strategies. The Committee urges the Secretary, in collaboration with other agencies such as SAMHSA and CDC, to raise awareness of the symptoms and risk factors of overdose, how to deploy naloxone, rescue breathing and emergency services for someone experiencing an overdose, and how to help individuals make the linkage to treatment and recovery services. (Page 147)

Action taken or to be taken

SAMHSA continues to promote its Opioid Overdose Prevention Toolkit (Toolkit) to its Block Grant and discretionary grantees to raise awareness of overdose prevention and reversal strategies. SAMHSA released the Toolkit in August 2013 which has been widely disseminated via SAMHSA's Regional Administrators, HRSA, CDC's Morbidity and Mortality Weekly Report (MMWR), and non-federal partners. SAMHSA also intends to inform discretionary grantees about the increasing number of unintentional overdose deaths attributable to prescription and nonprescription opioids and to urge them to include this issue in their strategic planning, screening, and referral to treatment protocols. In addition, SAMHSA will include opioid overdose prevention messages and strategies derived from the Toolkit in various continuing medical education (CME) efforts. These efforts include live CME courses offered around the country 7 times per year; a listing of an online learning module devoted to the subject with free CME on opioidprescribing.com, a SAMHSA funded site; and, webinars on the Prescriber Clinical Support Systems for both Opioids and Medication Assisted Treatment aimed at SAMHSA grantees. These activities will be jointly coordinated with CDC. SAMHSA is also holding stakeholder calls on the subject of opioid overdose, the first of which was held on February 20, 2014. Additionally, SAMHSA plans to expand its overdose prevention education to opioid treatment providers, disseminate information in the Revised Federal Opioid Treatment Program Guidelines (to be published in 2014); and, continue to host the Emerging Opioid Overdose Strategic Group, a biweekly teleconference for stakeholders nationwide.

Since CSAP/DWP can provide linkages with workplace employees and treatment, CSAP/DWP intends to promote SAMHSA's Opioid Overdose Prevention Toolkit through the Prevention of Prescription Drug Abuse in the Workplace (PAW) Technical Assistance contract as well as through the education of federal Medical Review Officers who interpret drug test results of donors. In addition, SAMHSA will provide a link to its Opioid Overdose Prevention Toolkit on DWP's website.

SIGNIFICANT ITEMS FROM OMNIBUS CONFERENCE REPORT

Item

Mental Health First Aid - The Administrator is directed to focus on a broad public safety approach when implementing the Mental Health First Aid program that offers training for both school officials and the range of actors in the public sphere that interact with youth.

Action taken or to be taken

Under Project AWARE, Mental Health First Aid funding will promote widespread dissemination of the Mental Health First Aid curriculum. MHFA-Y prepares teachers and other individuals who work with youth to help schools and communities to understand, recognize, and respond to signs of mental illness or substance abuse in children and youth. In 2014, SAMHSA will award MHFA funds through competitive grants to State Education Agencies and Local Education Agencies. Grant recipients will be required to work with their respective mental health and

juvenile justice counterparts as well as other community based organizations to ensure that teachers and a broad array of community actors receive training in the MHFA-Y model.

Item

Screening, Brief Intervention, and Referral to Treatment (SBIRT) **-** The Administrator is directed to ensure the funds provided for the Screening, Brief Intervention and Referral to Treatment program are used for existing evidence-based models of providing early intervention and treatment services to those at risk of developing substance abuse disorders.

Action taken or to be taken

All SBIRT funds utilize the existing evidence-based SBIRT model and provide funds to applicants who demonstrate the ability to provide early intervention and substance abuse treatment referral services to those in need. In FY 2014, SAMHSA plans to support additional Screening, Brief Intervention, and Referral to Treatment (SBIRT) Medical Professional Training Program grants (SBIRT Training) and one State SBIRT grant. The purpose of SBIRT Training is to develop and implement training programs to teach health professionals (medical residents and students of nursing, social work and counseling) the skills necessary to provide evidence-based screening, brief intervention and brief treatment and to refer patients who are at risk for a substance use disorder (SUD) to appropriate treatment. The intended outcomes of this program are to increase the adoption and practice of SBIRT throughout the health care delivery system.

Item

STOP Act **-** The Administrator is commended for providing funding for the STOP Act within the budget request this year; however, the Administrator is strongly encouraged to eliminate the requirement for Community Enhancement Grant program applicants to provide evidence of State collaboration in the grant application. This program was intended by law to be a community program.

Action taken or to be taken

SAMHSA appreciates the support for the STOP ACT program which is an important component of a broader strategy for preventing and reducing alcohol use among America's youth. STOP ACT grantees will continue to be encouraged to collaborate with state, local and tribal governments to enhance and further their community initiatives.

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HIV Continuum of Care

SAMHSA Strengthening HIV Continuum of Care through Behavioral Health/Substance Abuse & Primary Care Integration Grants - Should show how SAMHSA intends to build new evidence and strengthen capacity for rigorous evaluation and data analytics.

The National HIV/AIDS Strategy and Implementation Plan

SAMHSA currently funds projects under the Minority AIDS Initiative (MAI) that implement the goals of the National HIV/AIDS Strategy which are sponsored through the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services (CMHS). CSAP-funded projects provide funding for substance abuse prevention services and HIV testing while CSAT and CMHS-funded projects support substance abuse/mental health treatment services, HIV testing and referral to quality HIV care.

In 2011, SAMHSA joined with the Office of HIV/ AIDS and Infectious Diseases and other HHS agencies nationally to better coordinate HIV responses under the 'HHS 12 Cities Project'. Consistent with this effort, through its three centers SAMHSA funded 11 cooperative agreements under the Minority AIDS Initiative-Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements (MAI-TCE Program) under the MAI. In this program, the 11 cities with the highest HIV/AIDS rates in the racial and ethnic minority communities who are most impacted by HIV/AIDS, are targeted through city/state health departments to develop/expand culturally competent and effective community-based treatment services. Integrated behavioral health and primary care networks were also expanded across behavioral health, HIV services and medical treatment. The program ensures that individuals who are at high risk for, or have a mental and/or substance use disorder, and who are most at risk for, or are living with HIV/AIDS, receive appropriate behavioral health services, including prevention and treatment (HIV testing), HIV/AIDS care and medical treatment in integrated behavioral health and primary care settings, such as infectious disease or other HIV specialty providers. The priority populations for this program included those identified in the National HIV/AIDS Strategy including Black and Latino women and men, gay and bisexual men, transgendered persons, and substance users, as appropriate to the grantee. SAMHSA provided supplemental funding to three grantees under the MAI-TCE to expand screening for substance use and mental disorders within HIV specialty treatment programs with a goal of increasing retention in treatment and successful establishment of antiretroviral treatment.

SAMHSA's programs to deliver and sustain high quality, accessible substance abuse and HIV prevention services focus on preventing and reducing onset of substance abuse and transmission of HIV/AIDS among at-risk racial/ethnic minority subpopulations. Nationally, approximately 50% of HIV-infected persons who are aware of their HIV status are not receiving regular HIV care or antiretroviral therapy. Large numbers of these individuals have behavioral health conditions. Mental and Substance Use Disorders (M/SUDs) have a disproportionate impact on those at risk for or living with HIV/AIDS. It is estimated that fifty percent of those in HIV care have a co-occurring behavioral health condition. While these illnesses can arise either independently of infection, predispose to (through risk-related behaviors), or be a psychological consequence of having HIV, co-occurrence of mental and/or substance use disorders in the

presence of HIV poses particular challenges for care of this population. It is known that untreated M/SUDs are among the top 5 predictors of poor adherence to HIV/AIDS treatment. Furthermore, alcohol and drug abuse are linked to poor treatment response and more rapid progression of HIV. Addressing the complexities of co-occurring disorders in which HIV/AIDS and behavioral health conditions can be treated effectively requires new approaches that simplify care.

In 2014, SAMHSA is implementing a program that will explore a pilot of integrated care that bring HIV and primary care to those receiving treatment in either substance abuse or mental health treatment programs. In addition, the program will integrate substance abuse primary prevention education and messaging into the broader service spectrum. This 2014 braided funding RFA, which utilizes recycle funds in the amount of $24 million, will support behavioral health programs that both integrate and co-locate HIV/primary care. In integrating HIV care into behavioral health settings, people living with HIV/AIDS and M/SUDs will have greater access to treatment for these conditions. Integrated care programs developed as a result of this grant will make it possible for behavioral health and HIV care needs to be addressed in one setting. This will result in effective, person-centered, treatment that will reduce the risk of HIV transmission, improve outcomes for those living with HIV, and ultimately reduce new infections.

Budget Request

SAMHSA expects that data generated from the 2014 pilot will help to inform an expanded program proposed for 2015 to continue the co-location and integrated HIV/primary care within either substance abuse or community mental health treatment programs. Braided funds in 2015 in the amount of $24 million would be dedicated to establishing integrated behavioral health and HIV care in addition to primary care needed by those living with or at high risk for HIV infection in minority communities heavily impacted by HIV. In addition, because of the significant comorbidity of viral hepatitis with HIV infection and because viral hepatitis occurs in up to 20% of those with either substance use disorders or serious mental illness, 5% of the allocated funds will be used to provide services to prevent, screen, test and refer to treatment as clinically appropriate those at risk for or living with viral hepatitis. In integrating HIV care into behavioral health settings, people living with HIV/AIDS and M/SUDs will have greater access to treatment for these conditions. Integrated care programs developed as a result of this grant program will make it possible for behavioral health and HIV care needs to be addressed in one setting. This will result in effective, person-centered, treatment that will reduce the risk of HIV transmission, improve outcomes for those living with HIV, and ultimately reduce new infections. SAMHSA's Common Data platform (CDP), now under development, will integrate substance abuse and mental health elements with HIV and Hepatitis elements to ensure a more rigorous evaluation and data analysis to inform future public health intervention decision-making that addresses the intersection of behavioral health and HIV.