DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2016

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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I am pleased to present the Substance Abuse and Mental Health Services Administration (SAMHSA) Budget Request for Fiscal Year (FY) 2016. SAMHSA is requesting a total of $3.7 billion, reflecting a $44.6 million increase from the FY 2015 Enacted Budget. Of the request, $103.0 million provides additional funding to support the Administration's top behavioral health priorities: strengthening crisis systems, addressing prescription drug and opioid abuse, expanding the behavioral health workforce, and fostering tribal behavioral health.

The impact of untreated behavioral health conditions on people, communities, and healthcare costs in the United States is staggering. For example, costs for Medicaid enrollees with common chronic conditions and co-occurring mental and substance use disorders are two to four times higher than average Medicaid enrollees. As Federal and state health agencies face major budget constraints and changes to their systems which disproportionately affect people with behavioral health needs, addressing behavioral and physical health issues together can reduce costs and improve overall health. This budget recognizes that reality and leverages SAMHSA's resources to build a stronger health system.

Too frequently, we hear of challenges experienced by people with serious mental illnesses or substance use disorders and their families who cannot access needed care during times of acute crisis. The proposed Crisis Systems program mitigates the demand for inpatient beds by those with serious mental illness and substance use disorders by coordinating crisis response with ongoing outpatient services and supports. The Budget Request will help communities build, fund, and sustain crisis systems capable of preventing and deescalating behavioral health crises as well as connecting individuals and families with needed post-crisis services.

Each year, more than 20,000 individuals die from prescription opioids and heroin. Preventing opioid misuse that results in overdoses and deaths requires a comprehensive approach that includes prevention, treatment, and recovery support services. The Budget Request proposes a new community-based program to prevent prescription drug and opioid overdose-related deaths and increases funding for medication-assisted treatment.

The Budget Request strengthens the behavioral health workforce by adding 8,000 new professionals. In particular, SAMHSA recognizes the complementary role and value of peer providers working together with licensed clinicians. The Budget Request includes additional funding for a Peer Professional Workforce Development program and increases funding for the SAMHSA-Health Resources and Services Administration Behavioral Health Workforce Education and Training program.

During a recent trip to Indian Country, the President reaffirmed his commitment to tribal communities. Because American Indian/Alaska Native communities bear a disproportionate burden from mental and substance use disorders, the Budget Request includes additional funding for tribal efforts to address substance abuse, suicide, trauma, and school behavioral health issues.

SAMHSA submits this Budget Request to maintain its commitment to reducing the impact of substance abuse and mental illness on America's communities.

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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As of January 12th, 2015

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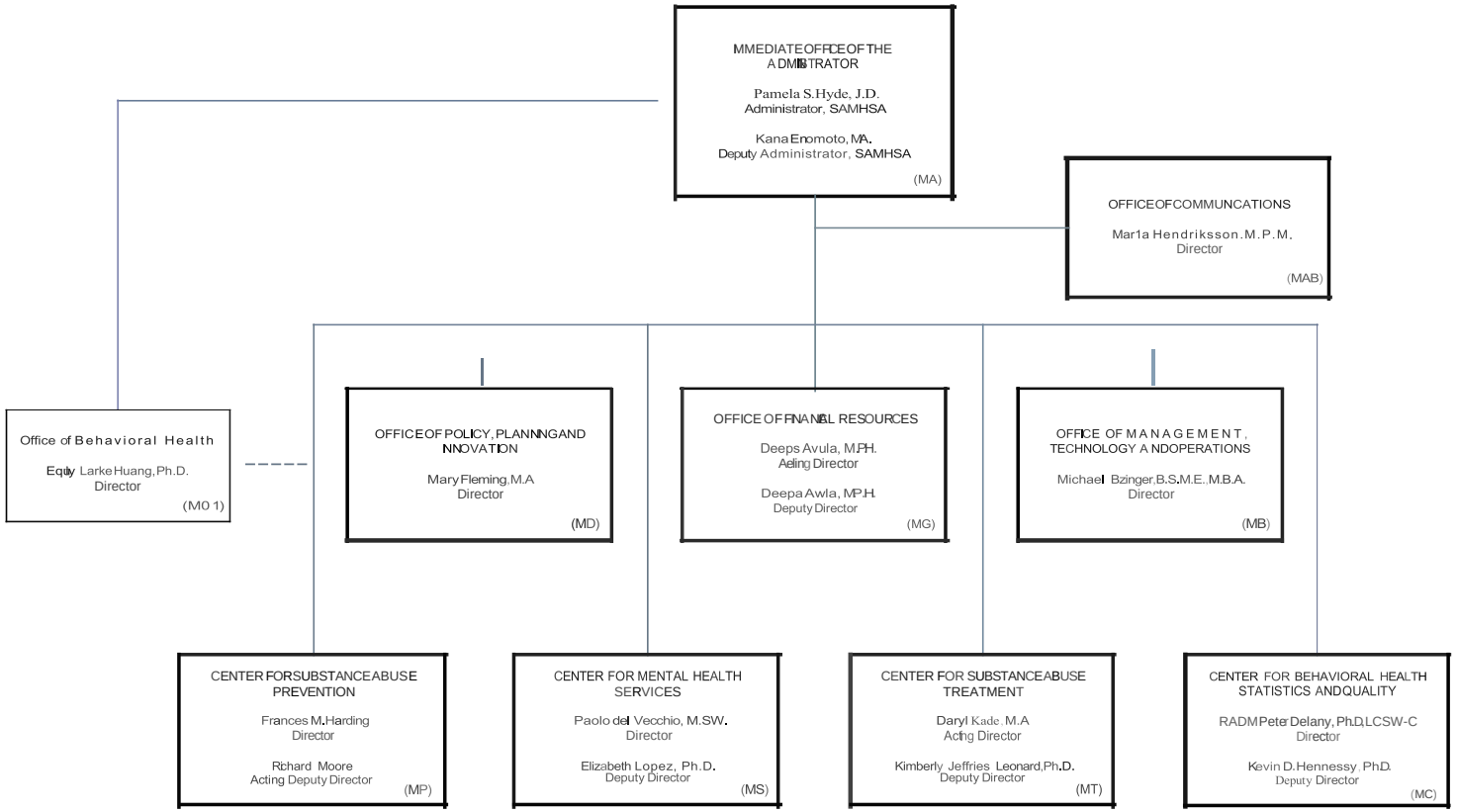
Organizational Structure:
Substance Abuse and Mental Health Services Administration (SAMHSA)



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Performance Budget Overview

Introduction

Addressing mental health and substance abuse is critical to the health of individuals and families. Prevention, treatment, and recovery support services for behavioral health are essential components of health service systems. These services improve health status and lower the economic and societal costs that mental illness and substance abuse have on individuals, families, businesses, and governments. Substance abuse, addiction, poor emotional health, and mental illnesses take a toll on individuals, families, and communities. As with physical illnesses, these conditions cost money, and they cost lives, particularly when steps are not taken to prevent, or manage them effectively. Substance abuse and mental illness increase the cost of treating co-morbid physical diseases and are leading drivers of disability. SAMHSA has a unique responsibility to focus the nation's health and human services agendas on these preventable and treatable problems, which stem from disease, trauma, and inadequate access to appropriate care, and insufficient community and family supports.

Mission

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes this mission through partnerships, policies, and programs that build resilience and facilitate recovery for people with, or at risk for, mental and/or substance use disorders.

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Strategic Vision of Budget Request Overview

Behavioral Health in America

"We must promote—to the best of our ability and by all possible and appropriate means—the mental and physical health of all our citizens."
John F. Kennedy, February 5, 1963

"We whisper about mental health issues and avoid asking too many questions. The brain is a body part, too. We just know less about it. And there should be no shame in discussing or seeking help for treatable illnesses that affect too many people that we love."
Barack Obama, June 3, 2013

Behavioral health remains one of America's most pressing needs, yet it is also one of the most undervalued and least-addressed. Half of all Americans will experience symptoms of a behavioral health condition during their lives. Unfortunately, of the estimated 43.7 million adults with a mental illness[1] and 20.3 million adults with a substance use disorder in the past year[1], many did not or could not seek the care they need. SAMHSA's National Survey on Drug Use and Health (NSDUH) found that only 41 percent of adults with diagnosable mental health problems[1] received needed treatment. Similarly, only 2.5 million people received treatment at a specialty substance abuse treatment facility, far fewer than the estimated 22.7 million Americans with a substance use disorder.[1]

Untreated behavioral health conditions exact a high cost on American individuals, families, and society. This cost includes involvement with the criminal justice system, homelessness, unemployment, poorer physical health, hospitalization, and even early death. A recent meta-analysis suggests that major mental diagnoses such as schizophrenia were associated with death anywhere between seven and 24 years earlier than for individuals without these diagnoses.[2] Substance use disorders can cause physical health problems and/or exacerbate existing physical health problems. For example, cardiovascular complications, including heart attacks and strokes, are closely related to illicit drug use.[3]

Though costs are high across all racial and ethnic groups, American Indian/Alaska Native (AI/AN) communities shoulder a disproportionate share, as these communities have some of the highest rates of mental illness, substance abuse, and suicide.[4] Roughly 23 percent of AI/AN adults meet criteria for having a mental illness in the past year, compared to 18 percent of all adults. AI/AN adults are more than twice as likely as all adults to have a mental illness with serious functional impairment (9 percent AI/AN persons versus 4 percent all adults). Similarly,

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[1] Substance Abuse and Mental Health Services Administration, *Results from the National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series Rockville, MD: Substances Abuse and Mental Health Services Administration, 2014.
[2] E. Chesney et al., Risks of all-cause and suicide mortality in mental disorders: a meta-review, World Psychiatry; 2014: 13:1153-160.
[3] http://www.heart.org/HEARTORG/Conditions/Cocaine-Marijuana-and-Other-Drugs_UCM_428537_Article.jsp.
[4] Behavioral Health, United States, 2012, http://www.samhsa.gov/data/sites/default/files/2012-BHUS.pdf

AI/AN persons are more than twice as likely to have a substance use disorder than adults in general (16.9 percent AI/AN persons versus 8.5 percent all adults) and more than twice as likely to have an alcohol use disorder than adults in general (14.4 percent AI/AN persons versus 7.1 percent all adults).

Behavioral health problems have a powerful negative impact on our economy. Mental and substance use disorders have higher costs than many other diseases. The World Economic Forum estimates that, by the year 2030, mental illnesses and substance use disorders will account for $6.0 trillion in direct and indirect costs and 35 percent of lost economic output.[5] The lost economic output due to mental illnesses and substance use disorders is greater than the anticipated loss incurred by all cancers (18 percent), diabetes (4 percent) and chronic respiratory diseases (10 percent) *combined*.[6] In the United States, the total burden of behavioral health conditions, including lost earnings/productivity and treatment expenses, is estimated to be nearly $500 billion per year.[7] Adding even more to the economic burden, evidence suggests that behavioral health conditions also increase the cost of treating common physical disorders. The Centers for Medicare & Medicaid Services (CMS) found that healthcare costs for persons diagnosed with mental illness and common chronic conditions were 75 percent higher than those without a mental health diagnosis. The cost of care for Medicaid enrollees with common chronic conditions and co-occurring mental and substance use disorders is two to three times higher than the cost for Medicaid enrollees without these conditions.[8] It is clear, both from a clinical and financial perspective, that failure to address physical and behavioral health conditions imposes steep costs on society. Working towards an integrated health system which addresses behavioral and physical health problems across settings in a coordinated fashion is a promising strategy to reform a system that currently allocates health system spending inefficiently.

Despite the clear need for mental and substance use disorder prevention, treatment, and recovery services, access to affordable and appropriate care remains a barrier. The Affordable Care Act, in conjunction with the Mental Health Parity and Addiction Equity Act (MHPAEA), has the potential to create or enhance access to coverage for behavioral health services for 62 million Americans, nearly one-fifth of the nation's population.[9]The current behavioral healthcare infrastructure and workforce, however, will need additional capacity to absorb the influx of patients with behavioral health needs who now have the coverage to seek treatment.

The Health Resources and Services Administration (HRSA) reported that, as of June 2014, there were more than 4,000 Mental Health Care Health Professional Shortage Areas (HPSAs) in the

[5] The Global Economic Burden of Non-Communicable Diseases, World Economic Forum, 2011, http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf.
[6] Bloom, DE, Cafiero, ET, Jané-Llopis, E, Abrahams-Gessel, S, Bloom, LR, Fathima, S, Feigl, AB, et al. (2011). The Global Economic Burden of Non-communicable Diseases. Geneva: World Economic Forum.
[7] TR Insel, Assessing the Costs of Serious Mental Illness, Am J Psychiatry, 2008 June; 165(6): 663-665. Dep't of Justice National Drug Threat Assessment 2011The Economic Impact of Illicit Drug Use on American Society, 2011, U.S. Department of Justice, http://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf.
[8] http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/bh-briefing-document-1006.pdf
[9] http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm.

United States, containing nearly a third of the American population (96 million people).[10] One recent study found that more than 75 percent of counties reported shortages of prescribing and non-prescribing behavioral health professionals, including psychiatrists, social workers, counselors, and therapists. Nearly one-third of counties, many in rural areas, lack an outpatient mental health center that accepts Medicaid. Many counties also lack substance abuse treatment facilities that accept Medicaid. Such gaps exacerbate racial, ethnic and geographic disparities in access to behavioral health care.[11] A 2007 SAMHSA analysis of workforce issues noted that more than 50 percent of U.S. counties in rural areas lack practicing psychiatrists, psychologists, or social workers. There is also a lack of racial and ethnic minority providers, which impacts the field's ability to provide culturally and linguistically competent and effective services to racial and ethnic minority persons seeking care.

In addition to building the behavioral health workforce, there is also a pressing need for more accessible and appropriate community crisis systems. In 2010, 2.2 million hospitalizations and 5.3 million emergency department visits involved a diagnosis related to a mental illness.[12] In 2011, there were 5.1 million drug-related emergency department visits, of which about one half (49 percent, or 2.5 million visits) were attributed to drug misuse or abuse. Of those, 1.4 million visits involved prescription pharmaceuticals, and 1.3 million involved illicit drugs.[13] Such services as 23-hour crisis stabilization, warm lines, peer crisis services, mobile crisis services, short-term crisis residential services, and community-based crisis follow-up services can help avoid unnecessary and expensive hospitalization and emergency room visits and provide improved outcomes to adults and children with behavioral health conditions. However, many communities encounter challenges in funding and coordinating these systems. More than half of people with mental illnesses and 90 percent of people with substance use disorders do not get specialty care services.

Despite the gaps and needs identified, as a result of the Affordable Care Act and parity protections, nearly one-fifth of the American population now has new or enhanced access to coverage for behavioral health care. In addition, behavioral health has never been more widely discussed than it is today. High profile tragedies, while devastating, have sparked an unprecedented conversation about the impact of mental and substance use disorders in America, but this discourse requires leadership and science to guide it. For more than 22 years, SAMHSA has been focused on advancing the nation's behavioral health and reducing the impact of substance abuse and mental illness in America's communities. To guide its work and the national approach to behavioral health, SAMHSA has developed six strategic initiatives (SIs) for FY 2015 through FY 2018. These six SIs include prevention of substance abuse and mental illness, health care and health systems integration, trauma and justice, recovery support, health information technology, and workforce. Along with SAMHSA's vision of a nation that knows and acts on the knowledge that, behavioral health is essential to health; prevention works;

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[10] HRSA Data Ware House Shortage Area Summaries, http://datawarehouse.hrsa.gov/topics/shortageareas.aspx; Designated Health Professional Shortage Area Statistics, August 2014.

[11] KC Thomas et al. County-Level Estimates of Mental Health Professional Shortage in the United States, Psychiatric Services, 60:1323–1328, 2009.

[12] Agency for Healthcare Research and Quality. (2010). *Healthcare Cost and Utilization Project (HCUP). Custom data query*. Retrieved from http://www.hcup-us.ahrq.gov/.

[13] http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm.

treatment is effective; and people recover, these six SIs are woven throughout SAMHSA's policy and budget priorities. While each of SAMHSA's programs is noted as contributing primarily to one SI, programs typically support the development and advancement of multiple SIs. These initiatives focus SAMHSA's efforts and the nation's resources toward the state of the art in behavioral health – the most effective and promising programs, practices, policies, data, and information.

SAMHSA's Strategic Budget Framework

SAMHSA's public health obligation – to the Department of Health and Human Services (HHS) and the American people – is to ensure that federal behavioral health programs are effective, that national policies improve systems and services, and that SAMHSA's leadership improves health outcomes for people with or at risk for mental and substance use disorders. SAMHSA carries out its mission through six key roles and activities: leadership and voice; data and surveillance; practice improvement; strategic grant-making; regulations and guidelines; and public awareness/education. Through these activities, SAMHSA helps states, territories, tribes, and communities promote health and prevent illness, support evidence-based practices, train their workforce, increase access to treatment, integrate with general health care, advance technology, support recovery, and improve Americans' understanding of behavioral health. As SAMHSA leads public health efforts to advance the behavioral health of the nation, SAMHSA strives to help Americans accept, seek help for, and support people with mental and substance use disorders just as they do for people with other health conditions.

To guide SAMHSA in its leadership role, the strategic plan, *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018*, creates a framework that focuses SAMHSA's ongoing work. *Leading Change* is designed to align SAMHSA's ongoing portfolio of programs to increase awareness and understanding about mental and substance use disorders, promote emotional health and wellness, prevent substance abuse and mental illness, increase access to effective treatment, and support recovery.

Emerging public health needs and new developments in health system structure, policy, and service delivery, require SAMHSA to focus its current resources and expertise on specific areas of need. Addressing changes and needs in the behavioral health and health fields requires partnerships across government, improved alignment of programs, and clear focus on the issues. In FY 2016, SAMHSA is prioritizing its public health leadership role in four specific areas: strengthening crisis systems, addressing prescription drug and opioid abuse, expanding the behavioral health workforce, and fostering tribal behavioral health. These priorities stem from identified gaps and emerging priorities within the nation's health promotion, treatment, and recovery systems. The devastating community consequences of increased opioid misuse, overdose and overdose death; the structural, financing, and health insurance coverage improvements through the Affordable Care Act in conjunction with MHPAEA; and an unprecedented public discourse around behavioral health in America have provided SAMHSA the opportunity and responsibility to address these issues.

The FY 2016 Budget begins to formalize SAMHSA's priorities as programmatic budget requests that are aligned with the priorities in *Leading Change 2.0.* As such, SAMHSA's budget

priorities focus on the emerging needs of the nation's behavioral health system through advancing crisis systems; addressing prescription opioid misuse and opioid death prevention (contributing SAMHSA's unique capacity in substance abuse prevention and treatment to the overall HHS prescription and illicit opioid overdose prevention plan); and improving tribal substance abuse and mental health programs (especially for suicide prevention and substance abuse).

It has been 50 years since President Kennedy first challenged government to do more for individuals with behavioral health conditions. In recent decades, seeking behavioral health services has become more acceptable and the science that addresses these conditions has advanced. Mental and substance use disorder treatment has become more mainstream with advances in neuroscience, medication and services and technologies to engage, treat, and support individuals with mental illnesses and/or addictions. Many people receive this treatment within the general healthcare system allowing the specialty behavioral health system to focus on the needs of people with the most severe illnesses and/or addictions. However, even with expanded access to treatment, more than half of people with mental illnesses and 90 percent of people with substance use disorders do not get the services they need. The nation can do better.

To address behavioral health as the public health issue that it is, the nation has to raise awareness and educate universally; invest in infrastructure; create real impact by preventing adverse health conditions; and ensure the availability of treatment. SAMHSA's budget request for FY 2016 moves the needle in all of these areas and takes a public health approach to what has erroneously and historically been seen as social or moral issues.

It has been almost two years since President Obama publically released the *Now is the Time* initiative assuring individuals with behavioral health issues that they are not alone and providing the nation with hope. Behavioral health can and should be addressed as a public health issue by ensuring that the programs and policies focus on these tenets: behavioral health is essential to health; prevention works; treatment works; and people recover. By focusing on these principles, the issues faced by many communities, families and individuals can be addressed successfully. Improving the behavioral health of the nation requires SAMHSA's federal leadership and this Budget Request allows the Agency to address emerging needs and build a cohesive behavioral health service system, ultimately fulfilling a 50 year-old promise repeated just two years ago.

Budget Request

SAMHSA's Budget Request for FY 2016 of $3.7 billion reflects a $44.6 million increase from the FY 2015 Enacted Level.

Program Increases:

Crisis Systems (+$10.0 million)
The FY 2016 Budget requests $10.0 million, including $5.0 million in the Mental Health appropriation and $5.0 million in the Substance Abuse Treatment appropriation, for a new braided program line entitled Crisis Systems. This represents an increase of $10.0 million from the FY 2015 Enacted Level. Funding supports the Increasing Crisis Access Response Efforts

(ICARE), a demonstration activity to help communities build, fund, and sustain crisis systems capable of preventing and deescalating behavioral health crises as well as connecting individuals and families with needed post-crisis services. In many incidences, responses to these situations by emergency medical responders and other behavioral health care providers are under-coordinated and un-sustained. These grants will help mitigate the demand for inpatient beds by those with serious mental illnesses and substance use disorders by coordinating effective crisis response with ongoing outpatient services and supports. As a braided activity, SAMHSA will track separately any amounts spent or awarded under Crisis Systems through its distinct appropriation and ensure that funds are used for purposes consistent with legislative direction and intent of that appropriation.

Medication Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction (+$13.0 million)

The FY 2016 Budget requests $25.1 million, an increase of $13.0 million over the FY 2015 Enacted Level. The increase will be used to support a new activity under the Targeted Capacity Expansion program entitled Medication Assisted Treatment for Prescription Drug and Opioid Addiction. This funding is part of a joint effort by SAMHSA and the Agency for Healthcare Research and Quality (AHRQ) to improve access to MAT services for treating opioid use disorders, with a focus on heroin and prescription opioids. SAMHSA will use this funding to provide grants to states to support opioid MAT efforts in high-risk communities, to educate, and to provide technical assistance. States can use this funding to purchase medication to expand MAT services. This program will increase the number of states from 11 to 22 that receive funding to expand services that address prescription drug misuse and heroin use in high-risk communities. This new funding is expected to serve an additional 24 high-risk communities.

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths (+$12.0 million)

The FY 2016 Budget requests $12.0 million for a new program line entitled Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths. This new program will provide grants to 10 states to reduce significantly the number of opioid overdose-related deaths. Funding will help states purchase naloxone, equip first responders in high-risk communities, support education on the use of naloxone and other overdose death prevention strategies, provide the necessary materials to assemble overdose kits, as well as cover expenses incurred from dissemination efforts.

Strategic Prevention Framework (+$8.8 million)

The FY 2016 Budget requests $118.3 million, an increase of $8.8 million from the FY 2015 Enacted Level. The request includes $10.0 million, new in FY 2016, for the Strategic Prevention Framework for Prescription Drugs (SPF-Rx) program. SPF-Rx will raise public awareness about the dangers of sharing medications and to work with pharmaceutical and medical communities to raise awareness on the risks of overprescribing. The FY 2016 SPF program will provide funds to develop capacity and expertise in the use of data from state prescription drug monitoring programs to identify communities by geography and high-risk populations (e.g., age group), particularly those communities that are in need of primary and secondary prevention. In addition, grantees can use SAMHSA's resources to provide technical assistance and training on the use of SAMHSA's Opioid Overdose Prevention Tool Kit to help prevent opioid overdose related deaths. Funding will support up to 20 state planning grants, technical assistance and

evaluation to build capacity to address prescription drug abuse, and overdose prevention efforts, in conjunction with other state and local partners.

Agency-Wide Initiatives (+$31.0 million)

The FY 2016 Budget requests $77.7 million for Behavioral Health Workforce, an increase of $31.0 million from the FY 2015 Enacted Level. The request includes an increase of $10.0 million for a new program entitled Peer Professional Workforce Development, which will award grants to provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs, resulting in 1,200 additional peer professionals in the behavioral health workforce. The request also includes a $21.0 million increase over the FY 2015 Enacted Level for the SAMHSA-HRSA Behavioral Health Workforce Education and Training (BHWET) Grant Program to expand the behavioral health workforce. The $56.0 million program will support the addition of approximately 5,600 health professionals to the workforce, an increase of 2,100 individuals over FY 2015 levels. SAMHSA's collective workforce efforts will help add several thousand new professionals to the workforce each year.

Tribal Behavioral Health Grants (+$25.0 million)

The FY 2016 Budget Request for the Tribal Behavioral Health Grant (TBHG) program is $30.0 million, including $15.0 million in the Mental Health appropriation and $15.0 million in the Substance Abuse Prevention appropriation. This request represents an increase over the FY 2015 Enacted Level of $10.0 million in the Mental Health appropriation and $15.0 million for a newly established line in the Substance Abuse Prevention appropriation. This funding is part of Generation Indigenous, a Native youth initiative focused on removing possible barriers to success for Native youth. This initiative will take a comprehensive, culturally appropriate approach to help improve the lives and opportunities for Native youth. In addition to HHS, multiple agencies, including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing Native youth. This funding will allow SAMHSA to expand activities that are critical to preventing substance abuse and promoting mental health and resiliency among youth in tribal communities. The additional funding will expand these activities to approximately 103 additional tribes and tribal entities. With the expansion of the TBHG program, SAMHSA aims to reduce substance use and the incidence of suicide attempts among Native youth and to address behavioral health conditions which impact learning in Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion and substance use prevention activities for high-risk Native youth and their families, enhance early detection of mental and substance use disorders among Native youth, and increase referral to treatment.

Primary Care and Addiction Services Integration (PCASI) (+$20.0 million)

The FY 2016 Budget requests $20.0 million to provide grants to behavioral health and primary care providers to integrate substance abuse treatment services and primary care. Individuals with substance use disorders are at risk for co-occurring health conditions. Several cardiovascular complications such as heart attack, heart failure, and stroke are closely related to cocaine use. Alcohol use is a major risk factor for many conditions including chronic hypertension, obesity and diabetes. In addition, individuals with other chronic health issues may develop substance abuse problems due to self-medication. Not only do people with substance use disorders

experience health disparities in morbidity and mortality, Medicare and Medicaid cost data tell us that for people with multiple chronic conditions, costs are exponentially higher when one of those conditions is a substance use disorder.[14, 15] The goal of this program is to improve the health of people with substance use disorders though coordinated and integrated primary care services in community substance abuse treatment settings. Through PCASI, integrated teams of professionals will be able to provide needed primary care services to individuals seeking care for a substance use disorder (SUD), with the objective of improving health outcomes, enhancing the experience of care, and reducing the cost of care by controlling physical healthcare costs. SAMHSA expects that PCASI will complement the successful Primary and Behavioral Health Care Integration (PBHCI) grant program by promoting integrated services for individuals with SUDs and using lessons learned from PBHCI.

Health Surveillance (+$2.2 million)

The FY 2016 Budget requests $49.4 million, an increase of $2.2 million from the FY 2015 Enacted Level. This additional funding supports the President's *Now is the Time* initiative. Specifically, this funding will be used for a new initiative, Science of Changing Social Norms: Building the Evidence, to measure and track attitudes, behaviors and community norms regarding mental health and substance abuse. These data will enable SAMHSA to understand more fully the impact of social messaging, improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority. The Science of Changing Social Norms will have a second component, Social Media, funded from Public Awareness and Support.

Public Awareness and Support ($+2.1 million)

The FY 2016 Budget requests $15.6 million, an increase of $2.1 million from the FY 2015 Enacted Level. These funds will support the President's *Now is the Time* initiative and allow SAMHSA to continue to streamline our web presence, develop innovative mobile apps, expand SAMHSA's presence on social media, and provide other critical resources to support behavioral health and other health. SAMHSA will use $2.0 million to support the Science of Changing Social Norms, to develop and test an array of messages designed to improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority.

[14] 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

[15] 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.

Mental Health First Aid (MHFA) for Veterans' Families (+$4.0 million)
The FY 2016 Budget requests $4.0 million to expand the Mental Health First Aid program to reach 55,000 more people. This request will provide MHFA training to individuals who work with veterans, military service members and their families.

Grants for Adult Trauma Screening and Brief Response (GATSBR) (+$2.9 million)
The FY 2016 Budget requests $2.9 million, an increase of $2.9 million from the FY 2015 Enacted Level to implement GATSBR. The program will facilitate and evaluate the impact of appropriate trauma screening and responses in primary care in order to further advance the nation's understanding of the need for, and complexity of, addressing trauma in non-behavioral health settings. SAMHSA, in consultation with its federal partners, is developing the concept and design for these grants.

Suicide Prevention: National Strategy for Suicide Prevention (+$2.0 million)
The FY 2016 Budget requests $4.0 million, an increase of $2.0 million over the FY 2015 Enacted Level. This increase will expand support so states can further establish evidence-based suicide prevention efforts that support the goals and objectives of the National Strategy for Suicide Prevention.

Program Support (+$7.6 million)
The FY 2016 Budget requests $79.6 million for Program Support, a one-time $7.6 million increase from the FY 2015 Enacted Level in the Heath Surveillance and Program Support Appropriation. The funding request covers the additional costs associated with the move to 5600 Fishers Lane in FY 2016 including extending the current building lease, the Federal Acquisition Service (FAS) loan repayment program, and security charges as part of government-wide efforts to reduce long-term rent and utility costs though reductions in per person space use and periodic re-evaluation of competing lease offers.

Program Decreases:

Primary and Behavioral Health Care Integration (-$23.9 million)
The FY 2016 Budget requests $28.0 million for Primary and Behavioral Health Care Integration (PBHCI), a $23.9 million decrease from the FY 2015 Enacted Level. This funding will continue to support the coordination and integration of primary care services into publicly-funded community behavioral health settings. PBHCI grantees have made great strides in demonstrating methods of integrating physical health care into specialty behavioral health settings for people with serious mental illnesses. This learning is being incorporated into SAMHSA guidance to the states around the block grants, SAMHSA's consultation on the Medicaid health homes program, implementation of the section 223 program, and into a broader focus on integration across SAMHSA's grant portfolio.

Screening, Brief Intervention and Referral to Treatment (-$16.9 million)
The FY 2016 Budget requests $30.0 million for Screening, Brief Intervention and Referral to Treatment (SBIRT), a $16.9 million decrease from the FY 2015 Enacted Level. Funding will support 49 grant continuations (three five-year state SBIRT and 46 three-year Medical

Professional Training grants), 13 new Medical Professional Training grants, and four contracts to continue to integrate SBIRT into general medical and primary care settings. This reduction will not result in the termination of any grants. Funding is requested to continue to support the coordination and integration of primary care services into publicly-funded community behavioral health settings. With the increasing adoption of SBIRT in healthcare settings, the Budget redirects resources to other substance abuse treatment activities, such as heroin and prescription drug abuse treatment.

Access to Recovery ($-38.2 million)

SAMHSA is proposing eliminating the Access to Recovery (ATR) program in FY 2016. Many of the clinical services provided under ATR will now be covered by public and private insurance. In addition, states are able to support recovery support services and client choice with Substance Abuse Prevention and Treatment Block Grant funding. Since 2004, ATR has served over 650,000 clients through 75 grantees. SAMHSA has been able to identify successful substance abuse treatment and recovery-oriented systems of care models and will continue to offer technical assistance to states that would like to continue this activity.

Criminal Justice Activities (-$16.1 million)

The FY 2016 Budget Request is $61.9 million, a decrease of $16.1 million from the FY 2015 Enacted Level. This reduction will not result in the termination of any grants. As a result of multi-year funding of FY 2014 grants, these funds will still provide sufficient support to existing sites/programs at each of the current grantees receiving continuations, as well as new grants in the Drug Court and ORP programs. SAMHSA plans to support 136 grant continuations consisting of 109 Drug Court and 27 ORP grant continuations, Ex-Offender Reentry grants, five contract continuations, approximately 41 new Drug Court grants, and two new contracts. These programs will continue to provide comprehensive treatment and recovery support services for adolescents and adults with substance use disorders coming into contact with the criminal justice system as well as offenders re-entering the community. SAMHSA proposes to focus this portfolio more strategically to explore new approaches and a variety of models within the drug court umbrella rather than using a significant portion of SAMHSA's limited funding to support what is already a robust system.

Addiction Technology Transfer Centers (-$1.0 million)

The FY 2016 Budget Request includes $8.1 million, a decrease of $1.0 million from the FY 2015 Enacted Level. Funding will support grant continuations to continue to disseminate evidence-based, promising practices to addiction treatment/recovery professionals, public health/mental health personnel, institutional and community corrections professionals, and other related disciplines. With the ongoing success of the ATTC program, the Budget redirects resources to other substance abuse treatment activities such as technical assistance specific to heroin and prescription drug abuse treatment.

Braided Programs

(Dollars in thousands)

Braided Programs	FY 2016 Request
Crisis Systems	$10,000
Mental Health: Crisis Systems: Increasing Crisis Access Response Efforts (ICARE) (non-add)	*5,000*
Substance Abuse Treatment: Crisis Systems: Increasing Crisis Access Response Efforts (ICARE) (non-add)	*5,000*
Tribal Behavioral Health Grants	$30,000
Mental Health: Tribal Behavioral Health Grants (non-add)	*15,000*
Substance Abuse Prevention: Tribal Behavioral Health Grants (non-add)	*15,000*

The FY 2016 Budget Request includes two new braided programs that draw on funds from the Mental Health, Substance Abuse Prevention and Substance Abuse Treatment appropriations. As a braided program, SAMHSA will track these activities through their distinct appropriations and any amounts spent or awarded and will only be used for purposes consistent with legislative direction and intent of the appropriation. The braided programs include the new programs, Crisis Systems and Tribal Behavioral Health Grants, described below.

- $10.0 million, including $5.0 million in the Mental Health appropriation and $5.0 million in the Substance Abuse Treatment appropriation, for a new braided program line entitled Crisis Systems. This represents an increase of $10.0 million from the FY 2015 Enacted Level. Funding supports the Increasing Crisis Access Response Efforts (ICARE), a demonstration activity to help communities build, fund, and sustain crisis systems capable of preventing and deescalating behavioral health crises as well as connecting individuals and families with needed post-crisis services. In many incidences, responses to these situations by emergency medical responders and other behavioral health care providers are under-coordinated and un-sustained. These grants will help mitigate the demand for inpatient beds by those with serious mental illnesses and substance use disorders by coordinating effective crisis response with ongoing outpatient services and supports. As a braided activity, SAMHSA will track separately any amounts spent or awarded under Crisis Systems through its distinct appropriation and ensure that funds are used for purposes consistent with legislative direction and intent of that appropriation.

- $30.0 million, including $15.0 million in the Mental Health appropriation and $15.0 million in the Substance Abuse Prevention appropriation. This request represents an increase over the FY 2015 Enacted Level of $10.0 million in the Mental Health appropriation and $15.0 million for a newly established line in the Substance Abuse Prevention appropriation. This funding is part of Generation Indigenous, a Native youth initiative focused on removing possible barriers to success for Native youth. This initiative will take a comprehensive, culturally appropriate approach to help improve the lives and opportunities for Native youth. In addition to HHS, multiple agencies, including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing Native youth. This funding will allow SAMHSA to expand activities that are critical to preventing substance abuse and promoting mental health and resiliency among youth in tribal communities. The additional funding will expand these activities to

approximately 103 additional tribes and tribal entities. With the expansion of the TBHG program, SAMHSA aims to reduce substance use and the incidence of suicide attempts among Native youth and to address behavioral health conditions which impact learning in Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion and substance use prevention activities for high-risk Native youth and their families, enhance early detection of mental and substance use disorders among Native youth, and increase referral to treatment.

Overview of Performance

Consistent with the Government Performance and Results Modernization Act of 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) continues to refine its use of performance and evaluation data to measure impact and mitigate risk. Data-driven performance reviews help SAMHSA leadership analyze outcome data and identify areas for improvement. As impact is measured and reported, SAMHSA seeks to identify the conditions that foster success, address barriers, collaborate across programs, and promote overall efficiency.

SAMHSA's performance measures are included in 12 HHS 2014-2018 Strategic Plan goals and objectives, HHS' FY 2016 Annual Performance Plan and Report, as well as HHS' Strategic Reviews. SAMHSA continues to participate in an HHS priority goal to reduce cigarette smoking, is co-leading the HHS internal priority goal about childhood trauma, and provides leadership in response to urgent situations across the country, such as disaster relief. These activities help advance the nation's behavioral health by influencing the risks and contributing factors associated with substance abuse and mental illness in communities under stress.

As part of HHS's Program Integrity Initiative, SAMHSA is using performance data to advance agency priorities. For example, SAMHSA adapted an existing review process to include the use of progress reports in making funding decisions. In addition, SAMHSA is currently working across the agency to develop an enterprise reporting system capable of linking program performance with financial performance data with plans to identify outliers in both domains for further review and follow-up. The enterprise reporting system – the Common Data Platform (CDP) – is designed to integrate disparate data sources into a single centralized system. Such integration will streamline performance reporting and management, validate data quality, link different data sources, and promote evidence-based decision-making. The CDP will enable SAMHSA to analyze program data more quickly and use that data to inform program direction, resources, and policies.

As SAMHSA strengthens its data analysis capacity, it also seeks opportunities to improve data collection. Efforts are being made to streamline and reduce reporting burden while enhancing access and use of available data to more carefully target areas in need of improvement without overburdening grantees or SAMHSA's infrastructure.

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Discretionary All-Purpose Table Substance Abuse and Mental Health Services Administration

(Dollars in thousands)

Program Activities	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Now is the Time Presidential Initiatives Mental Health:				
Project AWARE	**$54,865**	**$54,865**	**$54,865**	**$---**
Project AWARE State Grants (non-add)	39,902	39,902	39,902	---
Mental Health First Aid (non-add)	14,963	14,963	14,963	---
Healthy Transitions	**19,951**	**19,951**	**19,951**	---
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	**40,160**	**41,246**	72,246	+31,000
Minority Fellowship Program Expansion - Youth (non-add)	5,246	5,246	5,246	**---**
SAMHSA-HRSA BHWET Grant Program (non-add)	34,914	35,000	56,000	+21,000
Peer Professional Workforce Development (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)	**114,976**	**116,062**	**151,062**	**+35,000**
Mental Health:				
Programs of Regional and National Significance	377,315	370,538	377,289	+6,751
Prevention and Public Health Fund (non-add)	*12,000*	*12,000*	*38,000*	+26,000
PHS Evaluation Funds (non-add)	---	---	*5,000*	+5,000
Children's Mental Health Services	117,026	117,026	117,026	---
Projects for Assistance in Transition from Homelessness	64,635	64,635	64,635	---
Protection and Advocacy for Individuals with Mental Illness	36,146	36,146	36,146	---
Community Mental Health Services Block Grant	482,571	482,571	482,571	---
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*21,039*	---
Total, Mental Health	**1,077,693**	**1,070,916**	**1,077,667**	**+6,751**
Substance Abuse Prevention:				
Programs of Regional and National Significance	175,129	175,148	210,918	+35,770
PHS Evaluation Funds (non-add)	---	---	16,468	+16,468
Total, Substance Abuse Prevention	**175,129**	**175,148**	**210,918**	**+35,770**
Substance Abuse Treatment:				
Programs of Regional and National Significance	360,698	361,463	320,701	-40,762
Prevention and Public Health Fund (non-add)	*50,000*	---	---	---
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30000*	+28,000
Substance Abuse Prevention and Treatment Block Grant	1,815,443	1,819,856	2,140,557	---
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	---
Total, Substance Abuse Treatment	**2,176,141**	**2,181,319**	**2,140,557**	**-40,762**
Health Surveillance and Program Support:				
Health Surveillance and Program Support:	119,260	119,260	128,987	+9,727
Prevention and Public Health Fund (non-add)	---	---	*20,000*	+20,000
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*29,428*	*-1,000*
Public Awareness and Support	13,482	13,482	15,571	+2,089
PHS Evaluation Funds (non-add)	---	---	*15,571*	+15,571
Performance and Quality Information Systems	12,918	12,918	12,918	---
PHS Evaluation Funds (non-add)	---	---	*12,918*	+12,918
Agency-W ide Initiatives	45,583	46,669	77,669	+31,000
PHS Evaluation Funds (non-add)	---	*1,000*	*1,000*	---
Data Request/Publications User Fees	1,500	1,500	1,500	---
Total, Health Surveillance/Program Support	**192,743**	**193,829**	**236,645**	**+42,816**
TOTAL, SAMHS A Discretionary PL	**3,621,706**	**3,621,212**	**3,665,787**	**+44,575**
Less PHS Evaluation Funds	*132,667*	*133,667*	*210,624*	+76,957
Less Prevention and Public Health Funds	*62,000*	*12,000*	*58,000*	+46,000
Less Data Request and Publications User Fees	*1,500*	*1,500*	*1,500*	---
TOTAL, S AMHS A Budget Authority	**$3,425,539**	**$3,474,045**	**$3,395,663**	***-$78,382***
FTEs	**615**	**665**	**665**	**---**

[1] A total of $115 million in FY 2014, $116.1 million in FY 2015 and $151.1 million requested in FY 2016 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 comparably adjusted in this table to be in line with the FY 2016 Request and are reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

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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 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Now is the Time Presidential Initiatives				
Mental Health:				
Project AWARE	**$54,865**	**$54,865**	**$54,865**	**$---**
Project AWARE State Grants (non-add)	*39,902*	*39,902*	*39,902*	---
Mental Health First Aid (non-add)	*14,963*	*14,963*	*14,963*	---
Healthy Transitions	**19,951**	**19,951**	**19,951**	---
Health Surveillance and Program Support:				---
Health Surveillance	---	---	**2,000**	**+2,000**
Science of Changing Social Norms: Building the Evidence (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	**40,160**	**41,246**	**72,246**	**+31,000**
Minority Fellowship Program Expansion – Youth (non-add)	*5,246*	*5,246*	*5,246*	---
SAMHSA-HRSA BHWET Grant Program (non-add)	*34,914*	*35,000*	*56,000*	*+21,000*
Peer Professional Workforce Development (non-add)	---	---	*10,000*	+10,000
Behavioral Health Workforce Data and Development (non-add)	---	*1,000*	*1,000*	---
TOTAL	**$114,976**	**$116,062**	**$151,062**	**+$35,000**

Authorizing Legislation .....Sections 501, 505 and 520A the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....State and Local Education Agencies, Local Governmental Entities, Community Organizations and Provider Organizations

SAMHSA's *Now is the Time* activities support the President's plan, in response to the tragedy at Sandy Hook Elementary School, to improve access to mental health services for young people. SAMHSA-supported activities under this initiative are helping teachers and other adults who interact with youth recognize signs of mental illness, improve referrals and access to mental health services for young people ages 16 to 25. In addition, SAMHSA is funding the training of thousands of more behavioral health professionals with a focus on serving students and young adults. The Budget requests $151.1 million for Now is the Time. This is a $35.0 million increase over the FY 2015 Enacted Level of $116.0 million. The FY 2016 Budget Request includes an increase from the FY 2015 Enacted Level for:

- $21.0 million over the FY 2015 Enacted Level to expand the behavioral health workforce. The $56.0 million SAMHSA-HRSA Behavioral Health Workforce Education and Training (BHWET) Grant program will award a total 192 grants, an increase of 72 grants over FY 2015, and will support the addition of approximately 5,600 health professionals to the workforce, an increase of 2,100 individuals over FY 2015 levels.
- $10.0 million for the Peer Professional Workforce Development program, which will award grants to provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs, resulting in 1,200 additional peer professionals in the behavioral health workforce; and

- $4.0 million for a new initiative, Science of Changing Social Norms, which includes two components: Building the Evidence, to measure and track attitudes, behaviors and community norms regarding mental health and substance abuse; and Social Norms, to develop and test an array of messages. The data and messages will enable SAMHSA to understand more fully the impact of social messaging, improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority.

Project AWARE

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Project AWARE	$54,865	$54,865	$54,865	$---
Project AWARE State Grants (non-add)	*39,902*	*39,902*	*39,902*	---
Mental Health First Aid (non-add)	*14,963*	*14,963*	*14,963*	---

Authorizing Legislation..... Sections 501, 509, 516, and 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....State and Local Education Agencies,
Local Governmental Entities, Community Organizations and Provider Organizations
Community Colleges, Networks, States, National Non-Profit Organizations
States and Tribes

Program Description and Accomplishments

In FY 2014, SAMHSA provided $54.9 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 partnered 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 is composed of two components: Project AWARE State Educational Agency Grants ($39.9 million) built on the highly successful Safe Schools/Healthy Students Model, which is intended to create safe and supportive schools and communities. SAMHSA awarded these grants to 20 State Educational Agencies (SEAs) to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services.

The second component, Mental Health First Aid (MHFA), supports widespread dissemination of the MHFA curriculum. The MHFA curriculum 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 that they are more willing to seek treatment. The target for the first year of the program is 750,000 individuals trained or served.

In FY 2014, SAMHSA funded 20 Project AWARE SEA awards and 100 Local Educational Agencies (LEAs) multi-year awards to grantees who applied for Department of Education School Climate Change awards. The project period for Project AWARE awards is four years and the project period for MHFA awards is two years. In addition, SAMHSA will make 68 new MHFA awards to community organizations serving youth and families.

Funding History

Fiscal Year	Amount
FY 2014	$54,865,000
FY 2015	$54,865,000
FY 2016	$54,865,000

Budget Request

The FY 2016 Budget Request is $54.9 million at the program level. This is equal to the FY 2015 Enacted Level. SAMHSA requests funding to support third year continuation funding to the 20 SEA AWARE grantees and up to 68 MHFA continuation grant awards. In addition this funding supports *NITT* technical assistance and evaluation contracts.

Healthy Transitions

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Healthy Transitions	$19,951	$19,951	$19,951	$---

Authorizing Legislation.....Sections 520A of the Public Health Service Act FY 2016
Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Tribes

Program Description and Accomplishments

In FY 2014, SAMHSA provided $20.0 million to support five-year grants to 17 states to improve access to mental health treatment and related support services for youth and young adults ages 16 to 25 that either have, or are at risk of developing, a serious mental health condition. Individuals who are 16 to 25 years old are at high-risk of developing a mental illness or substance use disorder and are at high-risk for suicide. Unfortunately, these youth are among the least likely to seek help. As a result, they may not receive the help they need to assume safe and productive adult roles and responsibilities. In this program, states are expanding services, developing family and youth networks for information sharing and peer support, and disseminating best practices for services to these young individuals. In FY 2015, SAMHSA will provide support for 17 *NITT*

- Healthy Transition continuation grants and the *NITT* technical assistance and evaluation contracts.

Funding History

Fiscal Year	Amount
FY 2014	$19,951,000
FY 2015	$19,951,000
FY 2016	$19,951,000

Budget Request

The FY 2016 Budget Request is $20.0 million. This is equal to the FY 2015 Enacted Level. SAMHSA requests funding to support third year continuation funding for the 17 *NITT* Healthy Transition grantees. In addition this funding supports *NITT* technical assistance and evaluation contracts.

Science of Changing Social Norms

(Dollars in thousands)

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Science of Changing Social Norms	---	---	$4,000	+$4,000
Science of Changing Social Norms: Building the Evidence (non-add)	---	---	*2,000*	*+2,000*
Science of Changing Social Norms: Social Media (non-add)	---	---	*2,000*	*+2,000*

Authorizing Legislation..... Sections 501 and 505 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method ..... Contracts
Eligible Entities.....N/A

Program Description

SAMHSA is proposing a new initiative, the Science of Changing Social Norms to support the President's *Now is the Time* initiative.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	$4,000,000

Budget Request

The FY 2016 Budget Request includes $4.0 million to support a new initiative, the Science of Changing Social Norms. The program is comprised of two components. A total of $2.0 million in Health Surveillance funds will support the Science of Changing Social Norms: Building the Evidence, to measure and track attitudes, behaviors and community norms regarding mental health and substance abuse. A total of $2.0 million in Public Awareness and Support funds will support the Science of Changing Social Norms: Social Media, to develop and test an array of messages.

The messages and data will enable SAMHSA to understand more fully the impact of social messaging; improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority.

Behavioral Health Workforce

(Dollars in thousands)

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Behavioral Health Workforce	$40,160	$41,246	$72,246	+$31,000
Minority Fellowship Program Expansion – Youth (non-add)	*5,246*	*5,246*	*5,246*	---
SAMHSA-HRSA BHWET Grant Program (non-add)	*34,914*	*35,000*	*56,000*	*+21,000*
Peer Professional Workforce Development (non-add)	---	---	*10,000*	*+10,000*
Behavioral Health Workforce Data and Development (non-add)	---	*1,000*	*1,000*	---

Authorizing Legislation.....Section 501, 509, 516, and 520A of the Public Health Service Act FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Community Colleges, Networks, States, National Organizations

Program Description and Accomplishments

SAMHSA's workforce activities help train additional behavioral health professionals to work with students and young adults with mental illnesses and other behavioral health problems. Specifically, the FY 2015 Enacted Level included $5.3 million for SAMHSA's Minority Fellowship Program, $35.0 million for a jointly administered activity with HRSA, the Behavioral Health Workforce Education and Training (BHWET) Grant Program, and $1.0 million for Behavioral Health Workforce Data and Development. These programs are described below.

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

In FY 2014, funding was provided to expand the focus of the current MFP 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 expansion of the four-year program is called the Minority Fellowship Program-Youth (MFP-Y). The purpose of this grant program is to reduce health disparities and improve behavioral health care outcomes for racially and ethnically diverse populations by increasing the number of culturally competent master's level behavioral health professionals serving children, adolescents, and populations in transition to adulthood (aged 16 to 25) in an effort to increase access to, and the quality of, behavioral health care for this age group. MFP-Y uses the existing infrastructure of the MFP to expand the focus of the program to support 960 master's level trained behavioral health providers in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing. Funding supports 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.

In addition, in FY 2014, funding was provided to expand the focus of the current MFP to support master's level addiction counselors (MFP-AC). The purpose of this four-year grant program is to reduce health disparities and improve behavioral health care outcomes for racially and ethnically diverse populations by increasing the number of culturally competent master's level addiction counselors available to underserved minority populations with a specific focus on transition age youth (ages 16 to 25) in public and private non-profit sectors. MFP-AC grants will support students pursuing master's level degrees in addiction/substance abuse counseling. The MFP-AC grants support graduate student stipends to increase the number of masters-level addiction counselors across the nation by approximately 300 counselors. Funds also supported evaluation and technical assistance for these grantees.

Funding History

Fiscal Year	Amount
FY 2014	$5,246,000
FY 2015	$5,246,000
FY 2016	$5,246,000

Budget Request

The FY 2016 Budget Request includes $5.2 million, which is equal to the FY 2015 Enacted Level. This funding will provide continued support for two MFP-Y, two MFP-AC grants, and three technical assistance and evaluation support contracts.

Behavioral Health Workforce Data and Development

The Patient Protection and Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 will extend federal parity protections to over 60

million Americans—among them, over 30 million will gain coverage that includes mental health and substance use disorder treatment, and an additional 30 million who already have some coverage of these services will see their coverage enhanced.[16] These estimates take into account the states' decisions on whether to participate in the expansion of Medicaid.

As of June 2014, there were more than 4,000 Mental Health, Health Professional Shortage Areas (HPSAs) in the United States, containing nearly a third of the American population (96 million people). Recent data indicate that almost 90 percent of persons with substance use disorders do not receive the services they need and over half of those with mental disorders do not receive needed treatment.

The President's *Now is the Time* initiative, supports new activities to expand the behavioral health workforce. In FY 2015, the new workforce investments provide support for approximately 3,500 new behavioral health professionals. To ensure the existing workforce investments are achieving desired outcomes, SAMHSA workforce activities in FY 2015 include $1.0 million within the Center for Behavioral Health Statistics and Quality (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. In FY 2015, SAMHSA will continue 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.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	$1,000,000
FY 2016	$1,000,000

Budget Request

The FY 2016 Budget Request includes level funding of $1.0 million from the FY 2015 Enacted Level 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 with HRSA.

Peer Professional Workforce Development

The Peer Professional Workforce Development program's goal is to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-masters-level addiction counselors working with youth ages 16 to 25. Because they have lived through their own experience with behavioral health conditions, the entry-level providers supported by this program will play a significant role in the delivery of prevention, outreach and engagement, and recovery support services. Evidence has found that people who regularly

[16] Beronio K, Glied S, Frank R. How the Affordable Care Act and Mental Health Parity and Addiction Equity Act Greatly Expand Coverage of Behavioral Health Care. Journal of Behavioral Health Services and Research, 41:4, October 2014.

engage in peer-delivered interventions are more likely to abstain from substance abuse. The Peer Professional Workforce Development program will focus on helping communities develop the infrastructure to train and certify peers, or people with personal experiences with mental illness and/or substance use conditions as behavioral health providers.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	$10,000,000

Budget Request

The FY 2016 Budget Request includes $10 million for the new Peer Professionals Workforce Development program, which will award up to 19 grants to provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs, resulting in 1,200 additional peer professionals in the behavioral health workforce.

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

In FY 2014, SAMHSA and the Health Resources and Services Administration (HRSA) collaborated on the BHWET Grant Program. The purpose of this program is to increase the clinical service capacity of the behavioral health workforce by supporting training for masters-level social workers, psychologists, marriage and family therapists, psychology doctoral interns, as well as behavioral health paraprofessionals. In FY 2014, the grant program provided approximately 120 awards to organizations nationwide and SAMHSA's FY 2015 Budget Request included continued funding in the amount of $35.0 million to maintain this effort. The SAMHSA-HRSA BHWET grant program will help increase the behavioral health workforce by 3,500 individuals each year.

Funding History

Fiscal Year	Amount
FY 2014	$34,914,000
FY 2015	$35,000,000
FY 2016	$56,000,000

Budget Request

The FY 2016 Budget Request includes $56.0 million, an increase of $21.0 million over the FY 2015 Enacted Level to expand the behavioral health workforce. The program will award a total of 192 grants, an increase of 72 grants over FY 2015, and will support the addition of

approximately 5,600 health professionals to the workforce, an increase of 2,100 individuals over FY 2015 levels. SAMHSA's collective workforce efforts will help add several thousand new professionals to the workforce each year.

Outputs and Outcomes Table

Program: *Now is the Time*

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 president's Budget.

Measure	**Result /Target for Recent Result (Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target +/- FY 2016 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
3.2.34 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2014: 65.5 [1] Target:64.0 % (Target Exceeded)	64.0 %	64.0 %	Maintain
3.2.36 Percentage of clients receiving services who are currently employed at 6 month follow-up (Outcome)	FY 2014: 55.7 %[2] Target:56.0 % (Target Not Met)	56.0 %	56.0 %	Maintain
4.4.20 Increase the Minority Fellowship awards (Outcome)	FY 2015: Result Expected Dec 31, 2015 Target:1,260 (Pending)	1,260	1,260	Maintain
4.4.21 Increase the Peer Professional Workforce (Outcome)	FY 2015: Result Expected Dec 31, 2015 Target:1,200 (Pending)	1,200	1,200	Maintain
4.4.22 Increase Behavioral Health Workforce Education and Training (Outcome)	FY 2015: Result Expected Dec 31,2015 Target:3,500 (Pending)	3,500	5,600	Maintain

[1, 2] The 2013 result is a baseline and does not represent actual program activity. SAMHSA used results from the Garrett Lee Smith (GLS) State/Tribal Suicide Prevention Program to derive a baseline to use for the new 2014 Healthy Transitions Program. The GLS program was used because this program focused on the same age cohort.

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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, **[**$1,045,936,000**]** *$1,013,628,000*: *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 in this Act for fiscal year **[**2015**]** *2016*: **[***Provided further,* That of the amount appropriated under this heading, $45,887,000 shall be for the National Child Traumatic Stress Initiative as described in section 582 of the PHS Act:**]** *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: *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. *(Department of Health and Human Services Appropriations Act, 2015.)*

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, **[**$2,102,658,000**]** *$2,031,357,000*: *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. *(Department of Health and Human Services Appropriations Act, 2015.)*

SUBSTANCE ABUSE PREVENTION

For carrying out titles III and V of the PHS Act with respect to substance abuse prevention, **[**$175,219,000**]** *$194,450,000: 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*. *(Department of Health and Human Services Appropriations Act, 2015.)*

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, **[**$150,232,000**]** *$156,228,000*: *Provided*, That in addition to amounts provided herein, **[**$31,428,000**]** *$58,917,000* 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 awareness 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**]** *2017*: *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, 2015.)*

Language Analysis

Language Provision	Explanation
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,	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 activities supported in FY 2015.
Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated in this Act for fiscal year **[**2015**]** *2016*:	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 of the amount appropriated under this heading, $45,887,000 shall be for the National Child Traumatic Stress Initiative as described in section 582 of the PHS Act:**]**	It is not necessary to have specific PRNS PPA lines written into the statute. The Budget includes $45,887,000 for this activity.

Language Provision	Explanation
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:	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**[**, 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,	Sets out the budget authority for the Substance Abuse Treatment appropriation.
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	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.

Language Provision	Explanation
[; and (2) $2,000,000 to evaluate substance abuse treatment programs**]**:	The proviso previously mentioned eliminates the need for this separate proviso as the amount is included in the $109,200,000.
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.	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 amounts made available in this Act for carrying out section 501(m) of the PHS Act shall remain available through September 30, **[**2016**]** *2017*:	SAMHSA's emergency authority allows it to tap certain programs up to one percent for emergency response 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 allows funds tapped to be carried over one additional fiscal year, and only for the same purpose.

Language Provision	Explanation
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

(Whole dollars)

	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS, Ag, or, Interior)	3,434,935,000	3,474,045,000	3,395,663,000
Subtotal, adjusted appropriation	**3,434,935,000**	**3,474,045,000**	**3,395,663,000**
Transfer to the Department.	(9,396,000)	---	---
Subtotal, adjusted general fund discr. appropriation	**(9,396,000)**	---	---
Total, Discretionary Appropriation	3,425,539,000	3,474,045,000	3,395,663,000
Mandatory Appropriation:			
Transfer from the Prevention and Public Health Funds	62,000,000	12,000,000	58,000,000
Subtotal, adjusted mandatory appropriation	**62,000,000**	**12,000,000**	**58,000,000**
Offsetting collections from:			
Federal Source	132,667,000	133,667,000	210,624,000
Data Request and Publications User Fees	---	1,500,000	1,500,000
Unobligated balance, start of year	173,000	172,000	---
Unobligated balance, end of year	811,000	646,276	631,694
Unobligated balance, lapsing	---	---	---
Total obligations	**3,620,206,000**	**3,621,212,000**	**3,665,787,000**

Summary of Changes

(Whole dollars)

2015	
Total estimated budget authority	3,474,045,000
(Obligations)	3,474,045,000
2016	
Total estimated budget authority	3,395,663,000
(Obligations)	3,395,663,000
Net Change	**-$78,382,000**

Increases:	**FY 2016 President's Budget FTE**	**FY 2016 President's Budget BA**	**FY 2016 +/- FY 2015 FTE**	**FY 2016 +/- FY 2015 FTE**
A. Built-in:				
1. Annualization of 2016 commissioned corps pay increase	---	48,040	---	+$35,600
2. Annualization of 2016 civilian pay increase	---	660,570	---	+465,600
3. Increase in rental payments to GSA	---	6,830,000	---	+6,830,000
Subtotal, Built-in Increases	**---**	**7,538,610**	**---**	**+7,331,200**
A. Program:				
1. Substance Abuse Prevention PRNS	---	194,450,000	---	+19,302,000
2. Program Support	---	79,559,000	---	+7,557,000
3. Agency-Wide Initiatives	---	76,669,000	---	+31,000,000
Subtotal, Program Increases	---	350,678,000	---	+57,859,000
Total Increases	**---**	**---**	**---**	**+65,190,200**
Decreases:				
A. Built-in:				
1. Absorption of built increases	---	---	---	-7,538,610
Subtotal, Built-in Decreases	**---**	**---**	**---**	**-7,538,610**
A. Program:				
1. Mental Health PRNS	---	552,096,000	---	-24,249,000
2. Substance Abuse Treatment PRNS	---	290,701,000	---	-68,762,000
3. Health Surveillance	---	---	---	-16,830,000
4. Public Awareness and Support	---	---	---	-13,482,000
5. Performance and Quality Information Systems	---	---	---	-12,918,000
Subtotal, Program Decreases	**---**	**842,797,000**	**---**	**-136,241,000**
Total Decreases	**---**	**---**	**---**	**-143,779,610**
Net Change	**---**	**---**	**---**	**-78,589,410**

Budget Authority by Activity

(Dollars in thousands)

Program Activities	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
1. Mental Health:				
Programs of Regional and National Significance	377,315	370,538	377,289	+6,751
Prevention and Public Health Fund (non-add)	*12,000*	*12000*	*38,000*	+26,000
PHS Evaluation Funds	---	---	*5,000*	+5,000
Children's Mental Health Services	117,026	117,026	117,026	---
Projects for Assistance in Transition from Homelessness	64,635	64,635	64,635	---
Protection and Advocacy for Individuals with Mental Illness	36,146	36,146	36,146	---
Community Mental Health Services Block Grant	482,571	482,571	482,571	---
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*21,039*	---
Total, Mental Health	**1,077,693**	**1,070,916**	**1,077,667**	**+6,751**
2. Substance Abuse Prevention:				
Programs of Regional and National Significance	175,129	175,148	210,918	+35,770
PHS Evaluation Funds (non-add)	---	---	*16,468*	+16,468
Total, Substance Abuse Prevention	**175,129**	**175,148**	**210,918**	**+35,770**
3. Substance Abuse Treatment:				
Programs of Regional and National Significance	360,689	361,463	320,701	-40,762
Prevention and Public Health Fund (non-add)	*50,000*	---	---	---
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*	+28,000
Substance Abuse Prevention and Treatment Block Grant	1,815,443	1,819,856	1,819,856	---
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	---
Total, Substance Abuse Treatment	**2,176,141**	**2,181,319**	**2,140,557**	**-40,762**
4. Health Surveillance and Program Support:				
Health Surveillance and Program Support	119,260	119,260	128,987	+9,727
Prevention and Public Health Fund (non-add)	---	---	*20,000*	+20,000
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*29,428*	*-1,000*
Public Awareness and Support	13,482	13,482	15,571	+2,089
PHS Evaluation Funds (non-add)	---	---	15,571	+15,571
Performance and Quality Information Systems	12,918	12,918	12,918	---
PHS Evaluation Funds (non-add)	---	---	12,918	+12,918
Agency-Wide Initiatives [1]	45,583	46,669	77,669	+31,000
PHS Evaluation Funds (non-add)	---	1,000	1,000	---
Data Request/Publication User Fees	1,500	1,500	1,500	---
Total, Health Surveillance/Program Support	**192,743**	**193,829**	**236,645**	**+42,816**
TOTAL, SAMHSA Discretionary PL	**3,621,706**	**3,621,212**	**3,665,787**	**+44,575**
Less PHS Evaluation Funds	132,667	133,667	210,624	+76,957
Less Prevention and Public Health Funds	62,000	12,000	58,000	+46,000
Less Data Request and Publications User Fees	1,500	1,500	1,500	---
TOTAL, SAMHSA Budget Authority	**$3,425,539**	**$3,474,045**	**$3,395,663**	**-$78,382**
FTEs	**619**	**665**	**665**	**---**

[1] The Minority Fellowship Program budgets from the Mental Health, Substance Abuse Prevention and Treatment appropriations have been comparably adjusted in this table to be in line with the FY 2016 Request and are reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

Authorizing Legislation

(Whole dollars)

Program Description/PHS Act:	FY 2015 Amount Authorized	FY 2015 Appropriations Act	FY 2016 Amount Authorized	FY 2016 President's Budget
Grants for the Benefit of Homeless Individuals				
Sec. 506	Expired	$41,386,000	Expired	$41,386,000
Residential Treatment Programs for Pregnant and Postpartum Women				
Sec. 508	Expired	$15,931,000	Expired	$15,931,000
Priority Substance Abuse Treatment Needs of Regional and National Significance				
Sec. 509*	Expired	$272,541,000	Expired	$203,779,000
Substance Abuse Treatment Services for Children and Adolescents				
Sec. 514*	Expired	$29,605,000	Expired	$29,605,000
Priority Substance Abuse Prevention Needs of Regional and National Significance				
Sec. 516*	Expired	$167,148,000	Expired	$186,450,000
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	$199,503,000	Expired	$223,131,000
Youth Interagency Research, Training, and Technical Assistance Centers				
Sec. 520C*	Expired	$5,988,000	Expired	$5,988,000
Suicide Prevention for Children and Youth				
Sec. 520E*	Expired	$23,427,000	Expired	$25,427,000
Sec. 520E2*	Expired	$6,488,000	Expired	$6,488,000
Grants for Jail Diversion Programs				
Sec. 520G*	Expired	$4,269,000	Expired	$4,269,000
Awards for Co-locating Primary and Specialty Care in Community-based Health Settings				
Sec. 520K*	Expired	$49,877,000	Expired	0
PATH Grants to States				
Sec. 535 (a)	Expired	$64,635,000	Expired	$64,635,000
SSAN = Such Sums as Necessary				

Authorizing Legislation

(Whole dollars)

Program Description/PHS Act:	FY 2015 Aount Authorized	FY 2015 Appropriations Act	FY 2016 Amount Authorized	FY 2016 President's Budget
Community Mental Health Services for Children with Serious Emotional Disturbances				
Sec. 565 (f)	Expired	$117,026,000	Expired	$117,026,000
Children and Violence Program				
Sec. 581*	Expired	$23,099,000	Expired	$23,099,000
Grants for Persons who Experience Violence Related Stress				
Sec. 582	Expired	$45,887,000	Expired	$45,887,000
Community Mental Health Services Block Grants				
Sec. 1920(a)	Expired	$461,532,000	Expired	$461,532,000
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	$36,146,000	Expired	$36,146,000
Health Surveillance and Program Support Program Management				
Sec. 501	Indefinite	$72,002,000	Indefinite	$79,559,000
Total, Program Management	Indefinite	$72,002,000	Indefinite	$79,559,000
Heath Surveillance	Indefinite	$16,830,000	Indefinite	0
Public Awareness and Support (FY12)	Indefinite	$13,482,000	Indefinite	0
PQIS (FY12)	Indefinite	$12,918,000	Indefinite	0
Agency-Wide Initiatives	Indefinite	$45,669,000	Indefinite	$76,669,000
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**	**$3,474,045,000**	0	**$3,395,663,000**

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

Appropriations History

(Whole dollars)

	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)	---	---	---	-$1,681,000	1/
Transfers (Section 202)	---	---	---	-$2,201,000	
Subtotal	**$3,336,023,000**	**$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 Education	---	---	---	$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	$3,404,789,000	$3,291,543,000	
P.L. 110-161					
Rescission (P.L. 110-161)	---	---	---	-$57,503,000	4/
Subtotal	**$3,167,589,000**	**$3,393,841,000**	**$3,404,789,000**	**$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	$341,116,000	5/
P.L. 111-117					
Subtotal	**$3,393,882,000**	**$3,429,782,000**	**$3,419,438,000**	**$341,116,000**	

	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	---	$3,431,878,000	$3,474,045,000	9/
P.L. 113-235					
Subtotal	**$3,297,669,000**	**---**	**$3,431,878,000**	**$3,474,045,000**	
FY 2016					
General Fund Appropriation:					
Base	$3,395,663,000				
P.L. 113-235					
Subtotal	**$3,395,663,000**				

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

9/ Reflects the whole year appropriation

Appropriations Not Authorized by Law

(Whole dollars)

Program	Last Year of Authorization	Authorization Level	Appropriation in Last Year of Authorization	Appropriation in FY 2015
Grants for the Benefit of Homeless Individuals				
Sec. 506	2003	$50,000,000	$16,700,000	$41,386,000
Residential Treatment Programs for Pregnant and Postpartum Women				
Sec. 508	2003	SSAN	$0	$15,931,000
Priority Substance Abuse Treatment Needs of Regional and National Significance				
Sec. 509*	2003	$300,000,000	$322,994,000	$272,541,000
Substance Abuse Treatment Services for Children and Adolescents				
Sec. 514*	2003	$40,000,000	$20,000,000	$29,605,000
Priority Substance Abuse Prevention Needs of Regional and National Significance				
Sec. 516*	2003	$300,000,000	$138,399,000	$167,148,000
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	$199,503,000
Youth Interagency Research, Training, and Technical Assistance Centers				
Sec. 520C*	2007	$5,000,000	$3,960,000	$5,988,000
Suicide Prevention for Children and Youth				
Sec. 520E*	2007	$30,000,000	$17,829,000	$23,427,000
Sec. 520E2*	2007	$5,000,000	$4,950,000	$6,488,000
Grants for Jail Diversion Programs				
Sec. 520G*	2003	$10,000,000	$6,043,000	$4,269,000
PATH Grants to State				
Sec. 535 (a)	2003	$75,000,000	$46,855,000	$64,635,000
Community Mental Health Services for Children with Serious Emotional Disturbances				
Sec. 565 (f)	2003	$100,000,000	$96,694,000	$117,026,000
SSAN = Such Sums as Necessary				

Program	Last Year of Authorization	Authorization Level	Appropriation in Last Year of Authorization	Appropriation in FY 2015
Children and Violence Program				
Sec. 581*	2003	$100,000,000	$83,035,000	$23,099,000
Grants for Persons who Experienced Violence Related Stress				
Sec. 582*	2003	$50,000,000	$20,000,000	$45,887,000
Community Mental Health Services Block Grant				
Sec. 1920 (a)	2003	$450,000,000	$433,000,000	$461,532,000
Substance Abuse Prevention and Treatment Block Grant				
Sec. 1935 (a)	2003	$2,000,000,000	$1,785,000,000	$1,740,656,000
Other Legislative/Program Description				
Protection and Advocacy for Individuals with Mental Illness Act				
P.L. 99-319, Sec 117	2003	$19,500,000	$32,500,000	$36,146,000
TOTAL, SAMHSA Budget Authority		**$3,839,500,000**	**$3,124,664,000**	**$3,256,267,000**

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

**Congress authorized two provisions as section 514.

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Mental Health Appropriation

(Dollars in thousands)

Program Activities	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Programs of Regional and National Significance	$377,315	$370,538	$377,289	+$6,751
Prevention and Public Health Fund (non-add)	12,000	12,000	38,000	+26,000
PHS Evaluation Funds (non-add)	---	---	5,000	+5,000
Children's Mental Health Services	117,026	117,026	117,026	---
PATH Homeless Formula Grant	64,635	64,635	64,635	---
PAIMI	36,146	36,146	36,146	---
Community Mental Health Services Block Grant	482,571	482,571	482,571	---
PHS Evaluation Funds (non-add)	21,039	21,039	21,039	---
[1] **Total, Mental Health**	**$1,077,693**	**$1,070,916**	**$1,077,667**	**+$6,751**

[1] The Minority Fellowship Program budgets from the Mental Health, Substance Abuse Prevention and Treatment appropriations have been comparably adjusted in this table to be in line with the FY 2016 Request and are reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

The Mental Health appropriation request is $1.1 billion, an increase of $6.8 million from the FY 2015 Enacted Level. The request includes $1.0 billion in Budget Authority (a decrease of $24.2 million from the FY 2015 Enacted Level), $26.0 million in PHS Evaluation Funds (level funding from the FY 2015 Enacted Level), and $38.0 million in Prevention and Public Health Fund resources (an increase of $26.0 million from the FY 2015 Enacted Level).

Programs of Regional and National Significance
Mental Health Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
CAPACITY				
Seclusion and Restraint and Trauma	$1,147	$1,147	$1,147	$---
Youth Violence Prevention	23,099	23,099	23,099	---
Project AWARE	54,865	54,865	54,865	---
Project AWARE State Grants (non-add)	*39,902*	*39,902*	*39,902*	---
Mental Health First Aid (non-add)	*14,963*	*14,963*	*14,963*	---
Mental Health First Aid for Veterans' Families	---	---	4,000	+4,000
Healthy Transitions	19,951	19,951	19,951	---
National Child Traumatic Stress Initiative	45,887	45,887	45,887	---
Children and Family Programs	6,458	6,458	6,458	---
Consumer and Family Network Grants	4,954	4,954	4,954	---
Project LAUNCH	34,555	34,555	34,555	---
MH System Transformation and Health Reform	10,556	3,779	3,779	---
Primary and Behavioral Health Care Integration	49,877	49,877	26,004	-23,873
Prevention & Public Health Fund (non-add)	---	---	*26,004*	*+26,004*
Suicide Prevention	60,032	60,032	62,032	+2,000
National Strategy for Suicide Prevention (non-add)	*2,000*	*2,000*	*4,000*	*+2,000*
Prevention & Public Health Fund (non-add)	*2,000*	---	---	---
Suicide Lifeline (non-add)	*7,198*	*7,198*	*7,198*	---
Prevention & Public Health Fund (non-add)	*1,700*	---	---	---
GLS- Youth Suicide Prevention - States (non-add)	*35,427*	*35,427*	*35,427*	---
Prevention & Public Health Fund (non-add)	*5,800*	*12,000*	*10,000*	*-2,000*
GLS- Youth Suicide Prevention - Campus (non-add)	*6,488*	*6,488*	*6,488*	---
Prevention & Public Health Fund (non-add)	*1,500*	---	---	---
GLS - Suicide Prevention Resource Center (non-add)	*5,988*	*5,988*	*5,988*	---
Prevention & Public Health Fund (non-add)	*1,000*	---	---	---
AI/AN Suicide Prevention Initiative (non-add)	*2,931*	*2,931*	*2,931*	---
Tribal Behavioral Health Grants	4,988	4,988	15,000	+10,012
PHS Evaluation Funds (non-add)	---	---	*5,000*	*+5,000*
Homelessness Prevention Programs	30,696	30,696	30,696	---
Minority AIDS	9,224	9,224	15,935	+6,711
Grants for Adult Treatment, Screening, and Brief Response	---	---	2,896	+2,896
Crisis Systems	---	---	5,000	+5,000
Criminal and Juvenile Justice Programs	4,269	4,269	4,269	---
Subtotal, Capacity	**360,558**	**353,781**	**360,527**	**+6,746**

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
SCIENCE AND SERVICE				
Practice Improvement and Training	7,828	7,828	7,828	---
Consumer and Consumer Supporter Technical Assistance Centers	1,918	1,918	1,918	---
Primary and Behavioral Health Care Integration TTA	1,991	1,991	1,996	+5
Prevention & Public Health Fund (non-add)	---	---	*1,996*	*+1,996*
Disaster Response	1,953	1,953	1,953	---
Homelessness	2,296	2,296	2,296	---
HIV/AIDS Education	771	771	771	---
Subtotal, Science and Service	**16,757**	**16,757**	**16,762**	**+5**
TOTAL, PRNS[1/2]	**$377,315**	**$370,538**	**$377,289**	**+$6,751**

[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/] CMHS Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program for all years.

* Totals may not add due to rounding.

Authorizing Legislation ..... Sections 501, 520A, 520C, 520E, 520E-2, 520K, 581, and 582 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... States, Tribes, Provider Organizations, Community Organizations

Seclusion and Restraint and Trauma

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Seclusion and Restraint and Trauma	$1,147	$1,147	$1,147	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method ..... Contracts
Eligible Entities.....Not Applicable

Program Description and Accomplishments

This program provides technical assistance to 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.

People die because 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 both students and staff. Coercive practices such as seclusion and restraint impede recovery and well-being. Through SAMHSA's National Technical Assistance Center: Promoting Alternatives to Seclusion and Restraint Through Trauma-Informed Practices, trauma-informed approaches to care have been developed, proven effective, and implemented to reduce or eliminate the use of coercive practices.

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 organizations that may use coercive practices with people who have mental and/or co-occurring substance use disorders. This program facilitates the implementation of evidence-based strategies for preventing and reducing the use of seclusion and restraint and implementing a trauma-informed approach that reduces the use and harmful effects of coercive practices.

A five-year contract was awarded in FY 2013 to design, assess, and implement a technical assistance strategy to assist publicly funded systems, agencies, and organizations across the nation in addressing two high priority and interrelated objectives. The first objective is to promote alternatives to and, ultimately, eliminate restraint, seclusion, and other coercive practices. The second objective is to develop and implement training and technical assistance on SAMHSA's concept of trauma[17], key principles, and practice guidelines for a trauma-informed approach, recognizing that both organizational and culture change are necessary to sustain efforts to eliminate the use of seclusion and restraints. In addition, the contract facilitates dissemination of trauma-informed practices across multiple service settings. In FY 2015, SAMHSA plans to support the continuation of this contract.

Funding History

Fiscal Year	Amount
FY 2012	$2,444,371
FY 2013	$2,121,167
FY 2014	$1,147,000
FY 2015	$1,147,000
FY 2016	$1,147,000

Budget Request

The FY 2016 Budget Request is $1.1 million at the program level. This is the same level as the FY 2015 Enacted Level. SAMHSA requests funding to continue support for dissemination of trauma-informed practices across multiple service settings to advance the goal of reducing and

[17] Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

eliminating the use of seclusion, restraint, and other traumatizing practices in service systems and treatment agencies through continuation of the existing contract.

Youth Violence Prevention

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Youth Violence Prevention	$23,099	$23,099	$23,099	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method…….. .....Competitive Grants/Contracts
Eligible Entities……..... State Education Agencies, State Mental Health Authorities, Tribes and Territories

Program Description and Accomplishments

SAMHSA's Safe Schools/Healthy Students (SS/HS) Initiative is a discretionary grant program that seeks to create healthy learning environments that help students thrive, succeed in school, and build healthy relationships.

Although youth violence is decreasing in some parts of the country, due in part to programs such as the SS/HS Initiative, youth violence remains a public health problem in the United States. Data has found that fewer students are engaging in fights. The 2013 Youth Risk Behavior Surveillance System - US reports[18] the prevalence of high school students having been in a physical fight decreased from 2011 (32.8 percent) to 2013 (24.7 percent). The prevalence of having been in a physical fight on school property also decreased between 2011 and 2013, from 12.1 percent to 8.1 percent. Other indicators of violence have not significantly improved in recent years. Nationwide, in 2013, 17.9 percent of students had carried a weapon (e.g., gun, knife, or club) on at least one day during the 30 days before the survey. In 2013, an estimated 20 percent of high school students reported being bullied on school property.

For more than a decade, the SS/HS Initiative has successfully decreased violence and increased the number of students receiving mental health services, supporting programs in more than 300 local school districts.[19] 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: (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. This grant program builds on the investments

[18] Frieden, Thomas R., Jaffe, Harold W., Cono, Joanne, et. al. Youth Risk Behavior Surveillance – United States, 2013. MMWR 2014; 63 (No. SS 4: 8-10)
[19] http://www.sshs.samhsa.gov/initiative/currentinit.aspx.

in the SS/HS Initiative through state and community level partnerships across education, behavioral health, and criminal justice systems that promote systems integration, policy change, and sustainable policies, infrastructure, services, and supports.

The Interim Report of the SS/HS Initiative National Evaluation indicates that more than 90 percent of school staff has observed reduced violence on school grounds and almost 80 percent reported that SS/HS reduced violence in their communities. Children and adolescents in school districts participating in the SS/HS grant program experienced a 47 percent increase in access to school-based mental health services and a 30 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 lower rates of alcohol and other drug use among their students. In FY 2012 and FY 2013, SAMHSA exceeded targets for reducing the percentage of students engaging in substance abuse. This measure includes both middle school and high school students who reported having used alcohol or drugs in the past 30 days.

In addition to grants, funding also supports an ongoing SS/HS State Program evaluation that intended to (1) assess the extent to which implementation of comprehensive school violence prevention initiatives--guided by the SS/HS framework--is achieved at both the state and community levels; (2) determine the breadth and volume of activities necessary to achieve coordination across multiple service systems; (3) identify and describe the elements or activities that are associated with improved child wellness; and (4) estimate the extent to which states and communities improve access to mental health services for target populations and reduce subpopulation disparities in access, services, and outcomes. Three studies will address these issues. The studies include The Planning Collaboration & Partnership Study, The Implementation Study, and the Workforce Study. Each of these studies utilizes multiple data collection methods including information interviews, web-based surveys and document review.

In FY 2014, SAMHSA provided continuation funds for seven four-year grants through the SS/HS Planning, Local Education Agency and Local Community program grants (SS/HS State program). In FY 2015, SAMHSA plans to provide continuation funds for the third year for these same grants and contracts.

Funding History

Fiscal Year	Amount
FY 2012	$23,156,152
FY 2013	$21,944,947
FY 2014	$23,099,000
FY 2015	$23,099,000
FY 2016	$23,099,000

Budget Request

The FY 2016 Budget Request is $23.1 million at the program level. This is the same as the FY 2015 Enacted Level. Funding is requested to provide continuation funds for seven states through the Planning, Local Education Agency and Local Community program grants (SS/HS State program), and the related technical assistance and evaluation contracts to help students thrive, succeed in school, and build healthy relationships. These funds continue support for state and community-level partnerships across education, behavioral health, and juvenile justice systems, and promote systems integration and collaboration.

Outputs and Outcomes Table

Program: Youth Violence Prevention1

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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	952,142	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 of 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

[1] After the following Safe Schools/Healthy Students State and Tribal table has reported baseline data, some of the measures in this table will be discontinued.

Outputs and Outcomes Table

Program: Safe Schools/Healthy Students State Planning, Local Education Agency, and Local Community Cooperative Agreements

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.2.45 Number of organizations collaborating and sharing resources with other organizations as a result of the grant (Output)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain
3.2.46 Increase the number of individuals who receive training in prevention or mental health promotion (Intermediate Outcome)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain
3.2.47 Increase the number of people in mental health and related workforce trained in mental health-related practices/activities that are consistent with the goals of the grant (Output)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain
3.2.48 Increase the number of state and local policy changes completed as a result of the grant (Output)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain
3.2.49 Increase the number of organizations that entered into a formal written inter/intra organizational agreements (such as an MOU) to improve mental health related practices/activities that are consistent with the goals of the grant (Output)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			Maintain
3.2.50 Decrease the percentage of middle and high school students who report current alcohol use (Intermediate Outcome)	FY 2015: Result Expected Dec 31, 2015 Target: 18.1 % (Pending)	18.1 %	18.1 %	Maintain

Project AWARE

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Project AWARE	$54,865	$54,865	$54,865	$---
Project AWARE State Grants (non-add)	*39,902*	*39,902*	*39,902*	---
Mental Health First Aid (non-add)	*14,963*	*14,963*	*14,963*	---

Authorizing Legislation ..... Sections 501, 509, 516, and 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....State and Local Education Agencies,
Local Governmental Entities, Community Organizations and Provider Organizations
Community Colleges, Networks, States, National Non-Profit Organizations
States and Tribes

Program Description and Accomplishments

In FY 2014, in response to the tragedy at Sandy Hook Elementary School and as part of the President's *Now is the Time initiative,* SAMHSA provided $54.9 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 partnered 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 is composed of two components: Project AWARE State Educational Agency Grants ($39.9 million) built on the highly successful Safe Schools/Healthy Students Model, which is intended to create safe and supportive schools and communities. SAMHSA awarded these grants to 20 State Educational Agencies (SEAs) to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services.

The second component, Mental Health First Aid (MHFA), supports widespread dissemination of the MHFA curriculum. The MHFA curriculum 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 that they are more willing to seek treatment. The target for the first year of the program is 750,000 individuals trained or served.

In FY 2014, SAMHSA funded 20 Project AWARE SEA awards and 100 Local Educational Agencies (LEAs) multi-year awards to grantees who applied for Department of Education School Climate Change awards. The project period for Project AWARE awards is four years and the project period for MHFA awards is two years. In addition, SAMHSA will make 68 new MHFA awards to community organizations serving youth and families.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	$54,865,000
FY 2015	$54,865,000
FY 2016	$54,865,000

Budget Request

The FY 2016 Budget Request is $54.9 million at the program level. This is the same as FY 2015 Enacted Level. SAMHSA requests funding to support third year continuation funding to the 20 SEA AWARE grantees and up to 68 MHFA continuation grant awards. In addition this funding supports *NITT* technical assistance and evaluation contracts.

Outputs and Outcomes Table

Program: Project AWARE

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.2.18 Number of children served. (Output)	FY 2015: Result Expected Dec 31, 2015 Target: 750,000 (Pending)	750,000	750,000	
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)			
3.2.39 Number of individuals who have received training in prevention or mental health promotion (Outcome)	FY 2015: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			

Mental Health First Aid for Veterans' Families

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Mental Health First Aid for Veterans' Families	---	---	$4,000	+$4,000

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Community Organizations, LEA, Veterans Service Organizations, and Communities

Program Description

Military service members, veterans, and their families are often not aware of how to engage on issues related to mental illnesses and addictions. Military service not only affects service members and veterans, it also impacts their circle of family (significant others, children, parents, siblings, etc.) and friends.

The FY 2016 Budget Request will train veterans, their family and friends, and those that work with them on use of Mental Health First Aid (MHFA). The MHFA curriculum helps individuals understand, recognize, and respond to signs of mental illness or substance abuse. This training will help break down the negative perceptions associated with mental illnesses like anxiety, depression, post-traumatic stress disorder (PTSD) and substance use disorders as well as reach out to those who suffer in silence, reluctant to seek help and let veterans and their families know that support is available in their community. The MHFA for Veterans' Families program includes several key components: a discussion of military culture and its relevance to the topic of mental health; discussion of the specific risk factors faced by many service members and their families such as trauma, both mental and physical, stress, separation, etc.; applying the MHFA five step action plan in a number of scenarios designed specifically for veterans, service members, their families and those that support them; and a review of common mental health resources for service members, their families and those who support them.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$4,000,000

Budget Request

In FY 2016, SAMHSA requests $4.0 million, an increase from the FY 2015 Enacted Level to expand the Mental Health First Aid program to reach 55,000 more people. This request will provide MHFA training to individuals who work with veterans, military service members and their families.

Healthy Transitions

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Healthy Transitions	$19,951	$19,951	$19,951	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States and Tribes

Program Description and Accomplishments

In FY 2014, SAMHSA provided $20.0 million for this program within the *Now is the Time* initiative for five-year grants to 17 states to improve access to mental health treatment and related support services for youth and young adults ages 16 to 25 that either have, or are at risk of developing, a serious mental health condition. Individuals who are 16 to 25 years old are at high risk of developing a mental illness or substance use disorder and are at high risk for suicide. Unfortunately, these youth are among the least likely to seek help. As a result, they may not receive the help they need to assume safe and productive adult roles and responsibilities. In this program, states are expanding services, developing family and youth networks for information sharing and peer support, and disseminating best practices for services to these young individuals. In FY 2015, SAMHSA will provide support for 17 *NITT* - Healthy Transition continuation grants and the *NITT* technical assistance and evaluation contracts.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	$19,951,000
FY 2015	$19,951,000
FY 2016	$19,951,000

Budget Request

The FY 2016 Budget Request is $20.0 million at the program level. This is the same as the FY 2015 Enacted Level. SAMHSA requests funding to support third year continuation funding for the 17 *NITT* Healthy Transition grantees. In addition this funding supports *NITT* technical assistance and evaluation contracts.

Outputs and Outcomes Table

Program: Healthy Transitions[1]

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.2.34 Percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2014: 65.5 % Target: 64.0 % (Target Exceeded)	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 2014: 39.6 % Target: 36.0 % (Target Exceeded)	36.0 %	36.0 %	Maintain
3.2.36 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2014: 55.7 % Target: 56.0 % (Target Not Met)	56.0 %	56.0 %	Maintain
3.2.38 Increase the number of individuals referred to mental health or related services (Intermediate Outcome)	FY 2013: 7,389[1] Target:7,389 (Baseline)	5,911[2]	5,911	Maintain

[1]The 2013 baseline results do not represent actual program activity. SAMHSA used results from the Garrett Lee Smith State/Tribal Youth Suicide Prevention Program to derive the FY 2013 baseline for the new Healthy Transitions program which began in 2014 as these programs focus on the same age cohort.

[2]The decrease in the FY 2016 target was due to a $5 million reduction (from $25 million to $20 million) in program funding in the FY 2015 appropriation. The FY 2016 target was calculated using the cost per person served which was derived by dividing the FY 2013 Garrett Lee Smith State/Tribal appropriation by the FY 2013 baseline. This amount became the numerator and the FY 2015 appropriation of $20 million the denominator to determine the FY2016 target.

National Child Traumatic Stress Initiative

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
National Child Traumatic Stress Initiative	$45,887	$45,887	$45,887	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Local Governments, Tribes, Institutions of Higher Education, and Community Organizations

Program Description and Accomplishments

Established in 2000, the National Child Traumatic Stress Initiative (NCTSI) aims 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 sites to more than 165 funded and affiliate centers located nationwide in universities, hospitals, and other diverse community-based organizations, with thousands of national and local partners. The NCTSN's mission is to raise the standard of care and improve access to services for children experiencing trauma, their families, and communities. The SAMHSA-funded National Center for Child Traumatic Stress (NCCTS) recipient, UCLA's Neuropsychiatric Institute, partners with Duke University Medical Center. Network members work together within and across diverse settings, including a wide variety of governmental and non-governmental organizations.

Data collected through FY 2013 demonstrate that the current grantees in the NCTSN have provided trauma-informed treatment to nearly 25,000 children, adolescents and family members. The NCTSN continues to be a principal source of child-trauma training for the nation. In FY 2013, NCTSN grantee sites provided training to more than 170,000 individuals. The Network has developed resources for child/adolescent trauma on the NCTSN website, which receives on average 2,500 visits a day. During this same time period, 45 new resources were developed. In addition, individuals have downloaded site products such as fact sheets and toolkits more than 70,000 times. The Network has developed a Learning Center website that provides access to 195 expert webinars on trauma topics, 26 intensive learning collaboratives, and various online certification programs that offer continuing education credits free of charge.

In FY 2014, SAMHSA provided continuation support to 78 NCTSN four-year grants and continued to build on the robust work of the NCTSN and improve and enhance the capacity of the NCTSI to deliver effective interventions and core trauma practices. Recipients of these grants include community providers and research organizations with expertise in child trauma. In FY 2015, SAMHSA plans to support for the final year of the existing 78 NCTSI continuation grants.

Funding History

Fiscal Year	Amount
FY 2012	$45,713,438
FY 2013	$43,322,145
FY 2014	$45,887,000
FY 2015	$45,887,000
FY 2016	$45,887,000

Budget Request

The FY 2016 Budget Request is $45.9 million at the program level, the same as the FY 2015 Enacted Level. SAMHSA requests funding for 81 new grant awards to continue support for the improvement of behavioral health treatment, services, and interventions for children and adolescents exposed to traumatic events.

Outputs and Outcomes Table

Program: National Child Traumatic Stress Initiative (NCTSI)

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.2.02a Increase the percentage of children receiving trauma informed services who report positive functioning at 6 month follow-up (Outcome)	FY 2014: 77.9% Target: 76.1% (Target Exceeded)	65.9%	65.9%	Maintain
3.2.23 Unduplicated count of the number of children and adolescents receiving trauma- informed services (Outcome)	FY 2014: 46,106[1] Target: 3,052 (Target Exceeded)	48,872[2]	48,872	Maintain
3.2.24 Number of child-serving professionals trained in providing trauma-informed services (Outcome)	FY 2014: 213,093 Target: 95,186 (Target Exceeded)	225,710	225,710	Maintain

[1] The result has been revised to include an additional data source. Previously, the measure greatly underreported the number of children benefitting from NCTSI evidence-based practices as it only included those children who received services provided by the NCTSI Category III grantees. By including the additional data source, the total now includes the number of children receiving services from providers trained by NCTSI Category II and Category III grantees.

[2] The target has been revised to include an additional data source. Previously, the measure greatly underreported the number of children benefitting from NCTSI evidence–based practices as it only included those children who received services provided by the NCTSI Category III grantees. By including the additional data source, the total now includes the number of children receiving services from providers trained by NCTSI Category II and Category III grantees.

Children and Family Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Children and Family Programs	$6,458	$6,458	$6,458	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method ..... Competitive Grants/Contracts/ Interagency Agreements
Eligible Entities..... Tribes

Program Description and Accomplishments

SAMHSA's Children and Family Programs provide support for the Circles of Care grant program. These grants enhance and improve the quality of existing services, and promote the use of culturally competent services for American Indian/Alaska Native (AI/AN) children and youth with, or at risk for, mental disorders and their families. Initially funded in 1998, the Circles of Care Program is a three-year grant which seeks to eliminate mental health disparities by providing tribal and Alaska Native communities with tools and resources to build and sustain their own culturally competent systems of care model for children's mental health. The program reflects the unique history and needs of tribal and Alaska Native communities. The program also increases capacity and community readiness to address the mental health issues of children and families. There is tremendous need in Indian Country related to mental and substance use disorders, and through Circles of Care, SAMHSA has improved the availability, accessibility and acceptability of behavioral health services for native youth. In the last cohort of grantees, all four tribes that applied for a systems of care grant received funding.

In addition, SAMHSA's Children and Family Programs supports two technical assistance centers called the Rehabilitation Research and Training Centers (RRTCs) on Transition to Employment for Youth and Young Adults with Serious Mental Health Conditions. These RRTCs seek to advance the current knowledge base by supporting research, training, technical assistance, and knowledge translation activities that contribute to improved employment outcomes for youth and young adults with serious mental health conditions, including youth and young adults from high-risk, disadvantaged backgrounds.

In FY 2014, SAMHSA continued to support Children and Family programs, including 11 three-year new Circles of Care grants to tribal communities and two RRTCs. In FY 2015, SAMHSA plans to continue support for these Children and Family programs.

Funding History

Fiscal Year	Amount
FY 2012	$6,473,741
FY 2013	$6,460,794
FY 2014	$6,458,000
FY 2015	$6,458,000
FY 2016	$6,458,000

Budget Request

The FY 2016 Budget Request is $6.5 million at the program level. This is the same as the FY 2015 Enacted Level. SAMHSA requests funding to continue support for the Children and Family programs which enhance and improve the quality of existing services, and promote the use of culturally competent services and support for AI/AN children and youth with, or at risk for, mental health conditions and their families.

The outputs and outcomes measures for Children and Family Programs are part of the Mental Health - Other Capacity Activities outputs and outcomes table shown on page 110.

Consumer and Family Network Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Consumer and Family Network Grants	$4,954	$4,954	$4,954	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....Community Organizations

Program Description and Accomplishments

The Consumer and Family Network Programs support SAMHSA's Recovery Support Strategic Initiative by providing consumers, families, and youth with opportunities to meaningfully participate in the development of policies, programs, and quality assurance activities related to mental health systems across America. The Consumer and Family Network Programs support three grant activities: the Statewide Consumer Network Program, the Statewide Family Network Program, and the Statewide Peer Network Development Program for Recovery and Resiliency program.

The Statewide Consumer Network Grant Program focuses on the needs of adult mental health consumers (18 years and older) by strengthening the capabilities of statewide consumer-run organizations. These entities serve an important role in engaging consumers, caregivers and providers in improving and transforming the mental health and related systems in their states.

This network is a sustainable mechanism 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.

The Statewide Family Network Grant Program 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, children, youth, and young adults refer to individuals 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.

The Statewide Peer Network Development Program for Recovery and Resiliency began in FY 2014 and builds the capacity of statewide consumer-run, family member-run, and addiction recovery community organizations to promote infrastructure development across the mental health and addiction recovery communities. This program is braided between the Mental Health appropriation and the Substance Abuse Treatment appropriation to allow for collaborative partnerships across the mental and substance use disorder fields. SAMHSA tracks any braided amounts spent or awarded under their distinct appropriations and ensures that funds are used for purposes consistent with legislative direction and intent of the appropriations. Eligible applicants for this program were those organizations that had an existing mental health or addiction statewide network award from SAMHSA.

In FY 2014, SAMHSA provided continuation funds for 24 three-year Statewide Consumer Network grants and 32 three-year Statewide Family Network grants, awarded a technical assistance contract, and awarded nine one-year Statewide Peer Network Development Program for Recovery and Resiliency grants. In FY 2015, SAMHSA will provide continuation funds for 13 Statewide Consumer Network grants, 26 Statewide Family Network grants, and a technical assistance contract. In addition, SAMHSA will award a new cohort of Statewide Consumer Network, Statewide Family Network and Statewide Peer Network Development grants. All of these grants go to consumer-oriented community organizations.

Funding History

Fiscal Year	Amount
FY 2012	$6,224,371
FY 2013	$6,140,243
FY 2014	$4,954,000
FY 2015	$4,954,000
FY 2016	$4,954,000

Budget Request

The FY 2016 Budget Request is $5.0 million at the program level. This is the same as the FY 2015 Enacted Level. SAMHSA requests funding to continue support for these grant programs that promote consumer, family, and youth participation in the development of policies, programs, and quality assurance activities related to mental health systems reform across America.

The outputs and outcomes measures for Consumer and Family Network Programs are part of the Mental Health - Other Capacity Activities outputs and outcomes table shown on page 110.

Project LAUNCH

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Project LAUNCH	$34,555	$34,555	$34,555	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....States and Tribes

Program Description and Accomplishments

Project LAUNCH increases use of evidence-based practices that enhance the health of young children from birth through age eight. In FY 2008, Congress provided initial funding to implement the Linking Actions for Unmet Needs in Children's Health (Project LAUNCH) wellness initiative. This funding increases grantees' capacities to develop infrastructure and implement prevention/promotion strategies proven to promote the health of young children. Project LAUNCH drives federal, state, territorial, tribal, and local networks to coordinate key child-serving systems and to integrate behavioral and physical health services.

As of 2014, performance data for the program found:

- Approximately 145,000 children and parents were assessed on social and emotional functioning and screened for behavioral health issues in diverse settings (e.g., primary care, childcare, and home visiting)
- Project LAUNCH-supported home visiting and family strengthening programs have served nearly 2,300 families.
- Approximately 51,000 community providers have been trained on social-emotional and behavioral health for young children.
- Over 116,000 individuals received evidence-based mental health services.
- Project LAUNCH data also indicate that nearly 2,600 new organizations are collaborating, coordinating, and sharing resources to implement prevention/promotion strategies for young children.

The multi-site evaluation of Project LAUNCH is ongoing. Phase one of the evaluation used a meta-analytical approach to assess the implementation of Project Launch. The findings indicate that grantees successfully achieved three goals: improvements to the local child services system in the LAUNCH communities; improvements to the state child services system; and enhancements to the child and family services in the communities. In addition, Project LAUNCH grantees have reported improved social and academic functioning among the targeted population, and 78 percent have reported decreases in problem behaviors among the targeted population. As the program expands to new states and territories, the current phase of the multi-site evaluation has evolved to a quasi-experimental design to better assess the impact of LAUNCH around the following: social and emotional development of children; externalizing and internalizing behaviors of children; family relationships and mental health status of parents; cognitive development of children; and physical health of children.

GPRA data include the varying phases of a Project LAUNCH grant over a five-year cycle. Grantees move from planning in year one, increasing capacity in years two and three, achieving maximum service capacity in year four, and phasing down in year five. In FY 2013, three LAUNCH cohorts were in full service implementation, while in 2014, because of a skipped year of funding, only two cohorts of grantees were in the full service implementation phase of their grant. This cycle explains why results in 2014 were slightly below projections in most categories.

In FY 2014, SAMHSA provided funds to support 22 five-year continuation grants, 15 five-year new grants, and technical assistance and evaluation activities. In FY 2015, SAMHSA plans to support 31 five-year continuation grants, a new cohort of four-year grants, and a technical assistance and evaluation activities. The new grant cohort provides support to states and tribes that have successfully implemented Project LAUNCH with the goal of expanding the work beyond the pilot communities to additional communities across the states and tribes.

Funding History

Fiscal Year	Amount
FY 2012	$34,640,407
FY 2013	$32,828,505
FY 2014	$34,555,000
FY 2015	$34,555,000
FY 2016	$34,555,000

Budget Request

The FY 2016 Budget Request is $34.6 million at the program level. This is the same as the FY 2015 Enacted Level. Funding is requested to continue support of 35 five-year continuation grants that will improve health outcomes for young children.

Outputs and Outcomes Table

Program: Mental Health-Project LAUNCH

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
2.3.94 Number of persons served (Output)	FY 2014: 31,368 Target: 32,232 (Target Not Met)	38,588	38,594	+6
2.3.95 Number of persons trained in mental illness prevention or mental health promotion (Outcome)	FY 2014: 10,229 Target: 13,102 (Target Not Met)	13,102	13,102	Maintain
2.4.00 Number of 0-8 year old children screened for mental health or related interventions (Outcome)	FY 2014: 36,731 Target: 44,775 (Target Not Met)	44,775	44,775	Maintain
2.4.01 Number of 0-8 year old children referred to mental health or related interventions (Outcome)	FY 2014: 8,575 Target: 9,114 (Target Not Met)	9,114	9,114	Maintain

Mental Health System Transformation and Health Reform

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
MH System Transformation and Health Reform	$10,556	$3,779	$3,779	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States and Tribes

Program Description and Accomplishments

The Mental Health System Transformation and Health Reform includes two activities that facilitate the transformation of the mental health delivery system: Mental Health Transformation Grants (MHTG) and Transforming Lives through Supported Employment Grants.

The purpose of the MHTG 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. These grants support States and local governments to create and/or expand treatment capacity related to prevention and wellness, trauma-informed care, military families, housing and homelessness, jobs and the economy.

In FY 2013, MHT 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 program. In FY 2014, SAMHSA provided funds to 20 grantees to support the final year of five-year MHTG grant project.

The Transforming Lives through Supported Employment Grant program began in FY 2014 as a focused effort to enhance state and community capacity to provide evidence-based supported employment (SE) programs for adults and youth with serious mental illnesses/emotional disturbances (SMI/SED). Transforming Lives through Supported Employment Grants helps people with mental illnesses discover paths of self-sufficiency and recovery rather than disability and dependence. These grants support mental health consumers, treatment providers, and employers develop mutual understanding and successful relationships, with gainful employment as the target outcome.

In FY 2014, SAMHSA awarded seven five-year Transforming Lives through Supported Employment grants. In FY 2015, SAMHSA will support the continuation of these grants. In addition, SAMHSA will provide technical assistance.

Funding History

Fiscal Year	Amount
FY 2012	$10,602,923
FY 2013	$10,448,347
FY 2014	$10,556,000
FY 2015	$3,779,000
FY 2016	$3,779,000

Budget Request

The FY 2016 Budget Request is $3.8 million at the program level. This is the same as the FY 2015 Enacted Level. Funding is requested to support the continuation of seven five-year Transforming Lives through Supported Employment Grants to enhance state and community capacity to provide evidence-based supported employment programs for adults and youth with serious mental illnesses/emotional disturbances.

Outputs and Outcomes Table

Program: Mental Health System Transformation Grants

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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 2014: 4,259 Target: 1,488 (Target Exceeded)	1,540	4,303	+2,763
1.2.21 Percentage of clients receiving services who report positive functioning at 6 month follow-up (Outcome)	FY 2014: 57.1 Target: 52.1 (Target Exceeded)	52.1	52.1	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 2014: 76.7 Target: 73.7 (Target Exceeded)	73.7	73.7	Maintain
1.2.23 Percentage of clients receiving services who are currently employed at 6 month follow-up (Outcome)	FY 2014: 32.2 Target: 30.7 (Target Exceeded)	30.7	30.7	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	

Primary and Behavioral Health Care Integration (PBHCI)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Primary and Behavioral Health Care Integration	$49,877	$49,877	$26,004	-$23,873
Prevention & Public Health Fund (non-add)	---	---	*26,004*	*+26,004*
Primary and Behavioral Health Care Integration TTA	*1,991*	*1,991*	*1,996*	+5
Prevention & Public Health Fund (non-add)	---	---	*1,996*	*+1,996*

Authorizing Legislation .....Sections 520A and 520K of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Qualified Community Mental Health Programs

Program Description and Accomplishments

The Primary and Behavioral Health Care Integration (PBHCI) program began in FY 2009 and addresses the increased rates of morbidity and mortality among adults with serious mental illnesses (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. Physical health problems among people with SMI impact quality of life and contribute to premature death. Empirical findings indicate the clear link between early mortality among people with SMI and the lack of access to primary care services.

The PBHCI program supports two activities: PBHCI grants to community mental health centers and the PBHCI Training and Technical Assistance (TTA) Center, which is funded through a competitive cooperative agreement that is co-funded with the Health Resources and Services Administration (HRSA). These two activities collectively support the coordination and integration of primary care services into publicly funded community behavioral health settings. The expected outcome of improved health status for people with 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 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.

To date, SAMHSA has awarded 126 PBHCI grants. In FY 2014, the PBHCI grant program served more than 33,000 consumers. Improvements in three of four National Outcome Measures – functioning, social connectedness, and housing – were consistently positive as a result of this intervention. A cross-site evaluation of the PBHCI program funded by SAMHSA concluded in September of 2013, which examined the impact of the PBHCI grants on physical health outcomes. An additional PBCHI evaluation project, funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), is currently examining the impact of the program on consumers' use of medical services and their total health care costs as reflected in archival data from Medicaid/Medicare. The new FY 2015 PBHCI grant application improvements stem

from the results of the SAMHSA/HRSA evaluation. In FY 2015, SAMHSA plans to award a new PBHCI evaluation contract that builds on recommendations from the FY 2013 evaluation and seeks to use a more comprehensive approach to determine the impact of the PBHCI grants on the health of the clients served.

PCASI activities also support the braided HIV Continuum of Care effort to coordinate activities across the Federal government to improve the delivery of HIV/AIDS services. There is significant co-morbidity of hepatitis and HIV infection. Up to 20 percent of those with either substance use disorders or serious mental illness also are infected with viral hepatitis. In order to address this, five percent of funds can 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 works closely with the Centers for Disease Control and Prevention and HRSA to ensure these efforts are complimentary and aligned to best serve individuals living with HIV.

In FY 2014, SAMHSA supported 16 four-year continuation grants as well as awarded 26 four-year multi-funded new PBHCI grants and one technical assistance contract. In FY 2015, SAMHSA will support 16 continuation grants, a new cohort of 102 PBHCI grants, one technical assistance contract, and one evaluation contract.

Funding History

Fiscal Year	Amount
FY 2012	$67,744,995
FY 2013	$30,633,523
FY 2014	$51,868,000
FY 2015	$51,868,000
FY 2016	$28,000,000

Budget Request

The FY 2016 Budget Request is $28.0 million at the program level from the Prevention and Public Health Fund. This is a decrease of $23.9 million from the FY 2015 Enacted Level. This funding will continue to support the coordination and integration of primary care services into publicly-funded community behavioral health settings. PBHCI grantees have made great strides in demonstrating methods of integrating physical health care into specialty behavioral health settings for people with serious mental illnesses. This learning is being incorporated into SAMHSA guidance to the states around the block grants, SAMHSA's consultation on the Medicaid health homes program, implementation of the section 223 program, and into a broader focus on integration across SAMHSA's grant portfolio.

Outputs and Outcomes Table

Program: Primary & Behavioral Health Care Integration (PBHCI)

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.2.40 Number of clients served (Output)	FY 2014: 33,398 Target: 33,023 (Target Exceeded)	56,552	30,528	-26,024
3.2.41 Percentage of clients receiving services who report positive functioning at 6 month follow-up (Outcome)	FY 2014: 56.4% Target: 55.3% (Target Exceeded)	49.9%	49.9%	Maintain
3.2.42 Percentage of clients receiving services who are currently employed at 6 month follow-up (Outcome)	FY 2014: 21.4% Target: 21.1% (Target Exceeded)	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 2014: 70.4% Target: 71.6% (Target Not Met)	65.7%	65.7%	Maintain

Suicide Prevention Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Suicide Prevention	$60,032	$60,032	$62,032	+$2,000
National Strategy for Suicide Prevention (non-add)	*2,000*	*2,000*	*4,000*	*+2,000*
Prevention & Public Health Fund (non-add)	*2,000*	---	---	---
Suicide Lifeline (non-add)	*7,198*	*7,198*	*7,198*	---
Prevention & Public Health Fund (non-add)	*1,700*	---	---	---
GLS- Youth Suicide Prevention - States (non-add)	*35,427*	*35,427*	*35,427*	---
Prevention & Public Health Fund (non-add)	*5,800*	*12,000*	*10,000*	*-2,000*
GLS- Youth Suicide Prevention - Campus (non-add)	*6,488*	*6,488*	*6,488*	---
Prevention & Public Health Fund (non-add)	*1,500*	---	---	---
GLS - Suicide Prevention Resource Center (non-add)	*5,988*	*5,988*	*5,988*	---
Prevention & Public Health Fund (non-add)	*1,000*	---	---	---
AI/AN Suicide Prevention Initiative (non-add)	*2,931*	*2,931*	*2,931*	---

SAMHSA supports the goals and objectives of the National Strategy for Suicide Prevention (NSSP) though the Suicide Prevention Programs highlighted below.

National Strategy for Suicide Prevention

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
National Strategy for Suicide Prevention	$2,000	$2,000	$4,000	+$2,000
Prevention & Public Health Fund (non-add)	*2,000*	---	---	---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Territories, and the District of Columbia

Program Description and Accomplishments

This program supports states efforts to implement the 2012 *National Strategy for Suicide Prevention* (NSSP). While NSSP addresses all age groups and populations with specific needs (e.g. military families; lesbian, gay, bisexual, and transgender individuals, and Native American youth), the goals and objectives of the 2012 NSSP are focused on preventing suicide and suicide attempts among working-age adults 25 to 64 years old in order to reduce the overall suicide rate and number of suicides in the U.S. nationally.

In 2008, suicide became the 10th leading cause of death in the U.S. and remained so through 2010, the most recent year for which there is available mortality data. Previously, suicide had

been the 11th leading cause of death. In 2013, SAMHSA's National Survey on Drug Use and Health reported that approximately 1.3 million Americans age 18 and over attempted suicide; 9.3 million had seriously considered suicide and 2.7 million made a plan. 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. The nation's suicide prevention efforts must go beyond youth and address the issues of suicidal thoughts, plans, attempts, and deaths among adults.

Research 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. 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.

In FY 2014, SAMHSA awarded four new grants for five years to support states in implementing the NSSP goals and objectives. States use NSSP funding to support efforts such as suicide awareness, establishing emergency room referral processes, and improving clinical care practice standards. The grants focused on preventing suicide and suicide attempts among working-age adults 25 to 64 years old. In FY 2015, SAMHSA will provide continuation funds for these four grants.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	$2,000,000
FY 2015	$2,000,000
FY 2016	$4,000,000

Budget Request

The FY 2016 Budget requests $4.0 million, an increase of $2.0 million over the FY 2015 Enacted Level. This increase will expand support so states can further establish evidence-based suicide prevention efforts that support the goals and objectives of the NSSP. SAMHSA will award four continuation grants and four new grants for five years to assist states in further establishing evidence-based suicide prevention efforts that support the goals and objectives of the NSSP.

Suicide Lifeline

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Suicide Lifeline	$7,198	$7,198	$7,198	$---
Prevention & Public Health Fund (non-add)	*1,700*	---	---	---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Tribes, Community Organizations

Program Description and Accomplishments

Launched in FY 2005, the National Suicide Prevention Lifeline (Lifeline), 1-800-273-TALK, coordinates a network of 166 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 112,475 calls per month through November 2014, including a peak of 133,762 calls in August. 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."

Since FY 2007, SAMHSA has partnered with the Department of Veterans Affairs to ensure that veterans calling the Lifeline have 24/7 access to a specialized veterans' suicide prevention hotline. In FY 2014, over 35,500 callers per month that pressed "one" were seamlessly connected to the veterans' crisis line. The 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.

The Lifeline Evaluation is a part of the National Suicide Prevention Evaluation (NSPE), which includes all of the programs in SAMHSA's suicide prevention portfolio. The NSPE is a new evaluation, which will assess the effect of SAMHSA's suicide prevention initiatives on reducing suicide attempts, and mortality due to suicide. The NSPE will also provide training and technical assistance to grantees related to evaluation, data collection, and surveillance.

Prior Lifeline evaluations have been the primary vehicle for collaborating with the crisis centers to adopt standards and guidelines based on evaluation results. These evaluation-driven standards and guidelines have, to date, focused on suicide risk assessment, emergency intervention, and follow-up protocols.

In FY 2014, SAMHSA awarded 12 three-year crisis center follow up continuation grants which provide follow up services to suicidal people who have contacted the Lifeline. SAMHSA also awarded a supplement to the Lifeline from the Prevention and Public Health Fund. In FY 2015,

SAMHSA will award 12 crisis center follow up continuation grants, continue support for the evaluation contract, and award a new three-year Lifeline grant.

Funding History

Fiscal Year	Amount
FY 2012	$6,373,363
FY 2013	$6,085,275
FY 2014	$7,198,000
FY 2015	$7,198,000
FY 2016	$7,198,000

Budget Request

The FY 2016 Budget Request is $7.2 million at the program level. This is the same as the FY 2015 Enacted Level. SAMHSA is requesting funding to continue to support the National Suicide Prevention Lifeline which 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. In addition, the funding will support National Suicide Prevention Lifeline Crisis Center grants to focus on providing follow up to suicidal people discharged from emergency rooms and inpatient units.

Garrett Lee Smith Youth Suicide Prevention - State and Campus

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
GLS- Youth Suicide Prevention - States	$35,427	$35,427	$35,427	$---
Prevention & Public Health Fund (non-add)	*$5,800*	*$12,000*	*$10,000*	*-2,000*
GLS- Youth Suicide Prevention - Campus	$6,488	$6,488	$6,488	---
Prevention & Public Health Fund (non-add)	*1,500*	---	---	---

Authorizing Legislation ..... Sections 520E and 520E-2 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... States, Tribes, and Institutions of Higher Education

Program Description and Accomplishments

Campus Suicide Prevention program has awarded 190 grants to 175 institutions of higher education, inclusive of tribal colleges and universities, to prevent suicide and suicide attempts.

As of June 2014, 747,108 individuals have participated in 25,608 training events or educational seminars provided by grantees. Grantees often use their funds to provide suicide prevention training sessions 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 these individuals, and refer young people to appropriate services. About one third of trainees received training through campus-sponsored courses and educational seminars. More than 64 percent of trainees participated in state-sponsored training activities and 6.7 percent in tribal-sponsored training activities.

In FY 2014, SAMHSA provided continuation funds for 26 GLS State/Tribal grants and 41 GLS Campus programs, awarded 26 new GLS State/Tribal grants, 15 new GLS Campus grants, and one new evaluation contract. In FY 2015, SAMHSA plans to provide continuation funds for 33 GLS State/Tribal grants and 33 GLS Campus grants and award a new cohort of grants for both GLS State/Tribal and GLS Campus programs.

Funding History

Fiscal Year	Amount
FY 2012	$43,135,592
FY 2013	$41,323,125
FY 2014	$41,915,000
FY 2015	$41,915,000
FY 2016	$41,915,000

Budget Request

The FY 2016 Budget Request is $41.9 million at the program level with $31.9 million from Budget Authority (BA) and $10.0 million from the Prevention and Public Health Fund (PPHF). This is the same as FY 2015 Enacted Level with a $2.0 million decrease from PPHF and a $2.0 million increase in BA. SAMHSA requests funding to continue developing and implementing youth suicide prevention and early intervention strategies involving public-private collaborations among youth serving institutions. In addition, the funding will support prevention of suicide and suicide attempts at institutions of higher education.

Suicide Prevention Resource Center

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
GLS - Suicide Prevention Resource Center	$5,988	$5,988	$5,988	$---
Prevention & Public Health Fund (non-add)	*1,000*	---	---	---

Authorizing Legislation ..... Sections 520C of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method ..... Competitive Grants
Eligible Entities..... Domestic Public and Private Nonprofit Entities, Tribal and Urban Indian Organizations, Community and Faith-Based Organizations

Program Description and Accomplishments

In addition to programs that build suicide prevention capacity, SAMHSA also supports the Suicide Prevention Resource Center (SPRC). The purpose of this program is to build national capacity for preventing suicide by providing technical assistance, training, and resources to assist states, tribes, organizations, SAMHSA grantees to develop suicide prevention strategies (including programs, interventions, and policies) that advance the *National Strategy for Suicide Prevention* (NSSP), with the overall goal of reducing suicides and suicidal behaviors in the nation. This work includes support of the public-private National Action Alliance for Suicide Prevention, and working to advance high-impact objectives of the NSSP.

In FY 2014, SAMHSA funded the continuation of the five-year SPRC grant and a supplement from the Prevention and Public Health Fund. In FY 2015, SAMHSA plans to award a new five-year SPRC grant.

Funding History

Fiscal Year	Amount
FY 2012	$5,597,631
FY 2013	$5,338,840
FY 2014	$5,988,000
FY 2015	$5,988,000
FY 2016	$5,988,000

Budget Request

The FY 2016 Budget Request is $6.0 million at the program level. This is the same as the FY 2015 Enacted Level. Funding is requested to continue to promote the implementation of the NSSP and enhance 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.

AI/AN Suicide Prevention

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
AI/AN Suicide Prevention Initiative	$2,931	$2,931	$2,931	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method ..... Contracts
Eligible Entities..... Not applicable

Program Description and Accomplishments

The Tribal Training and Technical Assistance Center (Tribal TTA Center) is an innovative training and technical assistance project that helps tribal communities facilitate 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. These plans mobilize tribal communities existing social and educational resources to meet their goals. To date, 65 tribal communities have received specialized technical assistance and support in suicide prevention and related areas. In addition, more than 9,200 members of these communities received training in prevention and mental health promotion.

In FY 2014, SAMHSA supported the continuation of this five-year contract. In FY 2015, SAMHSA will continue to support this activity through the existing contract.

Funding History

Fiscal Year	Amount
FY 2012	$2,938,436
FY 2013	$2,784,738
FY 2014	$2,931,000
FY 2015	$2,931,000
FY 2016	$2,931,000

Budget Request

The FY 2016 Budget Request is $2.9 million at the program level. This is the same as the FY 2015 Enacted Level. SAMHSA requests funding to continue support of comprehensive, broad, focused, and intensive training and technical assistance to federally recognized tribes and other AI/AN communities, seeking to address and prevent mental and substance use disorders, suicide, and promote mental health through the contract continuation.

Outputs and Outcomes Table

Program: Suicide Prevention

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
2.3.59 Total number of individuals trained in youth suicide prevention (Intermediate Outcome)	FY 2014: 143,369[1] Target: 36,078 (Target Exceeded)	154,369	160,082	+5,713
2.3.60 Total number of youth screened (Output)	FY 2014: 26,053 Target: 3,427 (Target Exceeded)	61,626	64,091	+2,465
2.3.61 Increase of the number of calls answered by the suicide hotline (Output)	FY 2014: 1,308,825 Target: 765,638 (Target Exceeded)	1,308,825	1,308,825	Maintain
3.2.37 Increase of the number of individuals referred to mental health or related services (Output)	FY 2014: 8,219 Target: 5,911 (Target Exceeded)	8,850[2]	9,177	+327

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

[2] Changed from previously reported to reflect baseline results.

Homelessness Prevention and Housing Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Homelessness Prevention Programs	$30,696	$30,696	$30,696	$---
Homelessness	2,296	2,296	2,296	---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Domestic Public and Community Organizations, Private Nonprofit Entities, Community-based Public or Nonprofit Entities

Program Description and Accomplishments

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. A significant portion of persons who are chronically homeless have mental and/or substance use disorders.[20] The U.S. Interagency Council on Homelessness, in which HHS participates, has set aggressive goals to permanently house and address the needs of those who are chronically homeless and/or who are veterans and homeless. Two programs are helping to support the goal of this Strategic Initiative: Grants for the Benefit of Homeless Individuals-Services in Supportive Housing (GBHI-SSH) and Cooperative Agreements to Benefit Homeless Individuals (CABHI).

The first program, GBHI-SSH, implemented in FY 2007, provides comprehensive services including outreach, engagement, intensive case management, mental health services, substance abuse treatment, and benefits support, in conjunction with linkage to permanent supportive housing. The target population is individuals with serious mental illnesses (SMI) 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. In FY 2014, the GBHI-SSH program's outreach efforts resulted in 64,627 total contacts made.

In FY 2014, SAMHSA provided $2.0 million to five grantees to support the final year of the five-year GBHI-SSH project period. This marked the last year of funding for the GBHI-SSH grants.

The CABHI program, initiated in FY 2011, supports treatment and the development and/or expansion of local systems that provide permanent housing and supportive services. This

[20] *HUD's 2010 Annual Homeless Assessment Report to Congress* estimates that 26 percent of homeless adults staying in shelters live with serious mental illness and an estimated 46 percent live with severe mental illness and/or substance use disorders.

includes integration of treatment and other critical services for individuals with mental and substance use disorders; coordination at the local level with state or local Public Housing Authorities; local mental health, substance abuse, and primary care provider organizations; the local Continuum of Care (CoC); the state Medicaid Office; and the state Mental Health and Substance Abuse Authorities. As of FY 2013, 42 funded grants served 1,939 people. Evidence found that individuals served had reduced experiences of depression and anxiety (62.5 percent and 66.2 percent respectively). Data show that between intake and six-month follow up, abstinence from substance use increased by six percent, injection drug use decreased by 22 percent, and stability in housing increased by 49.8 percent.[21] This is a jointly funded program between SAMHSA's Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT).

In FY 2014, SAMHSA provided $11.9 million ($4.6 million from CMHS and $7.2 million from CSAT) to support continuation funding for the 19 three-year CABHI grants to community-based public or nonprofit entities and approximately $5.2 million (from CMHS) to support nine two-year grant supplements. In FY 2015, SAMSHA plans to support 10 CABHI continuation grants.

The CABHI-States program, which began in FY 2013, builds on the CABHI program by working with states to provide accessible, effective, comprehensive, coordinated/integrated, and evidenced-based treatment services; peer supports; and enhancement or development of a statewide plan to ensure sustained partnerships across public health and housing systems that will result in short-and long-term strategies to support behavioral health services for individuals who experience chronic homelessness. This activity is also jointly funded with SAMHSA's CSAT.

In FY 2014, SAMHSA provided approximately $20.4 million to award seven three-year new CABHI-States grants to State Mental Health Authorities (SMHAs) or the Single State Agencies (SSAs) for Substance Abuse to work 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 individuals with mental and/or substance use disorders experiencing homelessness.

In FY 2015, SAMHSA will support eight new three-year CABHI-States and 18 three-year new CABHI-States Enhancement grants to build upon lessons learned from the CABHI program.

SAMHSA awarded a consolidated evaluation contract in FY 2011 to identify commonalities across the programs to compare effectiveness of the programs and of the various models of services delivery, including evidence-based practices, used within and across programs. The first new cohort of CABHI grants was added to the original number of grants included an award of the evaluation contract. This contract will provide evaluation support through FY 2015. In FY 2015, SAMHSA plans to support three contracts (a national evaluation; technical assistance; and Security Insurance/Social Security Disability Outreach, Access and Recovery [SOAR].

[21] Services Accountability Improvement System (SAIS); www.samhsa-gpra.samhsa.gov; 2013.

Funding History

Fiscal Year	Amount
FY 2012	$33,073,373
FY 2013	$31,343,438
FY 2014	$32,992,000
FY 2015	$32,992,000
FY 2016	$32,992,000

Budget Request

The FY 2016 Budget Request is $33.0 million at the program level. This is the same as the FY 2015 Enacted Level. This funding will continue 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 housing; peer support; and other critical services for those who experience homelessness or chronic homelessness. In addition, funding is requested to continue to support innovative strategies to provide needed services and supports to individuals who are experiencing homelessness with substance use and mental health disorders in the community, by assisting providers in strengthening their infrastructure for delivering and sustaining housing to support recovery with integrated behavioral health, and providing other critical services.

Outputs and Outcomes Table

Program: Mental Health Homelessness Prevention Programs

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.4.01 Number of clients served (Output)	FY 2014: 3,976 Target: 5,034 (Target Not Met)	4,959	4,959	Maintain
3.4.02 Increase of the percentage of adults with severe mental illness receiving homeless support services who report positive functioning at 6 month follow-up (Outcome)	FY 2014: 66.0 % 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 2014: 25.9 % 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 2014: 83.0 % Target: 60.6 % (Target Exceeded)	81.2 %	81.2 %	Maintain

Minority AIDS

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Minority AIDS	$9,224	$9,224	$15,935	+$6,711
HIV/AIDS Education	771	771	771	---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Community and faith-based organizations, Tribes, Urban, Indian organizations, Hospitals, Public and private universities and colleges

Program Description and Accomplishments

The Minority AIDS program enhances and expands the provision of effective, culturally competent, HIV/AIDS-related mental health services in minority communities for people living with or at high risk for contracting HIV/AIDS. The Centers for Disease Control and Prevention (CDC) reports significantly higher rates of HIV/AIDS among racial/ethnic minorities compared with the general population. 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). Psychiatric and psychosocial complications are frequently not diagnosed or addressed at the time of HIV 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. More than 5,800 individuals received services in FY 2014.

The Mental Health Care Provider Education in HIV/AIDS Education program disseminates knowledge and training on the treatment of the neuropsychiatric and psychological complications of HIV/AIDS to front-line providers, including psychiatrists, psychologists, social workers, primary care practitioners, and medical students.

In FY 2014, SAMHSA's Center for Mental Health Services, Center for Substance Abuse Prevention, and Center for Substance Abuse Treatment supported a pilot HIV Continuum of Care grant program, 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 includes substance abuse primary prevention/treatment service programs, community mental health programs, and HIV integrated programs that can either co-locate or have fully integrated HIV prevention and medical care services. This program also provides substance abuse and HIV primary prevention services in local communities served by the behavioral health program. In addition, because of the significant co-morbidity 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 illnesses, five percent of the allocated funds were 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 addition SAMHSA awarded a contract to evaluate the MAI program. This contract will evaluate both the process and the impact of programs that integrate mental health promotion, substance abuse prevention and treatment, HIV prevention, testing, and counseling activities, linkage to services, and medical treatment, and care (as programmatically appropriate) for people most at risk for HIV infection and living with HIV/AIDS.

In FY 2014, SAMHSA awarded 34 four-year HIV Continuum of Care grants and a technical assistance contract. In FY 2015, SAMHSA will fund the continuation of 34 HIV Continuum of Care grants, a technical assistance contract, and award a new evaluation contract.

Funding History

Fiscal Year	Amount
FY 2012	$10,037,992
FY 2013	$9,571,658
FY 2014	$9,995,000
FY 2015	$9,995,000
FY 2016	$16,706,000

Budget Request

The FY 2016 Budget Request is $16.7 million at the program level. This is an increase of $6.7 million from the FY 2015 Enacted Level. Funding is realigned from CSAT to CMHS in order to enable SAMHSA to more effectively administer the braided MAI-Continuum of Care Program which will provide fully integrated medical care and mental and substance use disorder treatment to those living with HIV. This funding will enhance and expand the provision of effective, culturally competent, HIV/AIDS-related mental health services in minority communities for people living with HIV/AIDS.

The outputs and outcomes measures for Minority AIDS are part of the Mental Health - Other Capacity Activities outputs and outcomes table shown on page 110.

Criminal and Juvenile Justice Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Criminal Juvenile Justice Programs	$4,269	$4,269	$4,269	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Tribal Court Administrator, the Administrative Office of the Courts, the Single State Agency for Alcohol and Drug Abuse, the State Mental Health Agency, the Designated State Drug Court Coordinator, or local governmental unit

Program Description and Accomplishments

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.[22] The number of individuals involved in the criminal justice system with mental and/or substance use disorders whose treatment needs are unmet by community treatment and supportive services is significant. As a result, these individuals 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.

In FY 2014, SAMHSA supported a new four-year cohort of Behavioral Health Treatment Court Collaborative grants (BHTCC) from Mental Health and Substance Abuse Treatment appropriations. The purpose of this grant program is to allow municipal 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 focuses on diversion of adults with behavioral health problems from the criminal justice system, including alternatives to incarceration. The program supports community behavioral health services for individuals with mental and/or substance disorders and includes a focus on veterans involved with the criminal justice system.

An evaluation of the first cohort of grantees was completed in September 2014. Grantees built multi-agency workgroups or collaboratives to oversee programs; all grantees expanded access to specialty courts because of the grant. Most grantees anticipated that new screening and assessment processes addressing a broader array of behavioral health needs would continue after grant funding ended. Program innovations were divided into four main groups including court

[22] Steadman, HJ, Osher, FC, Robbins, PC, Case, BF, & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. Psychiatric Services, 60(6), 761-765.

and treatment collaboration, court and community collaboration, unified cross-court screening and referral, and meaningful peer involvement. The BHTCC served over 1,400 persons, many of them with co-occurring disorders and with significant trauma exposure in their lives. Based on self-report data, program participants generally experienced improvements in mental illness and reductions in substance use.

An evaluation of the first cohort of BHTCC grantees was completed in September 2014. Grantees built multi-agency workgroups or collaboratives to oversee programs. All grantees expanded access to specialty courts as a result of the grant. Most grants anticipated that new screening and assessment processes addressing a broader array of behavioral health needs would continue after grant funding ended. Program innovations were divided into four main groups, including court and treatment collaboration, court and community collaboration, unified cross-court screening and referral, and meaningful peer involvement. Over 1,400 persons were served through the BHTCC, many of them with co-occurring disorders and with significant trauma exposure in their lives. Based on self-report data, program participants generally experienced improvements in mental health and reductions in substance use.

In FY 2014, SAMHSA awarded the final year of one five-year continuation grant and 17 new four-year BHTCC grants. In FY 2015, SAMHSA plans to provide continuation support for 17 grants, a technical assistance contract, and award a new evaluation contract. The new BHTCC evaluation will focus on examining the clinical and functional outcomes of program participants with behavioral health disorders. The intent of the FY 2015 evaluation is to build off of the findings from the first cohort and to more deeply examine both the features of successful collaborations between the courts and community services as well as the clinical and functional outcomes of program participants with behavioral health disorders.

Funding History

Fiscal Year	Amount
FY 2012	$6,671,367
FY 2013	$5,876,801
FY 2014	$4,296,000
FY 2015	$4,296,000
FY 2016	$4,296,000

Budget Request

The FY 2016 Budget Request is $4.3 million at the program level. This is the same level as the FY 2015 Enacted Level. SAMHSA requests funding to continue the support for the Behavioral Health Treatment Court Collaboratives (BHTCC) grant program. Court collaboratives will focus on diversion of adults with behavioral health problems from the criminal justice system and alternatives to incarceration. These programs will continue to provide comprehensive treatment and recovery support services for adolescents and adults with substance use disorders coming into contact with the criminal justice system as well as offenders re-entering the community. SAMHSA proposes to focus this portfolio more strategically to explore new approaches and a

variety of models within the drug court umbrella rather than using a significant portion of SAMHSA's limited funding to support what is already a robust system.

The outputs and outcomes measures for Criminal and Juvenile Justice Programs is part of the Mental Health - Other Capacity Activities outputs and outcomes table shown on page 110.

Practice Improvement and Training

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Practice Improvement and Training	$7,828	$7,828	$7,828	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... 105 Nationally Recognized HBCUs, Federal Partners

Program Description and Accomplishments

SAMHSA facilitates health integration by engaging in activities that support mental health system transformation and reform. The Practice Improvement and Training programs address the need for disseminating key information, such as evidence-based mental health practices, to the mental health delivery system through three activities: the Historically Black Colleges and Universities Center for Excellence in Behavioral Health (HBCU-CFE) program, the Rehabilitation Research and Training Centers (RRTCs), and the Transforming Lives through Supported Employment Grant Program.

The purpose of the HBCU-CFE is to network the 105 HBCUs in the United States and promote behavioral health workforce development through expanding knowledge of best practices, developing leadership, and encouraging community partnerships that enhance the participation of African Americans in the substance use disorder treatment and mental health professions. The comprehensive focus of the HBCU-CFE will simultaneously expand service capacity on campuses and in other treatment venues.

In FY 2014, SAMHSA awarded a three-year new HBCU-Center of Excellence grant to a consortium of HBCUs with a lead university. SAMHSA will continue this effort in FY 2015.

The RRTCs 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. The RRTCs are funded in partnership with the National Institute on Disability, Independent Living, and Rehabilitation Research. 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.

In FY 2014, SAMHSA continued funding for the two RRTCs and will continue this funding in FY 2015.

The Recovery into Practice contract supports the expansion and integration of recovery-oriented care delivered by mental health providers through training and education, policy and analysis, and materials development. The effort crosses professional mental health disciplines to provide education and training on what recovery-oriented care is and how to implement it, hold meetings 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 2014, SAMHSA awarded the Recovery into Practice contract and in FY 2015 to support the continuation of this contract. In addition, in FY 2015, SAMHSA plans to award a Programs to Achieve Wellness contract to promote and facilitate wellness initiatives for people with or at risk for mental disorders, including those with the most serious mental illnesses and with co-occurring substance use disorders. The project will achieve this by engaging people who have lived through their own experience with mental disorders and/or co-occurring substance use disorders, national organizations, communities, states, and tribes in the promotion of evidence-based tools for wellness.

Funding History

Fiscal Year	Amount
FY 2012	$7,863,111
FY 2013	$7,413,110
FY 2014	$7,828,000
FY 2015	$7,828,000
FY 2016	$7,828,000

Budget Request

The FY 2016 Budget Request is $7.8 million at the program level. This is the same as the FY 2015 Enacted Level. SAMHSA requests funding to address the need for disseminating key information, such as evidence-based mental health practices, to the mental health delivery system and facilitate health reform by engaging in activities that support mental health system transformation and reform.

The outputs and outcomes measures for Practice Improvement and Training are part of the Mental Health - Science and Service Activities outputs and outcomes table shown on page 111.

Consumer and Consumer-Supporter TA Centers

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Consumer and Consumer Supporter Technical Assistance Centers	$1,918	$1,918	$1,918	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants
Eligible Entities.....Community Organizations

Program Description and Accomplishments

First funded in 1992, the purpose of Consumer and Consumer-Supporter TA Centers is to provide technical assistance to facilitate the quality improvement of the mental health system by promoting consumer directed approaches for adults with serious mental illnesses. Such approaches maximize consumer self-determination and recovery and assist individuals with serious mental illness by increasing their level of community involvement through work, school and social connectedness, decreasing their dependence on a variety of social service programs and decreasing 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.

In FY 2014, more than 9,500 persons received training and more than 1,700 consumers and family members participated in mental health-related planning and systems improvement.

In FY 2014, SAMHSA provided support for the final year of five five-year continuation grants. In FY 2015, SAMHSA plans to award a new cohort of five regionally focused Consumer and Consumer-Supporter TA Centers for the period of five years.

Funding History

Fiscal Year	Amount
FY 2012	$1,923,358
FY 2013	$1,875,102
FY 2014	$1,918,000
FY 2015	$1,918,000
FY 2016	$1,918,000

Budget Request

The FY 2016 Budget Request is $1.9 million at the program level. This is the same level as the FY 2015 Enacted Level. SAMHSA requests funding to provide technical assistance to facilitate the quality improvement of the mental health system by promoting consumer directed approaches for adults with Serious Mental Illness.

The outputs and outcomes measures for Consumer and Consumer-Supporter TA Centers are part of the Mental Health - Science and Service Activities outputs and outcomes table shown on page 111.

Disaster Response

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Disaster Response	$1,953	$1,953	$1,953	$---

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Domestic Public or Private Nonprofit Entities

Program Description and Accomplishments
SAMHSA helps ensure that the nation is prepared to address the behavioral health needs that follow a natural or man-made disaster. SAMHSA focuses on three major programs: the Crisis Counseling Assistance and Training Program (CCP), the Disaster Distress Helpline (DDH), and the use of any allocated supplemental funds to support survivors of natural and man-made disasters.

SAMHSA, through an interagency agreement with the Federal Emergency Management Agency (FEMA), operates the CCP. This program will assist individuals and communities in recovering from presidentially declared disasters through the provision of community-based behaviorally oriented outreach and psycho-educational services. SAMHSA provides technical assistance, program guidance and monitoring, as well as oversight of the CCP. SAMHSA and FEMA jointly fund a Disaster Technical Assistance Center (DTAC) designed to provide additional technical assistance, strategic planning, consultation, and logistical support.

SAMHSA's DDH is a toll-free, multilingual crisis systems service 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 resulting from disasters. In FY 2014, the DDH received 6,436 calls and 7,848 text messages from 720 users.

Periodically, SAMHSA receives additional funding to help survivors of a particular emergency or disaster. In FY 2013, SAMHSA received a total of $7.5 million in supplemental funds to assist the survivors of Hurricane Sandy. Efforts focused on providing behavioral health treatment, restoring the capability of medication-assisted substance abuse treatment services in the impacted areas, ensuring the operation of the DDH, and conducting resiliency training with educators.

In FY 2014, SAMHSA continued to support the DDH in the provision of crisis counseling services across the nation. Funding continued to support the DTAC in the provision of technical

assistance, consultation, and information dissemination. These services are designed to assist SAMHSA in advancing state and local capacity to deliver effective behavioral health services that are well integrated with traditional public health and disaster recovery efforts. These activities will continue in FY 2015.

Funding History

Fiscal Year	Amount
FY 2012	$1,052,008
FY 2013	$996,982
FY 2014	$1,953,000
FY 2015	$1,953,000
FY 2016	$1,953,000

Budget Request

The FY 2016 Budget Request is $2.0 million at the program level. This is the same as the FY 2015 Enacted Level. SAMHSA is requesting funding to continue the support of a nationally available disaster distress crisis counseling telephone line through a connection to local crisis lines throughout the country and the DTAC.

The outputs and outcomes measures for Disaster Response are part of the Mental Health - Science and Service Activities outputs and outcomes table shown on page 111.

Tribal Behavioral Health Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Tribal Behavioral Health Grants	$4,988	$4,988	$15,000	+$10,012
PHS Evaluation Funds (non-add)	---	---	*5,000*	*+5,000*

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Tribes

Program Description and Accomplishments

Suicide is the second leading cause of death among American Indian/Alaska Native (AI/AN) youth ages 8 to 24 years.[23] AI/AN high school students report higher rates of suicidal behaviors (serious thoughts of suicide, making suicide plans, attempting suicide, and getting medical

[23] Centers for Disease Control and Prevention. Fatal injury data, 2010. Web-based Injury statistics Query and Reporting System. Available at www.cdc.gov/injury/wisqars/fatal.html. Accessed May 27, 2014.

attention for a suicide attempt) than the general population of U.S. high school students.[24] In addition, about 90 percent of those who die by suicide had a mental disorder at the time of their deaths.[25]

In FY 2014, Congress appropriated $5.0 million to SAMHSA to address the high incidence of substance abuse and suicide among AI/AN populations. The Appropriations Committee recommended that HHS award 20 competitive grants to tribal entities with the highest rates of suicide for effective and promising strategies that address substance abuse and suicide and promote mental health among AI/AN young people.

SAMHSA awarded Tribal Behavioral Health competitive grants of up to $0.2 million annually for a total of five years to 20 tribes or tribal organizations with high rates of suicide in FY 2014. The grants will help grantees develop and implement a plan that addresses suicide and substance abuse, thereby promoting mental health among tribal youth. In addition, SAMHSA's Tribal Technical Assistance Center provides technical assistance to grantees to support their ability to achieve their goals. An evaluation component will allow grantees and SAMHSA to work collaboratively to monitor progress and learn from each other. SAMHSA will incorporate lessons learned to enhance this program and other national efforts to reduce suicide and substance abuse and support positive mental health among AI/ANs. SAMHSA will continue the support of this program in FY 2015.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	$4,988,000
FY 2015	$4,988,000
FY 2016	$15,000,000

Budget Request

The FY 2016 Budget Request for the Tribal Behavioral Health Grant (TBHG) program is $30.0 million, including $15.0 million in the Mental Health appropriation and $15.0 million in the Substance Abuse Prevention appropriation. This request represents an increase over the FY 2015 Enacted Level of $10.0 million in the Mental Health appropriation and $15.0 million for a newly established line in the Substance Abuse Prevention appropriation. This funding is part of Generation Indigenous, a Native youth initiative focused on removing possible barriers to success for Native youth. This initiative will take a comprehensive, culturally appropriate

[24] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Available at http://www.cdc.gov/healthyyouth/yrbs/index.htm. Accessed May 27, 2014.
[25] American Association of Suicidology. (2012). *Suicide in the USA Based on 2010 Data.* Washington, DC: American Association of Suicidology. Available at: http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/SuicideUSA2012.pdf.

approach to help improve the lives and opportunities for Native youth. In addition to HHS, multiple agencies, including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing Native youth. This funding will allow SAMHSA to expand activities that are critical to preventing substance abuse and promoting mental health and resiliency among youth in tribal communities. The additional funding will expand these activities to approximately 103 additional tribes and tribal entities. With the expansion of the TBHG program, SAMHSA aims to reduce substance use and the incidence of suicide attempts among Native youth and to address behavioral health conditions which impact learning in Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion and substance use prevention activities for high-risk Native youth and their families, enhance early detection of mental and substance use disorders among Native youth, and increase referral to treatment.

Outputs and Outcomes Table

Program: Tribal Behavioral Health

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
2.4.10 Number of grantees reporting a decrease in underage drinking in their community (Output)	FY 2016: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)			
2.4.11 Number of participants receiving evidence-based mental health – related services as a result of the grant (Output)	FY 2016: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			
2.4.12 Number of youth age 10 – 24 who received mental health or related services after screening, referral or attempt (Output)	FY 2016: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			
2.4.13 The number of programs/organizations that implemented specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2016: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			

Grants for Adult Treatment, Screening, and Brief Response

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Grants for Adult Treatment, Screening, and Briefing Response	---	---	$2,896	+$2,896

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....Communities,
Primary Care Settings (e.g. emergency departments, primary care clinics, and obstetrics/gynecology clinics),
Academic Research Settings in conjunction with Primary Care Settings

Program Description

The effects of trauma can significantly harm the behavioral health of individuals, families, and communities and create challenges for public institutions and service systems. Although many individuals who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. With appropriate support and intervention, individuals can overcome traumatic experiences. However, most individuals go without these services and support. Unaddressed trauma significantly increases the risk of mental and substance use disorders, chronic physical diseases, and early death. Thus, the ability to address proactively the effects of trauma is an important component of effective behavioral health service delivery.

Studies from research and clinical practice have increasingly documented the connection between experiences of traumatic events and physical and behavioral health problems. Building on these findings, SAMHSA released its paper "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach" in July 2014. In this paper, SAMHSA put forward a framework for addressing trauma and implementing a trauma-informed approach in various health and human service sectors. Recognizing that individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health, SAMHSA's framework was intentionally generalizable to different service systems. Particularly in primary care, many patients have trauma histories that affect their health and behavioral health. These experiences are rarely addressed, precluding positive health outcomes. In part, this was the rationale for the recommendation to examine past histories of trauma put forth by the Institute of Medicine report on Women's Preventive Services (IOM).[26]

In 2014 and 2015, SAMHSA, in conjunction with its federal partners at the National Institutes of Health, Office of Women's Health, Health Resources and Services Administration, CDC,

[26] http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx.

Agency for Healthcare Research and Quality, and the Administration on Children and Families, convened a series of expert meetings and virtual discussions to address screening for trauma, providing brief responses and facilitated referrals, and creating trauma-informed approaches in primary care and public health settings. Along with trauma survivors, research-practitioners working on this issue in primary care settings, such as emergency departments, community health clinics, Ryan White clinics, family practice and ob-gyn settings provided valuable information on strategies for addressing trauma in these settings. The challenges and the potential health impacts of appropriate screening and responses in primary care were clearly delineated, further advancing SAMHSA's understanding of the need for and complexity of addressing trauma in these non-behavioral health settings.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$2,896,000

Budget Request

The FY 2016 Budget requests $2.9 million, an increase of $2.9 million from the FY 2015 Enacted Level to implement GATSBR. The program will facilitate and evaluate the impact of appropriate trauma screening and responses in primary care in order to further advance the nation's understanding of the need for, and complexity of, addressing trauma in non-behavioral health settings. SAMHSA, in consultation with its federal partners, is developing the concept and design for these grants.

Crisis Systems: Increasing Crisis Access Response Efforts (ICARE)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Crisis Systems	---	---	$5,000	+$5,000

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Communities

Program Description

Behavioral health crises are critical times for intervention and treatment and key times to engage individuals in on-going treatment and recovery. Such crises often cause great disruption for individuals and those around them, including family members, teachers, law enforcement, and

employers. Well-managed crisis interventions can result in positive outcomes for the individual, family, and community, including increased understanding of mental and substance use disorders, while poorly managed crisis situations can result in frustration, increased health and social services system costs, and negative outcomes for all involved, including potential harm to the individual experiencing the crisis or others.

Comprehensive crisis systems can be challenging to conceive and fund as often there are multiple systems that need to be coordinated, such as emergency response systems such as 911 lines; first responders including police and EMT; emergency room and primary health care; court system; multiple payers; social service providers; and behavioral health providers. Comprehensive crisis systems also have to be designed, funded and staffed to address and manage a range of crisis situations, including various presenting conditions, ages, family situations, and locations. While models of comprehensive crisis delivery systems have been developed and are operating successfully, these comprehensive systems are the exception. More commonly, law enforcement and emergency room personnel respond to public safety and health situations without the benefit of the range of services and support needed to successfully prevent, manage, and follow up on behavioral health crises. Inadequate crisis delivery systems can result in harm to the individual in crisis, law enforcement, or others; unnecessary use of scarce and costly emergency room and inpatient settings; and inappropriate use of jails and criminal justice resources.

The program will seek to increase the engagement with and the functioning of individuals in crisis, increased support for families and caregivers, decreased use of emergency room and inpatient care, and increased understanding by the community of those who experience a behavioral health crisis.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$5,000,000

Budget Request

The FY 2016 Budget requests $10.0 million, including $5.0 million in the Mental Health appropriation and $5.0 million in the Substance Abuse Treatment appropriation, for a new braided program line entitled Crisis Systems. This represents an increase of $10.0 million from the FY 2015 Enacted Level. Funding supports the Increasing Crisis Access Response Efforts (ICARE), a demonstration activity to help communities build, fund, and sustain crisis systems capable of preventing and deescalating behavioral health crises as well as connecting individuals and families with needed post-crisis services. In many incidences, responses to these situations by emergency medical responders and other behavioral health care providers are under- coordinated and un-sustained. These grants will help mitigate the demand for inpatient beds by

those with serious mental illnesses and substance use disorders by coordinating effective crisis response with ongoing outpatient services and supports. As a braided activity, SAMHSA will track separately any amounts spent or awarded under Crisis Systems through its distinct appropriation and ensure that funds are used for purposes consistent with legislative direction and intent of that appropriation.

Outputs and Outcomes Tables

Program: Crisis Systems: Increasing Access Response Efforts (ICARE)

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
(TBD) The number of organizations that entered into formal written inter/intra-organizational agreements (e.g., MOUs/MOAs) to improve mental-health related practices/activities that are consistent with the goals of the grant (Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)			
(TBD) Percentage of clients receiving services who report positive functioning at 6 month follow-up (Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)			
(TBD) The amount of pooled, blended, or braided funding used for mental-health practices/activities that are consistent with the goals of the grant (Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)			
(TBD) Number of individuals referred to mental health or related services (Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline			

Program: Mental Health - Other Capacity Activities[1]

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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 2014: 18,348 Target: 30,987[2] (Target Not Met)	13,775[3]	29,813	+16,038

[1] Includes the following: Law Enforcement and Behavioral Health Partnerships for Early Diversion, Jail Diversion and Trauma Recovery Program-Priority to Veterans, Minority AIDS Initiative Targeted Capacity Expansion (MAI-TCE): Integrated Behavioral Health/Primary Care Network Cooperative Agreements.

[2] Target has been revised from previously reported.

[3] Primary and Behavioral Health Care Integration, and Healthy Transitions are reported separately for FY 2016 target

Program: Mental Health - Science and Service Activities

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
1.4.06 Number of people trained by CMHS Science and Service Programs (Output)	FY 2014: 8,109 Target: 5,568 (Target Exceeded)	16,271	16,271	Maintain
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2014: 54,883[1] Target: 110,000 (Target Not Met)	42,063[2]	40,947[3]	-1,116
1.4.14 Number of calls answered by the Disaster Distress Hotline (Output)	FY 2014: 3,416 Target: 6,436 (Target Not Met)	3,228	3,228	Maintain
1.4.15 Number of text messages answered by the Disaster Distress Hotline (Output)	FY 2014: 4,371 Target: 7,848 (Target Not Met)	4,131	4,131	Maintain

SAMHSA/Mental Health
PRNS Mechanism Table by APT

(Dollars in thousands)

Program Activity	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Programs of Regional & National Significance						
Grants/Cooperative Agreements						
Continuations	311	129,834	391	209,538	439	228,705
New/Competing	323	185,243	220	99,854	218	84,222
Subtotal	634	315,077	611	309,392	657	312,928
Contracts						
Continuations	13	30,870	26	58,153	25	51,824
New/Competing	13	31,368	4	2,993	6	12,538
Subtotal	26	62,238	30	61,146	31	64,361
Total, Mental Health PRNS [1]	**660**	**377,315**	**641**	**370,538**	**688**	**377,289**

[1] The PRNS FY 2014 and FY 2015 totals include $12,000,000 and FY 2016 Request total includes $38,000,000 funded by the Prevention and Public Health Fund.

*Totals may not add due to rounding.

SAMHSA/Mental Health
PRNS Mechanism Table by PPA

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
CAPACITY:						
Seclusion and Restraint and Trauma						
Grants						
Continuations	$---	$---	$---	$---	---	$---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	1,147	1	1,147	1	1,147
New/Competing	---	---	---	---	---	---
Subtotal	1	1,147	1	1,147	1	1,147
Total, SRT	**1**	**1,147**	**1**	**1,147**	**1**	**1,147**
Youth Violence Prevention						
Grants						
Continuations	8	20,079	8	20,083	8	20,087
New/Competing	---	---	---	---	---	---
Subtotal	8	20,079	8	20,083	8	20,087
Contracts						
Continuations	2	2,561	3	3,016	3	3,012
New/Competing	1	459	---	---	---	---
Subtotal	3	3,020	3	3,016	3	3,012
Total, YVP	**11**	**23,099**	**11**	**23,099**	**11**	**23,099**
Project AWARE						
Grants						
Continuations	---	---	20	38,354	55	46,926
New/Competing	120	48,144	35	8,612	---	---
Subtotal	120	48,144	55	46,965	55	46,926
Contracts						
Continuations	---	---	2	7,150	2	5,899
New/Competing	2	6,721	1	750	1	2,039
Subtotal	2	6,721	3	7,900	3	7,939
Total, Project AWARE	**122**	**54,865**	**58**	**54,865**	**58**	**54,865**
Mental Health First Aid for Veterans' Families						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	15	3,749
Subtotal	---	---	---	---	15	3,749
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	251
Subtotal	---	---	---	---	---	251
Total, Mental Health First Aid for Veterans	---	---	---	---	**15**	**4,000**

Programs of Regional & National Significance	FY2014 Final No.	FY2014 Final Amount	FY2015 Enacted No.	FY2015 Enacted Amount	FY2016 President's Budget No.	FY2016 President's Budget Amount
National Child Traumatic Stress Network						
Grants						
Continuations	78	41,349	78	42,708	---	---
New/Competing	---	1,200	---	---	81	42,694
Subtotal	78	42,549	78	42,708	81	42,694
Contracts						
Continuations	---	2,705	---	3,179	---	3,193
New/Competing	---	633	---	---	---	---
Subtotal	---	3,338	---	3,179	---	3,193
Total, NCTSI	**78**	**$45,887**	**78**	**$45,887**	**81**	**$45,887**
Children and Family Programs						
Grants						
Continuations	---	212	11	4,375	11	4,383
New/Competing	11	4,399	---	---	---	---
Subtotal	11	4,611	11	4,375	11	4,383
Contracts						
Continuations	---	360	2	2,083	2	2,075
New/Competing	2	1,488	---	---	---	---
Subtotal	2	1,847	2	2,083	2	2,075
Total, CFP	**13**	**6,458**	**13**	**6,458**	**13**	**6,458**
Healthy Transitions						
Grants						
Continuations	---	---	17	16,932	17	16,932
New/Competing	17	16,715	---	---	---	---
Subtotal	17	16,715	17	16,932	17	16,932
Contracts						
Continuations	---	---	---	3,019	---	2,296
New/Competing	---	3,236	---	---	---	723
Subtotal	---	3,236	---	3,019	---	3,019
Total, Healthy Transitions	**17**	**19,951**	**17**	**19,951**	**17**	**19,951**
Consumer and Family Network Grants						
Grants						
Continuations	56	3,781	39	2,708	12	1,140
New/Competing	9	450	12	1,540	33	3,152
Subtotal	65	4,231	51	4,248	45	4,292
Contracts						
Continuations	---	627	---	706	---	311
New/Competing	---	97	---	---	1	350
Subtotal	---	723	---	706	1	662
Total, CFN	**65**	**4,954**	**51**	**4,954**	**46**	**4,954**

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Project LAUNCH						
Grants/Cooperative Agreements						
Continuations	22	18,688	31	25,754	35	30,234
New/Competing	15	11,244	4	4,610	---	---
Subtotal	37	29,932	35	30,364	35	30,234
Contracts						
Continuations	1	4,347	1	4,191	1	4,321
New/Competing	---	276	---	---	---	---
Subtotal	1	4,623	1	4,191	1	4,321
Total, LAUNCH	**38**	**$34,555**	**36**	**$34,555**	**36**	**$34,555**
MH System Transformation and Health Reform						
Grants						
Continuations	20	6,517	---	2,637	---	2,638
New/Competing	---	2,647	---	---	---	---
Subtotal	20	9,164	---	2,637	---	2,638
Contracts						
Continuations	1	1,392	1	1,142	---	238
New/Competing	---	---	---	---	---	904
Subtotal	1	1,392	1	1,142	---	1,141
Total, MH-STHR	**21**	**10,556**	**1**	**3,779**	**---**	**3,779**
Primary and Behavioral Health Care Integration						
Grants						
Continuations	16	6,181	16	6,179	109	21,369
New/Competing	26	40,918	102	40,748	---	3,000
Subtotal	42	47,099	118	46,927	109	24,369
Contracts						
Continuations	---	2,778	---	2,950	---	1,635
New/Competing	---	---	---	---	---	---
Subtotal	---	2,778	---	2,950	---	1,635
Total, PBHCI	**42**	**49,877**	**118**	**49,877**	**109**	**26,004**
National Strategy for Suicide Prevention						
Grants						
Continuations	---	---	4	1,879	4	1,879
New/Competing	4	1,880	---	---	4	1,870
Subtotal	4	1,880	4	1,879	8	3,749
Contracts						
Continuations	---	---	---	121	---	251
New/Competing	---	120	---	---	---	---
Subtotal	---	120	---	121	---	251
Total, NSSP	**4**	**2,000**	**4**	**2,000**	**8**	**4,000**

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Suicide Lifeline						
Grants						
Continuations	13	4,389	12	690	1	5,288
New/Competing	---	1,448	1	5,288	12	690
Subtotal	13	5,838	13	5,979	13	5,978
Contracts						
Continuations	---	481	---	1,219	---	1,220
New/Competing	---	880	---	---	---	---
Subtotal	---	1,360	---	1,219	---	1,220
Total, Suicide Lifeline	**13**	**$7,198**	**13**	**$7,198**	**13**	**$7,198**
GLS- Youth Suicide Prevention - States						
Grants						
Continuations	26	11,530	33	22,120	38	27,646
New/Competing	26	19,046	12	8,567	4	2,941
Subtotal	52	30,576	45	30,686	42	30,587
Contracts						
Continuations	---	2,026	1	4,741	1	4,840
New/Competing	1	2,825	---	---	---	---
Subtotal	1	4,851	1	4,741	1	4,840
Total, GLS-States	**53**	**35,427**	**46**	**35,427**	**43**	**35,427**
GLS- Youth Suicide Prevention - Campus						
Grants						
Continuations	41	3,864	33	3,184	37	3,608
New/Competing	15	1,477	22	2,128	17	1,665
Subtotal	56	5,341	55	5,313	54	5,274
Contracts						
Continuations	---	441	---	1,175	---	1,214
New/Competing	---	706	---	---	---	---
Subtotal	---	1,147	---	1,175	---	1,214
Total, GLS-Campus	**56**	**6,488**	**55**	**6,488**	**54**	**6,488**
GLS - Suicide Prevention Resource Center						
Grants						
Continuations	1	4,471	---	---	1	5,612
New/Competing	---	1,183	1	5,634	---	---
Subtotal	1	5,654	1	5,634	1	5,612
Contracts						
Continuations	---	334	---	---	---	376
New/Competing	---	---	---	354	---	---
Subtotal	---	334	---	354	---	376
Total, SPRC	**1**	**5,988**	**1**	**5,988**	**1**	**5,988**

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
AI/AN Suicide Prevention Initiative						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	2,613	1	2,931	1	2,931
New/Competing	---	318	---	---	---	---
Subtotal	1	2,931	1	2,931	1	2,931
Total, AI/AN	**1**	**$2,931**	**1**	**$2,931**	**1**	**$2,931**
Homelessness Prevention Programs						
Grants						
Continuations	24	6,603	10	4,308	27	20,608
New/Competing	9	15,902	26	20,000	2	2,612
Subtotal	33	22,505	36	24,308	29	23,221
Contracts						
Continuations	2	4,169	3	6,388	2	4,508
New/Competing	1	4,023	---	---	---	2,968
Subtotal	3	8,191	3	6,388	2	7,475
Total, HPP	**36**	**30,696**	**39**	**30,696**	**31**	**30,696**
Minority AIDS						
Grants						
Continuations	---	---	34	7,751	34	7,751
New/Competing	34	7,755	---	---	---	6,218
Subtotal	34	7,755	34	7,751	34	13,969
Contracts						
Continuations	---	---	---	963	1	1,966
New/Competing	---	1,469	1	510	---	---
Subtotal	---	1,469	1	1,473	1	1,966
Total, MAI	**34**	**9,224**	**35**	**9,224**	**35**	**15,935**
Grants for Adult Treatment, Screening, and Brief Response						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	4	2,714
Subtotal	---	---	---	---	4	2,714
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	182
Subtotal	---	---	---	---	---	182
Total, GATSBR	---	---	---	---	**4**	**2,896**

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Crisis Systems						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	3	4,346
Subtotal	---	---	---	---	3	4,346
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	1	654
Subtotal	---	---	---	---	1	654
Total, Crisis Systems	**---**	**$---**	**---**	**$---**	**4**	**$5,000**
Criminal and Juvenile Justice Programs						
Grants						
Continuations	1	394	17	2,912	17	2,912
New/Competing	17	2,879	---	---	---	---
Subtotal	18	3,273	17	2,912	17	2,912
Contracts						
Continuations	1	996	1	907	1	738
New/Competing	---	---	1	450	1	618
Subtotal	1	996	2	1,357	2	1,357
Total, CJJP	**19**	**4,269**	**19**	**4,269**	**19**	**4,269**
Tribal Behavioral Health Grants						
Grants						
Continuations	---	---	20	3,811	20	3,818
New/Competing	20	3,856	---	---	43	8,571
Subtotal	20	3,856	20	3,811	63	12,390
Contracts						
Continuations	---	---	---	1,177	---	1,182
New/Competing	---	1,132	---	---	---	1,429
Subtotal	---	1,132	---	1,177	---	2,610
Total, TBHG	**20**	**4,988**	**20**	**4,988**	**63**	**15,000**
Subtotal, CAPACITY	**636**	**$360,558**	**617**	**$353,781**	**663**	**$360,527**

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
SCIENCE AND SERVICE:						
Practice Improvement Training						
Grants						
Continuations	---	---	8	3,151	8	3,152
New/Competing	8	3,162	---	---	---	---
Subtotal	8	3,162	8	3,151	8	3,152
Contracts						
Continuations	3	1,823	6	4,377	7	3,907
New/Competing	3	2,843	1	300	1	770
Subtotal	6	4,666	7	4,677	8	4,676
Total, PIT	**14**	**7,828**	**15**	**7,828**	**16**	**7,828**
Consumer and Consumer Supporter Technical Assistance Centers						
Grants						
Continuations	5	1,777	---	---	5	1,797
New/Competing	---	---	5	1,805	---	---
Subtotal	5	1,777	5	1,805	5	1,797
Contracts						
Continuations	---	141	---	---	---	121
New/Competing	---	---	---	113	---	---
Subtotal	---	141	---	113	---	121
Total, CCSTAC	**5**	**1,918**	**5**	**1,918**	**5**	**1,918**
Primary and Behavioral Health Care Integration TA						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	---	1	1,991	1	1,996
New/Competing	1	1,991	---	---	---	---
Subtotal	1	1,991	1	1,991	1	1,996
Total, PBHCI TA	**1**	**1,991**	**1**	**1,991**	**1**	**1,996**
Disaster Response						
Grants						
Continuations	---	---	---	---	---	924
New/Competing	1	936	---	923	---	---
Subtotal	1	936	---	923	---	924
Contracts						
Continuations	---	268	1	1,030	1	1,029
New/Competing	1	749	---	---	---	---
Subtotal	1	1,017	1	1,030	1	1,029
Total, Disaster Response	**2**	**$1,953**	**1**	**$1,953**	**1**	**$1,953**

Programs of Regional & National Significance	FY2014 Final No.	FY2014 Final Amount	FY2015 Enacted No.	FY2015 Enacted Amount	FY2016 President's Budget No.	FY2016 President's Budget Amount
Homelessness						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	1,663	1	1,781	---	646
New/Competing	---	633	---	515	1	1,650
Subtotal	1	2,296	1	2,296	1	2,296
Total, Homelessness	**1**	**2,296**	**1**	**2,296**	**1**	**2,296**
HIV/AIDS Education						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	---	1	771	1	771
New/Competing	1	771	---	---	---	---
Subtotal	1	771	1	771	1	771
Total, HIV/AIDS	**1**	**771**	**1**	**771**	**1**	**771**
Subtotal, SCIENCE AND SERVICE	**24**	**16,757**	**24**	**16,757**	**25**	**16,762**
TOTAL, MH PRNS[1/]	**660**	**$377,315**	**641**	**$370,538**	**691**	**$377,289**

Grant Awards Table

(Whole dollars)

	FY2014 Operating Level	FY2015 President's Budget	FY2016 Requested
Number of Awards	634	611	642
Average Awards	$496,966,655	$506,370,115	$481,587,458
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)

CMHI	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Budget Authority	$117,026	$117,026	$117,026	$---

Authorizing Legislation ..... Sections 561 to 565 of the Public Health Service Act
FY 2016 Authorization ..... Expired
Allocation Method ..... Competitive Grants/Contracts
Eligible Entities..... States, Tribes, Communities, Territories

Program Description and Accomplishments

Authorized in 1992, the Children's Mental Health Initiative (CMHI) supports the development of comprehensive, community-based services that use the system of care approach for the estimated nine to 13 percent of children and youth with serious emotional disturbances (SED) and their families. A system of care (SOC) is a strategic approach to the delivery of services and supports that incorporates 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. 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.

In FY 2011, SAMHSA awarded SOC Expansion Planning grants to bring systems of care to scale from community to 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 SOC Expansion Implementation grants to assist states, tribes and larger geographic areas in implementing their strategic plans to expand the SOC approach to improve outcomes for children and youth with serious mental disorders and their families.

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

CMHI has a current national evaluation, which is designed to provide information on (1) the mental health outcomes of children and youth, and their families; (2) the implementation, process, and sustainability of systems of care; and (3) critical and emerging issues in children's' and youths' mental health. The evaluation includes a system of care assessment that describes the infrastructure and an assessment of outcomes derived from direct system of care services. A service experience study evaluates (1) change in service use patterns of children and their

families; (2) whether there are differences between groups of children in the system of care communities who receive an evidence-based treatment and those who do not in terms of client satisfaction; and (3) whether children and families stay in services longer on average in communities with higher average service and system of care ratings.

With the growth of the program, the evaluation has continued to gather data from children and families involved in systems of care, particularly as the different cohorts of grantees have changed over the years. In addition to infrastructure and service evaluation, a sector and comparison study is being conducted to evaluate differences in outcomes between system of care eligible youth involved in education, juvenile justice, and child welfare systems and similar youth not enrolled in system of care services. The evaluation continues to monitor the outcomes of children, youth and families through various data profile reports, and continuous quality improvement reports. The evaluation has also added activities to assess the associated costs and cost savings of the system of care approach, and provides technical assistance to grantees to promote family engagement in the evaluation as well as the ability to sustain the programs at the end of federal funding.

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

- Sustained mental 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.

Funding History

Fiscal Year	Amount
FY 2012	$117,314,524
FY 2013	$111,430,194
FY 2014	$117,026,000
FY 2015	$117,026,000
FY 2016	$117,026,000

In FY 2014, SAMHSA provided funding to support 59 continuation grants (28 six-year grants, and 31 four-year grants), nine new one-year SOC Expansion Planning grants and 22 new four-year SOC Expansion Implementation grants as well as support for evaluation and technical assistance contracts. In FY 2015, SAMHSA will continue to support 54 continuation grants (nine six-year grants and 45 four-year grants) and three contracts. Also, SAMHSA will award approximately 30 four-year new System of Care Expansion and Sustainability Cooperative Agreements which will build upon progress made in developing comprehensive systems of care

across the country by focusing on sustainable financing, cross-agency collaboration, the creation of policy and infrastructure, and the development and implementation of services and supports that are consistent with the requirements authorized under Sections 561-565 of the Public Health Service Act, as amended. In addition, SAMHSA will support one new technical assistance contract and one new evaluation contract as well as support two full time employees (FTEs).

Budget Request

The FY 2016 Budget Request is $117.0 million at the program level. This is the same from the FY 2015 Enacted Level. SAMHSA is requesting funding to support the continuation of Children's Mental Health Initiative. The request will support 58 grants, four contract continuations, 27 new grants, and one new contract. In addition, the Budget Request continues to provide critical technical assistance (TA) and training to grantee communities. With the continuation of this funding level, SAMHSA is able to leverage the wealth of national, regional, and state systems of care capacity that has evolved over the past 25 years by disseminating lessons learned from the grantees along with flexible, developmentally phased TA model to support and advance more streamlined, timely, and relevant technical assistance capacity.

SAMHSA/Mental Health
Mechanism Table

(Dollars in thousands)

Program Activity	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Children's Mental Health Services						
Grants/Cooperative Agreements						
Continuations	59	54,245	54	51,579	58	69,582
New/Competing	31	42,776	30	45,000	27	26,129
Subtotal	90	97,021	84	96,579	85	95,711
Contracts						
Continuations	2	9,876	2	9,433	2	10,355
New/Competing	---	518	1	1,200	1	1,000
Subtotal	2	10,395	3	10,633	3	11,355
Technical Assistance	5	9,611	2	9,814	2	9,960
Total, Children's Mental Health Services	**97**	**117,026**	**89**	**117,026**	**90**	**117,026**

* Totals may not add due to rounding.

Outputs and Outcomes Table

Program: Children's Mental Health Services

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY2016 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 2014: 6,280 Target: 4,846[1] (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 2014: 86.6 % Target: 87.6 % (Target Not 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 2014: 62.5 % 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 2014: 4,825 Target: 3,517[2] (Target Exceeded)	5,101	5,101	Maintain

[1, 2] Target has been revised from previously reported.

Grant Awards Table

(Whole dollars)

	FY2014 Operating Level	FY 2015 President's Budget	FY2016 Requested
Number of Awards	90	84	85
Average Awards	$1,078,008,289	$1,149,753,464	$1,126,007,294
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)

PATH	FY 2014 Final No. Amount	FY 2015 Enacted No. Amount	FY 2016 President's Budget No. Amount	FY2016 +/- FY2015
Budget Authority	$64,635	$64,635	$64,635	$---

Authorizing Legislation .....Section 521 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Formula Grant
Eligible Entities..... States and Territories

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 and substance abuse treatment services, 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 one dollar for every three dollars 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 it is specifically authorized to address the needs of individuals with serious mental illnesses (SMI) and/or SMI with co-occurring substance use disorder who are experiencing homelessness or are at risk of homelessness. Behavioral health issues are common among people experiencing or at risk of homelessness, as are chronic physical illnesses and other disabling conditions. Almost half of all people experiencing homelessness have mental health problems and/or substance use disorders. In addition, many individuals who have SMI are at high risk of becoming homeless due to their disabling conditions. The PATH program has been highly successful in targeting assistance to individuals with SMI or experiencing a co-occurring mental and substance use disorder who are homeless or are at risk for homelessness.

The ability of PATH providers to build trusting and supportive relationships that lead to consumers making meaningful contributions to improve the delivery of services is a major accomplishment. Nearly all PATH provider agencies involve consumers in providing services, with consumers serving in such roles as peer specialist and committee member. PATH also presents opportunities for providers working with individuals who are homeless to coordinate services. PATH is included in the SAMHSA consolidated evaluation contract, awarded in 2011, which seeks to identify commonalities across homeless programs that may be used to compare effectiveness of the programs and of the various models of services delivery, including evidence-based practices, used within and across programs.

In FY 2014, SAMHSA awarded 56 annual grants to states and territories and supported related activities such as technical assistance and evaluation. This funding will continue in FY 2015.

Funding History

Fiscal Year	Amount
FY 2012	$64,794,307
FY 2013	$61,404,952
FY 2014	$64,635,000
FY 2015	$64,635,000
FY 2016	$64,635,000

Budget Request

The FY 2016 Budget Request is $64.6 million at the program level. This is the same as the FY 2015 Enacted Level. Funding is requested to support the continuation of PATH and support the same number of homeless individuals contacted, approximately 192,000 individuals, through the PATH program.

Outputs and Outcomes Table

Program: Projects to Assist in the Transition from Homelessness

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year andYear Most Recent Result/Target for Recent Result (Summary of Result	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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 2013: 66 Target: 50 (Target Exceeded)	66		Maintain
3.4.16 Number of homeless persons contacted (Outcome)	FY 2013: 192,017 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 2013: 61 Target: 55 (Target Exceeded)	58	58	Maintain
3.4.20 Increase the number of Projects for Assistance in Transition from Homelessness (PATH) providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits (Output)	FY 2014: 2,296 Target: 4,591 (Target Not Met)	2,296	2,296	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2016 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

State/Territory	FY2014 Actual	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Alabama	$613,000	$613,000	$609,000	-$4,000
Alaska	300,000	300,000	300,000	0
Arizona	1,349,000	1,349,000	1,341,000	-8,000
Arkansas	304,000	304,000	302,000	-2,000
California	8,810,000	8,809,000	8,759,000	-50,000
Colorado	1,019,000	1,019,000	1,013,000	-6,000
Connecticut	799,000	799,000	794,000	-5,000
Delaware	300,000	300,000	300,000	0
District of Columbia	300,000	300,000	300,000	0
Florida	4,333,000	4,332,000	4,308,000	-24,000
Georgia	1,669,000	1,669,000	1,660,000	-9,000
Hawaii	300,000	300,000	300,000	0
Idaho	300,000	300,000	300,000	0
Illinois	2,704,000	2,704,000	2,689,000	-15,000
Indiana	1,011,000	1,011,000	1,005,000	-6,000
Iowa	334,000	334,000	333,000	-1,000
Kansas	377,000	377,000	375,000	-2,000
Kentucky	469,000	469,000	466,000	-3,000
Louisiana	733,000	733,000	729,000	-4,000
Maine	300,000	300,000	300,000	0
Maryland	1,271,000	1,271,000	1,264,000	-7,000
Massachusetts	1,558,000	1,558,000	1,549,000	-9,000
Michigan	1,729,000	1,729,000	1,719,000	-10,000
Minnesota	811,000	811,000	806,000	-5,000
Mississippi	300,000	300,000	300,000	0
Missouri	893,000	893,000	888,000	-5,000
Montana	300,000	300,000	300,000	0
Nebraska	300,000	300,000	300,000	0
Nevada	616,000	616,000	612,000	-4,000
New Hampshire	300,000	300,000	300,000	0

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2016 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

State/Territory	FY2014 Actual	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
New Jersey	$2,137,000	$2,137,000	$2,125,000	-$12,000
New Mexico	300,000	300,000	300,000	0
New York	4,222,000	4,221,000	4,197,000	-24,000
North Carolina	1,379,000	1,379,000	1,371,000	-8,000
North Dakota	300,000	300,000	300,000	0
Ohio	1,986,000	1,986,000	1,974,000	-12,000
Oklahoma	453,000	453,000	450,000	-3,000
Oregon	631,000	631,000	627,000	-4,000
Pennsylvania	2,366,000	2,366,000	2,352,000	-14,000
Rhode Island	300,000	300,000	300,000	0
South Carolina	680,000	680,000	676,000	-4,000
South Dakota	300,000	300,000	300,000	0
Tennessee	909,000	909,000	904,000	-5,000
Texas	4,994,000	4,993,000	4,965,000	-28,000
Utah	591,000	591,000	588,000	-3,000
Vermont	300,000	300,000	300,000	0
Virginia	1,472,000	1,471,000	1,463,000	-8,000
Washington	1,329,000	1,329,000	1,321,000	-8,000
West Virginia	300,000	300,000	300,000	0
Wisconsin	836,000	836,000	832,000	-4,000
Wyoming	300,000	300,000	300,000	0
American Samoa	50,000	50,000	50,000	0
Guam	50,000	50,000	50,000	0
Northern Marianas	50,000	50,000	50,000	0
Puerto Rico	891,000	891,000	886,000	-5,000
Virgin Islands	50,000	50,000	50,000	0

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Protection and Advocacy for Individuals with Mental Illness (PAIMI)

(Dollars in thousands)

PAIMI	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Budget Authority	$36,146	$36,146	$36,146	$---

Authorizing Legislation ..... The PAIMI Act 42 USC 10801 et seq.
FY 2016 Authorization .....Expired
Allocation Method ..... Formula Grants
Eligible Entities..... States and Territories

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 (DD) 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, territory, 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 are protected; 2) protect and advocate for 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 and/or neglect of individuals with mental illness.

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 the least restrictive, appropriate, community-based setting. In FY 2013, the most recent data available, the PAIMI program met its target by successfully resolving complaints of alleged abuse, neglect, and rights violations 88 percent of the time.

In FY 2013, the 57 state PAIMI Programs:

- Served 15,192 P A I M I-eligible individuals/clients: 3,294 children and youth (ages 0 to 18) and 11,048 adults (ages 19 to 64), and 850 older adults (age 65 and older). These individuals filed 18,101 complaints alleging abuse, neglect, and/or rights violations.

- Of the closed 12,836 complaints: 2,493 of the allegations were not substantiated, lacked legal merit, or were withdrawn by the client; 10,343 were substantiated, including 2,086 for abuse, 2,097 for neglect, and 6,160 for rights violation allegations.

- Resolved 87 percent of abuse, 91 percent of neglect allegations, and 87 percent of rights violations allegations, and attained outcomes that resulted in positive change for the clients served. These positive outcomes included receipt of appropriate medical and mental health treatment; safer, cleaner facility environment; discharge into an appropriate community-based setting; and discharge from a nursing facility.

In FY 2014, SAMHSA continued to fund 57 annual grants to states and territories as well as continued technical assistance activities and support for grantees. This funding will continue in FY 2015.

Funding History

Fiscal Year	Amount
FY 2012	$36,238,380
FY 2013	$34,342,894
FY 2014	$36,146,000
FY 2015	$36,146,000
FY 2016	$36,146,000

Budget Request

The FY 2016 Budget Request is $36.1 million. This is the same as the FY 2015 Enacted Level. Funding is requested to support the continuation of the PAIMI grants in order to serve the same number of individuals, approximately 15,925, receiving support to address complaints with the mental health care system and 443,000 individuals trained, educated, or reached through the program.

Outputs and Outcomes Table

Program: Protection & Advocacy for Individuals with Mental Illness

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.4.12 Number of people served by the PAIMI program (Output)	FY 2013: 15,192 Target: 16,499[1] (Target Not Met)	15,925	15,192	-733
3.4.19 Number attending public education/constituency training and public awareness activities (Output)	FY 2013: 443,282[2] Target: 92,953 (Target Exceeded)	139,427[3]	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, e limination of other barriers to personal decision-making, as a result of Protection and Advocacy for Individuals with Mental Illness (PAIMI) involvement (Outcome)	FY 2013: 88.3 % Target: 87.0 % (Target Exceeded)	87.0 %	88.0 %	+1

[1]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.
[2]Preliminary result. Methodology under review.
[3]Target increase is under consideration pending review of reporting methodology/confirmation of FY 2013 result.

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2016 DISCRETIONARY STATE/FORMULA GRANTS
Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA#93.138

State/Territory	FY2014 Actual	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Alabama	$452,480	$456,090	$456,125	$35
Alaska	428,000	428,000	428,000	0
Arizona	609,040	616,908	620,705	+3,797
Arkansas	428,000	428,000	428,000	0
California	3,169,574	3,156,787	3,133,003	-23,784
Colorado	428,381	433,624	437,252	+3,628
Connecticut	428,000	428,000	428,000	0
Delaware	428,000	428,000	428,000	0
District of Columbia	428,000	428,000	428,000	0
Florida	1,680,238	1,704,717	1,724,103	+19,386
Georgia	909,612	917,657	924,459	+6,802
Hawaii	428,000	428,000	428,000	0
Idaho	428,000	428,000	428,000	0
Illinois	1,081,319	1,075,584	1,068,255	-7,329
Indiana	606,534	599,111	601,407	+2,296
Iowa	428,000	428,000	428,000	0
Kansas	428,000	428,000	428,000	0
Kentucky	428,000	428,000	428,000	0
Louisiana	428,000	428,000	428,000	0
Maine	428,000	428,000	428,000	0
Maryland	457,637	456,617	461,680	+5,063
Massachusetts	505,220	506,963	507,297	+334
Michigan	911,471	903,618	900,401	-3,217
Minnesota	445,048	444,348	447,128	+2,780
Mississippi	428,000	428,000	428,000	0
Missouri	541,644	544,367	538,532	-5,835
Montana	428,000	428,000	428,000	0
Nebraska	428,000	428,000	428,000	0
Nevada	428,000	428,000	428,000	0
New Hampshire	428,000	428,000	428,000	0

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Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA # 93.138

State/Territory	FY2014 Actual	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
New Jersey	$682,281	$681,414	$684,302	$2,888
New Mexico	428,000	428,000	428,000	0
New York	1,522,198	1,525,779	1,522,284	-3,495
North Carolina	894,253	896,314	900,601	+4,287
North Dakota	428,000	428,000	428,000	0
Ohio	1,042,233	1,031,064	1,025,955	-5,109
Oklahoma	428,000	428,000	428,000	0
Oregon	428,000	428,000	428,000	0
Pennsylvania	1,088,023	1,074,746	1,067,820	-6,926
Rhode Island	428,000	428,000	428,000	0
South Carolina	451,380	452,783	455,001	+2,218
South Dakota	428,000	428,000	428,000	0
Tennessee	588,392	586,600	587,119	+519
Texas	2,249,157	2,255,157	2,267,946	+12,789
Utah	428,000	428,000	428,000	0
Vermont	428,000	428,000	428,000	0
Virginia	663,461	666,587	672,507	+5,920
Washington	572,901	574,891	573,827	-1,064
West Virginia	428,000	428,000	428,000	0
Wisconsin	503,977	498,588	495,934	-2,654
Wyoming	428,000	428,000	428,000	0
American Samoa	229,300	229,300	229,300	0
Guam	229,300	229,300	229,300	0
Northern Marianas	229,300	229,300	229,300	0
Puerto Rico	566,333	551,889	538,532	-13,357
Virgin Islands	229,300	229,300	229,300	0
American Indian Consortium	229,300	229,300	229,300	0

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Community Mental Health Services Block Grant (MHBG)

(Dollars in thousands)

Program Activity	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Community Mental Health Services Block Grant	$482,571	$482,571	$482,571	$---
PHS Evaluation Funds (non-add)	*$21,039*	*$21,039*	*$21,039*	*$---*

Authorizing Legislation .....Section 1911 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Formula Grant
Eligible Entities..... States and Territories

Program Description and Accomplishments

Since 1992, the Community Mental Health Services Block Grant (MHBG) has distributed funds to 59 eligible states and territories and freely associated states 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. These services and activities must support state-developed plans for comprehensive community-based mental health services for children with serious emotional disturbances and adults with serious mental illness. Services funded by the MHBG include: outpatient mental health treatment for serious mental illnesses, such as schizophrenia and bipolar disorders; 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 vulnerable populations (e.g., persons who are homeless, those in rural and frontier areas, military families, and veterans). Through the administration of the MHBG, SAMHSA supports and encourages states in the implementation of practices demonstrated and proven effective in the Mental Health PRNS portfolio.

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. 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 9.6 million (4.1 percent) adults having a severe mental illness in the past year in 2012,[27] 43.7 million adults having any mental illness in the past year in 2012,[28] and another 24.6 million (9.4 percent) adults with illicit drug abuse in the past month in 2013,[29] demand clearly outpaces the public behavioral health system's established capacity.

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

[27] http://media.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm
[28] http://media.samhsa.gov/data/NSDUH/2013SummNatFindDetTables/NationalFindings/NSDUHresults2013.htm
[29] http://media.samhsa.gov/data/NSDUH/2013SummNatFindDetTables/NationalFindings/NSDUHresults2013.htm

evaluation are all important activities that are necessary to develop and maintain an effective public health system for mental health services. 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.

SAMHSA encourages states to use block grant resources to support and not supplant services that will be covered through commercial and public insurer plans. In FY 2011, SAMHSA redesigned the FY 2012-2013 MHBG and SABG applications to better align with changes in federal/state environments, including the impacts of 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 biennial versus an annual plan,[30,31] and provide information regarding their efforts to respond to various changes in federal and state law. Submitting the application/plan biennially, reduces the burden on states to prepare and submit an application/plan every year.

The FY 2014-2015 Block Grant application built upon the FY 2012-2013 application and the FY 2016-2017 Block Grant application is currently available for public comment. Under the application, SAMHSA Block Grant funds are 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 those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;
3) For the Substance Abuse Prevention and Treatment Block Grant: to fund primary prevention-universal, selective, and indicated prevention activities and services for persons 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.

SAMHSA is undertaking a series of agency-wide efforts designed to develop a set of common core performance, quality, and cost measures to demonstrate the impact of SAMHSA's programs. Ultimately, SAMHSA and its state partners will collaborate to develop a streamlined behavioral health data system that complements other existing systems (e.g., Medicaid administrative and billing data systems, and state mental health and substance abuse data systems), ensures consistency in the use of measures, and provides a more complete perspective of the delivery of mental health and substance abuse treatment services.

[30] 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)).
[31] State Plan (Sec.1932(b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x-32(b)).

Most block grant recipients 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 during 2013 show that:

- For the 57 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, 83 percent of the mental health consumers were living in private residences;
- For the 58 states and territories that reported data in the Access/Capacity Domain, state mental health agencies provided mental health services for 22.09 people per 1,000 population;
- For the 48 states and territories that reported data in the Retention Domain, only 8.6 percent of the patients returned to a state psychiatric hospital within 30 days of state hospital discharge; and
- For the 53 states and territories that reported data in the Perception of Care Domain, 70.6 percent of adult mental health consumers improved functioning as a direct result of the mental health services they received.

An independent evaluation of the MHBG demonstrated that funds allow states to explore new innovations and strategies, target emerging needs with special programs; pay for recovery-focused and consumer-centered services not covered by commercial insurance, Medicaid, or Medicare; and create the administrative, organizational, or service delivery linkages that foster a community-based, transformed system of mental health services. The study of the program has been completed and the final report is available on the SAMHSA website (http://store.samhsa.gov/shin/content//SMA10-4610/SMA10-4610.pdf).

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

Starting in FY 2014, states were required to set-aside five percent 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 serious mental illness experience their first symptoms during adolescence or early adulthood, and there are often long delays between the initial onset of symptoms and receiving treatment. The consequences of delayed treatment can include loss of family and social supports, reduced educational achievement, disruption of employment, substance abuse, increased hospitalizations, and reduced prospects for long-term recovery.

The five percent set-aside of $24.2 million, allocated to states consistent with the block grant formula, will support implementation 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. SAMHSA has collaborated closely with the NIH's National Institute for Mental Health in

providing guidance and technical assistance to states regarding effective programs funded by this set-aside. This set-aside funding will be continued in FY 2015.

Funding History

Fiscal Year	Amount
FY 2007	$428,256,000
FY 2008	$420,774,000
FY 2009	$420,774,000
FY 2010	$420,774,000
FY 2011	$419,974,530
FY 2012	$459,756,254
FY 2013	$436,808,709
FY 2014	$482,571,000
FY 2015	$482,571,000
FY 2016	$482,571,000

Budget Request

The FY 2016 Budget Request is $482.6 million at the program level with $461.5 million from Budget Authority and $21.0 million from PHS Evaluation Funds. This request is the same as the FY 2015 Enacted Level. The Budget Request will support the continuation of Community Mental Health Services Block Grant.

Outputs and Outcomes Table

Program: Mental Health Block Grant

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
2.3.11 Number of evidence based practices (EBPs) implemented (Output)	FY 2013: 5.0 per state Target: 4.2 per state (Target Exceeded)	4.5 per state	4.5 per state	Maintain
2.3.14 Number of people served by the public mental health system (Output)	FY 2013: 7,242,264 Target: 6,340,320 (Target Exceeded)	7,620,000	7,620,000	Maintain
2.3.15 Rate of consumers (adults) reporting positively about outcomes (Outcome)	FY 2013: 70.6% Target: 72% (Target Not Met)	71.8%	71.8%	Maintain
2.3.16 Rate of family members (children/adolescents) reporting positively about outcomes (Outcome)	FY 2013: 67.6% Target: 67% (Target Exceeded)	66.1%	66.1%	Maintain
2.3.81 Percentage of service population receiving any evidence based practice (Outcome)	FY 2013: 6.6 % Target: 7.2 % (Target Not Met but Improved)	6.2 %	6.2 %	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2016 DISCRETIONARY STATE/FORMULA GRANTS
Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	$6,713,670	$6,646,898	$6,660,799	$13,901
Alaska	775,287	793,287	880,918	+87,631
Arizona	10,564,627	10,737,941	10,546,669	-191,272
Arkansas	4,272,655	4,227,658	4,062,834	-164,824
California	62,185,567	63,093,869	62,683,086	-410,783
Colorado	6,829,619	6,900,325	7,686,147	+785,822
Connecticut	4,812,384	4,785,704	4,745,284	-40,420
Delaware	1,052,300	1,042,835	1,284,277	+241,442
District of Columbia	893,917	927,814	957,826	+30,012
Florida	31,110,919	31,701,900	30,619,749	-1,082,151
Georgia	14,264,923	14,325,637	15,566,399	+1,240,762
Hawaii	2,352,005	2,368,691	2,389,259	+20,568
Idaho	2,554,817	2,561,105	2,155,270	-405,835
Illinois	17,322,214	17,158,047	17,976,023	+817,976
Indiana	8,547,076	8,381,873	8,255,030	-126,843
Iowa	3,735,295	3,686,277	3,685,812	-465
Kansas	3,492,553	3,454,659	3,417,686	-36,973
Kentucky	6,469,100	6,357,925	6,006,311	-351,614
Louisiana	5,592,499	5,513,361	5,602,440	+89,079
Maine	1,831,044	1,802,317	1,820,701	+18,384
Maryland	9,076,153	9,032,488	7,730,745	-1,301,743
Massachusetts	9,997,620	9,971,207	9,507,918	-463,289
Michigan	14,638,954	14,515,920	14,513,995	-1,925
Minnesota	7,127,318	7,089,713	7,124,298	+34,585
Mississippi	4,215,406	4,187,582	4,235,346	+47,764
Missouri	7,852,761	7,793,723	7,757,861	-35,862
Montana	1,364,051	1,359,717	1,356,995	-2,722
Nebraska	2,152,297	2,103,021	2,106,915	+3,894
Nevada	4,547,235	4,651,021	4,598,833	-52,188
New Hampshire	1,863,286	1,841,227	1,638,448	-202,779

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2016 DISCRETIONARY STATE/FORMULA GRANTS
Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	$12,962,425	$12,975,405	$12,985,469	$10,064
New Mexico	2,809,998	2,791,090	2,714,303	-76,787
New York	28,564,852	28,236,385	29,379,836	+1,143,451
North Carolina	12,869,812	12,834,233	12,964,660	+130,427
North Dakota	826,569	816,996	796,971	-20,025
Ohio	15,274,428	15,076,166	14,762,661	-313,505
Oklahoma	4,974,309	4,978,056	4,923,689	-54,367
Oregon	5,988,749	5,983,509	6,095,036	+111,527
Pennsylvania	16,460,620	16,252,021	16,307,047	+55,026
Rhode Island	1,769,137	1,749,226	1,687,607	-61,619
South Carolina	6,671,692	6,656,055	6,737,414	+81,359
South Dakota	953,807	947,022	952,352	+5,330
Tennessee	8,833,476	8,802,254	9,356,048	+553,794
Texas	36,596,738	36,712,474	37,081,756	+369,282
Utah	3,478,559	3,490,243	3,496,453	+6,210
Vermont	839,604	821,044	811,934	-9,110
Virginia	11,406,542	11,372,201	10,491,012	-881,189
Washington	10,429,045	10,443,964	10,516,352	+72,388
West Virginia	2,715,750	2,646,507	2,633,146	-13,361
Wisconsin	7,379,783	7,274,287	7,647,820	+373,533
Wyoming	511,527	535,764	492,178	-43,586
American Samoa	88,385	88,293	88,869	+576
Guam	255,557	256,962	260,468	+3,506
Marshall Islands	107,574	110,039	113,275	+3,236
Micronesia	171,070	171,112	172,322	+1,210
Northern Marianas	83,532	82,585	83,105	+520
Palau	50,000	50,000	50,000	---
Puerto Rico	5,935,283	5,930,860	5,920,858	-10,002
Virgin Islands	169,385	169,164	170,102	+938

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SAMHSA
Substance Abuse Prevention
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Substance Abuse Prevention Appropriation

(Dollars in thousands)

Program Activities	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Programs of Regional and National Significance	$175,129	$175,148	$210,918	+$35,770
PHS Evaluation Funds (non-add)	---	---	*16,468*	*+16,468*
Total, Substance Abuse Prevention 1	**$175,129**	**$175,148**	**$210,918**	**+$35,770**

[1] The Minority Fellowship Program budgets from the Mental Health, Substance Abuse Prevention and Treatment appropriations have been comparably adjusted in this table to be in line with the FY 2016 Request and are reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

The Substance Abuse Prevention appropriation request is $210.9 million, an increase of $35.8 million from the FY 2015 Enacted Level. The request includes $194.5 million in Budget Authority (which is a $19.3 million increase from the FY 2015 Enacted Level) and $16.5 million in PHS Evaluations Funds (which is a $16.5 million increase from the FY 2015 Enacted Level).

Programs of Regional & National Significance (PRNS)
Substance Abuse Prevention Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
CAPACITY				
Strategic Prevention Framework	$109,484	$109,484	$118,254	+$8,770
Strategic Prevention Framework Rx PHS Evaluation Funds (non-	---	---	*10,000*	*+10,000*
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths	---	---	12,000	+12,000
Federal Drug-Free Workplace	4,894	4,894	4,894	---
Minority AIDS	41,205	41,205	41,205	---
Sober Truth on Preventing Underage Drinking (STOP Act)	6,983	7,000	7,000	---
Tribal Behavioral Health Grants	---	---	15,000	+15,000
Subtotal, Capacity	**162,566**	**162,583**	**198,353**	**+35,770**
SCIENCE AND SERVICE				
Fetal Alcohol Spectrum Disorder	998	1,000	1,000	---
Center for the Application of Prevention Technologies (CAPT)	7,493	7,493	7,493	---
PHS Evaluations Funds (non-add)	---	---	*6,468*	*+6,468*
Science and Service Program Coordination	4,072	4,072	4,072	---
Subtotal, Science and Service	**12,563**	**12,565**	**12,565**	**---**
TOTAL, PRNS [1]	**$175,129**	**$175,148**	**$210,918**	**+$35,770**

[1] The Minority Fellowship Program budget is reflected within the Health Surveillance and Program Support appropriation under the Agency-wide Initiatives Workforce program and is consistent with the FY 2015 and FY 2016 Budget Requests.

Authorizing Legislation ..... Sections 516, 519B, 519D of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities..... States, Tribes, Communities, and Private Non-Profit Organizations

Strategic Prevention Framework (SPF)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Strategic Prevention Framework	$109,484	$109,484	$118,254	+$8,770
Strategic Prevention Framework Rx (non-add)	---	---	*10,000*	*+10,000*

Authorizing Legislation ..... Sections 516, 519B, 519D of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities..... States, Tribes, and Territories

Program Description and Accomplishments

Strategic Prevention Framework (SPF)

The Strategic Prevention Framework-State Incentive Grant (SPF-SIG) program is an infrastructure and service delivery grant program. The program supports activities to help grantees build a solid foundation for delivering and sustaining effective substance abuse prevention services and reducing substance abuse problems. Following the SPF five-step process, SPF-SIG grantees develop comprehensive plans for prevention infrastructure and systems at the state and tribal levels. Ultimately, SPF-SIG States/Tribes assist and support selected sub-recipient communities to implement effective programs, policies and practices to reduce substance abuse and its related problems. The SPF-SIG program provides the foundation for success of the SPF - Partnerships for Success (PFS) Grant Program.

The SPF-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 use disorders; strengthening prevention capacity and infrastructure at the state and community levels in support of prevention; and leveraging, redirecting, and realigning statewide funding streams for substance abuse prevention. Beginning in FY 2012, the PFS program has concentrated on addressing two of the nation's top substance abuse prevention priorities: underage drinking among youth and young adults ages 12 to 20 and prescription drug misuse and abuse among individuals ages 12 to 25. Through the PFS program, SAMHSA will continue to address the nation's top emerging substance abuse priorities, such as prescription drugs, other opioids including heroin, underage drinking, marijuana, and intoxicative inhalants.

In FY 2014, SAMHSA awarded a new cohort of 21 PFS grants and 16 continuation PFS grants. Similar to the previous cohorts, these grantees will primarily address underage drinking among youth and young adults ages 12 to 20 and prescription drug misuse and abuse among individuals ages 12 to 25 during the project periods from FY 2014 to FY 2018. Eligible applicants in FY 2014, including tribal applicants, were also encouraged to address marijuana and heroin use as emergent priority issues.

In FY 2015, SAMHSA will award up to 38 new PFS grants and 32 continuation PFS grants. Grantees will address the overarching national issues of underage drinking among youth and young adults aged 12 to 20 and prescription drug misuse among youth and young adults 12 to 25. SAMHSA also encourages applicants for the FY 2015 PFS cohort (project periods FY 2015 to FY 2019) to address emergent issues related to marijuana and heroin use.

Data show that states/communities receiving PFS funding have made improvements on targeted National Outcome Measures indicators. The 2013 National Survey on Drug Use and Health (NSDUH) report shows that underage drinking and underage binge alcohol use are declining. The rate of past month alcohol use among 12 to 20 year olds decreased from 28.8 percent in 2002 to 22.7 percent in 2013. The binge drinking rate declined from 19.3 to 14.2 percent, and the rate of heavy drinking declined from 6.2 to 3.7 percent.

Although the number of persons aged 12 or older who used psychotherapeutics non-medically for the first time within the past year has decreased by over 400,000 persons, the overall rate of nonmedical use of psychotherapeutics, including nonmedical use of any prescription drug pain relievers, tranquilizers, stimulants, or sedatives, has remained constant. The percent of respondents reporting past month nonmedical use was 2.6 percent in 2012 and 2.5 percent in 2013.[32] Prescription drug and opioid misuse and abuse continues to be a concern, as overdose deaths increase. There is a need for targeted strategies geared toward education programs for families about the dangers of prescription drug and opioid interactions, educating consumers and prescribers about the dangers of high-risk prescribing, ensuring proper training of first responders, and implementing drug take back programs.

Trends in substance use often coincide with trends in perceived risk. Increases in perceived risk typically precede or occur simultaneously with decreases in use, and vice versa. For example, perceived risk in the use of marijuana continues to decrease as states lessen penalties for marijuana possession and change policies related to marijuana use. The percentage of youth aged 12 to 17 who indicated great risk in smoking marijuana once a month decreased from 34.4 percent in 2007 to 24.2 percent in 2013. The rate of youth who perceived great risk in smoking marijuana once or twice a week also decreased from 54.6 percent in 2007 to 39.5 percent in 2013. There have been consistent decreasing trends in the perceived risk of marijuana use over the past five years. The prevalence of past month marijuana use among youths was 6.7 percent in 2007 and 7.1 percent in 2013.[33]

A cross-site evaluation of PFS began in FY 2014 for those grantees funded since 2012. The evaluation is addressing the following: 1) Was the implementation of PFS programs associated with a reduction in underage drinking and/or prescription drug misuse and abuse? 2) Did variability in the total level of funding from all sources relate to outcomes? Did variability in the total level of PFS funding relate to outcomes, above and beyond other funding available to communities? 3) What intervention type, combinations of interventions, and dosages of

[32] http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm#fig5.6

[33] http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm#6.1

interventions were related to outcomes at the grantee level? What intervention type, combinations of interventions, and dosages of interventions were related to outcomes at the community level? 4) Were some types and combinations of interventions within communities more cost-effective than others? 5) How does variability in factors (strategy selection and implementation, infrastructure, geography, demography, sub-recipient selection, Training/TA, barriers to implementation) relate to outcomes across funded communities? Preliminary annual outcome findings should be available in FY 2015.

Strategic Prevention Framework for Prescription Drugs (SPF Rx)

Due to alarming trends related to prescription drug misuse and overdoses involving opioids, SAMHSA is prioritizing efforts to address prescription drug misuse. Drug overdose death rates have increased five-fold since 1980.[34] 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.[35] 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.[36]

According to the 2013 NSDUH survey, 2.5 percent (6.5 million) of the U.S. population aged 12 or older used prescription drugs non-medically in the past month in 2013, including (1.7 percent) users of pain relievers, (0.6 percent) users of tranquilizers, (0.5 percent) users of stimulants, and (0.1 percent) users of sedatives. Rates of nonmedical use of prescription drugs in the past month are highest among 18 to 25 year olds (4.8 percent). According to the Treatment Episode Data Set (TEDS), in 2012, admissions to substance abuse treatment facilities were reported by substance as 16.0 percent pain relievers (non-heroin opioids/synthetics), 6.0 percent benzodiazepines or other tranquilizers, 12.0 percent stimulants (methamphetamine, other amphetamines, or other stimulants) and 0.7 percent for barbiturates or other sedatives/hypnotics.

Funding for SAMHSA and the Centers for Disease Control and Prevention (CDC) in FY 2015 is 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's recently established policy and plan for prevention of Opioid-Related Overdoses and Deaths involving multiple Operating Divisions and offices. Through this program, CDC will launch the PDO Prevention for States program, a new competitive cooperative agreement program, to capitalize upon the infrastructure of the existing Prevention Boost and Core VIPP program, with a specific focus on those interventions which exhibit the most promise for reversing the PDO epidemic. CDC will fund states through a competitive cooperative agreement and will target states that contribute

[34] 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.
[35] 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.
[36] 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.

significantly to the national burden of prescription drug overdose morbidity and mortality. CDC will incorporate each state's burden of PDO in the competitive process to test and implement best practices for the identification, treatment, and control of prescription drug abuse. CDC will provide funding to states to address opioid prescribing on multiple fronts, and SAMHSA will provide funding to states 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 Strategic Prevention Framework for Prescription Drugs (SPF Rx) will raise awareness about the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing to young adults. 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.

The FY 2016 SPF Rx program will continue to develop capacity and expertise in the use of data from state prescription drug monitoring programs to identify communities by geography and high-risk populations (e.g., age group), particularly those communities that are in need of primary and secondary prevention. In addition, grantees can use these resources to provide technical assistance and training on the use of SAMHSA's Opioid Overdose Prevention Tool Kit to prevent overdose deaths. Funding will support up to 20 state planning grants, technical assistance and evaluation to build capacity to address prescription drug abuse, and overdose prevention efforts, in conjunction with other state and local partners.

SAMHSA will track reductions in opioid overdoses and the incorporation of Prescription Drug Monitoring Program (PDMP) data into needs assessments and strategic plans as indicators of program success.

Funding History

Fiscal Year	Amount
FY 2012	$109,754,080
FY 2013	$107,901,970
FY 2014	$109,484,000
FY 2015	$109,484,000
FY 2016	$118,254,000

Budget Request

The FY 2016 Budget Request is $118.3 million at the program level with $108.3 million from Budget Authority and $10.0 million from Public Health Service (PHS) Evaluation Funds. This is a net increase of $8.8 million from the FY 2015 Enacted Level with a $1.2 million decrease from Budget Authority and a $10.0 million increase in PHS Evaluation Funds for the new Strategic Prevention Framework for Prescription Drugs (SPF-Rx) program. SPF-Rx will raise public awareness about the dangers of sharing medications and to work with pharmaceutical and medical communities to raise awareness on the risks of overprescribing. The FY 2016 SPF program will provide funds to develop capacity and expertise in the use of data from state prescription drug monitoring programs to identify communities by geography and high-risk populations (e.g., age group), particularly those communities that are in need of primary and

secondary prevention. In addition, grantees can use SAMHSA's resources to provide technical assistance and training on the use of SAMHSA's Opioid Overdose Prevention Tool Kit to help prevent opioid overdose related deaths. Funding will support up to 20 state planning grants, technical assistance and evaluation to build capacity to address prescription drug abuse, and overdose prevention efforts, in conjunction with other state and local partners.

Outputs and Outcomes Table

Program: Partnerships for Success

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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 2013: 36[1] Target: 50 (Target Not Met)	142	375	+233
2.3.79 Number of EBPs implemented by sub-recipient communities (Output)	FY 2013: 846[2] Target: 950 (Target Not Met)	1,850	1,850	Maintain
2.3.80 Number of sub-recipient communities that improved on one or more targeted NOMs indicators (Outcome)	FY 2013: 45[3] Target: 50 (Target Not Met but Improved)	142	294	+152

[1,2,3] Only cohort I reporting

Outputs and Outcomes Table

Program: SPF Rx

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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, 2016 Target: Set Baseline (Pending)			
3.3.12 Number of funded states reporting reductions in opioid overdoses (Outcome)	FY 2015: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)			

Federal Drug-Free Workplace Program

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Federal Drug-Free Workplace	$4,894	$4,894	$4,894	$---

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method .....IAA/Contracts
Eligible Entities..... Federal Agencies, Regulated Entities (E.g. Department of Transportation, Nuclear Regulatory Commission), NLCP Certified Laboratories

Program Description and Accomplishments

The Federal Drug-Free Workplace Program (DFWP) consists of two principal activities mandated by Executive Order (E.O.) 12564 and Public Law (P.L.) 100-71: 1) oversight of the DFWP, aimed at the elimination of illicit drug use within Executive Branch agencies and the regulated industry; and 2) oversight of the National Laboratory Certification Program (NLCP), which certifies laboratories to conduct forensic drug testing for federal agencies, federally regulated industries and the private sector.

First signed on September 15, 1986, E.O. 12564 requires the head of each executive agency to establish a comprehensive Drug-Free Workplace Plan that includes supervisor/employee education, an Employee Assistance Program, and a random testing component to test for illegal drug use by federal employees in safety-sensitive positions. The E.O. also requires the Secretary of Health and Human Services (HHS) to promulgate scientific and technical guidelines for drug-testing programs.

The Supplemental Appropriations Act, 1987 (Public Law 100-71) included language which requires HHS to: (1) certify that each Executive Branch agency has developed a plan for achieving a drug-free workplace; and (2) publish Mandatory Guidelines (MG) 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 (800-WORKPLACE) for businesses that answers questions about drug testing in the workplace.

SAMHSA funded the DFWP drug testing activities in FY 2014 and will continue do so in FY 2015 through the National Laboratory Certification Program (NLCP) contract. The NLCP oversees the certification of the labs used for testing drug samples under the Drug-Free Workplace Program. The Drug Testing Advisory Board (DTAB) provides recommendations to the Administrator, SAMHSA, with an ongoing review of the direction, scope, balance, and emphasis of the Agency's drug testing activities and the NLCP. On January 10, 2012, SAMHSA

approved the DTAB recommendations to revise the MG to include oral fluid as an alternative specimen to urine as well as include additional Schedule II prescription drug medications (e.g., oxycodone, oxymorphone, hydrocodone and hydromorphone). The DTAB will continue to examine the scientific feasibility of hair as an alternative specimen to urine in the MG. All changes to the MG will be based on scientific supportability and legal defensibility. SAMHSA continues to use Subject Matter Experts and partners with other federal agencies to establish the scientific standards set out in the MG.

In FY 2015, continued funding for the Federal Drug-Free Workplace Program will ensure the testing of federal employees in national security, public health, and public safety positions for illegal drugs, and inspect/certify SAMHSA certified laboratories.

Funding History

Fiscal Year	Amount
FY 2012	$5,196,161
FY 2013	$5,251,583
FY 2014	$4,894,000
FY 2015	$4,894,000
FY 2016	$4,894,000

Budget Request

The FY 2016 Budget Request of $4.9 million is level with the FY 2015 Enacted Level. In FY 2016, SAMHSA will continue oversight of the Executive Branch Agencies' DFWP. This includes review of agency DFWP plans that perform federal employee testing, perform random testing for positions of national security, public health, and public safety, and perform testing for illegal drug use and the misuse of prescription drugs. SAMHSA will continue its oversight role to inspect and certify the NLCP laboratories.

Minority AIDS Initiative (MAI)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Minority AIDS	$41,205	$41,205	$41,205	$---

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities.....Local Government Entities, Community-based Organization and Institutions of Higher Education.

Program Description and Accomplishments

SAMHSA supports the National HIV/AIDS Strategy through its Minority AIDS Initiative (MAI) grant programs that focus on increasing 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 men and women, adolescents, incarcerated individuals or those who have been released within the past two years, and men having sex with men. 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 2013, SAMHSA continued to fund two ongoing MAI programs. The first, entitled Ready-To-Respond Initiative (RTR) is providing a final year of funding to 36 grantees. The purpose of the RTR program is to build on previous MAI grantee accomplishments by expanding knowledge and experience in developing blended substance abuse and HIV prevention practices for at-risk minority populations. The second, entitled Capacity-Building Initiative (CBI) is providing a final year of funding to 27 grantees. The purpose of the CBI program is to engage colleges, universities and community-level domestic public and private non-profit entities to prevent and reduce the onset of SA and transmission of HIV/AIDS among at-risk racial/ethnic minority adults.

In FY 2013, SAMHSA funded a new MAI grant program entitled Minority Serving Institutions Partnerships with Community-Based Organizations (MSI CBOs) to 29 grantees throughout 15 different states, including the Virgin Island and one Tribal College and/or University (TCU). The purpose of this program is to prevent and reduce substance abuse (SA) and the transmission of HIV/AIDS among minority young adults (ages 18 to 24) on campus and in the surrounding communities. In FY 2013, the number of program participants exposed to substance abuse prevention education was 6,437. This far exceeded the target of 5,734. The number of persons tested for HIV in FY 2013 equaled 37,173 which exceeded the target of 32,975 and represents an increase of over 4,000 persons tested from FY 2012. For participants in prevention education programs, 89.5 percent remained non-users of alcohol, from the start to the end of the program.

In FY 2014, SAMHSA awarded 21 additional MSI CBO grants in 13 different states including three additional TCUs. The purpose of these additional grants is to equip and empower MSIs located in communities at the highest risk of SA, HIV and Hepatitis-C (HCV) infections to increase access to comprehensive, integrated SA, HIV and HCV prevention services on their campus and surrounding community to young adults (ages 18-24).

The MAI programs cross-site evaluation report examines inputs, outputs, outcomes and the relationships among them. A few of the findings include: 1) participants who received Protocol-Based Counseling (PBC) when compared to participants who did not receive PBC were more likely to show decreases in past 30-day use of illicit drugs (excluding marijuana), increases in protected oral and vaginal sex, and increases in sexual self-efficacy, 2) participants who received Comprehensive Risk Counseling Services (CRCS) were more likely to increase their perception of risk of harm from using marijuana when compared to participants who did not receive this

intervention; 3) minority program participants who received Brief Alcohol Screening and Intervention for College Students (BASICS) had a higher likelihood of improving the following outcomes: past 30 day alcohol use, marijuana use, and illicit drug excluding marijuana, and perception of harm from unprotected anal sex.

SAMHSA's Center for Mental Health Services, Center for Substance Abuse Treatment and CSAP jointly administer the FY 2014 Minority AIDS Initiative Continuum of Care Pilot - Integration of HIV Prevention and Medical Care into Mental Health and Substance Abuse Treatment Programs for Racial/Ethnic Minority Populations at High Risk for Behavioral Health Disorders and HIV (Short Title: MAI CoC Pilot: Integration of HIV Medical Care into BH Programs or "CoC"). The purpose of this jointly funded program is to integrate care (mental and substance use disorder treatment, substance abuse prevention, and HIV medical care services) for racial/ethnic minority populations at high risk for behavioral health disorders and high risk for or living with HIV. The grant will fund programs that provide coordinated and integrated services through the co-location of behavioral health treatment and HIV medical care. There is significant co-morbidity of viral hepatitis with HIV infection; additionally, viral hepatitis occurs in up to 20 percent of those with either substance use disorders or serious mental illness. In order to address this, five 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 FY 2015, SAMHSA will provide funding for up to 77 new grantees under both the MSI CBO and CBI programs. The purpose of the MSI CBO program will continue to be prevention and reduction of substance abuse (SA) and the transmission of HIV/AIDS among minority young adults (ages 18 to 24) on campus and in the surrounding communities. The purpose of the CBI program will continue to be engagement of colleges, universities and community-level domestic public and private non-profit entities focused on the prevention and reduction of the onset of SA and transmission of HIV/AIDS among at-risk racial/ethnic minority adults.

SAMHSA supports an HIV Consolidated Evaluation. The primary purpose is to conduct a comprehensive process and outcome evaluation of all SAMHSA HIV Programs to address the degree to which SAMHSA is providing effective and efficient mental and substance use disorder services to those living with HIV through its funded HIV grant efforts. The evaluation results will be used to inform program development and refine the approach used in SAMHSA's HIV portfolio.

The expected outcomes for the MAI HIV programs include reducing the impact of mental and substance use disorders, HIV risk and incidence, and HIV-related health disparities in the nation. These programs ensure 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 have access to and receive appropriate behavioral health services (including prevention and treatment and rapid HIV testing), HIV/AIDS care and medical treatment in integrated behavioral health and primary care settings (that may include infectious disease or other HIV specialty providers).

Expected outcomes for the HIV CoC programs include: 1) increased HIV testing to identify behavioral health clients who are unaware of their HIV status; 2) increased diagnosis of HIV among behavioral health clients; 3) increased number of clients who are linked to HIV medical

care; 4) increased number of behavioral health clients who are retained in care; 5) increased number of behavioral health clients who are receiving antiretroviral therapy (ART); 6) improved adherence to behavioral treatment and ART; 7) increased number of behavioral health clients who have sustained viral suppression; and 8) increased adherence and retention in behavioral health (both substance use and mental disorders) treatment. SAMHSA HIV/AIDS programs to be evaluated under this task order include at least 4 cohorts of grantees.

Funding History

Fiscal Year	Amount
FY 2012	$41,306,782
FY 2013	$40,995,653
FY 2014	$41,205,000
FY 2015	$41,205,000
FY 2016	$41,205,000

Budget Request

The FY 2016 Budget Request of $41.2 million is level with the FY 2015 Enacted Level. These funds continue to address a critical public health problem and health disparity and provide life-saving prevention services, including testing.

Outputs and Outcomes Table

Program: Minority AIDS

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
2.3.56 Increase the number of program participants exposed to substance abuse prevention education services (Output)	FY 2013: 6,437 Target: 5,734[1] (Target Exceeded)	2,580[2]	2,580	Maintain
2.3.83 Percent of program participants who report no use of alcohol at pre-test who remain non-users at post-test (all ages) (Outcome)	FY 2013: 89.5% Target: 91.2% (Target Not Met but Improved)	91.2%	91.2%	Maintain
2.3.85a Number of persons tested for HIV through the Minority AIDS Initiative prevention activities (Outcome)	FY 2013: 37,173 Target: 32,975 (Target Exceeded)	35,074	35,074	Maintain

[1]Target has been revised from previously reported. Target has been changed to include Cohorts VII, VIII, IX, and X.
[2]Target has been reduced to reflect a decrease in number of grants in FY 2015 resulting in fewer participants.

Sober Truth on Preventing Underage Drinking Act (STOP Act)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Sober Truth on Preventing Underage Drinking (STOP Act)	$6,983	$7,000	$7,000	$---

Authorizing Legislation .....Section 519B of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Current and former Drug-Free Communities grantees

Program Description and Accomplishments

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 (Public Law 109-422) was the nation's first comprehensive legislation on underage drinking. One of the primary components of the STOP Act is the community-based coalition enhancement grant program, which provides up to $50,000 per year over four years to current or former grantees under the Drug Free Communities Act of 1997 to prevent and reduce alcohol use among youth under age 21. The STOP Act grant program enables organizations to strengthen collaboration and coordination among stakeholders to achieve a reduction in underage drinking in their communities. In FY 2014, SAMHSA supported 97 grant continuations and will continue that support in FY 2015.

In FY 2013, the STOP Act grantees' performance exceeded expectations on two of the three GPRA measures. Almost 74 percent of coalitions reported at least five percent improvement on past 30 day alcohol use in at least two grades. This is a slight increase since FY 2012. In FY 2013, 61.5 percent of coalitions reported an increase in youth perception of parental disapproval of alcohol use, exceeding the target and showing over a three percentage point increase over FY 2012. In FY 2013, 52.8 percent of coalitions reported improvement in perceived risk of alcohol in at least two grades. This is a reduction from the prior year and does not meet the target. These data are critical as perceptions play a key role in youth's alcohol use. If youth believe that alcohol is risky or their parents disapprove of alcohol use, they are less likely to drink. This result reflects recent national reductions in perceived risk. Perceived risk is a consistent leading indicator of future increases in use, and underscores the need to continue and expand SAMHSA's efforts to reduce underage drinking. SAMHSA will start a robust cross-site evaluation of current STOP Act grantees in FY 2015. Outcomes will be available in FY 2016.

Another component of the STOP Act is the National Adult-Oriented Media Public Service Campaign to prevent underage drinking "Talk. They Hear You". The national media campaign engages parents and caregivers of youth aged 9-15 on how to have a conversations about the dangers of underage drinking to delay the onset of, and ultimately reduce, underage drinking. In 2014, the campaign resulted in more than 2.5 billion impressions from television, radio, print and mobile platforms, with good representation across the United States. This includes a presence in all fifty states, over 300 cities nationwide, including American Indian/Alaska Native communities, and presence in more than 30,000 health care offices. Further research continues

to show that parents and caregivers of youth generally underestimate the extent of alcohol used by youth and the associated consequences. In FY 2015, SAMHSA will continue to support the National Adult-Oriented Media Public Service Campaign.

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 2015, SAMHSA will continue to support the ICCPUD.

Funding History

Fiscal Year	Amount
FY 2012	$6,986,770
FY 2013	$6,993,928
FY 2014	$6,983,000
FY 2015	$7,000,000
FY 2016	$7,000,000

Budget Request

The FY 2016 Budget Request of $7.0 million is level with the FY 2015 Enacted Level. This funding will support 97 continuation grants in FY 2016. Eligible entities include current and former Drug-Free Communities grantees.

Outputs and Outcomes Table

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

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.3.01 Percentage of coalitions that report at least 5% improvement in the past 30- day use of alcohol in at least two grades (Outcome)	FY 2013: 73.9% Target: 40%[1] (Target Exceeded)	62%	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 2013: 52.8% Target: 60.9%[2] (Target Not Met)	68%	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 2013: 61.5% Target: 54.5%[3] (Target Exceeded)	65%	65%	Maintain

[1,2,3] Targets were reduced due to fewer new grantees and annual closeout of mature grantees.

Fetal Alcohol Spectrum Disorders (FASD)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Fetal Alcohol Spectrum Disorder	$998	$1,000	$1,000	$---

Authorizing Legislation .....Sections 516 of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method ..... Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

The Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence (CFE) program focuses on preventing FASD among women of childbearing age and improving the quality of life for individuals and families affected by these disorders. The 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 affected by FASD.

As part of these efforts, the FASD CFE has successfully established a website that provides the public with information and resources on the prevention of FASD and chartered an expert panel that provides guidance and recommendations about best practices for healthcare providers and social service organizations. The FASD CFE has also organized a Self-Advocates with FASD Network (comprised of young adults with FASD) and a Birth Mothers Network which advocate for services, provide mutual support, and work to improve the quality of life for people with FASD. In addition, the FASD CFE partnered with the NIH National Institute on Alcohol Abuse and Alcoholism's Interagency Coordinating Committee on FASD to advance new research and best practices on FASD. The FASD CFE also 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 and provided ongoing support to the National Association of FASD State Coordinators to integrate FASD services into existing health care systems. Finally, the FASD CFE convened 10 "Building FASD State Systems" annual conferences to facilitate the development of comprehensive systems of care for people affected by FASD. The FASD CFE also established a Native Communities Initiative to address FASD in American Indian/Alaska Native (AI/AN)/Native Hawaiian populations.

In FY 2013 and FY 2014, 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, and other special populations, as well as health, social service, and faith-based providers who study and/or provide services for persons affected by FASD. In FY 2015, the FASD CFE will continue this technical assistance.

Funding History

Fiscal Year	Amount
FY 2012	$9,802,438
FY 2013	$1,103,511
FY 2014	$998,000
FY 2015	$1,000,000
FY 2016	$1,000,000

Budget Request

The FY 2016 Budget Request of $1.0 million is level with the FY 2015 Enacted Level. These funds will maintain the Center for Excellence.

Center for the Application of Prevention Technologies (CAPT)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Center for the Application of Prevention Technologies	$7,493	$7,493	$7,493	$---
PHS Evaluations Funds (non-add)	---	---	*6,468*	*+6,468*

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method ..... Contracts
Eligible Entities.....Not Applicable

Program Description and Accomplishments

The Center for the Application of Prevention Technologies (CAPT) program provides state-of-the-art training and technical assistance 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 2013, the CAPT completed a comprehensive revision and update of its flagship Substance Abuse Prevention Skills Training (SAPST), which offers participants 31 training hours toward certification as a Substance Abuse Prevention Specialist. The CAPT also developed a Pacific Islander and Native American adaptation of the training for six additional training hour credits. The CAPT also 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.

The CAPT is increasing emphasis on virtual or distance forms of service delivery and relying more heavily on webinars and online training. Eighty-eight percent of those served reported that the training increased their capacity to do prevention work and fully 100% reported that it increased their organizational capacity. In 2014, the CAPT delivered its foundational *SAPST* "Training of Trainers" to 296 participants who delivered the SAPST 31 times to 1,153 participants in 28 states. Also, in 2014, the CAPT developed; a series of self-paced courses to increase the capacity of community level grantees to use epidemiological data to guide their prevention planning efforts, as well as webinars and coaching consultations to help grantees identify risk and protective factors and appropriate strategies to address emerging prevention needs such as prescription drug misuse and youth marijuana use. In 2015, the CAPT will focus on building the organizational capacity of high-need communities to address health disparities and achieve benchmarks identified in SAMHSA's Partnerships for Success program. CAPT will continue to strengthen the prevention workforce, overall, by increasing the availability of interactive virtual trainings on using epidemiological data and risk and protective factors to guide implementation of effective prevention strategies for prescription drug misuse and opioid abuse and overdose, binge drinking in college populations and underage drinking.

In FY 2014, funding continued the CAPT activities and in FY 2015, funding will continue to support the delivery of technical assistance and workforce development to the prevention field.

Funding History

Fiscal Year	Amount
FY 2012	$8,058,740
FY 2013	$8,097,521
FY 2014	$7,493,000
FY 2015	$7,493,000
FY 2016	$7,493,000

Budget Request

The FY 2016 Budget Request of $7.5 million is level with the FY 2015 Enacted Level. These funds will continue to provide technical assistance and workforce development to the prevention field.

Outputs and Outcomes Table

Program: Prevention – Center for the Application of Prevention Technologies (CAPT)

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2014: 54,883[1] Target: 110,000 (Target Not Met)	42,063[2]	40,947	-1,116
1.4.11 Prevention: Increase the number of individuals trained by SAMHSA' Science and Services Program (Output)	FY 2013: 7,719 (Baseline)	5,216	5,216	Maintain
1.4.12 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 2013: 88% (Baseline)	90%	90%	Maintain
1.4.13 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: 93% (Baseline)	92%	95%	+3%

[1] Results are preliminary and will be updated when additional data is available.

[2] Target aggregates CSAT and CMHS Science and Service individuals trained, and CSAP CAPT individuals trained. Target reduced from previously reported due to methodological change in data collection.

Science and Service Program Coordination

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Science and Service Program Coordination	$4,072	$4,072	$4,072	$---

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method ..... Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

The Science and Service Program Coordination program funds the provision of technical assistance and training to states, tribes, communities, and grantees around substance abuse prevention. Specifically, the contracts support the Tribal Training and Technical Assistance (TTA) Center and the Underage Drinking Prevention Education Initiatives (UADPEI). The Tribal TTA Center is an innovative training and technical assistance project that helps tribal communities facilitate 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.

The 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, technical assistance, trainings, and a variety of tools and materials. 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 biennially, numbers served increase in the years the meetings occur and decrease in alternate years.

In FY 2014, community-based organizations registered to host 1,345 events. These events were held in all 50 states, the District of Columbia, and five territories. Approximately 1,160 individuals attended live online training webinars and SAMHSA responded to 1,301 requests for technical assistance in planning, promoting, hosting, and evaluating events. Science and Service performance data for FY 2012 demonstrate that 15,269 people were trained and almost 9,000 received technical assistance. In FY 2014 SAMHSA provided continuation funding for these activities and in FY 2015, SAMHSA will continue to support training and technical assistance.

Funding History

Fiscal Year	Amount
FY 2012	$4,779,949
FY 2013	$5,168,406
FY 2014	$4,072,000
FY 2015	$4,072,000
FY 2016	$4,072,000

Budget Request

The FY 2016 Budget Request of $4.1 million includes level funding from the FY 2015 Enacted Level to continue 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.

Tribal Behavioral Health Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Tribal Behavioral Health Grants	$---	$---	$15,000	+$15,000

Authorizing Legislation ..... Sections 516, 519B, 519D of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method ..... Contracts
Eligible Entities..... Tribes

Program Description

Suicide is the second leading cause of death among American Indian/Alaska Native (AI/AN) youth ages 8 to 24 years.[37] 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.[38] In addition, about 90 percent of those who die by suicide had a mental disorder at the time of their deaths.[39]

In FY 2014, Congress appropriated $5.0 million in the Mental Health appropriation to SAMHSA to address the high incidence of substance abuse and suicide among AI/AN populations. The

[37] Centers for Disease Control and Prevention. Fatal injury data, 2010. Web-based Injury statistics Query and Reporting System. Available at www.cdc.gov/injury/wisqars/fatal.html. Accessed May 27, 2014.
[38] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Available at http://www.cdc.gov/healthyyouth/yrbs/index.htm. Accessed May 27, 2014.
[39] American Association of Suicidology. (2012). *Suicide in the USA Based on 2010 Data.* Washington, DC: American Association of Suicidology. Available at: http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/SuicideUSA2012.pdf.

Appropriations Committee recommended that HHS award 20 competitive grants to tribal entities with the highest rates of suicide for effective and promising strategies that address substance abuse and suicide and promote mental health among AI/AN young people.

SAMHSA's Center for Mental Health Services (CMHS) awarded Tribal Behavioral Health competitive grants of up to $0.2 million annually for a total of five years to 20 tribes or tribal organizations with high rates of suicide in FY 2014. The grants will help grantees develop and implement a plan that addresses suicide and substance abuse, thereby promoting mental health among tribal youth. In addition, SAMHSA's Tribal Technical Assistance Center provides technical assistance to grantees to support their ability to achieve their goals. An evaluation component will allow grantees and SAMHSA to work collaboratively to monitor progress and learn from each other. SAMHSA will incorporate lessons learned to enhance this program and other national efforts to reduce suicide and substance abuse and support positive mental health among AI/ANs. SAMHSA will continue the support of this program in FY 2015.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$15,000,000

Budget Request

The FY 2016 Budget Request for the Tribal Behavioral Health Grant (TBHG) program is $30.0 million, including $15.0 million in the Mental Health appropriation and $15.0 million in the Substance Abuse Prevention appropriation. This request represents an increase over the FY 2015 Enacted Level of $10.0 million in the Mental Health appropriation and $15.0 million for a newly established line in the Substance Abuse Prevention appropriation. This funding is part of Generation Indigenous, a Native youth initiative focused on removing possible barriers to success for Native youth. This initiative will take a comprehensive, culturally appropriate approach to help improve the lives and opportunities for Native youth. In addition to HHS, multiple agencies, including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing Native youth. This funding will allow SAMHSA to expand activities that are critical to preventing substance abuse and promoting mental health and resiliency among youth in tribal communities. The additional funding will expand these activities to approximately 103 additional tribes and tribal entities. With the expansion of the TBHG program, SAMHSA aims to reduce substance use and the incidence of suicide attempts among Native youth and to address behavioral health conditions which impact learning in Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion and substance use prevention activities for high-risk Native youth and their families, enhance early detection of mental and substance use disorders among Native youth, and increase referral to treatment.

Program: Tribal Behavioral Health

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
2.4.10 Number of grantees reporting a decrease in underage drinking in their community (Output)	FY 2016: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)			
2.4.11 Number of participants receiving evidence-based mental health –related services as a result of the grant (Output)	FY 2016: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			
2.4.12 Number of youth age 10 – 24 who received mental health or related services after screening, referral or attempt (Output)	FY 2016: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			
2.4.13 The number of programs/organizations that implemented specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2016: Result Expected Dec 31, 2015 Target: Set Baseline (Pending)			

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths	$---	$---	$12,000	+$12,000

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants, Contracts
Eligible Entities.....States

Program Description

Opioid overdose is a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids. Opioid overdose accounted for 71 percent of all deaths related to pharmaceutical overdose in 2013.[40] Opioids include illegal drugs such as heroin, as well as prescription medications used to treat pain. These medications include morphine, codeine, methadone, oxycodone (Oxycontin, Percodan, Percocet), hydrocodone (Vicodin, Lortab, Norco), fentanyl (Duragesic, Fentora), hydromorphone (Dilaudid, Exalgo), and buprenorphine (Subutex, Suboxone). Opioids bind to specific receptors in the brain, spinal cord and gastrointestinal tract and reduce the body's perception of pain. As opioids reduce pain, they induce a slight sense of euphoria, which can lead to over use. Between 2001 and 2010, U.S. overdose deaths involving prescription opioid analgesics nearly doubled to almost 17,000 deaths a year.[41,42] This increase coincided with a nearly fourfold increase in the use of prescribed opioids for the treatment of pain.[43]

In 2013, SAMHSA released the Opioid Overdose Prevention Toolkit to help reduce the number of opioid-related overdose deaths and adverse events. Developed by the Association of State and Territorial Health Officials, the National Association of State Alcohol and Drug Abuse Directors, the American Association for the Treatment of Opioid Dependence and SAMHSA, the toolkit was the first federal resource that includes safety and prevention information for persons at risk for overdose, and provides information on how to recognize and respond appropriately to overdose, identifies specific drug-use behaviors to avoid, and describes the role of naloxone in preventing death from an overdose. Naloxone is an opioid antagonist that reverses the effects of opioids, including respiratory depression. A growing evidence base suggests that naloxone is a cost-effective method to reduce opioid overdose deaths.

[40] Prescription Drug Overdose in the United States: Fact Sheet.
[41] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. CDC WONDER Online Database, 2012.
[42] Beletsky LB, Rich JD, Walley AY. Prevention of fatal opioid overdose. JAMA. 2013;308(180): 1863–1864.
[43] Harvard Medical School. Painkillers fuel growth in drug addiction: Opioid overdoses now kill more people than cocaine or heroin. Harvard Mental Health Let. 2011;27(7):4–5.

The toolkit is currently the most downloaded SAMHSA publication with approximately 10,500 downloads per month. This highlights the success of the product and the magnitude of the problem which SAMHSA works to address. The toolkit provides evidence-based guidance for using safe prescribing practices, identifying patients at risk for overdose, engaging patients in prevention and risk-reduction efforts, and accessing addiction treatment. It gives communities and local governments the material to develop policies and practices in order to prevent and respond appropriately to opioid-related overdose.

As the rates of prescription drug misuse and abuse, heroin use, overdoses, and opioid-related overdose deaths increase, communities are searching for ways to reduce the death rate from opioid-related overdoses. SAMHSA proposes a $12.0 million grant program to help states identify communities of high need, and provide education, training, and resources necessary to tailor the overdose kits to meet their specific needs. The grant funds could be used for purchasing naloxone, equipping first responders with naloxone and other overdose death prevention strategies, supporting education on these strategies, providing materials to assemble and disseminate overdose kits.

These grantees would be required to develop a dissemination plan and a training course tailored to meet the needs of their community. The course would use SAMHSA's Opioid Overdose Prevention Toolkit as a guide, and include a comprehensive prevention program which will focus on prevention, treatment and recovery services to decrease the likelihood of drug overdose recurrence. The Centers for Disease Control and Prevention (CDC) will evaluate this grant program for its efficacy in reducing overdose deaths from opioids.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$12,000,000

Budget Request

The FY 2016 Budget Request is $12.0 million, which is $12.0 million above the FY 2015 Enacted Level. This new program will provide grants to 10 states to reduce significantly the number of opioid overdose-related deaths. Funding will help states purchase naloxone, equip first responders in high-risk communities, support education on the use of naloxone and other overdose death prevention strategies, provide the necessary materials to assemble overdose kits, as well as cover expenses incurred from dissemination efforts.

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table by APT

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final No.	FY2014 Final Amount	FY2015 Enacted No.	FY2015 Enacted Amount	FY2016 President's Budget No.	FY2016 President's Budget Amount
Grants						
Continuations	205	$71,911	198	$72,288	377	$141,457
New/Competing	77	60,715	108	65,119	89	27,666
Supplements	14	2,025	---	---	---	---
Subtotal	296	134,651	306	137,407	466	169,123
Contracts						
Continuations	18	34,341	20	27,769	24	39,143
New	6	6,137	4	9,972	---	2,651
Subtotal	24	40,478	24	37,741	24	41,795
Total, Substance Abuse Prevention PRNS [1]	**320**	**$175,129**	**330**	**$175,148**	**490**	**$210,918**

[1] The Minority Fellowship Program has been comparably adjusted in this table to be in line with the FY 2016 Request and is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table by PPA

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final No.	FY2014 Final Amount	FY2015 Enacted No.	FY2015 Enacted Amount	FY2016 President's Budget No.	FY2016 President's Budget Amount
CAPACITY:						
Strategic Prevention Framework						
Grants						
Continuations	28	$43,506	34	$55,720	131	$102,733
New/Competing	22	48,052	38	40,425	---	---
Supplements	14	2,025	---	---	---	---
Subtotal	64	93,583	72	96,145	131	102,733
Contracts						
Continuations	9	15,901	7	12,155	8	15,521
New	---	---	1	1,184	---	---
Subtotal	9	15,901	8	13,339	8	15,521
Total, Strategic Prevention Framework	**73**	**109,484**	**80**	**109,484**	**139**	**118,254**
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths						
Grants						
Continuations	---	---	---	---	---	---
New	---	---	---	---	10	11,246
Subtotal	---	---	---	---	10	11,246
Contracts						
Continuations	---	---	---	---	---	---
New	---	---	---	---	---	754
Subtotal	---	---	---	---	---	754
Total, Prescription and Opioid Overdose Death Prevention	**---**	**---**	**---**	**---**	**10**	**12,000**
Federal Drug-Free Workplace Program						
Contracts						
Continuations	2	4,123	5	4,427	4	3,963
New	2	771	---	467	---	931
Subtotal	4	4,894	5	4,894	4	4,894
Total, Federal Drug-Free Workplace Program	**4**	**4,894**	**5**	**4,894**	**4**	**4,894**

Programs of Regional & National Significance	FY2014 Final No.	FY2014 Final Amount	FY2015 Enacted No.	FY2015 Enacted Amount	FY2016 President's Budget No.	FY2016 President's Budget Amount
Minority AIDS						
Grants						
Continuations	80	23,759	67	11,922	149	34,078
New/Competing	55	12,663	70	24,694	19	2,363
Subtotal	135	36,422	137	36,616	168	36,441
Contracts						
Continuations	---	3,237	3	4,339	4	4,764
New	2	1,546	1	250	---	---
Subtotal	2	4,783	4	4,589	4	4,764
Total, Minority AIDS	**137**	**41,205**	**141**	**41,205**	**172**	**41,205**
Sober Truth on Preventing Underage Drinking Act						
Grants						
Continuations	97	4,646	97	4,646	97	4,646
New/Competing	---	---	---	---	---	---
Subtotal	97	4,646	97	4,646	97	4,646
Contracts						
Continuations	2	1,384	1	1,367	2	2,354
New	1	952	1	987	---	---
Subtotal	3	2,337	2	2,354	2	2,354
Total, STOP	**100**	**6,983**	**99**	**7,000**	**99**	**7,000**
Tribal Behavioral Health Grants						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	60	14,057
Subtotal	---	---	---	---	60	14,057
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	943
Subtotal	---	---	---	---	---	943
Total, Tribal Behavioral Health Grants	---	---	---	---	**60**	**15,000**
Subtotal, CAPACITY	**314**	**$162,566**	**325**	**$162,583**	**484**	**$198,353**

Programs of Regional & National Significance	FY2014 Final No.	FY2014 Final Amount	FY2015 Enacted No.	FY2015 Enacted Amount	FY2016 President's Budget No.	FY2016 President's Budget Amount
SCIENCE AND SERVICE:						
Fetal Alcohol Spectrum Disorder						
Contracts						
Continuations	1	$998	1	$966	1	$977
New	---	---	---	34	---	23
Subtotal	1	998	1	1,000	1	1,000
Total, Fetal Alcohol Spectrum Disorder	**1**	**998**	**1**	**1,000**	**1**	**1,000**
Center for the Application of Prevention Technologies						
Contracts						
Continuations	1	7,493	---	443	1	7,493
New	---	---	1	7,050	---	---
Subtotal	1	7,493	1	7,493	1	7,493
Total, Center for the Application of Prevention Technologies	**1**	**7,493**	**1**	**7,493**	**1**	**7,493**
Science & Service Program Coordination						
Contracts						
Continuations	3	1,205	3	4,072	4	4,072
New	1	2,867	---	---	---	---
Subtotal	4	4,072	3	4,072	4	4,072
Total, Science & Service Program Coordination	**4**	**4,072**	**3**	**4,072**	**4**	**4,072**
Subtotal, SCIENCE AND SERVICE	**6**	**12,563**	**5**	**12,565**	**6**	**12,565**
Total, CSAP [1]	**320**	**$175,129**	**330**	**$175,148**	**490**	**$210,918**

[1] The Minority Fellowship Program has been comparably adjusted in this table to be in line with the FY 2016 Request and is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

Grant Awards Table

(Whole dollars)

	FY2014 Final	FY2015 Enacted	FY2016 President's Budget
Number of Awards	320	330	490
Average Awards	$547,278	$530,752	$430,445
Range of Awards	$50,000 - $2,300,000	$50,000 - $2,300,000	$50,000 - $2,300,000

SAMHSA
Substance Abuse Treatment
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Substance Abuse Treatment Appropriation

(Dollars in thousands)

Program Activities	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Programs of Regional and National Significance	$360,698	$361,463	$320,701	-$40,762
Prevention and Public Health Fund (non-add)	*50,000*	---	---	---
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*	*+28,000*
Substance Abuse Prevention and Treatment Block Grant	1,815,443	1,819,856	1,819,856	---
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	---
Total, Substance Abuse Treatment 1	**$2,176,141**	**$2,181,319**	**$2,140,557**	**-$40,762**

[1] The Minority Fellowship Program budgets from the Mental Health, Substance Abuse Prevention and Treatment appropriations have been comparably adjusted in this table to be in line with the FY 2016 Request and are reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

The Substance Abuse Treatment appropriation request is $2.1 billion, a decrease of $40.8 million from the FY 2015 Enacted Level. The request includes $2.0 billion in Budget Authority (a decrease of $68.8 million from the FY 2015 Enacted Level) and $109.2 million in PHS Evaluation funds (which is an increase of $28.0 million from the FY 2015 Enacted Level).

Programs of Regional and National Significance
Substance Abuse Treatment Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
CAPACITY:				
Opioid Treatment Programs/Regulatory Activities	$8,724	$8,724	$8,724	$8,724
Screening, Brief Intervention and Referral to Treatment	46,889	46,889	30,000	-16,889
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*	*+28,000*
TCE-General	13,223	23,223	36,303	+13,080
Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (non-add)	---	12,000	25,000	+13,000
Pregnant & Postpartum Women	15,931	15,931	15,931	---
Strengthening Treatment Access and Retention	1,664	1,000	1,000	---
Recovery Community Services Program	2,434	2,434	2,434	---
Access to Recovery	50,000	38,223	---	-38,223
Prevention and Public Health Fund (non-add)	*50,000*	---	---	---
Primary Care and Addiction Services Integration	---	---	20,000	+20,000
Children and Families	29,605	29,605	29,605	---
Treatment Systems for Homeless	41,386	41,386	41,386	---
Minority AIDS	65,570	65,570	58,859	-6,711
Criminal Justice Activities	74,816	78,000	61,946	-16,054
Subtotal, Capacity	**350,242**	**350,985**	**306,188**	**-44,797**
SCIENCE AND SERVICE:				
Addiction Technology Transfer Centers	9,024	9,046	8,081	-965
Crisis Systems	---	---	5,000	+5,000
Special Initiatives/Outreach	1,432	1,432	1,432	---
Subtotal, Science and Service	**10,456**	**10,478**	**14,513**	+4,035
TOTAL, PRNS[1]	**$360,698**	**$361,463**	**$320,701**	**-$40,762**

[1]The Minority Fellowship Program budget is reflected within the Health Surveillance and Program Support appropriation under the Agency-wide Initiatives Workforce program and is consistent with the FY 2016 Budget Request.

Opioid Drug Treatment/Regulatory Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Opioid Treatment Programs/Regulatory Activities	$8,724	$8,724	$8,724	$---

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... American Society of Addiction Medicine
American Academy of Addiction Psychiatry, American Medical Association
American Osteopathic Association, American Psychiatric Association
American Dental Associations, and States

Program Description and Accomplishments

As part of its regulatory responsibility, the Substance Abuse and Mental Health Services Administration (SAMHSA) certifies Opioid Treatment Programs (OTPs) that use methadone, buprenorphine, or buprenorphine/naloxone to treat patients with opioid dependence. SAMHSA carries out this responsibility by enforcing regulations established by an accreditation-based system. This is accomplished in coordination with the Drug Enforcement Administration, states, territories, and the District of Columbia. SAMHSA also funds the OTP Medical Education and Supporting Services project aimed at preparing OTPs to achieve accreditation and providing technical assistance and clinical training to enhance program clinical activities. Program performance and the quality of the OTPs are monitored primarily by accreditation bodies to provide information that can be used to improve services and provide recommendations for future directions.

In FY 2013, SAMHSA awarded seven cooperative agreements for Electronic Health Record (EHR) and Prescription Drug Monitoring Program (PDMP) Data Integration grants. The purpose of this program is to reduce prescription drug misuse and abuse by providing healthcare providers with access to PDMP data. This allows providers to make sound clinical decisions by integrating that information into their regular clinical workflow. Grant funds will assist states in addressing prescription drug misuse and abuse by integrating the 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. The funds cannot be used to enhance or expand existing PDMPs.

SAMHSA funds a number of grants and contracts that support the regulatory oversight and monitoring activities of OTPs. In FY 2014, SAMHSA funded 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 on the appropriate use of opioids for the treatment of chronic pain and opioid addiction. In FY 2014, SAMHSA also supported continuations of two three-year grants (one Physicians Clinical Support Systems – Medication-Assisted Treatment (PCSS-MAT) and one ATTC-Hepatitis support). SAMHSA also supported 14 contracts that focused activities such as

physician waiver notifications refining the Buprenorphine Waiver Notification System, training to ensure the availability of qualified healthcare professionals, administering the appropriate treatment protocols, physician training on safe and appropriate prescribing of opioids, and technical support to address accreditation guidelines development.

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 addition to SAMHSA's significant regulatory oversight (42 CFR Part 8), the agency, in collaboration with other federal partners, provides guidance, education, training and other activities to enhance current efforts related to Medication-Assisted Treatment (MAT).

In order to strengthen efforts and reduce the negative consequences of increasing use/misuse and abuse of opioids, including heroin, SAMHSA will work to ensure that tools, information, and technical assistance about opioid treatment reach individuals, families, communities, states, and health professionals.

In FY 2015, SAMHSA intends to support three grant continuations (PCSS-O, PCSS-MAT and ATTC-Hepatitis), nine five-year contracts that focused on among other things, activities such as the Drug Addiction Treatment Act of 2000 (buprenophrine) physician waiver notification system, training to ensure the availability of qualified healthcare professionals, administering the appropriate treatment protocols, physician training on safe and appropriate prescribing of opioids, and technical support to address accreditation guidelines development.

Funding History

Fiscal Year	Amount
FY 2012	$12,886,173
FY 2013	$12,421,373
FY 2014	$8,724,000
FY 2015	$8,724,000
FY 2016	$8,724,000

Budget Request

The FY 2016 Budget Request is level with the FY 2015 Enacted Level. Funding will support two grant continuations, including the five-year ATTC-HEP support, one new three-year PCSS-MAT grant, and six contracts to continue technical assistance and regulatory oversight and monitoring of OTPs. Additionally, SAMHSA intends to fund a new cooperative agreement to pilot two Regional Medication Assisted Treatment Centers of Excellence (MATCoEs), in two of the ten HHS regions. The PCSS-MAT project will continue for one additional year and will provide MAT training and related services for the other regions. The PCSS-O project will not be continued. Eligible entities for the new RegMATCoE include academic health centers and leading MAT service providers in the region. The RegMATCoEs will assess the needs of the medical and health professions workforce, identify gaps in services within the region and engage with local leadership in addressing these needs and gaps while supporting the overall improvement in MAT quality of care.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Screening, Brief Intervention and Referral to Treatment	$46,889	$46,889	$30,000	-$16,889
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*	*+28,000*

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Single State Authority and Health Departments in States, Territories and District of Columbia, Federally Recognized American Indian/Alaska Native Tribe or Tribal Organizations, Domestic Public and Private Non-Profit Entities, Public and Private Universities Colleges

Program Description and Accomplishments

The Screening, Brief Intervention and Referral to Treatment (SBIRT) program requires state grant recipients to implement the SBIRT model at all levels of primary care and medical facilities, including hospitals, trauma centers, Federally Qualified Health Centers, and other relevant settings. Research and clinical experience support the use of SBIRT to intervene early with alcohol and other substance use disorders, which leads to early referral and treatment. SBIRT also identifies individuals with more serious health conditions and diverts them from costly emergency services to general practitioners. Funds may be used for screening of substance use and co-occurring disorders, evidence-based client-centered brief interventions such as motivational interviewing, brief treatment and referral to specialty care for individuals exhibiting signs of dependency.

The purpose of the SBIRT training grants is to develop primary care workforce in order to enhance the delivery system so that SBIRT is a part of standard medical practice. This program provides medical residents, students of dentistry, physician assistants, and pharmacists, nurses, social workers, counselors the opportunity to learn the elements of SBIRT and incorporate them as part of their permanent practice.

In FY 2014, SAMHSA funded 10 new and continuing five-year state SBIRT grants, 24 three-year Medical Professional Training grants totaling 22 continuation and 12 new grant awards, and supporting 11 five-year contracts. It is estimated that the state grants will support the screening of an additional 327,700 individuals.

In FY 2015, SAMHSA intends to support continuation of nine five-year state SBIRT grants and 15 three-year SBIRT Medical Professional Training grantees in addition to 49 new three-year SBIRT Health Professions Student Training grants. Furthermore, SAMHSA is supporting four contracts including technical assistance and evaluation.

The SBIRT model has proven successful on those populations to which it is targeted. Since its inception in 2003, SBIRT programs have screened over 2.0 million people. Evaluation findings from evaluation contracts since 2009 have increasingly shown positive results. Most recently, cross-site evaluation results of SAMHSA SBIRT implementation grants indicate that patients receiving SBIRT services significantly reduced their days of alcohol use, days of alcohol use to intoxication, and days of illicit drug use. The purpose of the evaluation is to conduct a robust process and outcome evaluation of the SBIRT program. Evaluation results suggest that implementation guidance and technical assistance for engaging medical staff and champions, securing adequate resources and infrastructure to deliver the full continuum of care, hiring staff with adequate training who are able to work in challenging medical settings, and tailoring services to the cultural needs of the patient population are essential for widespread adoption and diffusion of SBIRT. SBIRT programs in SAMHSA's third cohort provided evidence-based SBIRT services and engaged approximately 500,000 patients. These findings can be used to support the adaptation of SBIRT by states and tribal organizations. The findings also indicate that the value of SBIRT is that it makes an "invisible" clinical issue visible by providing the tools to identify and address alcohol and drug use disorders at every point in public health, from primary care to specialty care.

Funding History

Fiscal Year	Amount
FY 2012	$53,187,412
FY 2013	$47,463,652
FY 2014	$46,889,000
FY 2015	$46,889,000
FY 2016	$30,000,000

Budget Request

The FY 2016 Budget requests $30.0 million for Screening, Brief Intervention and Referral to Treatment (SBIRT), a $16.9 million decrease from the FY 2015 Enacted Level. Funding will support 49 grant continuations (three five-year state SBIRT and 46 three-year Medical Professional Training grants), 13 new Medical Professional Training grants, and four contracts to continue to integrate SBIRT into general medical and primary care settings. This reduction will not result in the termination of any grants. Funding is requested to continue to support the coordination and integration of primary care services into publicly-funded community behavioral health settings. With the increasing adoption of SBIRT in healthcare settings, the Budget redirects resources to other substance abuse treatment activities, such as heroin and prescription drug abuse treatment.

Outputs and Outcomes Table

Program: Screening, Brief Intervention and Referral to Treatment

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
1.2.40 Number of clients served (Output)	FY 2014: 283,160 Target: 75,015 (Target Exceeded)	143,783[1]	143,783	Maintain
1.2.41 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2014: 24% Target: 36% (Target Not Met)	36%	36%	Maintain

[1]Increase in target from previously reported levels.

Targeted Capacity Expansion-General (TCE-General)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
TCE-General	$13,223	$23,223	$36,303	+$13,080
Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (non-add)	---	*12,000*	*25,000*	*+13,000*

Authorizing Legislation ..... Sections 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Domestic Public and Private Non-Profit Entities, States, Opioid Medication-Assisted Treatment Service Providers, Outpatient Substance Abuse Providers, Community Mental Health Centers, and Federally Qualified Health Centers, SAMHSA Certified Opioid Treatment Programs, Licensed Outpatient Substance Abuse Treatment Programs

Program Description and Accomplishments

The Targeted Capacity Expansion-General (TCE-General) program was initiated in FY 1998 to help communities expand or enhance their ability to provide rapid, strategic, comprehensive, integrated, and community-based responses to a specific and well-documented substance abuse capacity problem. Since inception, TCE-General grants have been awarded to address the following targeted populations as well as urgent, unmet, and emerging treatment needs: American Indian and Alaska Natives (AI/AN), Asian Americans, Pacific Islanders, rural populations, methamphetamine abuse, e-therapy, grassroots partnerships, and other populations and issues.

Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA)
Medication-Assisted Treatment (MAT) for Opioid Addiction refers to the use of Food and Drug Administration (FDA)-approved pharmacotherapies (i.e., buprenorphine/naloxone, methadone, injectable extended release naltrexone) approved for the treatment of opioid use disorders in conjunction with psychosocial and other needed interventions such that comprehensive substance abuse treatment is provided to achieve the ultimate goal of recovery. Opioid MAT is clinically driven with a focus on individualized patient care and has been demonstrated to be effective in the treatment of opioid use disorders. As part of a comprehensive treatment program, opioid MAT has been shown to: improve survival; increase retention in treatment; decrease illicit opioid use; decrease hepatitis and HIV seroconversion; decrease criminal activities; increase employment; and improve birth outcomes. A recent study by researchers at the University of Washington found that more than half of U.S. counties don't have access to one of only three medications approved to treat opioid addiction.

SAMHSA has been involved in opioid MAT for more than a decade when the oversight of methadone treatment was transferred from the FDA to SAMHSA. In 2000, the Drug Addiction Treatment Act (DATA) expanded the clinical context of opioid MAT by allowing qualified

physicians to dispense or prescribe specifically-approved Schedule III, IV, and V narcotic medications for the treatment of opioid addiction in office-based settings. More recently, SAMHSA has worked with the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism to develop guidance around the use of pharmacotherapies for alcohol and opioid use disorders. In August 2014, SAMHSA convened a state policy academy with officials from 10 states to assist the agency in developing strategies to address prescription drug abuse, with a focus on prevention, treatment (specifically MAT) and recovery.

In 2015, Congress appropriated to SAMHSA $12.0 million to expand or enhance MAT and other clinically-appropriate services for persons with opioid use disorders. The program will support grants in 11 states at $1.0 million for each of three years. In addition, SAMHSA will use $1.0 million to support a contract to provide technical assistance to new grantees. The program will target those states that have demonstrated a dramatic increase in admissions for treatment of opioid use disorders and that have experienced the highest rates of admissions for treatment of opioid use disorders. Eligible populations may be limited to regions or communities at highest risk within a state based on epidemiologic justification provided by applicants to include data from SAMHSA's Treatment Episode Data (TEDs) and other relevant SAMHSA datasets. Treatment providers may include: a) existing opioid MAT service providers such as Opioid Treatment Programs (OTPs); b), non-OTP facilities that offer opioid MAT services and office-based opioid MAT providers; and c) providers that currently do not offer opioid MAT services such as outpatient substance abuse programs, community mental health centers and federally qualified health centers. Services covered by grant funds include: MAT, case management, relapse prevention and recovery support. These new funds will enable 12 states to expand access to opioid addiction treatment services in approximately 24 communities of greatest need.

TCE-Technology Assisted Care (TCE-TAC)

Current grants include the Expanding Care Coordination through the Use of Technology- Assisted Care in Targeted Areas of Need (TCE-TAC) grants. People are underserved for a number of reasons, including lack of access to treatment in their geographic location and an inadequate number of providers. Technology, such as Health Information Technology (HIT), web-based services, smart phones, mobile applications, and telehealth, can improve access to services for these populations. Financial constraints limit use of technology by providers. The TCE-TAC's purpose is to enhance and/or expand the capacity of treatment providers to serve persons who are traditionally underserved through increased use of technology. In FY 2013, the rating of social connectedness among program persons served by participants who received grants under this program improved from 60.3 percent at intake to 70.5 percent at six-month follow-up. Also, those who reported abstinence from alcohol and/or drugs for the last 30 days increased from 76.6 percent at intake to 79.2 percent at six-month follow-up.[44]

TCE-Peer to Peer (PTP)

The TCE-Peer to Peer (PTP) program expands and enhances service capacity through addiction peer recovery support services for individuals with substance use disorders. The primary objective is to help achieve, then maintain, recovery and to improve the overall quality of life for

[44] Services Accountability Improvement System (SAIS); www.samhsa-gpra.samhsa.gov; 2013.

those being served. This is assessed through increased employment, housing stability, abstinence from substance use, social connectedness, and decreased criminal justice involvement. In FY 2013, those who were employed or currently attending school improved from 16.4 percent at intake to 34.2 percent at six-month follow-up; abstinence in the past 30 days from alcohol and drug use improved from 71.2 percent at intake to 86.8 percent at six-month follow-up; and those who reported stability in housing improved from 46.5 percent at intake to 56.5 percent at six-month follow-up.

In FY 2014, SAMHSA funded the continuation of 29 three-year grants, one new TCE-PTP multi-year grant, one new five-year contribution to Community Anti-Drug Coalition of America (CADCA) grant with CSAP, and eight contracts. SAMHSA will continue to monitor the progress of the four FY 2012 HIT and four FY 2013 TCE-PTP grants. FY 2014 funds will serve approximately 3,300 clients.

In FY 2015, SAMHSA intends to support 30 three-year grant continuations and three contracts that provide a mechanism by which SAMHSA grantees may obtain professional technical help with the implementation and operation of most aspects of grant work.

Funding History

Fiscal Year	Amount
FY 2012	$27,980,018
FY 2013	$26,516,495
FY 2014	$13,223,000
FY 2015	$23,223,000
FY 2016	$36,303,000

Budget Request

The FY 2016 Budget Request of $36.3 million includes an increase of $13.1 million from the FY 2015 Enacted Level for Targeted Capacity Expansion-General. The increase will be used to support a new activity under the Targeted Capacity Expansion program entitled Medication Assisted Treatment for Prescription Drug and Opioid Addiction. This funding is part of a joint effort by SAMHSA and the Agency for Healthcare Research and Quality (AHRQ) to improve access to MAT services for treating opioid use disorders, with a focus on heroin and prescription opioids. SAMHSA will use this funding to provide grants to states to support opioid MAT efforts in high-risk communities, to educate, and to provide technical assistance. States can use this funding to purchase medication to expand MAT services. This program will increase the number of states from 11 to 22 that receive funding to expand services that address prescription drug misuse and heroin use in high-risk communities. This new funding is expected to serve an additional 24 high-risk communities.

In addition, FY 2016 funding will support 11 MAT-PDOA grant continuations, a three-year continuation for the Community Anti-Drug Coalition of America grant, and three contracts that offer professional technical assistance, as well as 16 new TCE-PTP and 13 new TCE-TAC three-year grants to continue to enhance and/or expand the capacity of treatment providers to serve

persons who are traditionally underserved and to help achieve and maintain recovery and to improve the overall quality of life for those being served.

Outputs and Outcomes Table

Program: Treatment – Opioid Medication-Assisted Treatment: Prescription Drug and Opioid Addiction

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/ Target for Recents Result (Summary of Result)	FY 2016 Target	Fy 2017 Target	FY 2017 Target +/- FY 2016 Target
1.3.01 Increase the number of admissions for Medication Assisted Treatment (Output)	FY 2016: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)			
1.3.02 Increase number of clients receiving integrated care (Output)	FY 2016: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)			
1.3.03 Decrease illicit drug use at 6-months follow-up	FY 2016: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)			

Pregnant and Postpartum Women (PPW)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY2015
Pregnant & Postpartum Women	$15,931	$15,931	$15,931	$---

Authorizing Legislation .....Section 508 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

As part of SAMHSA's Trauma and Justice Strategic Initiatives, the Pregnant and Postpartum Women (PPW) program has supported gender-specific 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, the PPW program is designed to support comprehensive substance abuse prevention, treatment, and recovery support services for women, their minor children, and family members. PPW supports sustained recovery for individuals and family members, coordinates with services in the community, and improves overall family functioning.

The PPW program provides a variety of services and case management for women, children, and families. Services available to women include: outreach, engagement, pre-treatment, screening and assessment; detoxification, substance abuse education, treatment, and relapse-prevention, healthcare services, including mental health services; postpartum health care including attention to depression, anxiety, and medication needs; parenting education and interventions; home management and life skills training and education; testing, counseling, and treatment of hepatitis, HIV/AIDS and other sexually transmitted diseases. Services available to children include screenings and developmental diagnostic assessments regarding the social, emotional, cognitive, and physical status of infants at birth through their developmental trajectories; developmental diagnostic assessments, prevention assessments; and interventions related to mental, emotional, and behavioral wellness. Services for families include family-focused programs to support family strengthening; including involvement with the child's other parent. The PPW program provides crucial services not covered under most public and private insurance.

Performance outcomes from the PPW program from 2003-2013 find that six months following admission to services, approximately 82 percent of clients are abstinent from illicit substance use, 26 percent are employed or engaged in productive activity, and 22 percent report having permanent housing.[45] Based on an in-depth review of cross-site evaluation and performance data in FY 2014, SAMHSA built the current PPW model on an evidence-based approach for serving

[45] Services Accountability Improvement System (SAIS); www.samhsa-gpra.samhsa.gov; 2013.

pregnant and post-partum women in need of residential substance abuse treatment. Beginning in January 2015, a new five year evaluation of the PPW Program will begin. The evaluation will assess the effectiveness of the PPW Program, document best practices and lessons learned, disseminate lessons learned that can be applied in other treatment modalities, and guide programmatic and policy changes. The evaluation will include a process and outcome evaluation based on data from biannual and quarterly progress reports, local evaluations, GPRA data, and other qualitative or quantitative data, as is deemed necessary.

In FY 2013, SAMHSA funded 25 three-year continuation awards and supported four contracts that provide technical assistance to help grantees with the implementation and operation of most aspects of grant work. In FY 2014, SAMHSA funded 19 new three-year grants, six grant continuations, and four contracts to continue support of comprehensive substance abuse prevention, treatment, and recovery support services for women. The FY 2014 funds supported services to approximately 950 women, 1,900 children, and 1,000 other family members. The PPW program continues to be enhanced with the addition of tobacco use counseling and interventions, screening and assessment for Fetal Alcohol Syndrome Disorders (FASD), screening and assessment for depression and anxiety; and offering a comprehensive service system that is trauma-informed.

In FY 2015, SAMHSA plans to award six three-year PPW grants totaling $3 million. In addition, SAMHSA will fund 1 one-year Addiction Technology Transfer Center (ATTC) supplemental grant, which will develop curriculum and disseminate the PPW family-centered model to organizations and providers outside the grant program. SAMHSA will fund four contracts to continue support of comprehensive substance abuse prevention, treatment, and recovery support services for women as done in FY 2014. SAMHSA is also studying sustainability models, developing training curriculum and planning for a state policy academy in order to encourage the wider adoption of the PPW family-centered approach at the state level.

Funding History

Fiscal Year	Amount
FY 2012	$15,969,760
FY 2013	$15,634,446
FY 2014	$15,931,000
FY 2015	$15,931,000
FY 2016	$15,931,000

Budget Request

The FY 2016 Budget Request includes level funding from the FY 2015 Enacted Level for the PPW program. Funding will support 25 three-year residential treatment grant continuations and five contracts to continue support for comprehensive substance abuse prevention, treatment, and recovery support services for women, their minor children, and family members. SAMHSA expects that these funds will support services to 950 women, 1,900 children, and 1,000 other family members.

Strengthening Treatment Access and Retention (STAR)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Strengthening Treatment Access and Retention	$1,664	$1,000	$1,000	$---

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method ..... Contracts
Eligible Entities.....Domestic Public and Private Entities

Program Description and Accomplishments

SAMHSA's Center for Substance Abuse Treatment (CSAT) joined with the Robert Wood Johnson Foundation to substantially increase client access to and retention in substance abuse treatment services through use of process improvement methods. This partnership has allowed SAMHSA to work with numerous grantees to improve substance abuse treatment processes to affect positive client outcomes. Activities have focused on 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). Based on STAR program successes, CSAT funded a follow-up effort through an infrastructure initiative that promoted state-level implementation of process improvement methods to improve access to and retention in outpatient treatment.

Treatment organizations that implement business operations practices use evidence-based plan, do, study, and act cycles (PDSA) as part of their improvement process. This includes collecting data before, during, and following the changes that are implemented.

In FY 2013, SAMHSA funded two contracts to provide technical assistance to grantees to promote service efficiency. In FY 2014, SAMHSA funded four contracts to sustain the operations of 15 provider business operations learning networks, involving an estimated 300 provider organizations. These networks expanded training to include strategic business planning, third party contracting, and ensuring client eligibility and engagement in treatment.

In FY 2015, SAMHSA intends to support three contracts, one of which is the continuation of the provider business operations learning network contract.

Funding History

Fiscal Year	Amount
FY 2012	$1,671,834
FY 2013	$1,584,387
FY 2014	$1,664,000
FY 2015	$1,000,000
FY 2016	$1,000,000

Budget Request

The FY 2016 Budget Request is level with the FY 2015 Enacted Level for Strengthening Treatment Access and Retention. Funding will support two contracts to continue to promote state-level implementation of process improvement methods to improve access to and retention in outpatient treatment.

Recovery Community Services Program (RCSP)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Recovery Community Services Program	$2,434	$2,434	$2,434	$---

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Family/Consumer Controlled Organizations
Domestic Public and Private Non-Profit Organizations in States, Territories, and Tribes
Recovery Community Organizations of Domestic Private Non-Profit Entities in States Territories, and Tribes

Program Description and Accomplishments

SAMHSA's Strategic Initiative on Recovery Support focuses on health, home, purpose, and community. The Recovery Community Services Program (RCSP) contributes to a better quality of life for people in recovery, including their families and communities. The RCSP program advances peer-to-peer recovery support services and has focused on a variety of underserved groups including women, African Americans, Latinos, rural populations, persons recently released from incarceration, the homeless, adolescents, and lesbian, gay, bisexual, and transgender populations. In addition, RCSP serves family members and allies of individuals in recovery. The primary population for RCSP includes individuals with substance use disorders who are in, or are 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 and employment, educational assistance, and recovery drop-in centers. These types of services offer social supports that help prevent relapse and promote sustained recovery from mental and/or substance use disorders. FY 2013 data demonstrated positive outcomes, with 84 percent of clients served reporting being abstinent at follow-up, 68 percent reporting being employed, 63 percent reporting being housed, and 99 percent reporting not being involved in the criminal justice system.[46]

The RCSP and Targeted Capacity Expansion-Peer To Peer (TCE-PTP) grant programs design and deliver peer recovery support services. Both programs use CSAT Government Performance Results Act (GPRA) outcome data to evaluate relapse, social connectedness, housing, employment/education, and criminal justice involvement. Additionally, these grant programs use 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 evidence-based practices that support peer recovery supports. Data are used to evaluate the usefulness of specific recovery practices within different cultural contexts, and to identify program models that best address the needs of individuals in

[46] Services Accountability Improvement System (SAIS); www.samhsa-gpra.samhsa.gov; 2013.

recovery from addiction. The FY 2014 RCSP Statewide Network grant program built on evaluations of previous cohorts to move forward on strengthening the capacity of community organizations to support addiction recovery through the building of statewide networks.

In FY 2013, SAMHSA funded five grant continuations and supported two contracts. In FY 2014, SAMHSA funded five contracts, 10 new three-year grants, and nine three-year Statewide Peer Networks for Recovery and Resiliency grants in collaboration with the Center for Mental Health Services ($0.4 million in CSAT and $0.4 million in the CMHS) in support of the Recovery Support Strategic Initiative. These funds are used to build capacity for statewide consumer-run, family member-run, or addiction recovery community organizations to promote infrastructure development that is recovery-focused and resiliency oriented. To ensure a stronger policy voice across the behavioral health field and facilitate readiness for the implementation of health reform, SAMHSA awarded additional funding 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 networks. This program is braided between the Mental Health appropriation and the Substance Abuse Treatment appropriation to allow for collaborative partnerships across the mental and substance use disorder fields. SAMHSA tracks any braided amounts spent or awarded under their distinct appropriations and ensures that funds are used for purposes consistent with legislative direction and intent of the appropriations.

In FY 2015, SAMHSA intends to support the continuation of 10 grants, four contracts, and eight new three-year Statewide Peer Network grants in collaboration with CMHS.

Funding History

Fiscal Year	Amount
FY 2012	$2,445,369
FY 2013	$2,445,461
FY 2014	$2,434,000
FY 2015	$2,434,000
FY 2016	$2,434,000

Budget Request

The FY 2016 Budget Request is level with the FY 2015 Enacted Level for Recovery Community Services Program: Funding will support 10 continuation three-year grants, 8 new grants and four contracts to continue to advance peer-to-peer recovery support services targeted toward a variety of underserved groups.

Access to Recovery (ATR)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Access to Recovery	$50,000	$38,223	$---	-$38,223
Prevention and Public Health Fund (non-add)	*50,000*	---	---	---

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... States, Territories, District of Columbia, Federally Recognized American Indian/Alaska Native Tribes and Tribal Organizations

Program Description and Accomplishments

Access to Recovery is a grant program which promotes client choice and supports states/tribes in developing expanded provider networks, including faith-based and secular providers, to provide comprehensive clinical substance abuse treatment and recovery support services. Since 2004, the ATR program has served over 650,000 clients through 75 grantees. The majority of services provided are recovery support related and not reimbursable by insurance. Services include transportation, housing, and jobs support.

ATR supplements and does not supplant other funding for substance abuse treatment services. Outpatient clinical treatment services and residential services, typically covered by Medicaid and marketplace plans, are for the most part not allowed under this program. Providers work with clients to link them to other sources of coverage for treatment services where appropriate. Under ATR, states and tribes are required to establish provider networks and develop a voucher-based mechanism to ensure client choice of treatment providers. The ATR grant funds support creating linkages between clients and treatment providers through state health information exchanges that ensure coordination and non-duplication of services and include both traditional and non-traditional providers, such as faith-based and peer providers. Performance data has found increased functioning of clients receiving services through ATR. In FY 2013, clients who were employed or currently attending school improved from 30.3 percent at intake to 49.6 percent at six-month follow-up; abstinence past 30-day alcohol and drug use improved from 68 percent at intake to 83.5 percent at six-month follow-up; and those who reported stability in housing improved from 34.9 percent at intake to 45.6 percent at six-month follow-up.[47]

Beginning in FY 2014, the ATR program encouraged grantees to seek reimbursement from third party payers to the extent possible for services covered by insurance, to focus on, the provision of services unlikely to be covered by insurance such as supportive services, and direct services to those who are ineligible for insurance or unable to acquire it. Performance data are compared

[47] Services Accountability Improvement System (SAIS); www.samhsa-gpra.samhsa.gov; 2013.

across time and between programs to identify high performing programs. Successful ATR innovations are communicated and new evidence shared to strengthen capacity nationwide.

In FY 2014, SAMHSA awarded six grants fully funded for the three-year project period of up to $3.0 million each per year; these grants were multi-year funded with Prevention and Public Health Funds. In addition, FY 2014 funds supported one contract. In FY 2015, SAMHSA intends to support six additional multi-year funded ATR grant awards, and one contract that focuses on providing policy and practice analyses, as well as training and technical assistance, to states, providers, and systems to increase the adoption and implementation of integrated, peer-driven, recovery supports, services, and systems for people with substance use disorders and mental health problems.

Funding History

Fiscal Year	Amount
FY 2012	$98,267,922
FY 2013	$93,127,920
FY 2014	$50,000,000
FY 2015	$38,223,000
FY 2016	---

Budget Request

SAMHSA is proposing eliminating the Access to Recovery (ATR) program in FY 2016. Many of the clinical services provided under ATR will now be covered by public and private insurance. In addition, states are able to support recovery support services and client choice with Substance Abuse Prevention and Treatment Block Grant funding. Since 2004, ATR has served over 650,000 clients through 75 grantees. SAMHSA has been able to identify successful substance abuse treatment and recovery-oriented systems of care models and will continue to offer technical assistance to states that would like to continue this activity.

Outputs and Outcomes Table

Program: Access to Recovery

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2016 Target	FY 2016 Target +/- FY 2014 Target
1.2.32 Number of clients gaining access to treatment (Output)	FY 2014: 63,870 Target: 50,000 (Target Exceeded)	50,000	8,000[1]	-42,000
1.2.33 Increase the percentage of adults receiving services who had no past month substance use (Outcome)	FY 2014: 84.2% Target: 81%[2] (Target Exceeded)	81%	80%	-1
1.2.35 Percentage of adults receiving services who had no/reduced involvement with the criminal justice system (Outcome)	FY 2014: 97.2% Target: 94% (Target Exceeded)	94%	93%	-1
1.2.36 Percentage of adults receiving services who had improved social support (Outcome)	FY 2014: 92.9% Target: 89% (Target Exceeded)	89%	88%	-1

[1] The target reduction reflects reduced funding level. Clients are supported through multi-year funding grants in FY 2014 and FY 2015, and this performance target is the result of previous year funding.

[2] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

Primary Care and Addiction Services Integration (PCASI)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Primary Care and Addiction Services Integration (PCASI)	$---	$---	$20,000	+$20,000

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Community Behavioral Health and Primary Care Service Organizations

Program Description

The Primary Care and Addiction Services Integration (PCASI) seeks to improve the health of people with substance use disorders (SUD) though coordinated and integrated primary care services. Through PCASI, integrated teams of professionals will be able to provide needed primary care services to individuals seeking care for a SUD. Provision of coordinated and integrated services improves 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 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.

Individuals with SUD are at risk for co-occurring health conditions. Several cardiovascular complications such as heart attack, heart failure and stroke are closely related to cocaine use. Alcohol use is a major risk factor for many conditions including chronic hypertension, obesity and diabetes. In addition, individuals with other chronic health issues may develop substance abuse problems due to self-medication. Not only do people with SUD experience health disparities in morbidity and mortality, Medicare and Medicaid cost data tell us that for people with multiple chronic conditions, costs are exponentially higher when one of those conditions is a SUD. Currently, a significant component of the overall higher cost of care for those with SUD is untreated chronic disease.[48] Partnerships between primary care and behavioral health organizations, as well as information technology entities, are crucial to the success of this program**.**

The goal of this Program is to improve the health of people with substance use disorders though coordinated and integrated primary care services in community substance abuse treatment settings. Through PCASI, integrated teams of professionals will be able to provide needed primary care services to individuals seeking care for a Substance Use Disorder (SUD), with the objective of improving health outcomes, enhancing the experience of care, and reducing the cost of care by controlling physical healthcare costs. SAMHSA expects that PCASI will complement the successful PBHCI grant program by promoting integrated services for individuals with SUDs and using lessons learned from PBHCI.

[48] Barnett, P.G. (2009). Comparison of costs and utilization among buprenorphine and methadone patients. Addiction, 104, 982-992.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$20,000,000

Budget Request

The FY 2016 request includes $20.0 million for PCASI, a $20.0 million increase over the FY 2015 Enacted Level to provide grants to behavioral health and primary care providers to integrate substance abuse treatment services and primary care. Individuals with substance use disorders are at risk for co-occurring health conditions. Several cardiovascular complications such as heart attack, heart failure, and stroke are closely related to cocaine use. Alcohol use is a major risk factor for many conditions including chronic hypertension, obesity and diabetes. In addition, individuals with other chronic health issues may develop substance abuse problems due to self-medication. Not only do people with substance use disorders experience health disparities in morbidity and mortality, Medicare and Medicaid cost data tell us that for people with multiple chronic conditions, costs are exponentially higher when one of those conditions is a substance use disorder.[49, 50] The goal of this program is to improve the health of people with substance use disorders though coordinated and integrated primary care services in community substance abuse treatment settings. Through PCASI, integrated teams of professionals will be able to provide needed primary care services to individuals seeking care for a substance use disorder (SUD), with the objective of improving health outcomes, enhancing the experience of care, and reducing the cost of care by controlling physical healthcare costs. SAMHSA expects that PCASI will complement the successful Primary and Behavioral Health Care Integration (PBHCI) grant program by promoting integrated services for individuals with SUDs and using lessons learned from PBHCI.

This funding will support a total of 21 grants to behavioral health and primary care providers of approximately $0.5 million annually for up to three years. Funding will also be used to award an HIV continuum of care grant award. In addition, SAMHSA will award a contract to support technical assistance and evaluation activities which will assess the clinical and cost effectiveness of these programs and other programs in the field, grantee ensure fidelity to program implementation, and to assist with documentation and dissemination of lessons learned from the program.

[49] 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

[50] 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.

Outputs and Outcomes Table

Program: Primary Care and Addiction Services Integration (PCASI)

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
1.2.52 Number of persons served (Output)	FY 2015: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)			
1.2.53 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2015: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)			
1.2.54 Percentage of clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2015: Result Expected Dec 31, 2016 Target: Set Baseline (Pending)			

Children and Family Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Children and Families	$29,605	$29,605	$29,605	$---

Authorizing Legislation .....Section 514 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Single State Agencies in States, Territories, and District of Columbia
Federally Recognized American Indian/Alaska Native Tribes and Tribal Organizations

Program Description and Accomplishments

In support of SAMHSA's Trauma and Justice Strategic Initiatives, adolescent and transition-aged youth treatment programs are designed to address the gaps in substance abuse treatment services by providing services to young people and their families/primary caregivers using effective family-centered practices.

In FY 2012, SAMHSA supported Cooperative Agreements for State Adolescent Treatment Enhancement and Dissemination (SAT-ED) and in FY 2013 supported Cooperative Agreements for State Adolescent and Transitional-Aged Youth Treatment Enhancement and Dissemination (SYT) based on lessons learned from SAT-ED. The purpose of these programs is 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 these programs include evidence-based assessment and treatment interventions. The target populations for SAT-ED are adolescents ages 12 through 17 and their families/caregivers. The target populations for SYT include adolescents that are ages 12 through 17, transition-aged youth 18 through 25, and their respective families/caregivers. Approximately 2,500 individuals were served as a result of these programs, with approximately 56 percent of clients reporting being abstinent from substance abuse and 80 percent employed or engaged in productive activities.

In addition to the state-based treatment award programs, SAMHSA collaborates 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). Activities of this National Center include providing in-depth technical assistance to states, forging more extensive partnerships with family drug courts, and promoting work with tribes. The 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.

In FY 2013, the adolescent portfolio supported six contracts that provide SAMHSA grantees technical help with the implementation and operation of grant projects. In FY 2014, SAMHSA funded 23 four-year grant continuations (13 SAT-ED grant continuations, and 10 SYT awards), one new award, and 12 contracts that advance the application of state-of-the-art knowledge

around substance use and mental health needs for women and families, as well as foster the growth of emerging leaders in the women and family substance use and mental health treatment field. In FY 2015, SAMHSA intends to support continuation of 11 SYT grants and six contracts, 12 new two-year SYT planning grants, and 12 new three-year SYT implementation grants so as to facilitate infrastructure development in those states in need of enhancement and to provide funding for those states ready to expand services.

The new evaluation will assess the effectiveness of these programs, document best practices and lessons learned, disseminate these lessons learned and guide programmatic and policy changes. The evaluation will utilize data from the biannual reports, GPRA performance reports, local evaluations, and other qualitative or quantitative information, as deemed necessary.

Funding History

Fiscal Year	Amount
FY 2012	$30,620,019
FY 2013	$29,018,408
FY 2014	$29,605,000
FY 2015	$29,605,000
FY 2016	$29,605,000

Budget Request

The FY 2016 Budget Request includes level funding from the FY 2015 Enacted Level for Children and Families. Funding will support 35 grant continuations (11 for SYT, 12 for SYT planning, and 12 for SYT Implementation) and six contracts. These efforts will continue to address the gaps in substance abuse treatment by providing services to young people and their families/primary caregivers using proven effective family-centered practices.

Treatment Systems for Homelessness

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Treatment Systems for Homeless	$41,386	$41,386	$41,386	$---

Authorizing Legislation ..... Section 506 and 509 of the Public Health Service Act
FY 2016 Authorization ..... Expired
Allocation Method ..... Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Community-Based Public and Private Non-Profit Entities State Mental Health Authorities, Single State Authorities for Substance Abuse in Partnership with Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

CSAT's Treatment Systems for Homelessness portfolio supports services, including short-term residential treatment and medication-assisted treatment, to those with substance use disorders or co-occurring substance use and mental disorders. These activities target the chronic homelessness and homeless veterans.

Stable permanent housing linked with behavioral health services is critical for achieving and maintaining recovery from substance use and mental disorders. SAMHSA and the U.S. Department of Housing and Urban Development (HUD) facilitate these links in a variety of ways. The primary objective of HUD's Continuum of Care (CoC), HUD's program is to increase housing stability for the homeless through mechanisms such as rental assistance; construction, acquisition, and rehabilitation of transitional and permanent housing; operating costs; and the provision of some supportive services. CoC funds may not be used for entities that only provide housing services-only. Entities who receive HUD CoC funds are eligible to apply for SAMHSA funding. Playing a complementary role to HUD's activities, SAMHSA/CSAT homelessness programs do not fund housing, but support an array of integrated behavioral health treatment and recovery-oriented services and supports, including outreach, engagement, intensive case management, treatment for mental and/or substance use disorders, enrollment in mainstream benefits (Medicaid, SSI/SSDI, SNAP, etc.), and employment readiness services.

SAMHSA's targeted homelessness programs are a component of SAMHSA's Recovery Support Strategic Initiative. One of the goals of the Strategic Initiative is to ensure that supportive services are available for individuals with mental and substance use disorders. SAMHSA/CSAT manages four Treatment Systems for Homelessness grant programs:

- Grants for the Benefit of Homeless Individuals (GBHI)-General are designed to expand and strengthen treatment services for persons experiencing homelessness (including those who experience chronic homelessness) with substance use and mental disorder or co-occurring substance use and mental disorders. The primary goal is to link treatment services with housing programs and other services (example primary care).

- GBHI-Services in Supportive Housing (GBHI-SSH) seek to use a permanent supportive housing approach to expand and strengthen substance use treatment or co-occurring substance use and mental disorders treatment services for individuals who experience chronic homelessness and veterans who experience homelessness.

- The Cooperative Agreements to Benefit Homeless Individuals (CABHI) program, initiated in 2011, is a jointly funded program between SAMHSA's Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT) and supports treatment and the development and/or expansion of local systems. This includes integration of treatment and other critical services for individuals with mental and substance use disorders; coordination at the local level with state or local Public Housing Authorities; local mental health, substance abuse, and primary care provider organizations; the local CoC; the state Medicaid Office; and the state Mental Health and Substance Abuse Authorities. As of FY 2013, 42 funded grants served 1,939 people with evidence of reduced experiences of depression and anxiety (62.5 percent and 66.2 percent respectively). Data show that between intake and six-month follow up abstinence from substance use increased by six percent, injection drug use decreased by 22 percent, and stability in housing increased by 49.8 percent.[51]

- The CABHI-States program, jointly funded with CMHS and using a permanent supportive housing approach, built on the CABHI program to provide accessible, effective, comprehensive, coordinated/integrated, and evidenced-based treatment services; peer supports; and enhancement or development of a statewide plan to ensure sustained partnerships across public health and housing systems that will result in short- and long-term strategies to support behavioral health services for individuals who experience homelessness.

Overall, in FY 2014 SAMHSA funded approximately $21.0 million in CABHI State cooperative agreements for work 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 individuals with mental and/or substance use disorders experiencing chronic homelessness. The US Interagency Council on Homelessness (USICH), in which HHS participates, has set aggressive goals to permanently house and address the needs of those who are chronically homeless and/or who are veterans and homeless. Therefore, the purpose of this jointly funded SAMHSA program is to enhance or develop the infrastructure and capacity of states and their treatment services systems to house and provide needed treatment and support services for individuals with mental and/or substance use disorders who are chronically homeless or who are veterans experiencing homelessness. SAMHSA seeks to increase the number of program-enrolled individuals who live in permanent housing that supports recovery through combining housing assistance with comprehensive treatment and recovery-oriented services for behavioral health issues.

[51] Services Accountability Improvement System (SAIS); www.samhsa-gpra.samhsa.gov; 2013.

An estimated 62 percent of clients report abstinence from substance use at a six-month follow up, while approximately 31 percent of clients report being employed or engaged in productive activities and 48.4 percent of clients report having a permanent place to live in the community.[52]

In 2011, a five-year contract, *Evaluation of Programs to Provide Services to Persons Who Are Homeless with Mental Illnesses and/or Substance Use Disorders*, was initiated to evaluate SAMHSA's programs for providing services to persons who are homeless and have mental and/or substance use disorders, including the GBHI-SSH and CABHI. This evaluation contract consolidated existing CSAT-CMHS program evaluations (SSH, GBHI) and added the new CABHI program. A central feature of this consolidated evaluation is to identify commonalities across the programs that may be used to compare effectiveness of the programs and of the various models of service delivery, including evidence-based practices, used within and across programs. The first new cohort of CABHI grants was added to the original number of grants included at award of the evaluation contract. However, subsequent grantees, such as the CABHI States cooperative agreements, could not be subsumed under this evaluation.

In FY 2014, SAMHSA funded approximately $10.2 million for 26 new three-year GBHI-SSH grants to domestic public or private nonprofit entities. The FY 2014 CABHI-States funding supported 18 new three-year grants of approximately $9.7 million to community-basic public or nonprofit entities. In FY 2014, SAMHSA supported a total of 34 grant continuations and five contracts. There were 11 CABHI-States grant continuations and 23 GBHI grant continuations.

In FY 2015, SAMHSA intends to support $42.0 million in new three-year programming for individuals with substance use disorders, SMI, or co-occurring mental and substance use disorders who are experiencing chronic homelessness (CSAT, $21.0 million; CMHS, $21.0 million). This includes funding for 26 new grants to build upon lessons learned from the CABHI programs and 10 continuation grants. SAMHSA also plans to fund up to seven new five-year GBHI-SSH grants and 26 GBHI-SSH five-year continuation grants. Additional funds will be used to support four contracts that include a national evaluation and technical assistance.

[52] Services Accountability Improvement System (SAIS); www.samhsa-gpra.samhsa.gov; 2013.

Funding History

Fiscal Year	Amount
FY 2012	$41,571,281
FY 2013	$39,396,852
FY 2014	$41,386,000
FY 2015	$41,386,000
FY 2016	$41,386,000

Budget Request

The FY 2016 Budget Request is level with the FY 2015 Enacted Level for Treatment Systems for Homelessness. Funding will support 60 annual grant continuations (27 CABHI-States continuation grants, 33 GBHI five-year continuation grants), nine new three-year grants, and three contracts. These programs will allow SAMHSA to continue to support 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 use disorders, enrollment in mainstream benefits, employment readiness, and linkage to permanent housing.

Outputs and Outcomes Table

Program: Treatment System for Homelessness (GBHI)

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.4.22 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2014: 64.9 % Target: 66.4 % (Target Not Met but Improved)	66.4 %	66.4 %	Maintain
3.4.23 Number of clients served (Output)	FY 2014: 3,963 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 2014: 31.7 % Target: 31.7 % (Target Met)	31.7 %	31.7 %	Maintain
3.4.25 Increase the percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2014: 45.3 % Target: 24.6 % (Target Exceeded)	33 %	33 %	Maintain

Minority AIDS

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Minority AIDS	$65,570	$65,570	$58,859	-$6,711

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

The purpose of the Minority AIDS Initiative (MAI) grants is to facilitate the development and expansion of culturally competent and effective community-based treatment systems for substance use and co-occurring substance use and mental disorders within racial and ethnic minority communities. The goals of the program are to reduce the impact of behavioral health problems, reduce HIV risk and incidence, and increase access to treatment for individuals with co-existing behavioral health, HIV, and Hepatitis conditions. SAMSA supports the following four Minority AIDS programs:

- The FY 2012 Targeted Capacity Expansion Program: Substance Abuse Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS (TCE-HIV). The purpose of this program is to facilitate the development and expansion of culturally competent and effective community-based treatment systems for substance use and co-occurring substance use and mental disorders within racial and ethnic minority communities in States with the highest HIV prevalence rates (at or above 270 per 100,000). The populations of focus include young men who have sex with men (YMSM; ages 18-29), adult heterosexual women and men; and men who have sex with men (MSM; ages 30 and older). SAMHSA funded the continuation of 52 TCE-HIV grant continuations and supported contracts for evaluation and technical assistance (e.g., client recruitment and retention, training on and implementation of evidence-based practices [EBPs], sustainability) to these grantees in FY 2013, FY 2014 and FY 2015. In FY 2016 SAMHSA will fund 52 grant continuations and support contracts for evaluation and technical assistance.

- The FY 2013 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 high-risk populations, including, African American, Hispanic/Latina and other racial/ethnic minority women (ages 18 years and older), 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. SAMHSA funded 35 TCE-HIV: Minority Women grant continuations and supported contracts for evaluation and technical assistance for these grantees in FY 2013. SAMHSA funded 35

TCE-HIV: Minority Women grant continuations and five new TCE-HIV: Minority Women off-the-shelf grants and supported contracts for evaluation and technical assistance for all TCE-HIV: Minority Women grantees in FY 2014. SAMHSA funded 40 TCE-HIV: Minority Women grant three-year continuations and supported contracts for evaluation and technical assistance for these grantees in FY 2015. SAMHSA will fund 40 TCE-HIV: Minority Women three-year grant continuations and support contracts for evaluation and technical assistance to these grantees in FY 2016.

There are currently two braided MAI programs jointly funded by Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) by the MAI:

- The FY 2011 Minority AIDS Initiative Targeted Capacity Expansion: Integrated Behavioral Health/Primary Care Network Cooperative Agreements (MAI-TCE). The purpose of this program is to facilitate 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 12 Metropolitan Statistical Areas (MSAs) and Metropolitan Divisions (MDs) most impacted by HIV/AIDS. SAMHSA funded 11 MAI-TCE grant continuations and supported contracts for evaluation and technical assistance for these grantees in FY 2012, FY 2013 and FY2014.

- The FY 2014 Minority AIDS Initiative Continuum of Care Pilot - Integration of HIV Prevention and Medical Care into Mental Health and Substance Abuse Treatment Programs for Racial/Ethnic Minority Populations at High Risk for Behavioral Health Disorders and HIV (MAI CoC Pilot: Integration of HIV Medical Care into BH Programs or "CoC"). The purpose of this jointly funded program is to integrate care (mental and substance use disorder treatment, substance abuse prevention, and HIV medical care services) for racial/ethnic minority populations at high risk for behavioral health disorders and high risk for or living with HIV. The grant will fund programs that provide coordinated and integrated services through the co-location of behavioral health treatment and HIV medical care. There is significant co-morbidity of viral hepatitis with HIV infection; additionally, viral hepatitis occurs in up to 20 percent of those with either substance use disorders or serious mental illness. In order to address this, five 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. SAMHSA awarded 34 awards and supported two contracts for evaluation and technical assistance to these grantees in FY 2014. SAMHSA will fund 35 CoC grant continuations and two supporting contracts for evaluation and technical assistance to these grantees in FY 2015 and FY 2016.

SAMHSA supports an HIV Consolidated Evaluation. The primary purpose is to conduct a comprehensive process and outcome evaluation of all SAMHSA HIV Programs to address the degree to which SAMHSA is providing effective and efficient mental and substance use disorder services to those living with HIV through its funded HIV grant efforts. The evaluation results

will be used to inform program development and refine the approach used in SAMHSA's HIV portfolio.

Technical assistance for these programs is executed primarily through a contract which focuses on: fostering the development and expansion of culturally competent, effective and integrated substance abuse prevention, mental and substance use disorder treatment and primary care networks and services for those living with HIV/AIDS.

Funding History

Fiscal Year	Amount
FY 2012	$65,863,283
FY 2013	$61,918,238
FY 2014	$65,570,000
FY 2015	$65,570,000
FY 2016	$58,859,000

Budget Request

The FY 2016 Budget requests $58.9 million, a decrease of $6.7 million from the FY 2015 Enacted Level. The funding decrease reflects a realignment between CSAT and CMHS Minority AIDS activities. Total Minority AIDS funds across SAMHSA are equal to the FY 2015 Enacted Level. This funding level will provide substance abuse treatment services, and provide literature and other materials to support behavior change, perform HIV/AIDS testing and counseling services and facilitate linkage to other medical and social services in local communities to racial/ethnic minority populations with substance use disorders and at high risk for HIV or living with HIV. SAMHSA will administer the braided MAI-Continuum of Care Program which will provide fully integrated medical care and mental and substance use disorder treatment to those living with HIV.

Criminal Justice Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Criminal Justice Activities	$74,816	$78,000	$61,946	-$16,054

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities, Operational Individual Misdemeanor and Felony Adult Criminal Courts, Municipal Courts, Tribal, State, Local Government Proxies and Government with Direct Involvement with Adult Criminal Courts, Tribal Organizations and Individual Adult Tribal Healing to Wellness Courts, Individual Juvenile Treatment Drug Courts

Program Description and Accomplishments

SAMHSA's Criminal Justice portfolio includes several grant programs which focus on diversion, alternatives to incarceration, drug courts, 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

Drug courts are designed to combine the sanctioning power of courts with effective treatment services for a range of populations with problems such as alcohol and/or drug use, child abuse/neglect or criminal behavior, mental illness, and veterans' issues. SAMHSA's adult drug court programs supports a variety of services, including direct treatment services for diverse populations at risk; wraparound/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.

The SAMHSA Drug Court grant programs use existing evidence from numerous studies to support current programs and new proposals. There have been more than 125 evaluation and research studies of the effectiveness of drug courts and several micro-analyses in addition to Government Accountability Office (GAO) reports. SAMHSA's requests for applications (RFAs) require evidence-based practices to be used from federal inventories of such practices, including the agency's National Registry of Evidence-Based Programs. SAMHSA also has regular communications with the National Association of Drug Court Professionals to obtain and incorporate the latest findings and field expertise.

Performance data shows that SAMSA Drug Court grant programs are effective in improving the lives of dug court participants. In FY 2013, drug court participants who were employed or

currently attending school improved from 31.4 percent at intake to 47.4 percent at six-month follow-up; abstinence past 30-day alcohol and drug use improved from 72. percent at intake to 85.4 percent at six-month follow-up; social connectedness improved from 92.1 percent at intake to 95.1 percent at six-month follow-up, those who had no past 30-day arrest increased from 89 percent at intake to 92.2 percent at follow-up. Those who reported stability in housing also increased from 28 percent at intake to 40.7 percent at six-month follow-up.

In FY 2013, SAMHSA funded the continuation of 78 three-year drug court grants, 39 new three-year drug court grants, and four contracts which provide the mechanism by which SAMHSA grantees may obtain professional technical help with implementation and operation of most aspects of grant work. In FY 2014, SAMHSA funded 85 three-year and 7 four-year drug court grant continuations, 47 new three-year and 17 new four-year drug court grants, including five contracts that provides the mechanism by which SAMHSA grantees may obtain professional technical help with implementation and operation of most aspects of grant work. SAMHSA's treatment drug court grant programs focused on Tribal Healing to Wellness Courts, Juvenile Treatment Drug Courts, and SAMHSA's collaboration with the Bureau of Justice Assistance at the Department of Justice. In FY 2015, SAMHSA intends to support the continuation of 103 drug court grants, four contracts, 35 new adult and family drug court grants and 10 new BJA jointly funded drug court grants.

In FY 2015, SAMHSA will also conduct a performance evaluation of the FY 2015 Family Treatment Drug Court (FTDCC) grant program. The purpose of this evaluation is to measure the performance of each FY 2015 FTDC grantee, including assessing the progress of children, parents and family functioning after receiving SAMHSA funding.

Offender Reentry Program

In addition to the drug court portfolio, criminal justice funds also support Offender Reentry Program (ORP) grants, which provide screening, assessment, 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. 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, referrals related to substance abuse treatment for clients, alcohol and drug treatment, wraparound services, addressing 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.

In FY 2013, SAMHSA funded 39 three-year ORP grant continuations, 16 new three-year ORP grants, and six evaluation and behavioral health contracts. In FY 2014, SAMHSA funded 39 three-year ORP continuation grants, 17 new three-year ORP grants and four contracts. In FY 2015, SAMHSA intends to support 30 three-year ORP grant continuations, three contracts, and up to 18 new ORP grants which will have a particular emphasis on opioid overdose prevention.

Behavioral Health Treatment Court Collaborative Program

In FY 2011, SAMHSA awarded grants to develop and expand the Behavioral Health Treatment Court Collaborative (BHTCC). 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 address the behavioral health needs of adults who are involved with the criminal justice system. In FY 2014, SAMHSA supported a second cohort, modified to require the inclusion of municipal courts as key components of the programs. In FY 2015, SAMHSA intends to support the continuation of these grants.

An evaluation of the first cohort of BHTCC grantees was completed in September 2014. Grantees built multi-agency workgroups or collaboratives to oversee programs. All grantees expanded access to specialty courts as a result of the grant. Most grants anticipated that new screening and assessment processes addressing a broader array of behavioral health needs would continue after grant funding ended. Program innovations were divided into four main groups, including court and treatment collaboration, court and community collaboration, unified cross-court screening and referral, and meaningful peer involvement. Over 1,400 persons were served through the BHTCC, many of them with co-occurring disorders and with significant trauma exposure in their lives. Based on self-report data, program participants generally experienced improvements in mental health and reductions in substance use.

In FY 2015, SAMHSA will provide support for continuation grants in the BHTCC program, and there is a new evaluation of the BHTCC program beginning in FY 2015. The new BHTCC evaluation will focus on examining the clinical and functional outcomes of program participants with behavioral health disorders. The intent of the FY 2015 evaluation is to build off of the findings from the first cohort and to examine both the features of successful collaborations between the courts and community services as well as the clinical and functional outcomes of program participants with behavioral health disorders.

Funding History

Fiscal Year	Amount
FY 2012	$66,903,205
FY 2013	$63,558,000
FY 2014	$74,816,000
FY 2015	$78,000,000
FY 2016	$61,946,000

Budget Request

The FY 2016 Budget Request is $61.9 million, a decrease of $16.1 million from the FY 2015 Enacted Level. This reduction will not result in the termination of any grants. As a result of multi-year funding of FY 2014 grants, these funds will still provide sufficient support to existing sites/programs at each of the current grantees receiving continuations, as well as new grants in the Drug Court and ORP programs. SAMHSA plans to support 136 grant continuations consisting of 109 Drug Court and 27 ORP grant continuations, Ex-Offender Reentry grants, five contract continuations, approximately 41 new Drug Court grants, and two new contracts. These programs will continue to provide comprehensive treatment and recovery support services for adolescents and adults with substance use disorders coming into contact with the criminal justice

system as well as offenders re-entering the community. SAMHSA proposes to focus this portfolio more strategically to explore new approaches and a variety of models within the drug court umbrella rather than using a significant portion of SAMHSA's limited funding to support what is already a robust system.

Outputs and Outcomes Tables

Program: Criminal Justice - Drug Courts

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
1.2.72 Percentage of adult clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2014: 59.8% Target: 55% (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 2014: 42.2% Target: 41% (Target Exceeded)	41%	41%	Maintain
1.2.74 Percentage of adult clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2014: 91.2% Target: 91% (Target Exceeded)	91%	91%	Maintain
1.2.76 Percentage of adult clients receiving services who had no past month substance use (Outcome)	FY 2014: 85.6% Target: 71% (Target Exceeded)	71%	71%	Maintain
1.2.79 Number of adult clients served (Output)	FY 2013: 7,064 Target: 5,265 (Target Exceeded)	6460	6460	Maintain

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

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
1.2.80 Number of clients served (Outcome)	FY 2014: 2,232 Target: 2,912 (Target Not Met)	2,500	2,300[1]	-200
1.2.81 Percentage of clients who had no past month substance use (Outcome)	FY 2014: 79.1% Target: 80% (Target Not Met but Improved)	74%	73%[2]	-1
1.2.84 Percentage of clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2014: 93.8 % Target: 94.9 % (Target Not Met)	94 %	94 %	Maintain

[1, 2] Decrease in target from prior year level reflects changes in funding and data trends.

Addiction Technology Transfer Centers (ATTCs)

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Addiction Technology Transfer Centers	$9,024	$9,046	$8,081	-$965

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

The Addiction Technology Transfer Centers (ATTC) network supports national and regional activities that decrease 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. Ten ATTC grants support programs in each of the 10 HHS regions to provide technical assistance, workforce training, and development with other HHS Operating Divisions, such as Health Resources and Services Administration (HRSA), Centers for Medicare & Medicaid Services (CMS), Administration for Children and Families (ACF), and the SAMHSA Regional Administrators. Five awards support one national and four focus area ATTCs. Data show 36,391 people were trained in FY 2013. Overall, approximately 90 percent of participants report implementing improvements in treatment methods on the basis of information and training provided by the program with roughly 20,516 clients served.[53]

In FY 2014 SAMHSA funded the continuation of all 15 five-year ATTC grants and will continue that support in FY 2015. Approximately 20,516 individuals will be trained through this program. In FY 2014, SAMHSA also supplemented a current ATTC grantee to develop a Center of Excellence (CoE) to help decrease the rate of substance abuse and new HIV infections among racial/ethnic Young Men who have Sex with Men (YMSM) (ages 18-29). The primary function of this ATTC-CoE is to serve this population as well as expand/develop efforts focusing on the Lesbian, Gay, Bi-sexual, Transgender populations in general.

In FY 2015, one ATTC will receive supplemental funding to develop a Center of Excellence to strengthen the behavioral health workforce that provides addictions treatment and recovery support services to Pregnant and Postpartum Women (PPW), their children and their families.

[53] Services Accountability Improvement System (SAIS); www.samhsa-gpra.samhsa.gov; 2013.

Funding History

Fiscal Year	Amount
FY 2012	$9,063,837
FY 2013	$9,008,366
FY 2014	$9,024,000
FY 2015	$9,046,000
FY 2016	$8,081,000

Budget Request

The FY 2016 Budget Request includes $8.1 million, a decrease of $1.0 million from the FY 2015 Enacted Level. Funding will support grant continuations to continue to disseminate evidence-based, promising practices to addiction treatment/recovery professionals, public health/mental health personnel, institutional and community corrections professionals, and other related disciplines. With the ongoing success of the ATTC program, the Budget redirects resources to other substance abuse treatment activities such as technical assistance specific to heroin and prescription drug abuse treatment.

Crisis Systems: Increasing Crisis Access Response Efforts (ICARE)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Crisis Systems	$---	$---	$5,000	+$5,000

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Communities

Program Description and Accomplishments

Behavioral health crises are critical times for intervention and treatment and key times to engage individuals in on-going treatment and recovery. Such crises often cause great disruption for individuals and those around them, including family members, teachers, law enforcement, and employers. Well-managed crisis interventions can result in positive outcomes for the individual, family, and community, including increased understanding of mental and SUD, while poorly managed crisis situations can result in frustration, increased health and social services system costs, and negative outcomes for all involved, including potential harm to the individual experiencing the crisis or others.

Comprehensive crisis systems can be challenging to conceive and fund as often there are multiple systems that need to be coordinated, such as emergency response systems such as 911 lines; first responders including police and EMT; emergency room and primary health care; court system; multiple payers; social service providers; and behavioral health providers. Comprehensive crisis systems also have to be designed, funded and staffed to address and manage a range of crisis situations, including various presenting conditions, ages, family situations, and locations. While models of comprehensive crisis delivery systems have been developed and are operating successfully, these comprehensive systems are the exception. More commonly, law enforcement and emergency room personnel respond to public safety and health situations without the benefit of the range of services and support needed to successfully prevent, manage, and follow up on behavioral health crises. Inadequate crisis delivery systems can result in harm to the individual in crisis, law enforcement, or others; unnecessary use of scarce and costly emergency room and inpatient settings; and inappropriate use of jails and criminal justice resources.

The program will seek to increase the engagement with and the functioning of individuals in crisis, increased support for families and caregivers, decreased use of emergency room and inpatient care, and increased understanding by the community of those who experience a behavioral health crisis.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$5,000,000

Budget Request

The FY 2016 Budget requests $10.0 million, including $5.0 million in the Mental Health appropriation and $5.0 million in the Substance Abuse Treatment appropriation, for a new braided program line entitled Crisis Systems. This represents an increase of $10.0 million from the FY 2015 Enacted Level. Funding supports the Increasing Crisis Access Response Efforts (ICARE), a demonstration activity to help communities build, fund, and sustain crisis systems capable of preventing and deescalating behavioral health crises as well as connecting individuals and families with needed post-crisis services. In many incidences, responses to these situations by emergency medical responders and other behavioral health care providers are under- coordinated and un-sustained. These grants will help mitigate the demand for inpatient beds by those with serious mental illnesses and substance use disorders by coordinating effective crisis response with ongoing outpatient services and supports. As a braided activity, SAMHSA will track separately any amounts spent or awarded under Crisis Systems through its distinct appropriation and ensure that funds are used for purposes consistent with legislative direction and intent of that appropriation.

Special Initiatives/Outreach

(Dollars in thousands)

Programs of Regional & National Significance	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY 2015
Special Initiatives/Outreach	$1,432	$1,432	$1,432	$---

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Historically Black Colleges and Universities

Program Description and Accomplishments

Special Initiatives/Outreach supports a grant program for the Historically Black Colleges and Universities (HBCU) Center for Excellence (CFE), an innovative national resource center dedicated to continuing the effort to network the 105 HBCUs throughout the United States. The HBCU-CFE promotes workforce development through expanding knowledge of best practices and leadership development that enhance the participation of African-Americans in the mental and substance use disorder professions. The Center also supports a policy academy that focuses on workforce and leadership development, cross-systems collaboration, cultural competence, and eliminating disparities. The Center collaborates with other HHS agencies, including the HHS Office of Minority Health (OMH).

Through this program, approximately 31 Substance Abuse Treatment Workforce Development pilots were funded to provide opportunities for 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 in substance abuse treatment, committed to increasing diversity in the addictions field.

In FY 2014, SAMHSA funded one new HBCU grant and five contracts including Project Leadership Initiatives for Tomorrow (Project LIFT) that focuses on addressing the policy and leadership needs of the changing healthcare landscape. In FY 2015, SAMHSA intends to support the continuation of one HBCU grant and three contracts including Project LIFT.

Funding History

Fiscal Year	Amount
FY 2012	$2,266,708
FY 2013	$1,991,588
FY 2014	$1,432,000
FY 2015	$1,432,000
FY 2016	$1,432,000

Budget Request

The FY 2016 Budget Request includes level funding from the FY 2015 Enacted Level for Special Initiatives/Outreach. Funding will support one grant continuation and two contracts including Project LIFT to continue to network the 105 HBCU's and promote workforce development through expanding knowledge of best practices and leadership development that enhance the participation of African-Americans in the mental and substance use disorder professions.

Outputs and Outcomes Tables

Program: Treatment - Science and Service Activities

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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 2014: 72.2% Target: 90% (Target Not Met)	90%	82%[1]	-8
1.4.02 Number of individuals trained per year (Output)	FY 2014: 39,055 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 201: 67,944 Target: 110,000[3] (Target Not Met)	42,063	40,947[2]	-1,116

[1]SAMHSA is revising targets based on recent data trends.

[2]Target reduced from previously reported due to methodological change in data collection. Target aggregates CSAT and CMHS Science and Service individuals trained, and CSAP CAPT individuals trained.

[3]Decrease from previous year due to impact of state economies and restricted limits on meeting approvals.

Program: Treatment - Other Capacity[1]

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
1.2.25 Percentage of adults receiving services who had no past month substance use (Outcome)	FY 2014: 64% Target: 60% (Target Exceeded)	58%	60%	+2
1.2.26 Number of clients served (Output)	FY 2014: 19,533 Target: 30,849 (Target Not Met)	28,998	31,000	+2,002
1.2.27 Percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2014: 43.2% Target: 45% (Target Not Met)	43%	43%	Maintain
1.2.28 Percentage of adults receiving services who had a permanent place to live in the community (Outcome)	FY 2014: 50.8% Target: 47% (Target Exceeded)	45%	47%	+2
1.2.29 Percentage of adults receiving services who had no involvement with the criminal justice system (Outcome)	FY 2014: 97.1% Target: 93% (Target Exceeded)	91%	93%	+2

[1] Other Capacity measures include the, Community Resilience and Recovery Initiative, HIV/AIDS Outreach, Pregnant Postpartum Women, Recovery Community Services Program - Services, Recovery-Oriented Systems of Care, SAT-ED, TCE/HIV, Targeted Capacity Expansion, Targeted Capacity Expansion- Health Information Technology, Targeted Capacity Expansion- Peer to Peer, Targeted Capacity Expansion- Technology Assisted Care, and Crisis Support programs.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by APT

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Grants/Cooperative Agreements:						
Continuations	349	$169,631	395	$160,642	452	$198,343
New/Competing	215	130,959	227	146,817	166	66,553
Subtotal	564	300,590	622	307,460	618	264,896
Contracts:						
Continuations	11	40,964	15	40,757	14	42,972
New/Competing	9	19,144	6	13,246	7	12,834
Subtotal	20	60,108	21	54,003	21	55,805
Total, Substance Abuse Treatment [1]	**584**	**$360,698**	**643**	**$361,463**	**639**	**$320,701**

[1] The Minority Fellowship Program budget is reflected within the Health Surveillance and Program Support appropriation under the Agency-wide Initiatives Workforce program and is consistent with the FY 2016 Budget Request.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by PPA

(Dollars in thousands)

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
CAPACITY:						
Opioid Treatment Programs/Regulatory Activities						
Grants						
Continuations	2	$1,398	3	$2,400	2	$1,397
New/Competing	1	998	---	---	1	1,000
Subtotal	3	2,396	3	2,400	3	2,397
Contracts						
Continuations	5	4,896	3	5,208	3	3,385
New/Competing	3	1,432	3	1,116	3	2,942
Subtotal	8	6,328	6	6,324	6	6,327
Total, Opioid Treatment Programs/Regulatory Activities	**11**	**8,724**	**9**	**8,724**	**9**	**8,724**
Screening, Brief Intervention and Referral to Treatment						
Grants						
Continuations	22	19,473	24	20,576	49	20,721
New/Competing	12	18,313	49	19,215	13	3,844
Subtotal	34	37,786	73	39,790	62	24,566
Contracts						
Continuations	---	3,324	2	5,109	1	4,975
New/Competing	2	5,779	---	1,990	1	459
Subtotal	2	9,103	2	7,099	2	5,434
Total, Screening, Brief Intervention and Referral to Treatment	**36**	**46,889**	**75**	**46,889**	**64**	**30,000**
TCE - General						
Grants						
Continuations						
New/Competing	2	800	11	12,000	40	17,699
Subtotal	31	8,411	41	19,502	52	29,749
Contracts						
Continuations	---	1,812	1	2,867	2	5,128
New/Competing	1	3,000	---	854	1	1,426
Subtotal	1	4,812	1	3,721	3	6,554
Total,TCE-General	**32**	**13,223**	**42**	**23,223**	**55**	**36,303**

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Pregnant & Postpartum Women						
Grants						
Continuations	6	3,073	19	9,482	26	12,783
New/Competing	19	9,569	7	3,663	---	---
Subtotal	25	12,642	26	13,144	26	12,783
Contracts						
Continuations	---	3,140	---	996	---	2,941
New/Competing	---	149	---	1,791	---	207
Subtotal	---	3,289	---	2,787	---	3,148
Total, Pregnant & Postpartum Women	**25**	**15,931**	**26**	**15,931**	**26**	**15,931**
Strengthening Treatment Access and Retention						
Contracts						
Continuations	1	1,584	1	1,000	1	630
New/Competing	---	80	---	---	---	370
Subtotal	1	1,664	1	1,000	1	1,000
Total, Strengthening Treatment Access and Retention	**1**	**1,664**	**1**	**1,000**	**1**	**1,000**
Recovery Community Services Program						
Grants						
Continuations	---	---	10	1,000	---	---
New/Competing	19	1,450	8	400	10	1,000
Subtotal	19	1,450	18	1,400	10	1,000
Contracts						
Continuations	---	491	---	852	---	1,433
New/Competing	---	493	---	182	---	1
Subtotal	---	984	---	1,034	---	1,434
Total, Recovery Community Services Program	**19**	**2,434**	**18**	**2,434**	**10**	**2,434**

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Treatment Systems for Homeless						
Grants						
Continuations	34	16,505	36	14,954	60	32,809
New/Competing	33	19,989	33	21,940	9	4,083
Subtotal	67	36,494	69	36,894	69	36,892
Contracts						
Continuations	---	4,784	2	4,492	---	2,697
New/Competing	---	108	---	---	---	1,797
Subtotal	---	4,892	2	4,492	---	4,494
Total, Treatment Systems for Homeless	**67**	**41, 386**	**71**	**41,386**	**69**	**41,386**
Minority AIDS						
Grants						
Continuations	87	49,831	113	46,270	116	47,379
New/Competing	40	9,334	26	13,111	25	5,234
Subtotal	127	59,165	139	59,381	141	52,613
Contracts						
Continuations	1	4,606	2	5,133	3	6,246
New/Competing	1	1,798	1	1,056	---	---
Subtotal	2	6,405	3	6,189	3	6,246
Total, Minority AIDS	**129**	**65,570**	**142**	**65,570**	**144**	**58,859**
Criminal Justice Activities						
Grants						
Continuations	131	41,275	133	39,571	136	40,515
New/Competing	81	22,064	63	28,127	41	12,941
Subtotal	212	63,339	196	67,698	177	53,456
Contracts						
Continuations	1	7,684	2	7,063	1	8,381
New/Competing	---	3,794	1	3,239	---	109
Subtotal	1	11,477	3	10,302	1	8,490
Total, Criminal Justice Activities	**213**	**74,816**	**199**	**78,000**	**178**	**61,946**
Subtotal, CAPACITY	**567**	**$350,242**	**626**	**$350,985**	**619**	**$306,188**

Programs of Regional & National Significance	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
SCIENCE AND SERVICE:						
Addiction Technology Transfer Centers						
Grants						
Continuations	15	8,572	15	8,529	15	7,573
New/Competing	---	---	---	---	---	---
Subtotal	15	8,572	15	8,529	15	7,573
Contracts						
Continuations	---	407	---	517	---	508
New/Competing	---	45	---	---	---	---
Subtotal	---	452	---	517	---	508
Total, Addiction Technology Transfer Centers	**15**	**9,024**	**15**	**9,046**	**15**	**8,081**
Crisis Systems						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	3	4,512
Subtotal	---	---	---	---	3	4,512
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	488
Subtotal	---	---	---	---	---	488
Total, Crisis Systems	**---**	**---**	**---**	**---**	**3**	**5,000**
Special Initiatives/Outreach						
Grants						
Continuations	---	---	1	300	1	300
New/Competing	1	300	---	---	---	---
Subtotal	1	300	1	300	1	300
Contracts						
Continuations	---	80	1	1,078	1	1,090
New/Competing	1	1,052	---	54	---	42
Subtotal	1	1,132	1	1,132	1	1,132
Total, Special Initiatives/Outreach	**2**	**1,432**	**2**	**1,432**	**2**	**1,432**
Subtotal, SCIENCE AND SERVICE	**17**	**10,456**	**17**	**10,478**	**20**	**14,513**
Total, CSATPRNS[1]	**584**	**$360,698**	**64**	**$361,463**	**639**	**$320,701**

[1]The Minority Fellowship Program budget is reflected within the Health Surveillance and Program Support appropriation under the Agency-wide Initiatives Workforce program and is consistent with the FY 2016 Budget Request.

Grant Awards Table

(Whole dollars)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	564	622	618
Average Award	$532,962	$494,309	$428,634
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)

Program Activity	FY2014 Final	FY2015 Enacted	FY2016 President's Budget	FY2016 +/- FY2015
Substance Abuse Block Grant	$1,815,443	$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 2016 Authorization .....Expired
Allocation Method ..... Formula Grants
Eligible Entities.....States, Territories, Freely Associated States, District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota.

Program Description and Accomplishments

The Substance Abuse Prevention and Treatment Block Grant Program (SABG) distributes funds to 60 eligible states, territories and freely associated states, the District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota (states) 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. The SABG's overall goal is to support and expand substance abuse prevention and treatment services while providing maximum flexibility to grantees. Targeted technical assistance is available for the states through SAMHSA's technical assistance contract.

The SABG is critically important because it provides the states 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. SABG accounts for approximately 32 percent of total state substance abuse agency funding, and 23 percent of total state substance abuse prevention and public health funding. Individuals and families without health coverage or whose health insurance benefit will not cover certain services (e.g., recovery support) rely on services funded by the SABG. States also rely on the SABG funding for an array of non-clinical activities and services that support critical needs of their respective service systems, such as planning, coordination, needs assessment, workforce development, quality assurance, program development, and evaluation.

SABG funds are distributed through a formula grant that provides funding based on specified economic and demographic factors and is administered by Substance Abuse and Mental Health Services Administration's (SAMHSA) Centers for Substance Abuse Treatment (CSAT) and Substance Abuse Prevention (CSAP). Of the amounts appropriated for the SABG program, 95 percent are distributed to states through a formula included in 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 also includes "hold harmless" provisions that limit fluctuations in allotments as the total block grant appropriation changes from year to year. The SABG requires states to maintain expenditures for authorized activities at a level that is no less than the state's

average expenditures for the two-year period preceding the current year for which the state is applying for a grant.

States submit to SAMHSA for approval a Block Grant Assessment and an annual plan that contains detailed provisions for complying with each funding requirement specified in the PHS Act, and describe how the grantees and their respective SABG sub-recipients intend to expend SABG funds. The legislation includes specific funding set-asides, including 20 percent for primary prevention, and five percent for HIV early intervention for designated[54] states. The legislation also includes performance requirements for the treatment of substance-using pregnant women and women with dependent children, and provides states with the flexibility to expend a combination of federal and non-federal funds. There are also requirements and potential penalty reduction of the Block Grant allotment if the recipient fails to prohibit and enforce sale of tobacco products to individuals under the age of 18.

SAMHSA encourages states to use block grant resources to support and not supplant services that will be covered through commercial and public insurer plans. In FY 2011, SAMHSA redesigned the FY 2012-2013 MHBG and SABG applications to better align with changes in federal/state environments, including the impacts of 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 biennial versus an annual plan,[55] and provide information regarding their efforts to respond to various changes in federal and state law. Submitting the application/plan biennially, reduces the burden on states to prepare and submit an application/plan every year.

The FY 2014-2015 Block Grant application built upon the FY 2012-2013 application and the FY 2016-2017 Block Grant application is currently available for public comment. Under the application, SAMHSA Block Grant funds are 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 those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;
> 3) To fund primary prevention-universal, selective, and indicated prevention activities and services for persons 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.

SAMHSA also encourages the states to use their Block Grants to: (1) allow recovery to be pursued through personal choice and many pathways; (2) encourage providers to assess

[54] 42 U.SC. 300x24(b)(2) and 45 CFR 96.128(b)
[55] 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)).

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.

An independent evaluation of the SABG demonstrated how states have leveraged the statutory requirements of this Block Grant program 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.[56] The SABG has been successful in expanding treatment capacity by supporting approximately 2 million[57] 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 2012, 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 2012, the most recent year for which data is available:

- For the 50 states[58] and D.C. that reported data in the Abstinence from Drug/Alcohol Use Domain for alcohol use, 50 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, 49 of 50 identified improvements in client employment;
- For the 50 states and D.C. that reported data in the Criminal Justice Domain, 45 of 51 reported an increase in clients with no arrests based on data reported to TEDS; and
- For the 49 states and D.C. that reported data in the Housing Domain, 44 of 50 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 SABG. This is one of SAMHSA's main vehicles for supporting SAMHSA's Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness (All substance abuse prevention funds are used according to the relevant authorities to focus on substance abuse). 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.

[56] http://tie.samhsa.gov/SAPT2010.html#Evaluation.
[57] Source: 2013 SABG Report – Table II.
[58] Source: West Virginia numbers have been included in the text, but they appear lower than expected.

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, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People.*[59] SAMHSA regularly works with states to improve their accountability systems for prevention and to establish 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.

While the national weighted retailer violation rate declined steadily from the program's baseline year in FY 1997 through FY 2011, the rate has increased slightly since FY 2012. One of the greatest predictors of a state's retailer violation rate is the amount and reach of their enforcement efforts. As states have faced budget shortfalls, some have scaled back on their enforcement programs and this may be contributing to the increase in the rate of tobacco sales to youth. Also, under the Synar program, SAMHSA encourages states to include in their inspections the types of tobacco products most often used by youth in their states. As states have expanded the types of tobacco products included in their Synar inspections, some states are reporting that retailers are sometimes more likely to sell non-cigarette tobacco products, including smokeless tobacco, to youth. These factors are likely contributing to the overall increase in the national weighted retailer violation rate. SAMHSA is addressing this increase by providing technical assistance to states, as well as examining Synar data in order to provide states with guidance on best practices including enforcement, merchant education, and community mobilization.

In 2010, SAMHSA redesigned the planning section of the assessment and plan process for both the Mental Health Block Grant (MHBG) and SABG. SAMHSA is aligning the block grants to align with the recent expansion of health insurance coverage under the 2014 Affordable Care Act implementation in which state and federal responsibility is supporting behavioral health services and supports for those otherwise unable to receive services through Medicaid, Medicare, and/or private insurance plans offered through employers or through the new insurance marketplaces. 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,[60] 44.7 million adults having any mental illness,[61] and another 22.1 million adults with a substance use disorder,[62] demand clearly

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

[60] http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm.

[61]http://www.samhsa.gov/data/2k12/NSDUH110/sr110-adult-mental-illness.htm.

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 changes to the health care system brought about by the ACA process is the start of assembling 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. In the FY 2014-2015 budgets, 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 (Medicaid and Medicare). The Uniform Application and SAMHSA's block grant reporting system are tools to assist in this process.

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[62] http://www.samhsa.gov/data/NSDUH/2k10ResultsRev/NSDUHresultsRev2010.htm#Ch7.

Funding History

Fiscal Year	Amount
FY 2007	$1,758,591,000
FY 2008	$1,758,728,000
FY 2009	$1,699,391,000
FY 2010	$1,798,591,000
FY 2011	$1,798,591,000
FY 2012	$1,800,331,901
FY 2013	$1,710,306,000
FY 2014	$1,815,443,000
FY 2015	$1,819,856,000
FY 2016	$1,819,856,000

Budget Request

The FY 2016 Budget Request is $1.8 billion. This is equal to the FY 2015 Enacted Level. Despite the wide scale opportunity to obtain insurance coverage created by the ACA, significant gaps in coverage, as well as the subsequent reliance on the public behavioral health safety net remain. Among the gaps, the states' decision regarding Medicaid expansion is perhaps the most significant. To date, 33[63] states have chosen not to expand their Medicaid programs resulting in approximately 3.7 million Americans with behavioral health conditions without health insurance.[64]

Additionally, a recent report by the Urban Institute finds that adults with physical and/or mental health issues, particularly those in low income families, have more difficulties obtaining and affording health care than adults who reported no health problems. For adults with physical and/or behavioral health issues, ongoing barriers to care exist even with full-year health insurance, affordability being the greatest barrier compared to healthier individuals.[65] For example, after state-based healthcare expansion efforts in Massachusetts, only 2.6 percent of state residents were uninsured but yet more than 20 percent of clients admitted to substance abuse treatment facilities were uninsured, even though they were eligible for some form of insurance coverage.

SABG funds will also continue the support certain services (e.g., recovery supports) not covered by commercial insurance and non-clinical activities and services that support critical needs of state substance abuse prevention and treatment service systems.

[63] Indiana's approval is pending at this time

[64] http://www.amhca.org/assets/content/AMHCA_DashedHopes_Report_2_21_14_final.pdf

[65] http://hrms.urban.org/briefs/evidence-of-significant-gaps.html

Outputs and Outcomes Tables

Program: Treatment Activities

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
1.2.43 Number of admissions to substance abuse treatment programs receiving public funding (Output)	FY 2013: 1,928,675 Target: 1,937,960 (Target Not Met but Improved)	1,880,000	1,880,000	Maintain
1.2.48 Percentage of clients reporting no drug use in the past month at discharge (Outcome)	FY 2013: 74.6% Target: 74% (Target Exceeded)	74%	74%	Maintain
1.2.49 Percentage of clients reporting no alcohol use in the past month at discharge (Outcome)	FY 2013: 85.2% Target: 78% (Target Exceeded)	78%	78%	Maintain
1.2.50 Percentage of clients reporting being employed/in school at discharge (Outcome)	FY 2013: 43.2% Target: 43% (Target Exceeded)	43%	40%[1]	-3
1.2.51 Percentage of clients reporting no involvement with the Criminal Justice System (Outcome)	FY 2013: 94.8% Target: 92% (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 2013: 92.7% Target: 92% (Target Exceeded)	92%	92%	Maintain

[1]SAMHSA is revising targets based on recent data trends.

Program: Synar Amendment

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/ Target for Recent/ Result (Summary of Results)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
2.3.49 Number of States (including Puerto Rico) whose retail sales violations is at or below 20% (Outcome)	FY 2013: 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 2013: 29 Target: 34 (Target Not Met)	33	33	Maintain

Program: Prevention Set-Aside

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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 2013: 19.6% (Historical Actual)	22%	22%	Maintain
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 2013: 67.3%[1] Target: 52.9% (Target Exceeded)	67.5%	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 2013: 68.6% Target: 64.7% (Target Exceeded)	63%	63%	Maintain
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 2013: 43.1% Target: 37.3% (Target Exceeded)	43%	43%	Maintain

[1] Virginia and West Virginia estimates were suppressed due to low precision.

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2016 DISCRETIONARY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

State/Territory	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	$22,926,066	$22,940,958	$22,940,949	-$9
Alaska	5,499,891	5,539,999	5,539,997	-2
Arizona	39,323,249	39,546,174	39,546,159	-15
Arkansas	13,428,775	13,437,498	13,437,493	-5
California	249,086,920	250,323,608	250,323,511	-97
Colorado	25,283,810	25,300,234	25,300,224	-10
Connecticut	17,584,936	17,596,359	17,596,352	-7
Delaware	6,807,911	6,824,460	6,824,457	-3
District Of Columbia	6,807,911	6,824,460	6,824,457	-3
Florida	109,951,627	110,662,825	110,662,782	-43
Georgia	51,074,888	51,162,012	51,161,992	-20
Hawaii	8,150,210	8,212,595	8,212,592	-3
Idaho	8,475,423	8,480,929	8,480,926	-3
Illinois	67,166,999	67,210,630	67,210,604	-26
Indiana	32,017,858	32,038,656	32,038,644	-12
Iowa	13,000,677	13,009,122	13,009,117	-5
Kansas	11,815,441	11,823,116	11,823,111	-5
Kentucky	20,234,141	20,247,285	20,247,277	-8
Louisiana	24,849,301	24,865,443	24,865,433	-10
Maine	6,807,911	6,824,460	6,824,457	-3
Maryland	33,838,777	33,860,758	33,860,745	-13
Massachusetts	39,563,072	39,588,772	39,588,757	-15
Michigan	55,656,128	55,692,281	55,692,259	-22
Minnesota	23,931,452	23,946,997	23,946,988	-9
Mississippi	13,705,865	13,714,768	13,714,763	-5
Missouri	26,346,394	26,363,508	26,363,498	-10
Montana	6,807,911	6,824,460	6,824,457	-3
Nebraska	7,587,158	7,592,087	7,592,084	-3
Nevada	16,462,188	16,698,170	16,698,164	-6
New Hampshire	6,807,911	6,824,460	6,824,457	-3

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2016 DISCRETIONARY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

State/Territory	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	$46,349,018	$46,379,126	$46,379,108	-$18
New Mexico	9,497,415	9,503,584	9,503,580	-4
New York	111,038,560	111,110,689	111,110,646	-43
North Carolina	43,346,419	43,374,576	43,374,559	-17
North Dakota	6,101,774	6,146,271	6,146,269	-2
Ohio	64,078,971	64,120,596	64,120,571	-25
Oklahoma	17,027,963	17,039,024	17,039,017	-7
Oregon	20,011,555	20,024,554	20,024,546	-8
Pennsylvania	58,681,907	58,720,026	58,720,003	-23
Rhode Island	7,544,696	7,549,597	7,549,594	-3
South Carolina	23,149,144	23,164,181	23,164,172	-9
South Dakota	5,642,441	5,683,588	5,683,586	-2
Tennessee	29,340,645	29,359,704	29,359,693	-11
Texas	139,747,042	139,837,820	139,837,766	-54
Utah	16,471,172	16,481,871	16,481,865	-6
Vermont	6,032,970	6,076,965	6,076,963	-2
Virginia	41,682,781	41,709,858	41,709,842	-16
Washington	37,271,989	37,296,200	37,296,186	-14
West Virginia	8,372,996	8,378,435	8,378,432	-3
Wisconsin	27,005,484	27,023,026	27,023,016	-10
Wyoming	3,920,161	3,948,749	3,948,747	-2
Red Lake Indians	589,822	590,206	590,206	0
American Samoa	333,113	333,546	335,697	2,151
Guam	963,165	970,730	983,907	13,177
Northern Marianas	314,821	311,984	313,924	1,940
Puerto Rico	22,369,385	22,405,098	22,365,770	-39,328
Palau	126,467	127,671	129,496	1,825
Marshall Islands	405,435	415,696	427,892	12,196
Micronesia	644,741	646,411	650,940	4,529
Virgin Islands	638,392	639,053	642,553	3,500

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SAMHSA
Health Surveillance and Program Support
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Health Surveillance

(Dollars in thousands)

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Health Surveillance and Program Support	$47,258	$47,258	$49,428	+$2,170
Prevention and Public Health Fund (non-add)	---	---	*20,000*	*+20,000*
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*29,428*	*-1,000*
Data Request and Publication User Fees	$1,500	$1,500	$1,500	$---

Authorizing Legislation ..... Section 501 and 505 of the Public Health Service Act
FY 2016 Authorization ..... Expired
Allocation Method ..... Direct Federal/Intramural, Contracts, Other Eligible Entities..... Not Applicable

Program Description and Accomplishments

SAMHSA's national surveys and the analyses conducted through them are used by federal, state, and local authorities, as well as other healthcare stakeholders, to inform mental and substance use disorder policy. The Health Surveillance budget supports many of the critical behavioral health data systems, national surveys, and surveillance activities for HHS undertaken by SAMHSA.

SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) administers the National Survey on Drug Use and Health (NSDUH), which 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 annual surveys through 2017.

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, they can then direct targeted prevention efforts to the vulnerable populations. Under the Community Behavioral Health Data Initiative (CDI) structure, SAMHSA will more closely coordinate three separate existing data efforts: the Community Early Warning and Monitoring System (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 use existing or declining resources. Data from this coordinated initiative can be combined with data from other agencies such as the Centers for Medicare and Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ), and then be reported by regional and community type. Moreover, these data will allow those evaluating the effectiveness of services and policies in a community to measure the impact and outcomes of those interventions.

Emergency Department (ED) data remains an important component of public health data because it provides a picture of the most urgent health conditions, 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. The SAMHSA Emergency Department Surveillance System (SEDSS) collects data in many hospitals in a variety of communities and will provide a summary of visits by patients with mental health conditions and substance use problems. By collaborating with the National Center for Health Statistics (NCHS), SAMHSA has an opportunity to understand more comprehensively the nature and course of behavioral health presentations to ED. Thus, SEDSS, which will replace DAWN, will collect ED visit information on both mental and substance use disorders.

The Behavioral Health Services Information System (BHSIS) provides crucial information of behavioral health surveillance and data across a number of treatment and condition domains. One aspect of this system 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 posted a new up-to-date Behavioral Health Treatment Services Locator that provides accurate, timely, and regularly updated information on mental health and substance abuse treatment facilities across the country in FY 2014 as well as information on Federally Qualified Health Centers. During FY 2015, SAMHSA will explore the potential for integrating buprenorphine providers (those authorized under 21 U.S.C. Section 823 to dispense (but not prescribe) opioid treatment medication) and National Health Corps facilities into the Services Locator.

BHSIS funding was increased to $17.0 million in FY 2013 with SAMHSA's Center for Mental Health Services (CMHS) providing an additional $7.1 million for this co-funded behavioral health facility survey. BHSIS funding in FY 2014 increased to $21.0 million with CMHS providing an additional $7.5 million. In FY 2015 and FY 2016, $21.0 million for BHSIS continues to provide coordinated substance abuse and mental health facility surveys.

Funding was also provided in FY 2013 and FY 2014 for CMHS's Transformation Accountability System (TRAC), the Center for Substance Abuse Treatment (CSAT)'s Services Accountability Improvement System (SAIS), and the Center for Substance Abuse Prevention (CSAP)'s Data Collection, Analyses, and Reporting (DCAR). These data systems were 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 by 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 (Centers for Disease Control and Prevention (CDC), AHRQ, the Food and Drug Administration (FDA), and the Surgeon General's Office), the Office of National Drug Control Policy, and the Department of Justice. ASC's funding in Health Surveillance was $2.0 million in FY 2013 and $1.7 million in FY 2014, and $2.0 million in FY 2015. In FY 2016 funding

remains at $2.0 million for the ASC contract (formerly the Analytic Support and CBHSQ Logistics contracts).

SAMHSA will continue to finance NSDUH surveys in FY 2015 and FY 2016, with Substance Abuse Block Grant Budget Authority funding and Prevention and Public Health Funds. Also in FY 2015, CBHSQ will fund $3.0 million for Community Early Warning and Monitoring System (C-EMS), and $3.5 million for the National Registry of Evidence-based Programs and Practices (NREPP), $2.2 million from Health Surveillance. In FY 2016, funding will remain at the same level as FY 2015 for C-EMS funded by the Prevention Fund and NREPP with $1.1 million from Health Surveillance.

$3.5 million for Grantee Data Development Technical Assistance (GDTA) was provided in FY 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. Funding for GDTA in FY 2016 will remain at the same level and from the same funding source as FY 2015.

In FY 2014, SAMHSA partially funded $4.4 million of the $5.1 million data collection and evaluation activities from Health Surveillance. The activities include expanding the pilot efforts with the C-EMS; pilot implementation of a data room for use by agency research staff to access confidential data in a secure environment; a pilot study to collect behavioral health data from electronic health records; and a pilot project with the Epidemic Intelligence Service (EIS) of the CDC to secure an EIS graduate to identify and address public health outbreaks related to behavioral health, including deaths due to heroin laced with fentanyl and increases in heroin in specific communities. In FY 2015, the Data Collection and Evaluation Activities funds will be reallocated as pilot activities and integrated into normal operations.

Health Surveillance funding in FY 2016 includes $1.1 million in Operations and $7.1 million in FTE Payroll to support the administrative costs and support of CBHSQ personnel, programs and interagency agreements.

Funding History

Fiscal Year	Amount
FY 2012	$47,428,000
FY 2013	$45,421,000
FY 2014	$47,258,000
FY 2015	$47,258,000
FY 2016	$49,428,000

Budget Request

The FY 2016 Budget Request for Health Surveillance is $49.4 million at the program level with $29.4 million from PHS Evaluation Funds, and $20.0 million from Prevention and Public Health Funds. This is a total increase of $2.2 million from the FY 2015 Enacted Level, with a $16.8 million decrease from Budget Authority, a $1.0 million decrease from PHS Evaluation

Funds, and a $20.0 million increase from Prevention and Public Health Funds. This funding will support the continuation of the NREPP, BHSIS, C-EMS, the CBHSQ Analytic Support Center contract.

The additional funding supports the President's Now is the Time initiative. Specifically, this funding will be used for a new initiative, Science of Changing Social Norms: Building the Evidence, to measure and track attitudes, behaviors and community norms regarding mental health and substance abuse. These data will enable SAMHSA to understand more fully the impact of social messaging, improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority. The Science of Changing Social Norms will have a second component, Social Media, funded from Public Awareness and Support.

SAMHSA/Health Surveillance
Mechanism Table

(Dollars in thousands)

Program Activity	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Health Surveillance						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	41,630	4	47,258	4	49,428
New/Competing	3	5,628	---	5,628	---	---
Subtotal	4	47,258	4	52,886	4	49,428
Total, Health Surveillance	**4**	**47,258**	**4**	**52,886**	**4**	**49,428**

Program Support

(Dollars in thousands)

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY2015
Program Support	$72,002	$72,002	$79,559	+$7,557

Authorizing Legislation .....Section 501 of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method ..... Direct Federal/Intramural, Contracts, Other
Eligible Entities.....Not Applicable

Program Description and Accomplishments

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 are financed with Block Grant set-aside funds for activities associated with technical assistance, data collection and evaluation, and from other program lines for activities directly relating to the administration of those particular programs. 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 supports a total of 665 FTEs from various funding sources including funds from the Mental Health, Substance Abuse Treatment, and Health Surveillance and Program Support appropriations. Budget authority funds, Public Health Service (PHS) Evaluation Set-Aside Funds, and other reimbursable funds support these positions. Of SAMHSA's 665 FTEs, 535 are supported with Budget Authority. Of these, 495 are supported directly from Program Support funds.

SAMHSA applies an estimated internal administrative charge for overhead expenses to all programs, projects and activities.

SAMHSA is pursuing an agency-wide program integrity initiative to mitigate the risk of improper payments throughout its 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. SAMHSA's Office of Management, Technology, and Operations and CBHSQ are working to develop an enterprise reporting system which should be capable of linking program performance and financial performance data with plans to identify outliers in both domains of performance for further review and follow up.

Funding History

Fiscal Year	Amount
FY 2012	$76,889,616
FY 2013	$77,997,779
FY 2014	$72,002,000
FY 2015	$72,002,000
FY 2016	$79,559,000

Budget Request

The FY 2016 Budget requests $79.6 million for Program Support, a one-time $7.6 million increase from the FY 2015 Enacted Level. This increase will cover the additional costs associated with the move to 5600 Fishers Lane in FY 2016 including extending the current building lease, the Federal Acquisition Service (FAS) loan repayment program, and security charges as part of government-wide efforts to reduce long-term rent and utility costs though reductions in per person space use and periodic re-evaluation of competing lease offers.

In FY 2016, SAMHSA plans to support a total of 665 FTEs from various funding sources, including funds from the Mental Health, Substance Abuse Treatment, and Health Surveillance and Program Support appropriations. Funding from Budget Authority as well as PHS Evaluation Funds supports these positions.

SAMHSA/ Program Support
Mechanism Table

(Dollars in thousands)

Program Activity	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Program Support						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	72,002	---	72,002	---	79,559
New/Competing	---	---	---	---	---	---
Subtotal	---	72,002	---	72,002	---	79,559
Total, Program Support	**---**	**72,002**	**---**	**72,002**	**---**	**79,559**

Public Awareness and Support

(Dollars in thousands)

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Program Level	$13,482	$13,482	**$15,571**	**+$2,089**
PHS Evaluation Funds (non-add)	---	---	**15,571**	**+15,571**

Authorizing Legislation ..... Section 501, 509, 516, and 520A of the Public Health Service Act
FY 2016 Authorization ..... Expired
Allocation Method ..... Grants and Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

The behavioral healthcare system is under increased attention as a result of the expansion of access to behavioral health care through the Affordable Care Act (ACA) and the implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA), recent highly-publicized tragic events, and the President's *Now is the Time* initiative. Americans want to know what more can be done to make sure everyone has access to the mental health and substance use treatment they need to live healthy, productive lives in their communities. SAMHSA and the Centers for Disease Control and Prevention (CDC) estimate that at some point in their lives, almost half of all Americans will experience symptoms of a behavioral health disorder – mental illness or addiction. Perhaps even more concerning, half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24. For these reasons, it is important to identify issues early and help individuals get the treatment they need as soon as possible. Communities are increasingly engaging in prevention strategies and approaches that are effective in supporting the overall health and wellness of their residents. 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.

In FY 2015, SAMHSA plans to launch or continue a number of vital programs and activities, both internally and externally, to position SAMHSA effectively as a leader of public health efforts to advance the behavioral health of the nation.

Collaborating Across Agencies

In FY 2015, SAMHSA plans to continue collaborations with other agencies to promote awareness of behavioral health. For example, through the Materials Development and Marketing Support (MDMS) contract, SAMHSA will coordinate with the Centers for Disease Control and Prevention (CDC) to promote the Million Hearts Campaign, and will work with the White House to continue to support the National Dialogue on Mental Health. SAMHSA will also continue to support the National Outreach, Public Education and Engagement Initiative (NOPEEI) contract,

which provides communications support for national outreach and public education initiatives across a variety of behavioral health topics.

Funding 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. For example, the funding will support the agency's continued collaboration with CDC on 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.

Providing Critical Resources to the Behavioral Health Community

SAMHSA's strategic communications plan ensures that the vital information and training materials produced through SAMHSA's centers and offices are available to the behavioral and health care community 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 service providers. The various channels of communication managed by SAMHSA generated more than 26.6 million customer interactions in FY 2014, shipped over 7.3 million copies of SAMHSA publications, and had more than 1.3 million total online visitors to the SAMHSA Store where publications are available for order by mail or instantaneous download.

SAMHSA is also responsible for managing 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. SAMHSA quickly mobilizes in the aftermath of a disaster to deliver behavioral health information and support services to responders and survivors. For example, in response to community unrest stemming from the events in Ferguson, Missouri, SAMHSA disseminated an e-blast on November 25, 2014, less than 24 hours after the grand jury's decision was announced, to nearly 213,000 constituents. The e-blast featured SAMHSA's Disaster Distress Helpline and SAMHSA's new publication, "Tips for Survivors: Coping with Grief After Community Violence," which has been downloaded over 1,100 times since it was released in November, 2014.

To further support behavioral health first responders, SAMHSA has also developed and launched the behavioral health disaster mobile app, available on iTunes, Android, and the Blackberry World. Using this mobile app, behavioral health first responders can zero in on the exact location to respond to a disaster and 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. Within a month of its initial launch in February 2014, more than 2,500 people downloaded the app. In August of 2014, SAMHSA released "Know Bullying," a mobile app that gives parents and caregivers the tools they need to talk to their children about bullying. In the future, SAMHSA will continue to innovate in these new platforms by launching additional mobile apps to address topics such as suicide prevention.

SAMHSA is also collaborating with WebMD, which reaches more than three million U.S. healthcare providers every month, to provide critical information to both the behavioral health workforce and primary care providers. With WebMD, SAMHSA developed 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.

Funding is important for SAMHSA to continue providing critical information resources in a timely fashion, and access to emergency response networks, for the public and the behavioral health workforce.

Leveraging SAMHSA's Online Presence

Available 24/7, SAMHSA.gov is the public's primary access point for behavioral health information in the federal government. SAMHSA's website and social media channels such as Facebook, Twitter, and YouTube are critical to efforts to engage with citizens about behavioral health. The increasingly effective reach of these online channels is demonstrated by the fact that the number of people following SAMHSA on Twitter has increased more than 580 percent (from 7,000 to nearly 48,000) in 18 months, and posts to the SAMHSA Facebook page typically reach tens of thousands of people a week.

In the course of prioritizing the internet as a strategic business initiative and communications asset, SAMHSA consolidated and modernized SAMHSA's web presence. Through an ongoing focused effort (Project Evolve), almost 90 disparate websites created for various SAMHSA-sponsored campaigns and programs are being consolidated into one site. In FY 2014 and into FY 2015, SAMHSA moved forward with the integration of SAMHSA's public information and data into a single, redesigned website, SAMHSA.gov.

SAMHSA's focused efforts will ensure that the agency speaks to the nation with a unified voice. It also helps eliminate multiple web development and maintenance efforts, resulting in lower overall operating costs, greater efficiency, increased effectiveness, and improved service for visitors to SAMHSA's website. SAMHSA 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

A key goal of the agency's Public Awareness and Support effort is to make certain that valuable health and behavioral 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 aforementioned vehicles —MDMS, PEP, the Web, and social media—as well as through other program operations such as the press releases issued by SAMHSA to highlight latest findings, including the National Survey on Drug Use and Health (NSDUH), and SAMHSA's Behavioral Health Barometer, which provides data on

behavioral health problems at the national level, and for each of the 50 states and the District of Columbia. SAMHSA has also completed and is implementing an agency-wide Strategic Communications Plan in order to elevate recognition of SAMHSA as a thought leader and premier source of behavioral health information. The plan's goal is to effectively reach the media, providers, government agencies, and academic arenas in order to position SAMHSA at the forefront of public health efforts to advance the behavioral health of the nation. As a result, SAMHSA will expand public awareness about behavioral health, increase understanding and sensitivity, encourage open dialog, and influence changes in perceptions.

Funding History

Fiscal Year	Amount
FY 2012	$13,545,351
FY 2013	$13,545,351
FY 2014	$13,482,000
FY 2015	$13,482,000
FY 2016	$15,571,000

Budget Request

The FY 2016 Budget Request for Public Awareness and Support is $15.6 million, an increase of $2.1 million from the FY 2015 Enacted Level. These funds will support the President's *Now is the Time* initiative and allow SAMHSA to continue to streamline our web presence, develop innovative mobile apps, expand SAMHSA's presence on social media, and provide other critical resources to support behavioral health and other health. SAMHSA will use $2.0 million to support the Science of Changing Social Norms, to develop and test an array of messages designed to improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority.

Mechanism Table

(Dollars in thousands)

Program Activity	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Public Awareness and Support						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	6	13,482	5	11,020	5	12,093
New/Competing	---	---	1	2,462	2	3,478
Subtotal	6	13,482	6	13,482	7	15,571
Total, Public Awareness and Support	**6**	**13,482**	**6**	**13,482**	**7**	**15,571**

Outputs and Outcomes Table

Program: Public Awareness and Support

NOTE: SAMHSA grant awards are made late in the year. Therefore, the FY 2016 targets are based on the FY 2015 Enacted Level and the FY 2017 targets are based on the FY 2016 President's Budget.

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
2.3.76 Number of persons receiving prevention information indirectly from advertising, broadcast, or website (Output)	FY 2013: 18,966,150 Target: 1,250,000 (Target Exceeded)	Discontinued[1]	**Discontinued**	**N/A**
4.4.12 Number of individuals referred for behavioral health treatment resources. (Output)	FY 2013: 365,919 Target: 310,000 (Target Exceeded)	310,000	350,000	+40,000
4.4.13 Total number of interactions through phone inquiries, e-blasts, dissemination of SAMHSA publications, and total website hits (Output)	FY 2013: 25,793,007 (Historical Actual)	33,000,000	34,320,000	+1,320,000

[1]Measure was discontinued due to change in data source and replaced with measure 4.4.13.

Performance and Quality Information Systems

(Dollars in thousands)

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY2015
Program Level	*$12,918*	*$12,918*	**$12,918**	**$---**
PHS Evaluation Funds (non-add)	---	---	**12,918**	**+12,918**

Authorizing Legislation ..... Section 501, 509, 516, and 520A of the Public Health Service Act
FY 2016 Authorization ..... Expired
Allocation Method ..... Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

Performance and Quality Information Systems (PQIS) provides continuous support for the performance measurement efforts with quality improvement activities and promotes greater efficiencies in the collection, analysis, and reporting of data and other information to facilitate accountability, clarity in outcomes measures, and improvements in the quality and accessibility of data and other information for use by program staff, grantees, and the public. In FY 2014, funding supported a new contract for the National Registry of Evidence-based Programs and Practices (NREPP) to reduce the backlog of interventions accepted and pending review. NREPP is a searchable online system that provides states, tribes, and communities with 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 in FY 2014 was used for the continued creation 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, Services Accountability Improvement System (SAIS), Transformation Accountability System (TRAC), and Data Collection, Analyses, and Reporting (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 of Health Information Technology (ONC); and coordination with Health Information Technology efforts and Meaningful Use Measures for application in electronic health records, led by ONC and Centers for Medicare and Medicaid Services (CMS). These activities were substantially completed in FY 2014 and will move to regular operations beginning in FY 2015.

In FY 2015, funds will be used to continue support for the CDP, which was awarded in FY 2013 and implemented in FY 2014, as well as provide support for the continuation of NREPP. Funding for Grantee Data Development Technical Assistance (TA) will increase to $5.0 million in FY 2015 and continue to fund a support contract and TA Team for an integrated approach to performance and quality data collection and reporting, including support of regional data coordinators. This increased funding from FY 2014 supports further analysis which suggests the need for a continued investment in the technical assistance support for agency grantees.

Funding for PQIS includes $1.5 million for Operations. The operations budget funds the administrative costs, support costs for CBHSQ programs, and interagency agreements.

Funding History

Fiscal Year	Amount
FY 2012	$12,940,413
FY 2013	$8,803,289
FY 2014	$12,918,000
FY 2015	$12,918,000
FY 2016	$12,918,000

Budget Request

The FY 2016 Budget Request is $12.9 million for Performance and Quality Information Systems, which is level with the FY 2015 Enacted Level. SAMHSA will use these funds to continue support for the National Registry of Evidence-Based Programs and Practices (NREPP), Common Data Platform (CDP) and Grantee Data Development Technical Assistance.

Mechanism Table

(Dollars in thousands)

Program Activity	FY 2014 Final No.	FY 2014 Final Amount	FY 2015 Enacted No.	FY 2015 Enacted Amount	FY 2016 President's Budget No.	FY 2016 President's Budget Amount
Performance and Quality Information Systems						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	4	9,959	3	12,918	3	12,918
New/Competing	1	2,959	---	---	---	---
Subtotal	5	12,918	3	12,918	3	12,918
Total, Performance and Quality Information Systems	**5**	**12,918**	**3**	**12,918**	**3**	**12,918**

Outputs and Outcomes Table

Program: Performance and Quality Improvement Systems

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
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 2014: 1,745,133[1] Target: 1,882,149 (Target Not Met)	2,390,402	2,390,402	Maintain
4.4.11 Number of evidence-based programs or practices in review (Output)	FY 2014: 51[2] Target: 48 (Target Exceeded)	55	55	-5

[1, 2] There is no delay between fiscal year funding and the performance year.

Agency-Wide Initiatives

(Dollars in thousands)

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Agency-Wide Initiatives	**$45,583**	**$46,669**	**$77,669**	**+$31,000**
Behavioral Health Workforce	45,583	46,669	77,669	+31,000
Minority Fellowship Program (non-add)	10,669	10,669	10,669	---
Minority Fellowship Program- Base (non-add) 1/	5,423	5,423	5,423	---
Minority Fellowship Program- Youth/Addictions Counselor (non-add)	5,246	5,246	5,246	---
Peer Professional Workforce Development (non-add)	---	---	10,000	+10,000
SAMHSA-HRSA BHWET Grant Program (non-add)	34,914	35,000	56,000	+21,000
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 and prior years have been comparably adjusted.

Authorizing Legislation ..... Section 501, 509, 516, and 520A of the Public Health Service Act
FY 2016 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Community Colleges, Networks, States, National Organizations

Program Description and Accomplishments

Behavioral Health Workforce

Minority Fellowship Program

As SAMHSA implements the *Leading Change 2.0* Strategic Initiatives for 2015-2018, the new Strategic Initiative on Workforce Development provides the opportunity for a concerted focus on developing the behavioral health workforce.

SAMHSA's Minority Fellowship Program (MFP) 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 MFP has helped to enhance services to racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology, and since 2006, marriage and family therapy. 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 professionals eligible to receive funds through this program to include professional counselors. In FY 2014 SAMHSA funded continuation grants and in FY 2015, SAMHSA anticipates funding continuation grants.

In previous years, MFP activities were spread through CMHS, CSAP, and CSAT. SAMHSA is realigning the Minority Fellowship Program (MFP) to Agency-Wide Initiatives to more effectively and efficiently administer these workforce programs. 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.

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

In FY 2014, funding was provided to expand the focus of the current MFP 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 expansion of the four-year program is called the Minority Fellowship Program-Youth (MFP-Y). The purpose of this grant program is to reduce health disparities and improve behavioral health care outcomes for racially and ethnically diverse populations by increasing the number of culturally competent master's level behavioral health professionals serving children, adolescents, and populations in transition to adulthood (aged 16 to 25) in an effort to increase access to, and the quality of, behavioral health care for this age group. MFP-Y uses the existing infrastructure of the MFP to expand the focus of the program to support 960 master's level trained behavioral health providers in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing. The FY 2015 Budget included $5.3 million for MFP-Y to continue providing 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.

In addition, in FY 2014, funding was provided to expand the focus of the current MFP to support master's level addiction counselors (MFP-AC). The purpose of this four-year grant program is to reduce health disparities and improve behavioral health care outcomes for racially and ethnically diverse populations by increasing the number of culturally competent master's level addiction counselors available to underserved minority populations with a specific focus on transition age youth (ages 16 to 25) in public and private non-profit sectors. MFP-AC grants will support students pursuing master's level degrees in addiction/substance abuse counseling. The MFP-AC grants support graduate student stipends to increase the number of masters-level addiction counselors across the nation by approximately 300 counselors. Funds also supported evaluation and technical assistance for these grantees.

Funding History

Fiscal Year	Amount
FY 2012	$5,706,195
FY 2013	$5,436,000
FY 2014	$10,669,000
FY 2015	$10,669,000
FY 2016	$10,669,000

Budget Request

The FY 2016 Budget Request is $10.7 million, which is the same as the FY 2015 Enacted Level to provide continued support for both base and expansion activities. The funds will support six MFPs, two MFP-Y, two MFP-AC grants, and three technical assistance and evaluation support contracts.

Behavioral Health Workforce Data and Development

The Patient Protection and Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 will extend federal parity protections to over 60 million Americans. Of them, over 30 million will gain coverage that includes mental health and substance use disorder treatment, and an additional 30 million who already have some coverage of these services will see their coverage enhanced.[66] These estimates take into account the states' decisions on whether to participate in the expansion of Medicaid.

As of June 2014, there were more than 4,000 Mental Health, Health Professional Shortage Areas (HPSAs) in the United States, containing nearly a third of the American population (96 million people). Recent data indicate that almost 90 percent of persons with substance use disorders do not receive the services they need and over half of those with mental disorders do not receive needed treatment.

The President's *Now is the Time* initiative, supports new activities to expand the behavioral health workforce. In FY 2015, the new workforce investments provide support for approximately 3,500 new behavioral health professionals. To ensure the existing workforce investments are achieving desired outcomes, SAMHSA workforce activities in FY 2015 include
$1.0 million within the Center for Behavioral Health Statistics and Quality (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. In FY 2015, SAMHSA will continue 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.

[66] Beronio K, Glied S, Frank R. How the Affordable Care Act and Mental Health Parity and Addiction Equity Act Greatly Expand Coverage of Behavioral Health Care. Journal of Behavioral Health Services and Research, 41:4, October 2014.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	$1,000,000
FY 2016	$1,000,000

Peer Professional Workforce Development

The Peer Professional Workforce Development program's goal is to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-masters-level addiction counselors working with youth ages 16 to 25. Because they have lived through their own experience with behavioral health conditions, the entry-level providers supported by this program will play a significant role in the delivery of prevention, outreach, engagement, and recovery support services. Evidence has found that people who regularly engage in peer-delivered interventions are more likely to abstain from substance abuse. While the Behavioral Health Workforce Education and Training program focuses on supporting clinical internships, field placements, and certificate program completion across a range of professional and paraprofessional disciplines (some of whom may be peers), the Peer Professional Workforce Development program will focus on helping communities develop the infrastructure to train and certify peers, or people with personal experiences with mental illness and/or substance use conditions as behavioral health providers.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$10,000,000

Budget Request

The FY 2016 Budget Request includes $10.0 million for the new Peer Professionals Workforce Development program, which will award up to 19 grants to provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs, resulting in 1,200 additional peer professionals in the behavioral health workforce.

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

In FY 2014, SAMHSA and the Health Resources and Services Administration (HRSA) collaborated on the BHWET Grant Program. The purpose of this program is to increase the clinical service capacity of the behavioral health workforce by supporting training for masters-level social workers, psychologists, marriage and family therapists, psychology doctoral interns, as well as behavioral health paraprofessionals. In FY 2014, the grant program provided approximately 120 awards to organizations nationwide and SAMHSA's FY 2015 Budget Request included continued funding in the amount of $35.0 million to maintain this effort. The SAMHSA-HRSA BHWET grant program will help increase the behavioral health workforce by 3,500 individuals each year.

Funding History

Fiscal Year	Amount
FY 2012	---
FY 2013	---
FY 2014	$34,914,000
FY 2015	$35,000,000
FY 2016	$56,000,000

Budget Request

The FY 2016 Budget Request includes an increase of $21.0 million over the FY 2015 Enacted Level to expand the behavioral health workforce. The $56.0 million program will award a total 192 grants, an increase of 72 grants over FY 2015, and will support the addition of approximately 5,600 health professionals to the workforce, an increase of 2,100 individuals over FY 2015 levels. SAMHSA's collective workforce efforts will help add several thousand new professionals to the workforce each year.

Mechanism Table

(Dollars in thousands)

Program Activity Agency-Wide Initiatives	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
BEHAVIORAL HEALTH WORKFORCE:						
Minority Fellowship Program-Base[1/]						
Grants						
Continuations	---	---	6	4,796	6	4,776
New/Competing	6	4,764	---	---	---	---
Subtotal	6	4,764	6	4,796	6	4,776
Contracts						
Continuations	---	---	1	627	1	647
New/Competing	1	659	---	---	---	---
Subtotal	1	659	1	627	1	647
Total, MFP-Base	**7**	**5,423**	**7**	**5,423**	**7**	**5,423**
Minority Fellowship Program-Youth						
Grants						
Continuations	---	---	7	4,314	7	4,267
New/Competing	4	4,261	---	---	---	---
Subtotal	4	4,261	7	4,314	7	4,267
Contracts						
Continuations	---	---	2	932	2	979
New/Competing	---	985	---	---	---	---
Subtotal	---	985	2	932	2	979
Total, MFP-Youth	**4**	**5,246**	**9**	**5,246**	**9**	**5,246**
Peer Professionals Workforce Development						
Grants						
Continuations	---	---	---	---	19	9,343
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	19	9,343
Contracts						
Continuations	---	---	---	---	---	657
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	657
Total, PPWD	**---**	**---**	**---**	**---**	**19**	**10,000**
SAMHSA-HRSA MBHET Grant Program						
Grants						
Continuations	---	---	110	30,100	192	48,160
New/Competing	110	30,100	---	---	---	---
Subtotal	110	30,100	110	30,100	192	48,160
Contracts						
Continuations	---	---	---	4,900	---	7,840
New/Competing	---	4,814	---	---	---	---
Subtotal	---	4,814	---	4,900	---	7,840
Total, SAMHSA-HRSA Behavioral Health Workforce Education and Training (BHWET) Grant Program	**110**	**34,914**	**110**	**35,000**	**192**	**56,000**
Behavioral Health Workforce Data and Development						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	---	---	---	1	1,000
New/Competing	---	---	1	1,000	---	---
Subtotal	---	---	1	1,000	1	1,000
Total, Behavioral Health Workforce Data and Development	**---**	**---**	**1**	**1,000**	**1**	**1,000**
Subtotal, BEHAVIORAL HEALTH WORKFORCE:	**121**	**45,583**	**127**	**46,669**	**228**	**77,669**
Total, Agency-Wide:	**121**	**45,583**	**127**	**46,669**	**228**	**77,669**

1/The Minority Fellowship Program budget is reflected within the Health Surveillance and Program Support appropriation under the Agency-wide Initiatives Workforce program as is consistent with the FY 2015 and FY 2016 Budget Requests.

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)

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Substance Abuse Treatment Appropriation				
Substance Abuse Block Grant (SABG) Set Aside				
Budget Authority				
SAMHSA's Emergency Department Surveillance System (SEDSS) formerly Drug Abuse Warning Network (DAWN)	**375**	---	---	---
National Survey on Drug Use and Health (NSDUH)	---	601	601	---
Data Collection and Evaluation Activities	83	---	---	---
Subtotal, Budget Authority	**458**	**601**	**601**	---
PHS Evaluation Funds				
NSDUH	42,709	38,331	38,331	---
Analytic Support Center (ASC) formerly National Analytic Center (NAC)	1,000	1,000	1,000	---
Drug & Alcohol Services Information System (DASIS)/Behavioral Health Services Information System (BHSIS)	2,000	3,972	3,972	---
Substance Abuse and Mental Health Data Archive (SAMHDA)	1,291	1,291	1,291	---
Community Behavioral Health Data Initiative	7,967	7,000	5,750	-1,250
Community Early Warning and Monitoring System (C-EMS) (non-add)	3,000	---	---	---
SEDSS (formerly DAWN) (non-add)	4,625	4,000	4,500	500
Program Studies on Treatment and Recovery (PSTAR) (non-add)	342	3,000	1,250	-1,750
Data Collection and Evaluation Activities	579	---	---	---
Operations	221	702	201	-501
FTE Payroll	3,455	5,371	7,122	1,751
Subtotal, PHS Evaluation Funds	**59,223**	**57,667**	**57,667**	**---**
Subtotal, SABG Set Aside	**59,681**	**58,268**	**58,268**	**---**
Health Surveillance and Program Support Appropriation				
Health Surveillance				
Budget Authority				
NSDUH	4,603	13,794	---	-13,794
Grantee Data Development Technical Assistance (GDTA)	3,500	---	---	---
ASC (formerly NAC)	1,000	---	---	---
Community Behavioral Health Data Initiative	1,000	2,000	---	-2,000
C-EMS (non-add)	1,000	2,000	---	-2,000
Content Migration	3,538	---	---	---
Innovation and Logistical Services Support	811	---	---	---
Data Collection and Evaluation Activities	1,157	---	---	---
Operations	1,221	1,036	---	-1,036
Subtotal, Budget Authority	16,830	16,830	---	-16,830
PHS Evaluation Funds				
(National Registry for Evidence Based Programs and Practices NREPP)	---	2,212	1,103	-1,110
BHSIS (formerly DASIS)	18,983	17,028	17,028	**---**
ASC (formerly NAC)	670	2,000	1,012	-988
Science of Changing Social Norms: Building the Evidence Base	---	---	2,000	2,000
Community Behavioral Health Data Initiative	458	1,000	---	-1,000
C-EMS (non-add)	---	1,000	---	-1,000
PSTAR (non-add)	458	---	---	---
Data Collection and Evaluation Activities	2,262	---	---	---
Content Migration	2,995	---	---	---
Operations	979	1,190	1,118	-72
FTE Payroll	4,080	6,998	7,168	170
Subtotal, PHS Evaluation Funds	**$30,428**	**$30,428**	**$29,428**	-1,000

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Prevention and Public Health Fund				
ASC (formerly NAC)	---	---	***1,008***	***1,008***
NSDUH	---	---	13,795	13,795
NREPP	---	---	**940**	**940**
Community Behavioral Health Data Initiative	---	---	3,000	3,000
C-EMS (non-add)	---	---	3,000	3,000
Operations	---	---	1,257	1,257
Subtotal, Prevention and Public Health Fund	---	---	**20,000**	**20,000**
Subtotal, Health Surveillance	**47,258**	**47,258**	**49,428**	**2,170**
Performance and Quality Information System (PQIS)				
Budget Authority				
NREPP	2,959	1,288	---	-1,288
Common Data Platform (CDP)	1,400	5,000	---	-5,000
CDP Legacy Program: Service Accountability Improvement System (SAIS) and Transformation Accountability System (TRAC)	3,925	---	---	---
CDP Legacy Program: Data Collection, Analyses, and Reporting (DCAR)	---	5,000	---	-5,000
GDTA	---	5,000	---	-1,288
Data Collection and Evaluation Activities	995	---	---	---
Operations	768	1,630	---	-1,630
Subtotal, Budget Authority	**12,918**	**12,918**	---	-12,918
PHS Evaluation Funds				
NREPP	---	---	1,463	1,463
CDP	---	---	**5,000**	**5,000**
GDTA	---	---	5,000	5,000
Operations	---	---	1,455	1,455
Subtotal, Budget Authority	12,918	12,918	---	-12,918
Agency-Wide Initiatives				
PHS Evaluation Funds				
Behavioral Health Workforce Data and Development	---	965	966	1
Operations	---	35	34	-1
Subtotal, Agency-Wide Initiatives	**---**	**1,000**	**1,000**	**---**
Subtotal, Health Surveillance and Program Support	**$60,176**	**$61,176**	**$63,346**	**2,170**
Total, CBHSQ*	**119,857**	**119,444**	**121,614**	**2,170**

*Totals may not add due to rounding.

Resources by Activity

(Dollars in thousands)

Program Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
CBHSQ Activities				
NSDUH	$47,312	$52,726	$52,727	+$1
DASIS/BHSIS	20,983	21,000	21,000	---
CBHSQ Logistics and ASC	2,670	3,000	3,020	+20
SAMHDA/Data Archive	1,291	1,291	1,291	---
CDP	1,400	5,000	5,000	---
Grantee Data Development Technical Assistance	3,500	5,000	5,000	---
CDP Legacy Programs (DCAR)	2,871	---	---	---
CDP Legacy Programs (SAIS) and (TRAC)	3,925	---	---	---
NREPP	2,959	3,500	3,505	+5
Science of Changing Social Norms: Building the Evidence	---	---	2,000	+2,000
Community Behavioral Health Data Initiative	9,800	10,000	8,750	-1,250
C-EMS (non-add)	*4,000*	*3,000*	*3,000*	---
SEDSS (formerly DAWN) (non-add)	*5,000*	*4,000*	*4,500*	+500
PSTAR (non-add)	*800*	*3,000*	*1,250*	-1,750
Behavioral Health Workforce Data and Development	---	965	966	+1
Materials Development	---	---	---	---
Content Migration	6,533	---	---	---
Innovation and Logistical Services Support	811	---	---	---
Data Collection and Evaluation Activities	5,076	---	---	---
Operations	3,190	4,593	4,065	-528
CBHSQ FTE Payroll	7,536	12,369	14,290	+1,921
Total, CBHSQ*	**$119,857**	**$119,444**	**$121,614**	**+$2,170**

*Totals may not add due to rounding.

Authorizing Legislation .....Sections 501, 505, 1911, 1921 of the PHS Act
FY 2016 Authorization .....Expired
Allocation Method ..... Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

In FY 2015, Substance Abuse and Mental Health Services Administration (SAMHSA) continues the streamlining efforts to improve data, outcomes, and quality by realigning 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 lead efforts to improve 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 the behavioral health care delivery system.

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, SAMHSA 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 that determined that many mission-critical contracted activities would be less expensive to accomplish by insourcing, resulting in hiring approximately 36 positions in FY 2014.

Funding in FY 2016 includes $4.1 million in Operations and $14.3 million in FTE Payroll to support the administrative costs and support of CBHSQ personnel, programs and interagency agreements. Funding also supports the phasing in of the programs full complement of 88 FTEs over FY 2014, FY 2015, and FY 2016. SAMHSA proposes to hire 10 additional FTEs in FY 2015 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 (GDTA) project, state and community data TA support, additional data collection activities across the public behavioral health surveys supported within CBHSQ, and two additional staff to provide statistical and data programming support.

Budget Request

The FY 2016 Budget Request for Health Surveillance Initiative is $2.0 million. This additional funding supports the President's *Now is the Time* initiative. Specifically, this funding will be used for a new initiative, Science of Changing Social Norms: Building the Evidence, to measure and track attitudes, behaviors and community norms regarding mental health and substance abuse. These data will enable SAMHSA to understand more fully the impact of social messaging, improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority. The Science of Changing Social Norms will have a second component, Social Media, funded from Public Awareness and Support.

Surveillance and Data Collection

SAMHSA manages a number of critical behavioral health data systems for the Department of Health and Human Services (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 mental and substance use disorders and related health conditions. A new NSDUH contract was awarded in FY 2013 that will support the annual surveys through FY 2017, pending the availability of funds. NSDUH's funding in FY 2013 was $54.8 million and FY 2014 was $47.3 million. In addition to those amounts,

SAMHSA's Center for Mental Health Services (CMHS) provides approximately $1.0 million a year for NSDUH to support mental health-related data collection.

SAMHSA's authorization stipulates that SAMHSA provide estimates of serious emotional disturbances (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 have guided ongoing work to extend the development of definitions and procedures, taking into account new mental disorder criteria specified in the Diagnostic and Statistical Manual – Fifth Edition (DSM-5). This entailed the development of a valid diagnostic clinical interview tool for children, and the determination of an operational definition of SED. In addition, CBHSQ partnered with the Office of the Assistant Secretary for Planning and Evaluation (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 into the NSDUH including possible development and methods to produce credible estimates of SED within the NSDUH survey framework.

In FY 2015, funding for NSDUH and NSDUH-related activities is expected to be $52.7 million. This funding represents a continuation of the new contract awarded in FY 2013, survey technology purchases and the development and pilot testing of the trauma, recovery, and serious emotional disturbance among children modules that may be developed for the NSDUH. Also, in response to Congressional recommendations, SAMHSA will explore the feasibility of incorporating Puerto Rico, the U.S. Virgin Islands, and U.S. territories into the NSDUH data collection efforts. During FY 2015, development work will begin to determine how such efforts could be effectively included in future surveys and short- and long-term costs. SAMHSA intends to continue funding for NSDUH in FY 2016 at the same level as FY 2015.

Behavioral Health Services Information System (BHSIS)
(Formerly Drug Abuse Services Information System/ Behavioral Health Services Information System)

In FY 2013, SAMHSA modified the Drug Abuse Services Information System (DASIS) contract, which became the new Behavioral Health Services Information System (BHSIS). DASIS/BHSIS is 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. In FY 2014, SAMHSA posted a new up-to-date Behavioral Health Treatment Services Locator that provides accurate, timely, and regularly updated information on mental health and substance abuse treatment facilities across the country. The Services Locator was fully integrated in FY 2014 ahead of schedule. Also in FY 2014, CBHSQ collaborated with the Health Resources and Services Administration (HRSA) for the inclusion of health center locator information into the treatment locator. CBHSQ will also explore during FY 2015 the potential for integrating buprenorphine providers and National Health Corps Facilities into the Services Locator. In addition, SAMHSA implemented a coordinated strategy for conducting the substance abuse and mental health facility surveys in FY 2014. Funding from Health Surveillance and Public Health Service (PHS) Evaluation Funds in FY 2013 and FY 2014 provided $17.0 million and $21.0 million respectively for BHSIS. In addition, CMHS provided $7.1 million in FY 2013 and $7.5 million in FY 2014. SAMHSA

intends to continue funding for BHSIS in FY 2015 at the same level as FY 2014. SAMHSA will continue the transition from DASIS to BHSIS in FY 2016. Funding for BHSIS in FY 2016 will remain at the same level as FY 2015.

Community Behavioral Health Data Initiative (CDI)

Data collected from local communities are used to design and deliver programs and services, and 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, communities can then direct targeted prevention efforts at the vulnerable populations. Under the Community Behavioral Health Data Initiative (CDI) structure, SAMHSA more closely coordinates the three separate existing data efforts, the Community Early Warning and Monitoring System (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 use existing or declining resources. Data from this coordinated initiative can be combined with data from other agencies such as Center for Medicare and Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ), and then be reported by regional and community type. 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. One such collaborative effort initially funded in FY 2013 at $3.0 million and continued in FY 2014 with $4.0 million is a partnership with the U.S. Department of Agriculture (USDA) that funded cooperative extension sites to develop and collect community-level behavioral health indicators that can inform prevention and early intervention efforts. The pilot program was expanded in FY 2014 in concert with USDA and a report is expected late in calendar year 2014 that will serve as the basis for development of the next phase of this project, which expands to a greater number of sites.

In FY 2015, CDI's $10.5 million funding will support the development and integration of the C-EMS, SEDSS, and PSTAR data collection programs.

In FY 2016, funding for CDI decreases to $8.8 million and will continue to support C-EMS at the same level as FY 2015. SEDSS funding increases to $4.5 million to continue the support of its development and integration. PSTAR funding decreases to $1.3 million.

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 2015. CBHSQ will further develop the data system that began in FY 2012 in collaboration with AHRQ of community level data collection related to emergency departments. This expanded collaboration will engage additional federal partners (USDA and National Institute of Health's Institute of Environmental Health Sciences) to apply data from resources at the local, state, and national levels 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. CBHSQ provided $3.0 million in FY 2013 and $4.0 million in FY 2014 and plans to provide another $3.0 million in FY 2015 and FY 2016 to expand their current inter- agency agreement (IAA) with the United States Department of Agriculture (USDA)/National Institute of Food and Agriculture (NIFA) and other community data resources 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 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) initiates data collection in many hospitals in a variety of communities, ED data can provide a summary of visits by patients with mental health conditions and substance use problems. By collaborating with CDC's National Center for Health Statistics (NCHS), SAMHSA has an opportunity to understand more comprehensively the nature and course of behavioral health presentations to ED's. Thus, SEDSS, which is replacing 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 $5.0 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, CBHSQ provided another $5.0 million and intends to fund $4.0 million in FY 2015 and $4.5 million in FY 2016 to fully implement data collection efforts. As SEDSS continues, SAMHSA will also consider other recruitment protocols to increase hospital participation and 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).

In FY 2014, SAMHSA awarded a new contract, the Analytic Support Center, which will include support for a feasibility study to assess the best and most cost-effective ways to implement the PSTAR program. Of special interest is furthering an understanding of how local variations may impact special populations of interest (e.g., veterans, minorities, and 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 CDI as well as NSDUH, other facility data systems, and ongoing analytic projects within CBHSQ to respond to critical questions related to health reform implementation, parity, program effectiveness, financing, and access. In FY 2014, CBHSQ provided $0.8 million for planning and development activities.

In FY 2015, as part of the Analytic Support Center contract, CBHSQ plans to provide $3.0 million to phase in implementation of the PSTAR survey.

In FY 2016, funding for PSTAR decreases to $1.3 million. The results of a FY 2014 funded feasibility study of options for implementing the PSTAR survey will be available in FY 2015, and the initiation of the project will likely be more incremental than originally envisioned, thus requiring fewer funds in FY 2016.

Data Collection and Evaluation Activities

In FY 2014, SAMHSA provided $5.1 million for data collection and evaluation activities. This includes expanding the pilot efforts with C-EMS; pilot implementation of a data room for use by agency research staff to access confidential data in a secure environment; a pilot study to collect behavioral health data from electronic health records (EHR); and a pilot project with the Epidemic Intelligence Service (EIS) of the CDC. This project will secure an EIS graduate to identify and address public health outbreaks related to behavioral health including the sudden increase in deaths due to heroin laced with fentanyl and increases in heroin in specific communities. In FY 2015, the Data Collection and Evaluation Activities funds will be integrated into normal operations.

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 SAMHSA's 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 SAMHSA program activity in which an evaluation is proposed, CBHSQ meets with program staff and the SAMHSA Evaluation Team 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 2014, CBHSQ continued implementation of the evaluation guidance and began to provide 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.

SAMHSA proposes the following areas of focus within its evaluation program:

- testing new policies as implemented in service programming,
- examining the impact of changes in policies that have evolved from either practitioner led or SAMHSA led changes in programming,
- testing guidelines for translating or disseminating services and policies to the field, e.g., standards for enrollment or EHR interoperability, and
- evaluating the effectiveness of policies or service practices on quality, cost, and outcomes (payer, provider and population).

SAMHSA will undertake evaluations that advance the behavioral health of the nation. Data will be collected in order to answer specific policy and practice questions as outlined above. The decision criteria for proceeding with new evaluations include consideration of the following:

- Is this a new program or a program where there have been significant changes that may lead to improved or different outcomes?
- If not a new program but a new cohort of grantees, is there a specific question that can be answered by tracking trends within the program?
- If not a new program or cohort, is there value to examining all or part of the program that will expand the evidence base for work conducted in that specific area?
- If not a new program or cohort, is there value in examining the program to determine if continuing the program will achieve relevant outcomes in support of SAMHSA's mission?

SAMHSA will continue to move forward to fully implement the evaluation policy, develop its evaluation staff, and expand availability of information developed through evaluations for program use and public awareness of the impact of SAMHSA's program efforts.

Statistical and Analytic Support

A number of activities have been undertaken to support a broad range of analytic work that is carried out by CBHSQ. These activities include support for a CBHSQ Analytic Support Center (ASC), formerly The National Analytic Center (NAC), 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 (the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), the Food and Drug Administration (FDA), and the Surgeon General's Office), along with the Office of National Drug Control Policy, and the Department of Justice. In FY 2014, funding for the ASC contract was modified to include a PSTAR feasibility study. $3.5 million was funded for statistical support services, and logistical and consultant services to promote knowledge about the field of behavioral health, thereby, furthering the knowledge and understanding of behavioral health problems and consequences. Funding for FY 2015 is $6.0 million, as CBHSQ plans to provide $3.0 million to phase in implementation of the PSTAR survey. In FY 2016, funding decreases to $4.3 million as the initiation of the PSTAR project will likely be more incremental than originally envisioned, thus requiring fewer funds.

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 FY 2013, FY 2014, FY 2015 and FY 2016 is $1.3 million per year. 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 support 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 appropriation's 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 available within existing SAMHSA resources. Often, these requests are by private or public entities that are interested in additional data analyses that will be supported by SAMHSA's Data Request and Publication User Fees. In FY 2015, SAMHSA will work to implement a mechanism to collect user fees.

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 the National Institutes of Health (NIH), AHRQ, and CDC in FY 2015 and FY 2016. 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, substance use disorders, 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 is 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). 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 the efficient and effective implementation of projects.

In FY 2013, CDP funding was $4.4 million. This was reduced in FY 2014 to $1.4 million due to the contract total cost coming in lower than expected. These savings were used to continue to

fund the CDP-related Legacy programs which were necessary due to the later than expected start for the CDP. CDP Legacy systems will be phased out fully in FY 2015.

In FY 2015 and FY 2016, funding for CDP increases to $5.0 million to support the continued creation of 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.

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) is 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 provided $3.5 million for NREPP, $1.5 million from PQIS and FY 2014 provided $3.0 million. In FY 2015 and FY 2016, funding for NREPP will increase to $3.5 million to support growth of the registry to address the continued demand for the use of evidence-based programs within states and communities.

Grantee Data Technical Assistance (GDTA)

In FY 2014, SAMHSA awarded a new contract, Grantee Data Development Technical Assistance (GDTA). The contract provides SAMHSA with assistance in its mission to support grantees and staff in their data collection and management processes as well as support in the utilization of data for program performance monitoring and management and quality improvement. Specifically the objectives of this contract support the Agency's ability to ensure conformance to program specifications through:

- surveying grantees to determine current training requirements;
- maintaining current records of all SAMHSA data collection requirements;
- providing training to grantees related to the collection, management, analysis, and utilization of data; and
- providing technical assistance to grantees regarding data in manner that supports sustainable practices researching and disseminating information related to data collection, management, and utilization.

In FY 2014, GDTA funding was $3.5 million provided from Health Surveillance to support the initial ramping up of TA activities around development and implementation of measures. $5.0 million is planned for FY 2015 from PQIS to support further analysis, which suggests the need for a continued investment in the technical assistance support for agency grantees. Funding for GDTA in FY 2016 will remain at the same level and funding source as FY 2015.

Agency-Wide Initiatives

(Dollars in thousands)

Prevention and Public Health Fund	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Primary and Behavioral Health Care Integration	**$---**	**$---**	**$26,004**	**$26,004**
Primary and Behavioral Health Care Integration TTA	---	---	1,996	1,996
Suicide Prevention	12,000	12,000	10,000	-2,000
National Strategy on Suicide Prevention (non-add)	2,000	---	---	---
GLS- Youth Suicide Prevention-States (non-add)	5,800	12,000	10,000	-2,000
GLS-Youth Suicide Prevention- Campus	1500	---	---	---
GLS-Suicide Prevention Resource Center (non-add)	1,000	---	---	---
Suicide Lifeline (non-add)	1,700	---	---	---

1/ The Minority Fellowship Program budgets from the MH, SAP, and SAT appropriations are reflected under the Workforce initiative and prior years have been comparably adjusted.

Program Description and Accomplishments

Behavioral Health Workforce Data and Development

The Patient Protection and Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 will extend federal parity protections to over 60 million Americans, among them, over 30 million will gain coverage that includes mental health and substance use disorder treatment, and an additional 30 million who already have some coverage of these services will see their coverage enhanced.[67] These estimates take into account the states' decisions on whether to participate in the expansion of Medicaid.

As of June 2014, there were more than 4,000 Mental Health, Health Professional Shortage Areas (HPSAs) in the United States, containing nearly a third of the American population (96 million people). Recent data indicate that almost 90 percent of persons with substance use disorders do not receive the services they need and over half of those with mental disorders do not receive needed treatment.

The President's *Now is the Time* initiative, supports new activities to expand the behavioral health workforce. In FY 2015, the new workforce investments provide support for approximately 3,500 new behavioral health professionals. To ensure the existing workforce investments are achieving desired outcomes, SAMHSA workforce activities in FY 2015 include $1.0 million within the Center for Behavioral Health Statistics and Quality (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. In FY 2015, SAMHSA will continue to work with HRSA to develop a consistent and common data set and to develop clear

[67] Beronio K, Glied S, Frank R. How the Affordable Care Act and Mental Health Parity and Addiction Equity Act Greatly Expand Coverage of Behavioral Health Care. Journal of Behavioral Health Services and Research, 41:4, October 2014.

goals and objectives to meet the national behavioral health workforce needs in America. SAMHSA intends to continue funding in FY 2016 at the same level as FY 2015.

The FY 2016 Budget requests $77.7 million for Behavioral Health Workforce, an increase of $31.0 million from the FY 2015 Enacted Level. This includes $10.0 million for a new program entitled Peer Professional Workforce Development, which will award grants to provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs, resulting in 1,200 additional peer professionals in the behavioral health workforce. SAMHSA is also requesting $21.0 million above the FY 2015 Enacted Level for the SAMHSA-HRSA Behavioral Health Workforce Education and Training (BHWET) Grant Program to expand the behavioral health workforce. In FY 2016, the Agency-Wide programs will support the addition of approximately 5,600 health professionals to the workforce, an increase of 2,100 individuals over FY 2015 levels. SAMHSA's collective workforce efforts will help add several thousand new professionals to the workforce each year.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
(Dollars in millions)

Resource Summary	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Drug Resources by Decision Unit and Function - Substance Abuse Prevention Programs of Regional and National Significance (PRNS)			
Prevention 1	175.129	175.148	210.918
Total, SAPPRNS	**175.129**	**175.148**	**210.918**
Substance Abuse Treatment PRNS			
Treantment 2	360.698	361.463	320.701
Total, SATPRNS	**360.698**	**361.463**	**320.701**
Substance Abuse Prevention and Treatment Block Grant			
Prevention 3	363.089	363.971	363.971
Treantment 3	1452.354	1455.885	1455.885
Total, SABG	**1815.443**	**1819.856**	**1819.856**
Health Surveillance and Program Treatment			
Prevention 4	24.184	24.341	28.936
Treatment 4	96.734	97.363	115.743
Total, HSPS	**120.918**	**121.703**	**144.679**
Total Funding	**2472.188**	**2478.17**	**2496.154**
Drug Resources Personnel Summary			
Total FTEs (direct only)	**619**	**665**	**665**
Drug Resources as a Percent of Budget			
Total Agency Budget	**3621.706**	**3621.212**	**3654.585**
Drug Resources Percentage	**68.30%**	**68.40%**	**68.30%**

[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 2014 – FY 2016
Substance Abuse and Mental Health Services Administration

(Dollars in thousands)

Prevention and Public Health Fund	**FY 2014 Final**	**FY 2015 Enacted**	**FY 2016 President's Budget**
Primary and Behavioral Health Care Integration	**$---**	**$---**	**$26,004**
Primary and Behavioral Health Care Integration TTA	---	---	1,996
Suicide Prevention	12,000	12,000	10,000
National Strategy on Suicide Prevention (non-add)	2,000	---	---
GLS- Youth Suicide Prevention-States (non-add)	5,800	12,000	10,000
GLS-Youth Suicide Prevention- Campus	1500	---	---
GLS-Suicide Prevention Resource Center (non-add)	1,000	---	---
Suicide Lifeline (non-add)	1,700	---	---
Health Surveillance	---	---	20,000
Total, Prevention and Public Health **Fund**	12,000	12,000	58,000
Access to Recovery	50,000	38,223	---
Prevention and Public Health Fund (non-add)	50,000	---	---
Primary Care and Addiction Services Integration (PCAST)	**---**	**---**	**20,000**
Children and Family Programs	29,605	29,605	29,605
Treatment Systems for Homeless	41,386	41,386	41,386
Minority AIDS	**65,570**	**65,570**	**58,859**
Criminal Justice Activities	74,816	78,000	61,946
Addiction Technology Transfer Centers	9,024	9,046	8,081
Crisis Systems	---	---	5,000
Special Initiatives/Outreach	1,432	1,432	1,432
Total, Substance **Abuse Treatment PRNS** [1]	360,698	361,463	210,318
Substance Abuse Prevention and Treatment **Block Grant**	1,452,354	1,455,885	1,455,885
PHS Evaluation Funds (non-add)	63,360	63,360	63,360
Total, Substance Abuse Block Grant	1,452,354	1,455,885	1,455,885
Health Surveillance and Program Support			
Health Surveillance	25,924	25,993	27,116
Prevention and Public Health Fund (non-add)	---	---	10,972
PHS Evaluation Funds (non-add)	**16,692**	**16,736**	**16,144**
Program Support	**39,498**	**39,603**	**43,645**

[1] The Minority Fellowship Program budgets from the Mental Health, Substance Abuse Prevention and Treatment appropriations have been comparably adjusted in this table to be in line with the FY 2016 Request and are reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

Prevention and Public Health Fund	**FY 2014 Final**	**FY 2015 Enacted**	**FY 2016 President's Budget**
Primary and Behavioral Health Care Integration	**$---**	**$---**	**$26,004**
Primary and Behavioral Health Care Integration TTA	---	---	1,996
Suicide Prevention	12,000	12,000	10,000
National Strategy on Suicide Prevention (non-add)	2,000	---	---
GLS- Youth Suicide Prevention-States (non-add)	5,800	12,000	10,000
GLS-Youth Suicide Prevention- Campus	1500	---	---
GLS-Suicide Prevention Resource Center (non-add)	1,000	---	---
Suicide Lifeline (non-add)	1,700	---	---
Health Surveillance	---	---	20,000
Total, Prevention and **Public Health Fund**	12,000	12,000	58,000
Access to Recovery	50,000	38,223	---
Prevention and Public Health Fund (non-add)	50,000	---	---
Primary Care and Addiction Services Integration (PCAST)	---	---	20,000
Children and Family Programs	29,605	29,605	29,605
Treatment Systems for Homeless	41,386	41,386	41,386
Minority AIDS	65,570	65,570	58,859
Criminal Justice Activities	74,816	78,000	61,946
Addiction Technology Transfer Centers	9,024	9,046	8,081
Crisis Systems	**---**	**---**	**5,000**
Special Initiatives/Outreach	1,432	1,432	1,432
Total, Substance Abuse Treatment PRNS 1	360,698	361,463	210,318
Substance Abuse Prevention and Treatment Block Grant	**1,452,354**	**1,455,885**	**1,455,885**
PHS Evaluation Funds (non-add)	63,360	63,360	63,360
Total, Substance **Abuse Block Grant**	1,452,354	1,455,885	1,455,885
Health Surveillance and Program Support			
Health Surveillance	25,924	25,993	27,116
Prevention and Public Health Fund (non-add)	---	---	10,972
PHS Evaluation Funds (non-add)	16,692	16,736	16,144
Program Support	39,498	39,603	43,645
Public Awareness and Support	5,393	5,393	6,228
PHS Evaluation Funds (non-add)	---	---	6,228
Performance and Quality Information Systems	7,086	7,105	7,087
PHS Evaluation Funds (non-add)	---	---	7,087
Agency Wide Initiatives 1	18,233	18,668	31,068
PHS Evaluation Funds (non-add)	**---**	**400**	**400**
Data Rquest/Pblication User Fees	**600**	**600**	**600**

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 2016 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 of funding from the Health Surveillance and Program Support (HSPS) appropriation.

The portion of the Health Surveillance and Program Support account attributed to the Drug Budget uses the following calculations:

- 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 specifically appropriated for prevention activities 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 2016, SAMHSA requests a total of $2.5 billion for drug control activities, which is an increase of $18.0 million from the FY 2015 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 2016 Request: $210.9 million
(Reflects $35.8 million increase from the FY 2015 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 2016 President's Budget request for SAMHSA's Substance Abuse Prevention PRNS includes $210.9 million which covers nine programmatic activities, an increase of $35.8 million from the FY 2015 Enacted Level. The request includes: $118.3 million for Strategic Prevention Framework; $4.9 million for Mandatory Drug Testing; $41.2 million for Minority AIDS; $7.0 million for Sober Truth on Preventing Underage Drinking; $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; $4.1 million for Science and Service Program Coordination; $12.0 million for Prescription and Opioid Overdose Death Prevention; and $15.0 million for Tribal Behavioral Health Grants.

Strategic Prevention Framework
Total FY 2016 Request: $118.3 million
(Reflects $8.8 million increase from the FY 2015 Enacted Level)

SAMHSA's Strategic Prevention Framework (SPF) grant programs support activities to help grantees build a solid foundation for delivering and sustaining effective substance abuse prevention services and reducing substance abuse problems. The program goals include: reducing substance abuse-related problems; preventing the onset and reducing the progression of substance use disorders; strengthening prevention capacity and infrastructure at the state and community levels in support of prevention; and leveraging, redirecting, and realigning statewide funding streams for substance abuse prevention. Through the PFS program, SAMHSA will continue to address the nation's top emerging substance abuse priorities, such as prescription drugs, other opioids, underage drinking, marijuana, heroin, and intoxicative inhalants.

See page 153 in the CSAP chapter for the start of the full description of this program.

Strategic Prevention Framework for Prescription Drugs (SPF Rx)

Due to alarming trends related to prescription drug misuse and overdoses involving opioids, SAMHSA is prioritizing efforts to address prescription drug misuse. SAMHSA's Strategic Prevention Framework for Prescription Drugs (SPF Rx) will raise awareness about the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing to young adults. 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.

See page 155 in the CSAP chapter for the start of the full description of these efforts.

Budget Request

The FY 2016 Budget Request is $118.3 million at the program level with $108.3 million from Budget Authority and $10.0 million from Public Health Service (PHS) Evaluation Funds. This is a net increase of $8.8 million from the FY 2015 Enacted Level with a $1.2 million decrease from Budget Authority and a $10.0 million increase in PHS Evaluation Funds for the new Strategic Prevention Framework for Prescription Drugs (SPF-Rx) program. SPF-Rx will raise public awareness about the dangers of sharing medications and to work with pharmaceutical and medical communities to raise awareness on the risks of overprescribing. The FY 2016 SPF program will provide funds to develop capacity and expertise in the use of data from state prescription drug monitoring programs to identify communities by geography and high-risk populations (e.g., age group), particularly those communities that are in need of primary and secondary prevention. In addition, grantees can use SAMHSA's resources to provide technical assistance and training on the use of SAMHSA's Opioid Overdose Prevention Tool Kit to help prevent opioid overdose related deaths. Funding will support up to 20 state planning grants, technical assistance and evaluation to build capacity to address prescription drug abuse, and overdose prevention efforts, in conjunction with other state and local partners.

Federal Drug-Free Workplace Program (Formally Mandatory Drug Testing)
Total FY 2016 Request: $4.9 million
(Reflects level funding from the FY 2015 Enacted Level)

SAMHSA's activities related to the Federal Drug-Free Workplace Program (DFWP) support to two principal activities mandated by Executive Order (E.O.) 12564 and Public Law (P.L.) 100-71: 1) oversight of the DFWP, aimed at the elimination of illicit drug use within Executive Branch agencies and the regulated industry; and 2) oversight of the National Laboratory Certification Program (NLCP), which certifies laboratories to conduct forensic drug testing for federal agencies, federally regulated industries and the private sector.

See page 159 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request of $4.9 million is equal to the FY 2015 Enacted Level. In FY 2016, SAMHSA will continue oversight of the Executive Branch Agencies' DFWP. This includes review of agency DFWP plans that perform federal employee testing, perform random testing for positions of national security, public health, and public safety, and perform testing for illegal drug use and the misuse of prescription drugs. SAMHSA will continue its oversight role to inspect and certify the NLCP laboratories.

Minority AIDS Initiative
Total FY 2016 Request: $41.2 million
(Reflects level funding from the FY 2015 Enacted Level)

The purpose of the Minority AIDS Initiative (MAI) grants is to facilitate the development and expansion of culturally competent and effective community-based treatment systems for substance use and co-occurring substance use and mental disorders within racial and ethnic minority communities. The goals of the program are to reduce the impact of behavioral health problems, reduce HIV risk and incidence, and increase access to treatment for individuals with co-existing behavioral health, HIV, and Hepatitis conditions.

See page 160 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request of $41.2 million is equal to the FY 2015 Enacted Level. These funds continue to address a critical public health problem and health disparity and provide life-saving prevention services, including testing.

Sober Truth on Preventing Underage Drinking
Total FY 2016 Request: $7.0 million
(Reflects level funding from the FY 2015 Enacted Level)

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 (Public Law 109-422) was the nation's first comprehensive legislation on underage drinking. One of the primary components of the STOP Act is the community-based coalition enhancement grant program aimed at preventing and reducing alcohol use among youth under age 21.

See page 165 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request of $7.0 million is equal to the FY 2015 Enacted Level. This funding will support 97 continuation grants in FY 2016. Eligible entities include current and former Drug-Free Communities grantees.

Fetal Alcohol Spectrum Disorders
Total FY 2016 Request: $1.0 million
(Reflects level funding from the FY 2015 Enacted Level)

The Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence (CFE) program focuses on preventing FASD among women of childbearing age and improving the quality of life for individuals and families affected by these disorders. The 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 affected by FASD.

See page 168 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request of $1.0 million is equal to the FY 2015 Enacted Level. These funds will maintain the Center for Excellence.

Centers for the Application of Prevention Technologies
Total FY 2016 Request: $7.5 million
(Reflects level funding from the FY 2015 Enacted Level)

The Center for the Application of Prevention Technologies (CAPT) program provides state-of-the-art training and technical assistance 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.

See page 169 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request of $7.5 million is equal to FY 2015 Enacted Level. These funds will continue to provide technical assistance and workforce development to the prevention field.

Science and Service Program Coordination
Total FY 2016 Request: $4.1 million
(Reflects level funding from the FY 2015 Enacted Level)

The Science and Service Program Coordination program funds the provision of technical assistance and training to states, tribes, communities, and grantees around substance abuse prevention. These contracts support the Tribal Training and Technical Assistance (TTA) Center and the Underage Drinking Prevention Education Initiatives (UADPEI). The TTA Center provides comprehensive, broad, focused, and/or intensive training to communities seeking to address and prevent mental and substance use disorders, suicide, and promote mental health.

See pages 172 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request of $4.1 million is equal to the FY 2015 Enacted Level to continue 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.

Tribal Behavioral Health Grants
Total FY 2016 Request: $15.0 million
(Reflects $15.0 million increase from the FY 2015 Enacted Level)

SAMHSA's Tribal Behavioral Health Grants focus on mental and substance use disorders and suicides among Native youth. Suicide is the second leading cause of death among American Indian/Alaska Native (AI/AN) youth ages 8 to 24 years.[68] 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.[69] In addition, about 90 percent of those who die by suicide had a mental disorder at the time of their deaths.[70]

See page 173 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request for the Tribal Behavioral Health Grant (TBHG) program is $30.0 million, including $15.0 million in the Mental Health appropriation and $15.0 million in

[68] Centers for Disease Control and Prevention. Fatal injury data, 2010. Web-based Injury statistics Query and Reporting System. Available at www.cdc.gov/injury/wisqars/fatal.html. Accessed May 27, 2014.
[69] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Available at http://www.cdc.gov/healthyyouth/yrbs/index.htm. Accessed May 27, 2014.
[70] American Association of Suicidology. (2012). *Suicide in the USA Based on 2010 Data.* Washington, DC: American Association of Suicidology. Available at: http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/SuicideUSA2012.pdf.

the Substance Abuse Prevention appropriation. This request represents an increase over the FY 2015 Enacted Level of $10.0 million in the Mental Health appropriation and $15.0 million for a newly established line in the Substance Abuse Prevention appropriation. This funding is part of Generation Indigenous, a Native youth initiative focused on removing possible barriers to success for Native youth. This initiative will take a comprehensive, culturally appropriate approach to help improve the lives and opportunities for Native youth. In addition to HHS, multiple agencies, including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing Native youth. This funding will allow SAMHSA to expand activities that are critical to preventing substance abuse and promoting mental health and resiliency among youth in tribal communities. The additional funding will expand these activities to approximately 103 additional tribes and tribal entities. With the expansion of the TBHG program, SAMHSA aims to reduce substance use and the incidence of suicide attempts among Native youth and to address behavioral health conditions which impact learning in Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion and substance use prevention activities for high-risk Native youth and their families, enhance early detection of mental and substance use disorders among Native youth, and increase referral to treatment.

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths
Total FY 2016 Request: $12.0 million
(Reflects $12.0 million increase from the FY 2015 Enacted Level)

Opioid-related overdose is a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids. SAMHSA's Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths program seeks to help states identify communities of high need, and provide education, training, and resources necessary to tailor the overdose kits to meet their specific needs. The grant funds could be used for purchasing naloxone, equipping first responders with naloxone and other overdose death prevention strategies, supporting education on these strategies, providing materials to assemble and disseminate overdose kits.

See page 176 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request is $12.0 million, which is $12.0 million above the FY 2015 Enacted Level. This new program will provide grants to 10 states to reduce significantly the number of opioid overdose-related deaths. Funding will help states purchase naloxone, equip first responders in high-risk communities, support education on the use of naloxone and other overdose death prevention strategies, provide the necessary materials to assemble overdose kits, as well as cover expenses incurred from dissemination efforts.

Substance Abuse Treatment

Substance Abuse Treatment Programs of Regional and National Significance
Total FY 2016 Request: $320.7 million
(Reflects $40.8 million decrease from the FY 2015 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 2016 President's Budget request for SAMHSA's Substance Abuse Treatment PRNS includes $320.7 million which covers sixteen programmatic activities, a decrease of $40.8 million from the FY 2015 Enacted Level. The request includes: $8.7 million for Opioid Treatment Programs/Regulatory Activities; $25.1 million for Prescription Drug and Opioid Medication-Assisted Treatment; $30.0 million for Screening, Brief Intervention and Referral to Treatment; $41.4 million for Treatment Systems for Homeless; $58.9 million for Minority AIDS Initiative; $61.9 million for Criminal Justice Activities of which $50.0 million will fund Drug Courts; $0 for Access to Recovery, $20 million for the Primary Care and Addiction Services Integration Program; and $74.7 million for other PRNS Treatment Programs.

Opioid Treatment Programs/Regulatory Activities
FY 2016 Request: $8.7 million
(Reflects level funding from the FY 2015 Enacted Level)

As part of its regulatory responsibility, SAMHSA certifies Opioid Treatment Programs (OTPs) that use methadone, buprenorphine, or buprenorphine/naloxone to treat patients with opioid dependence. SAMHSA carries out this responsibility by enforcing regulations established by an accreditation-based system.

See page 187 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request is equal to the FY 2015 Enacted Level. Funding will support two grant continuations, including the five-year ATTC-HEP support, one new three-year PCSS-MAT grant, and six contracts to continue technical assistance and regulatory oversight and monitoring of OTPs. Additionally, SAMHSA intends to fund a new cooperative agreement to pilot two Regional Medication Assisted Treatment Centers of Excellence (MATCoEs), in two of the ten HHS regions. The PCSS-MAT project will continue for one additional year and will provide MAT training and related services for the other regions. The PCSS-O project will not be continued. Eligible entities for the new RegMATCoE include academic health centers and leading MAT service providers in the region. The RegMATCoEs will assess the needs of the medical and health professions workforce, identify gaps in services within the region and engage with local leadership in addressing these needs and gaps while supporting the overall improvement in MAT quality of care.

Screening, Brief Intervention and Referral to Treatment
FY 2016 Request: $30.0 million
(Reflects $16.9 million decrease from the FY 2015 Enacted Level)

The Screening, Brief Intervention and Referral to Treatment (SBIRT) program requires state grant recipients to implement the SBIRT model at all levels of primary care and medical facilities, including hospitals, trauma centers, Federally Qualified Health Centers, and other relevant settings. Research and clinical experience support the use of SBIRT to intervene early with alcohol and other substance use disorders, which leads to early referral and treatment. The purpose of the SBIRT training grants is to develop primary care practices in order to enhance the delivery system that includes SBIRT as a part of standard medical practice. This program provides medical residents, students of dentistry, physician assistants, and pharmacists, nurses, social workers, counselors the opportunity to learn the elements of SBIRT and incorporate them as part of their permanent practice.

See page 189 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget requests $30.0 million for Screening, Brief Intervention and Referral to Treatment (SBIRT), a $16.9 million decrease from the FY 2015 Enacted Level. Funding will support 49 grant continuations (three five-year state SBIRT and 46 three-year Medical Professional Training grants), 13 new Medical Professional Training grants, and four contracts to continue to integrate SBIRT into general medical and primary care settings. This reduction will not result in the termination of any grants. Funding is requested to continue to support the coordination and integration of primary care services into publicly-funded community behavioral health settings. With the increasing adoption of SBIRT in healthcare settings, the Budget redirects resources to other substance abuse treatment activities, such as heroin and prescription drug abuse treatment.

Targeted Capacity Expansion-General
FY 2016 Request: $36.3 million
(Reflects $13.1 million increase from the FY 2015 Enacted Level)

The Targeted Capacity Expansion-General (TCE-General) program was initiated in FY 1998 to help communities expand or enhance their ability to provide rapid, strategic, comprehensive, integrated, and community-based responses to a specific and well-documented substance abuse capacity problem. As part of these efforts, SAMHSA's *Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA)* seeks to expand or enhance MAT and other clinically appropriate services for persons with opioid use disorders.

See page 192 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request of $36.3 million includes an increase of $13.1 million from the FY 2015 Enacted Level for Targeted Capacity Expansion-General. The increase will be used to support a new activity under the Targeted Capacity Expansion program entitled Medication Assisted Treatment for Prescription Drug and Opioid Addiction. This funding is part of a joint effort by SAMHSA and the Agency for Healthcare Research and Quality (AHRQ) to improve access to MAT services for treating opioid use disorders, with a focus on heroin and prescription opioids. SAMHSA will use this funding to provide grants to states to support opioid MAT efforts in high-risk communities, to educate, and to provide technical assistance. States can use this funding to purchase medication to expand MAT services. This program will increase the number of states from 11 to 22 that receive funding to expand services that address prescription drug misuse and heroin use in high-risk communities. This new funding is expected to serve an additional 24 high-risk communities.

In conjunction with this new program, SAMHSA will work with AHRQ which will evaluate clinical practices to identify effective treatment models. This information will improve and enhance the SAMHSA MAT grant program. This funding will help identify models that can be implemented in communities to achieve improvements in patient care outcomes, increased coordination of care for medical and psychiatric conditions, increased patient satisfaction, and other healthcare outcomes that will produce significant provider and community level public health impacts.

Treatment Systems for Homeless
FY 2016 Request: $41.4 million
(Reflects level funding from the FY 2015 Enacted Level)

SAMHSA's Treatment Systems for Homelessness portfolio supports services, including short-term residential treatment and medication-assisted treatment, to those with substance use disorders or co-occurring substance use and mental disorders. These homelessness programs do not fund housing, but complement HUD's activities by supporting an array of integrated behavioral health treatment and recovery-oriented services and supports, including outreach, engagement, intensive case management, treatment for mental and/or substance use disorders, enrollment in mainstream benefits (Medicaid, SSI/SSDI, SNAP, etc.), and employment readiness services.

See page 210 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request is equal to the FY 2015 Enacted Level for Treatment Systems for Homelessness. Funding will support 60 annual grant continuations (27 CABHI-States continuation grants, 33 GBHI five-year continuation grants), 9 new three-year grants, and three contracts. These programs will allow SAMHSA to continue to support 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 use disorders, enrollment in mainstream benefits, employment readiness, and linkage to permanent housing.

Minority AIDS Initiative
FY 2016 Request: $58.9 million
(Reflects $6.7 million decrease from FY 2015 Enacted Level)

The purpose of the Minority AIDS Initiative (MAI) grants is to facilitate the development and expansion of culturally competent and effective community-based treatment systems for substance use and co-occurring substance use and mental disorders within racial and ethnic minority communities. The goals of the program are to reduce the impact of behavioral health problems, reduce HIV risk and incidence, and increase access to treatment for individuals with co-existing behavioral health, HIV, and Hepatitis conditions.

See page 215 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget requests $58.9 million, a decrease of $6.7 million from the FY 2015 Enacted Level. The funding decrease reflects a realignment between CSAT and CMHS Minority AIDS activities. Total Minority AIDS funds across SAMHSA are equal to the FY 2015 Enacted Level. This funding level will provide substance abuse treatment services, and provide literature and other materials to support behavior change, perform HIV/AIDS testing and counseling services and facilitate linkage to other medical and social services in local communities to racial/ethnic minority populations with substance use disorders and at high risk for HIV or living with HIV. SAMHSA will administer the braided MAI-Continuum of Care Program which will provide fully integrated medical care and mental and substance use disorder treatment to those living with HIV. It will also enable SAMHSA to administer the braided MAI-Continuum of Care Program which will provide fully integrated medical care and mental and substance use disorder treatment to those living with HIV.

Treatment Drug Courts
FY 2016 Request: $50.0 million
(Reflects level funding from the FY 2015 Enacted Level)

Drug courts are designed to combine the sanctioning power of courts with effective treatment services for a range of populations with problems such as alcohol and/or drug use, child abuse/neglect or criminal behavior, mental illness, and veterans' issues. The SAMHSA Drug Court grant programs use existing evidence from numerous studies to support current programs and new proposals.

See page 218 in the CSAT chapter for the start of the full description of this program.

Offender Re-Entry Program
FY 2016 Request: $11.9 million
(Reflects $16.1 million decrease from the FY 2015 Enacted Level)

SAMHSA's criminal justice activities also include Offender Reentry Program (ORP) grants, which provide screening, assessment, 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.

See page 219 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget Request is $61.9 million, a decrease of $16.1 million from the FY 2015 Enacted Level. This reduction will not result in the termination of any grants. As a result of multi-year funding of FY 2014 grants, these funds will still provide sufficient support to existing sites/programs at each of the current grantees receiving continuations, as well as new grants in the Drug Court and ORP programs. SAMHSA plans to support 136 grant continuations consisting of 109 Drug Court and 27 ORP grant continuations, Ex-Offender Reentry grants, five contract continuations, approximately 41 new Drug Court grants, and two new contracts. These programs will continue to provide comprehensive treatment and recovery support services for adolescents and adults with substance use disorders coming into contact with the criminal justice system as well as offenders re-entering the community. SAMHSA proposes to focus this portfolio more strategically to explore new approaches and a variety of models within the drug court umbrella rather than using a significant portion of SAMHSA's limited funding to support what is already a robust system.

Access to Recovery
FY 2016 Request: $0.0 million
(Reflects $38.2 million decrease from the FY 2015 Enacted Level)

Access to Recovery is a grant program which promotes client choice and supports states/tribes in developing expanded provider networks, including faith-based and secular providers, to provide comprehensive clinical substance abuse treatment and recovery support services. Since 2004, the ATR program has served over 650,000 clients through 75 grantees. The majority of services provided are recovery support related and not reimbursable by insurance. Services include transportation, housing, and jobs support.

See page 202 in the CSAT chapter for the start of the full description of this program.

Budget Request

SAMHSA is proposing eliminating the Access to Recovery (ATR) program in FY 2016. Many of the clinical services provided under ATR will now be covered by public and private insurance. In addition, states are able to support recovery support services and client choice with Substance

Abuse Prevention and Treatment Block Grant funding. Since 2004, ATR has served over 650,000 clients through 75 grantees. SAMHSA has been able to identify successful substance abuse treatment and recovery-oriented systems of care models and will continue to offer technical assistance to states that would like to continue this activity.

Primary Care and Addiction Services Integration Program
FY 2016 Request: $20.0 million
(Reflects $20.0 million increase from the FY 2015 Enacted Level)

The Primary Care and Addiction Services Integration (PCASI) seeks to improve the health of people with substance use disorders though coordinated and integrated primary care services. Through PCASI, integrated teams of professionals will be able to provide needed primary care services to individuals seeking care for a SUD. Provision of coordinated and integrated services improves 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 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.

See page 205 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget requests $20.0 million to provide grants to behavioral health and primary care providers to integrate substance abuse treatment services and primary care. Individuals with substance use disorders are at risk for co-occurring health conditions. Several cardiovascular complications such as heart attack, heart failure, and stroke are closely related to cocaine use. Alcohol use is a major risk factor for many conditions including chronic hypertension, obesity and diabetes. In addition, individuals with other chronic health issues may develop substance abuse problems due to self-medication. Not only do people with substance use disorders experience health disparities in morbidity and mortality, Medicare and Medicaid cost data tell us that for people with multiple chronic conditions, costs are exponentially higher when one of those conditions is a substance use disorder. The goal of this program is to improve the health of people with substance use disorders though coordinated and integrated primary care services in community substance abuse treatment settings. Through PCASI, integrated teams of professionals will be able to provide needed primary care services to individuals seeking care for a substance use disorder (SUD), with the objective of improving health outcomes, enhancing the experience of care, and reducing the cost of care by controlling physical healthcare costs. SAMHSA expects that PCASI will complement the successful Primary and Behavioral Health Care Integration (PBHCI) grant program by promoting integrated services for individuals with SUDs and using lessons learned from PBHCI.

This funding will support a total of 21 grants to behavioral health and primary care providers of approximately $0.5 million annually for up to three years. Funding will also be used to award an HIV continuum of care grant award. In addition, SAMHSA will award a contract to support technical assistance and evaluation activities which will assess the clinical and cost effectiveness of these programs and other programs in the field, grantee ensure fidelity to

program implementation, and to assist with documentation and dissemination of lessons learned from the program.

Crisis Systems: Increasing Crisis Access Response Efforts (ICARE)
FY 2016 Request: $5.0 million
(Reflects $5.0 million increase from the FY 2015 Enacted Level)

Behavioral health crises are critical times for intervention and treatment and to engage individuals in on-going treatment and the pursuit of recovery. Such crises often cause great disruption for individuals and those around them, including family members, teachers, law enforcement, and employers. This program seeks to increase the engagement with and functioning of individuals in crisis, increased support for families and caregivers, decreased use of emergency room and inpatient care, and increased understanding by the community of behavioral health issues and those who experience a behavioral health crisis.

See page 225 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2016 Budget requests $10.0 million, including $5.0 million in the Mental Health appropriation and $5.0 million in the Substance Abuse Treatment appropriation, for a new braided program line entitled Crisis Systems. This represents an increase of $10.0 million from the FY 2015 Enacted Level. Funding supports the Increasing Crisis Access Response Efforts (ICARE), a demonstration activity to help communities build, fund, and sustain crisis systems capable of preventing and deescalating behavioral health crises as well as connecting individuals and families with needed post-crisis services. In many incidences, responses to these situations by emergency medical responders and other behavioral health care providers are under- coordinated and un-sustained. These grants will help mitigate the demand for inpatient beds by those with serious mental illnesses and substance use disorders by coordinating effective crisis response with ongoing outpatient services and supports. As a braided activity, SAMHSA will track separately any amounts spent or awarded under Crisis Systems through its distinct appropriation and ensure that funds are used for purposes consistent with legislative direction and intent of that appropriation.

Other PRNS Treatment Programs
FY 2016 Request: $58.5 million
(Reflects $1.0 million decrease from the FY 2015 Enacted Level)

The FY 2016 budget includes resources of $58.5 million for several other Treatment Capacity programs including: Pregnant and Post-Partum Women (PPW); Strengthening Treatment Access and Retention; Recovery Community Services Program (RCSP); Children and Family Programs; Addiction Technology Transfer Centers; and Special Initiatives/Outreach. The FY 2016 Budget includes funds for continuing grants and contracts in the various programs. 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 2016 Request: $1.8 billion
(Reflects level funding from the FY 2015 Enacted Level)

The Substance Abuse Prevention and Treatment Block Grant Program (SABG) distributes funds to 60 eligible states, territories and freely associated states, the District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota (states) 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.

See page 237 in the CSAT chapter for the start of the full description of this program.

Budget Request

In FY 2016, the budget request is $1.8 billion. This is equal to the FY 2015 Enacted Level. In the FY 2016 request for the SABG, SAMHSA continues to be cognizant of new coverage for some limited services for Substance Use Disorders (SUD) in some states, mostly after an addiction is already diagnosed. SAMHSA's FY 2016 budget also recognizes the increased case finding and demand for services likely to be created by additional coverage options. Despite the wide scale opportunity to obtain insurance coverage created by the Affordable Care Act, significant gaps in coverage, as well as the subsequent reliance on the public behavioral health safety net, are realities. Among the gaps, the states' decision regarding Medicaid expansion is perhaps the most significant. To date, 24 states have chosen not to expand their Medicaid programs resulting in approximately 3.7 million Americans with behavioral health conditions without health insurance.[71]

Additionally, a recent report by the Urban Institute finds that adults with physical and/or mental health issues, particularly those in low income families, have more difficulties obtaining and affording health care than adults who reported no health problems. For adults with physical and/or behavioral health issues, ongoing barriers to care exist even with full-year health insurance – affordability being the greatest barrier compared to healthier individuals.[72] For example, after state-based healthcare expansion efforts in Massachusetts, only 2.6 percent of state residents were uninsured but yet more than 20 percent of clients admitted to substance abuse treatment facilities were uninsured, even though they were eligible for some form of insurance coverage.

[71] http://www.amhca.org/assets/content/AMHCA_DashedHopes_Report_2_21_14_final.pdf
[72] http://hrms.urban.org/briefs/evidence-of-significant-gaps.html

Health Surveillance and Program Support Appropriation

The FY 2016 Request is $144.7 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 2016 Request: $88.5 million
(Reflects $6.5 million increase from the FY 2015 Enacted Level)

Health Surveillance and Program Support (HSPS) provides funding for personnel costs, building and facilities, equipment, supplies, administrative costs, and associated overhead to support SAMHSA programmatic activities, as well as provide 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.

See page 251 in the HSPS chapter for the start of the full description of this program.

Budget Request

A total of $88.5 million is requested in FY 2016 for Substance Abuse related Health Surveillance and Program Support activities. This is an increase of $6.5 million from the FY 2015 Enacted Level. The additional funding in Health Surveillance supports the President's *Now is the Time* initiative. Specifically, this funding will be used for a new initiative, Science of Changing Social Norms: Building the Evidence, to measure and track attitudes, behaviors and community norms regarding mental health and substance abuse. These data will enable SAMHSA to understand more fully the impact of social messaging, improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority. The Science of Changing Social Norms will have a second component, Social Media, funded from Public Awareness and Support.

The additional funding increase for Program Support covers the additional costs associated with the move to 5600 Fishers Lane in FY 2016 including extending the current building lease, the Federal Acquisition Service (FAS) loan repayment program, and security charges as part of government-wide efforts to reduce long-term rent and utility costs though reductions in per person space use and periodic re-evaluation of competing lease offers.

Public Awareness and Support
FY 2016 Request: $7.8 million
(Reflects $1.0 million increase from the FY 2015 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.

See page 257 in the HSPS chapter for the start of the full description of this program.

Budget Request

The FY 2016 request of $7.8 million will support the President's *Now is the Time* initiative and will allow SAMHSA to continue to streamline its web presence, develop innovative mobile apps, expand its presence on social media, and provide other critical resources to support behavioral health and other health. SAMHSA will use the increase to support the Science of Changing Social Norms, to develop and test an array of messages designed to improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority.

Performance and Quality Information Systems
FY 2016 Request: $8.9 million
(Reflects level funding from the FY 2015 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.

See page 263 in the HSPS chapter for the start of the full description of this program.

Budget Request

In FY 2016, these funds will be used to continue support for the National Registry of Evidence-Based Programs and Practices (NREPP), Common Data Platform (CDP) and Grantee Data Development Technical Assistance.

Agency-Wide Initiatives
FY 2016 Request: $38.8 million
(Reflects $15.5 million increase from the FY 2015 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.

Behavioral Health Workforce

Minority Fellowship Program

As SAMHSA implements the *Leading Change 2.0* Strategic Initiatives for 2015-2018, the new Strategic Initiative on Workforce Development provides the opportunity for a concerted focus on developing the behavioral health workforce. To increase the visibility of this issue and to manage and administer workforce programs more efficiently, SAMHSA is realigning the Minority Fellowship Program (MFP) to Agency-Wide Initiatives.

See page 267 in the HSPS chapter for the start of the full description of this program.

Behavioral Health Workforce Data and Development

As a result of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act, more than 60 million Americans have received first-time or expanded access to coverage for services for mental and substance use disorders.

See page 269 in the HSPS chapter for the start of the full description of this program.

Peer Professional Workforce Development

The Peer Professional Workforce Development program's goal is to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-masters-level addiction counselors working with youth ages 16 to 25.

See page 270 in the HSPS chapter for the start of the full description of this program.

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

In FY 2014, as part of the President's *Now is the Time* initiative, SAMHSA was provided funding to collaborate with the Health Resources and Services Administration (HRSA) for the BHWET Grant Program.

See page 271 in the HSPS chapter for the start of the full description of this program.

Behavioral Health Workforce Budget Request

The FY 2016 Budget Request includes $38.8 million in Substance Abuse related funding within Behavioral Health Workforce, which is an increase of $15.5 million from the FY 2015 Enacted Level. The request includes an increase for a new program entitled Peer Professional Workforce Development, which will award grants to provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs, resulting in 1,200 additional peer professionals in the behavioral health workforce. The request also includes an increase over the FY 2015 Enacted Level for the SAMHSA-HRSA Behavioral Health Workforce Education and Training (BHWET) Grant Program to expand the behavioral health workforce. The program will support the addition of approximately 5,600 health professionals to the workforce, an increase of 2,100 individuals over FY 2015 levels. SAMHSA's collective workforce efforts will help add several thousand new professionals to the workforce each year.

Data Request and Publication User Fees
FY 2016 Request: $0.8 million
(Reflects level funding from the FY 2015 Enacted Level)

In 2016, 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.

SAMHSA
Prevention and Public Health Fund
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Prevention and Public Health Fund
Summary of the Request

(Dollars in thousands)

Prevention and Public Health Fund	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Primary and Behavioral Health Care Integration	**$---**	**$---**	**$26,004**	**$26,004**
Primary and Behavioral Health Care Integration TTA	---	---	1,996	1,996
Suicide Prevention	12,000	12,000	10,000	-2,000
National Strategy on Suicide Prevention (non-add)	2,000	---	---	---
GLS- Youth Suicide Prevention-States (non-add)	5,800	12,000	10,000	-2,000
GLS-Youth Suicide Prevention- Campus	1500	---	---	---
GLS-Suicide Prevention Resource Center (non-add)	1,000	---	---	---
Suicide Lifeline (non-add)	1,700	---	---	---
Health Surveillance	---	---	20,000	20,000
Total, Prevention and Public Health Fund	**12,000**	**12,000**	**58,000**	**46,000**

Budget Request

The FY 2016 Budget Request for the Prevention and Public Health Fund is $58.0 million, which reflects a $46.0 million increase from the FY 2015 Enacted Level. The FY 2016 Prevention and Public Health Fund request includes the following:

- $28.0 million for Primary and Behavioral Health Care Integration,
- $10.0 million for Suicide Prevention, and
- $20.0 million for Health Surveillance.

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Primary and Behavioral Health Care Integration

Program Description and Accomplishments

The Primary and Behavioral Health Care Integration (PBHCI) program comprises competitive cooperative agreements and the PBHCI Training and Technical Assistance (TTA) Center, which is co-funded with the Health Resources and Services Administration (HRSA). The program supports the coordination and integration of primary care services into publicly funded community behavioral health settings. The expected outcome of improved health status for people with Serious Mental Illnesses 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 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.

For a complete description of the PBHCI program, see page 78.

Funding History

Fiscal Year	Amount	PPHF Funds
FY 2012	$47,428,000	$18,000,000
FY 2013	$45,421,000	$14,733,000
FY 2014	$47,258,000	---
FY 2015	$47,258,000	---
FY 2016	$49,428,000	$20,000,000

Budget Request

The FY 2016 Budget requests $28.0 million for Primary and Behavioral Health Care Integration (PBHCI), a $23.9 million decrease from the FY 2015 Enacted Level. This funding will continue to support the coordination and integration of primary care services into publicly-funded community behavioral health settings. PBHCI grantees have made great strides in demonstrating methods of integrating physical health care into specialty behavioral health settings for people with serious mental illnesses. This learning is being incorporated into SAMHSA guidance to the states around the block grants, SAMHSA's consultation on the Medicaid health homes program, implementation of the section 223 program, and into a broader focus on integration across SAMHSA's grant portfolio.

Suicide Prevention: GLS Youth Suicide Prevention

Program Description and Accomplishments

GLS Youth Suicide Prevention

The Garrett Lee Smith (GLS) Memorial Act (Public Law 108-355) authorizes SAMHSA to manage two significant youth suicide prevention programs and one resource center. These grants develop and implement youth suicide prevention and early intervention strategies involving public-private collaborations among youth-serving institutions.

For a complete description of the GLS Youth Suicide Prevention program, see page 84.

Funding History

Fiscal Year	Amount	PPHF Funds
FY 2012	$47,428,000	$18,000,000
FY 2013	$45,421,000	$14,733,000
FY 2014	$47,258,000	---
FY 2015	$47,258,000	---
FY 2016	$49,428,000	$20,000,000

Budget Request

The FY 2016 Budget Request is $41.9 million at the program level with $31.9 million from Budget Authority (BA) and $10.0 million from the Prevention and Public Health Fund (PPHF). This is the same as FY 2015 Enacted Level with a $2.0 million decrease from PPHF and a $2.0 million increase in BA. SAMHSA requests funding to continue developing and implementing youth suicide prevention and early intervention strategies involving public-private collaborations among youth serving institutions. In addition, the funding will support prevention of suicide and suicide attempts at institutions of higher education.

Health Surveillance

Program Description and Accomplishments

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

For a complete description of the programs supported by Health Surveillance budget, see page 251.

Funding History

Fiscal Year	Amount	PPHF Funds
FY 2012	$47,428,000	$18,000,000
FY 2013	$45,421,000	$14,733,000
FY 2014	$47,258,000	---
FY 2015	$47,258,000	---
FY 2016	$49,428,000	$20,000,000

Budget Request

The FY 2016 Budget requests $49.4 million, an increase of $2.2 million from the FY 2015 Enacted Level. This additional funding supports the President's *Now is the Time* initiative. Specifically, this funding will be used for a new initiative, Science of Changing Social Norms: Building the Evidence, to measure and track attitudes, behaviors and community norms regarding mental health and substance abuse. These data will enable SAMHSA to understand more fully the impact of social messaging, improve social acceptance of people with mental and substance use disorders; expand understanding of the health, economic, and social impact of untreated behavioral health conditions; increase the willingness of Americans to seek help for these issues; and help Americans see behavioral health as a public health priority. The Science of Changing Social Norms will have a second component, Social Media, funded from Public Awareness and Support.

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Budget Authority by Object Classification Tables

Substance Abuse and Mental Health Services Administration
Total Budget Authority – Object Class
(Dollars in thousands)

Object Class - Direct Budget Authority[1],[2],[3],[4]	FY2014 Final	FY2015 Enacted Level	FY2016 President's Budget	FY2016 +/- FY2015
Personnel compensation: Full-time permanent (11.1)	48,319	50,108	50,024	- 084
Other than full-time permanent (11.3)	3,027	3,134	3,147	+ 013
Other personnel compensation (11.5)	627	650	648	- 002
Military personnel (11.7)	3,286	3,680	3,426	- 254
Special personnel services payments (11.8)	27	---	---	---
Subtotal personnel compensation:	**55,286**	**57,573**	**57,246**	**- 327**
Civilian benefits (12.1)	14,693	15,235	15,474	+ 239
Military benefits (12.2)	1,703	1,900	1,803	- 097
Subtotal Pay Costs:	**71,681**	**74,707**	**74,522**	**- 185**
Travel and transportation of persons (21.0)	1,108	1,235	1,235	---
Transportation of things (22.0)	36	7	7	---
Rental payments to GSA (23.1)	6,481	9,558	12,153	+ 2,595
Rental payments to Others (23.2)	2	508	534	+ 026
Communication, utilities, and misc. charges (23.3)	447	880	1,296	+ 416
Printing and reproduction (24.0)	1,674	1,222	1,227	+ 005
Other Contractual Services: Advisory and assistance services (25.1)	26,747	26,067	26,067	---
Other services (25.2) (25.9)	169,252	156,379	152,494	- 3,885
Purchase Goods & Services Government Accounts (25.3)	39,662	33,432	33,432	---
Operation and maintenance of facilities (25.4)	1,604	301	301	---
Research and Development Contracts (25.5)	---	870	870	---
Operation and maintenance of equipment (25.7)	229	293	293	---
Subtotal Other Contractual Services:	**237,495**	**217,342**	**213,457**	**- 3,885**
Supplies and materials (26.0)	184	238	238	---
Equipment (31.0)	573	368	368	---
Grants, subsidies, and contributions (41.0)	3,167,857	3,179,980	3,148,626	- 31,354
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**3,415,858**	**3,411,338**	**3,379,141**	**- 32,197**
Total Direct Obligations	**3,487,539**	**3,486,045**	**3,453,663**	**- 32,382**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

[3] Includes Agency Wide Initiatives

[4] Does not include user fees

Substance Abuse and Mental Health Services Administration
Mental Health Services
Budget Authority – Object Class
(Dollars in thousands)

Object Class - Direct Budget Authority[(1),(2),(3),(4)]	FY2014 Final	FY2015 Enacted Level	FY2016 President's Budget	FY2016 +/- FY2015
Personnel compensation: Full-time permanent (11.1)	712	808	818	+ 011
Other than full-time permanent (11.3)	82	93	94	+ 001
Other personnel compensation (11.5)	5	6	6	+ 000
Military personnel (11.7)	32	---	---	---
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	**831**	**907**	**919**	**+ 012**
Civilian benefits (12.1)	238	271	279	+ 008
Military benefits (12.2)	24	---	---	---
Subtotal Pay Costs:	**1,094**	**1,178**	**1,198**	**+ 020**
Travel and transportation of persons (21.0)	36	232	232	---
Transportation of things (22.0)	---	---	---	---
Rental payments to GSA (23.1)	---	3,635	2,024	- 1,610
Rental payments to Others (23.2)	---	193	193	---
Communication, utilities, and misc. charges (23.3)	194	186	602	+ 416
Printing and reproduction (24.0)	447	37	37	---
Other Contractual Services: Advisory and assistance services (25.1)	14,213	15,000	15,000	---
Other services (25.2) (25.9)	53,503	51,400	51,722	+ 322
Purchase Goods & Services Government Accounts (25.3)	16,039	16,740	16,740	---
Operation and maintenance of facilities (25.4)	1,576	235	235	---
Research and Development Contracts (25.5)	---	870	870	---
Operation and maintenance of equipment (25.7)	4	32	32	---
Subtotal Other Contractual Services:	**85,335**	**84,277**	**84,599**	**+ 322**
Supplies and materials (26.0)	---	5	5	---
Equipment (31.0)	258	3	3	---
Grants, subsidies, and contributions (41.0)	969,290	960,132	962,735	+ 2,603
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**1,055,560**	**1,048,699**	**1,050,430**	**+ 1,731**
Total Direct Obligations	**1,056,654**	**1,049,877**	**1,051,628**	**+ 1,751**

[1)] Does not include PHS EVAL Funds.

[2)] Includes Prevention and Public Health Funds.

[3)] Does not in Agency Wide Initiatives

Substance Abuse and Mental Health Services Administration
Substance Abuse Prevention
Budget Authority – Object Class
(Dollars in thousands)

Object Class - Direct Budget Authority[(1),(2),(3),(4)]	FY2014 Final	FY2015 Enacted Level	FY2016 President's Budget	FY2016 +/- FY2015
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:	---	---	---	---
Travel and transportation of persons (21.0)	---	---	---	---
Transportation of things (22.0)	4	---	---	---
Rental payments to GSA (23.1)	65	1,161	647	- 515
Rental payments to Others (23.2)	---	62	62	---
Communication, utilities, and misc. charges (23.3)	253	33	33	---
Printing and reproduction (24.0)	595	230	230	---
Other Contractual Services: Advisory and assistance services (25.1)	4,391	2,878	2,878	---
Other services (25.2) (25.9)	30,029	30,739	26,532	- 4,207
Purchase Goods & Services Government Accounts (25.3)	4,720	2,392	2,392	---
Operation and maintenance of facilities (25.4)	28	66	66	---
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	211	175	175	---
Subtotal Other Contractual Services:	**39,379**	**36,250**	**32,043**	**- 4,207**
Supplies and materials (26.0)	8	5	5	---
Equipment (31.0)	174	---	---	---
Grants, subsidies, and contributions (41.0)	134,651	137,407	161,431	+ 24,024
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**175,129**	**175,148**	**194,450**	**+ 19,302**
Total Direct Obligations	**175,129**	**175,148**	**194,450**	**+ 19,302**

[1)] Does not include PHS EVAL Funds.

[2)] Includes Prevention and Public Health Funds.

[3)] Does not in Agency Wide Initiatives

Substance Abuse and Mental Health Services Administration
Substance Abuse Treatment
Budget Authority – Object Class
(Dollars in thousands)

Object Class - Direct Budget Authority[1),(2),(3)]	FY2014 Final	FY2015 Enacted Level	FY2016 President's Budget	FY2016 +/- FY2015
Personnel compensation: Full-time permanent (11.1)	2,755	2,740	2,967	+227
Other than full-time permanent (11.3)	365	363	393	+030
Other personnel compensation (11.5)	26	26	28	+002
Military personnel (11.7)	127	129	130	+002
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	**3,275**	**3,258**	**3,519**	**+261**
Civilian benefits (12.1)	935	929	1,023	+094
Military benefits (12.2)	51	52	53	+002
Subtotal Pay Costs:	**4,260**	**4,238**	**4,595**	**+356**
Travel and transportation of persons (21.0)	167	150	150	---
Transportation of things (22.0)	---	---	---	---
Rental payments to GSA (23.1)	6,341	3,541	1,972	- 1,569
Rental payments to Others (23.2)	---	188	188	---
Communication, utilities, and misc. charges (23.3)	---	459	459	---
Printing and reproduction (24.0)	521	835	835	---
Other Contractual Services: Advisory and assistance services (25.1)	6,846	6,826	6,826	---
Other services (25.2) (25.9)	48,483	35,982	35,982	---
Purchase Goods & Services Government Accounts (25.3)	5,911	6,000	6,000	---
Operation and maintenance of facilities (25.4)	---	---	---	---
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	---	---	---	---
Subtotal Other Contractual Services:	**61,240**	**48,809**	**48,809**	---
Supplies and materials (26.0)	12	25	25	---
Equipment (31.0)	---	---	---	---
Grants, subsidies, and contributions (41.0)	2,022,399	2,041,873	1,974,324	- 67,549
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**2,090,681**	**2,095,881**	**2,026,762**	**- 69,118**
Total Direct Obligations	**2,094,941**	**2,100,119**	**2,031,357**	**- 68,762**

[1)] Does not include PHS EVAL Funds.

[2)] Includes Prevention and Public Health Funds.

[3)] Does not in Agency Wide Initiatives

Substance Abuse and Mental Health Services Administration
Health Surveillance and Program Support
Budget Authority – Object Class
(Dollars in thousands)

Object Class - Direct Budget Authority[(1),(2),(3),(4)]	FY2014 Final	FY2015 Enacted Level	FY2016 President's Budget	FY2016 +/- FY2015
Personnel compensation: Full-time permanent (11.1)	44,851	46,561	46,239	- 322
Other than full-time permanent (11.3)	2,579	2,678	2,659	- 018
Other personnel compensation (11.5)	596	618	614	- 004
Military personnel (11.7)	3,127	3,551	3,296	- 255
Special personnel services payments (11.8)	27	---	---	---
Subtotal personnel compensation:	**51,180**	**53,408**	**52,808**	**- 600**
Civilian benefits (12.1)	13,520	14,035	14,172	+ 137
Military benefits (12.2)	1,627	1,848	1,749	- 099
Subtotal Pay Costs:	**66,327**	**69,291**	**68,729**	**- 562**
Travel and transportation of persons (21.0)	905	853	853	---
Transportation of things (22.0)	31	7	7	---
Rental payments to GSA (23.1)	76	1,221	7,510	+ 6,289
Rental payments to Others (23.2)	2	65	91	+ 026
Communication, utilities, and misc. charges (23.3)	---	202	202	---
Printing and reproduction (24.0)	111	120	125	+ 005
Other Contractual Services: Advisory and assistance services (25.1)	1,298	1,363	1,363	---
Other services (25.2) (25.9)	37,237	38,257	38,257	---
Purchase Goods & Services Government Accounts (25.3)	12,991	8,300	8,300	---
Operation and maintenance of facilities (25.4)	---	---	---	---
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	14	86	86	---
Subtotal Other Contractual Services:	**51,541**	**48,006**	**48,006**	**---**
Supplies and materials (26.0)	164	203	203	---
Equipment (31.0)	141	365	365	---
Grants, subsidies, and contributions (41.0)	41,518	40,568	50,137	+ 9,568
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**94,488**	**91,610**	**107,499**	**+ 15,889**
Total Direct Obligations	**160,815**	**160,901**	**176,228**	**+ 15,327**

[1)] Does not include PHS EVAL Funds.

[2)] Includes Prevention and Public Health Funds.

[3)] Includes Agency Wide Initiatives

[4)] Does not include user fees

Substance Abuse and Mental Health Services Administration
Total PHS Evaluation Funds – Object Class
(Dollars in thousands)

Object Class - Direct Budget Authority[(1),(2),(3),(4)]	FY2014 Final	FY2015 Enacted Level	FY2016 President's Budget	FY2016 +/- FY2015
Personnel Compensation: Full Time Permanent (11.1)	6,519	10,166	11,033	+ 868
Other than Full-Time Permanent (11.3)	362	431	642	+ 211
Other Personnel Compensation (11.5)	48	57	82	+ 025
Purchase Goods & Services Government Accounts (25.3)	651	894	1,127	+ 233
Subtotal Personnel Compensation:	**7,581**	**11,548**	**12,885**	**+ 1,337**
Civilian Personnel Benefits (12.1)	1,971	3,055	3,384	+ 330
Military Personnel Benefits (12.2)	365	500	647	+ 147
Subtotal Pay Costs:	**9,917**	**15,103**	**16,916**	**+ 1,814**
Travel (21.0)	21	183	183	---
Transportation of things (22.0)	9	---	---	---
Communications, Utilities and Misc. Charges (23.3)	---	174	174	---
Printing and Reproduction (24.0)	930	328	328	---
Other Contractual Services: Advisory and assistance services (25.1)	---	3,492	3,492	---
Other services (25.2)(25.9)	114,558	109,589	149,318	+ 39,729
Purchase Goods & Services Government Accounts (25.3)	6,044	3,492	3,492	---
Operation and maintenance of equipment (25.7)	3	---	---	---
Subtotal Other Contractual Services:	**120,605**	**116,573**	**156,302**	**+ 39,729**
Supplies and Materials (26.0)	5	129	129	---
Equipment (31.0)	18	15	15	---
Grants, Subsidies, and Contributions (41.0)	1,162	1,162	36,576	+ 35,414
Subtotal Non-Pay Costs	**122,750**	**118,564**	**193,708**	**+ 75,143**
Total Reimbursable Obligations	**132,667**	**133,667**	**210,624**	**+ 76,957**

Substance Abuse and Mental Health Services Administration
Mental Health Services
PHS Evaluation Funds – Object Class
(Dollars in thousands)

Object Class - PHS Evaluation	FY 2014 Final	FY 2015 Enacted Level	FY 2016 President's Budget	FY 2016 +/- FY 2015
Personnel compensation: Full-time permanent (11.1)	1,532	1,810	1,834	+ 024
Other than full-time permanent (11.3)	---	---	---	---
Other personnel compensation (11.5)	13	15	15	+ 000
Military personnel (11.7)	144	251	254	+ 003
Subtotal personnel compensation:	**1,689**	**2,076**	**2,103**	**+ 027**
Civilian benefits (12.1)	441	521	536	+ 016
Military benefits (12.2)	86	150	154	+ 004
Subtotal Pay Costs:	**2,216**	**2,747**	**2,794**	**+ 047**
Travel and transportation of persons (21.0)	20	61	61	---
Transportation of things (22.0)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	---	58	58	---
Printing and reproduction (24.0)	27	144	144	---
Other Contractual Services: Advisory and assistance services (25.1)	---	---	---	---
Other services (25.2) (25.9)	18,770	17,981	22,934	+ 4,953
Purchase Goods & Services Government Accounts (25.3)	---	---	---	---
Operation and maintenance of equipment (25.7)	---	---	---	---
Subtotal Other Contractual Services:	**18,770**	**17,981**	**22,934**	**+ 4,953**
Supplies and materials (26.0)	5	43	43	---
Equipment (31.0)	1	5	5	---
Grants, subsidies, and contributions (41.0)	---	---	---	---
Subtotal Non-Pay Costs	**18,823**	**18,292**	**23,245**	**+ 4,953**
Total Reimbursable Obligations	**21,039**	**21,039**	**26,039**	**+ 5,000**

Substance Abuse and Mental Health Services Administration
Substance Abuse Prevention
PHS Evaluation Funds – Object Class
(Dollars in thousands)

Object Class - PHS Evaluation	FY 2014 Final	FY 2015 Enacted Level	FY 2016 President's Budget	FY 2016 +/- FY 2015
Personnel compensation: Full-time permanent (11.1)	---	---	---	---
Other than full-time permanent (11.3)	---	---	---	---
Other personnel compensation (11.5)	---	---	---	---
Military personnel (11.7)	---	---	---	---
Subtotal personnel compensation:				
Civilian benefits (12.1)	---	---	---	---
Military benefits (12.2)	---	---	---	---
Subtotal Pay Costs:				
Travel and transportation of persons (21.0)	---	---	---	---
Transportation of things (22.0)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---	---
Printing and reproduction (24.0)	---	---	---	---
Other Contractual Services: Advisory and assistance services (25.1)	---	---	---	---
Other services (25.2) (25.9)	---	---	8,762	+ 8,762
Purchase Goods & Services Government Accounts (25.3)	---	---	---	---
Operation and maintenance of equipment (25.7)	---	---	---	---
Subtotal Other Contractual Services:	**---**	**---**	**8,762**	**+ 8,762**
Supplies and materials (26.0)	---	---	---	---
Equipment (31.0)	---	---	---	---
Grants, subsidies, and contributions (41.0)	---	---	7,706	+ 7,706
Subtotal Non-Pay Costs	**---**	**---**	**7,706**	**+ 7,706**
Total Reimbursable Obligations	**---**	**---**	**16,468**	**+ 16,468**

Substance Abuse and Mental Health Services Administration
Substance Abuse Treatment
PHS Evaluation Funds – Object Class
(Dollars in thousands)

Object Class - PHS Evaluation	FY2014 Final	FY2015 Enacted Level	FY2016 President's Budget	FY2016 +/- FY2015
Personnel compensation: Full-time permanent (11.1)	2,597	5,251	5,446	+ 195
Other than full-time permanent (11.3)	140	282	293	+ 010
Other personnel compensation (11.5)	21	42	43	+ 002
Military personnel (11.7)	89	180	91	- 089
Subtotal personnel compensation:	**2,846**	**5,754**	**5,873**	**+ 118**
Civilian benefits (12.1)	756	1,529	1,612	+ 083
Military benefits (12.2)	45	91	47	- 044
Subtotal Pay Costs:	**3,647**	**7,374**	**7,531**	**+ 158**
Travel and transportation of persons (21.0)	---	61	61	---
Transportation of things (22.0)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	---	58	58	---
Printing and reproduction (24.0)	903	144	144	---
Other Contractual Services: Advisory and assistance services (25.1)	---	1,692	1,692	---
Other services (25.2) (25.9)	72,163	68,969	69,103	+ 134
Purchase Goods & Services Government Accounts (25.3)	3,321	1,692	1,692	---
Operation and maintenance of equipment (25.7)	---	---	---	---
Subtotal Other Contractual Services:	**75,484**	**72,353**	**72,487**	**+ 134**
Supplies and materials (26.0)	---	43	43	---
Equipment (31.0)	4	5	5	---
Grants, subsidies, and contributions (41.0)	1,162	1,162	28,871	+ 27,709
Subtotal Non-Pay Costs	**77,553**	**73,826**	**101,669**	**+ 27,842**
Total Reimbursable Obligations	**81,200**	**81,200**	**109,200**	**+ 28,000**

Substance Abuse and Mental Health Services Administration
Health Surveillance and Program Support
PHS Evaluation Funds – Object Class
(Dollars in thousands)

Object Class - PHS Evaluation	FY2014 Final	FY2015 Enacted Level	FY2016 President's Budget	FY2016 +/- FY 2015
Personnel compensation: Full-time permanent (11.1)	2,390	3,105	3,754	+ 649
Other than full-time permanent (11.3)	222	149	349	+ 200
Other personnel compensation (11.5)	15	-	24	+ 024
Military personnel (11.7)	418	463	782	+ 319
Subtotal personnel compensation:	**3,045**	**3,717**	**4,909**	**+ 1,192**
Civilian benefits (12.1)	774	1,006	1,236	+ 231
Military benefits (12.2)	235	260	446	+ 186
Subtotal Pay Costs:	**4,054**	**4,982**	**6,591**	**+ 1,609**
Travel and transportation of persons (21.0)	1	61	61	---
Transportation of things (22.0)	9	---	---	---
Communication, utilities, and misc. charges (23.3)	---	58	58	---
Printing and reproduction (24.0)	---	40	40	---
Other Contractual Services: Advisory and assistance services (25.1)	---	1,800	1,800	---
Other services (25.2) (25.9)	23,626	22,639	48,519	+ 25,880
Purchase Goods & Services Government Accounts (25.3)	2,723	1,800	1,800	---
Operation and maintenance of equipment (25.7)	3	---	---	---
Subtotal Other Contractual Services:	**26,351**	**26,239**	**52,119**	**+ 25,880**
Supplies and materials (26.0)	---	43	43	---
Equipment (31.0)	13	5	5	---
Grants, subsidies, and contributions (41.0)	---	---	---	---
Subtotal Non-Pay Costs	**26,374**	**26,446**	**52,326**	**+ 25,880**
Total Reimbursable Obligations	**30,428**	**31,428**	**58,917**	**+ 27,489**

Substance Abuse and Mental Health Services Administration
Salaries and Expenses Tables
Direct Budget Authority – Object Class
(Dollars in thousands)

Object Class	FY2014 Final	FY2015 Enacted Level	FY2016 President's Budget	FY2016 +/- FY2015
Personnel compensation: Full-time permanent (11.1)	48,319	50,108	50,024	- 084
Other than full-time permanent (11.3)	3,027	3,134	3,147	+ 013
Other personnel compensation (11.5)	627	650	648	- 002
Military personnel (11.7)	3,286	3,680	3,426	- 254
Special personnel services payments (11.8)	27	---	---	---
Subtotal personnel compensation	**55,286**	**57,573**	**57,246**	**- 327**
Civilian benefits (12.1)	14,693	15,235	15,474	+ 239
Military benefits (12.2)	1,703	1,900	1,803	- 097
Subtotal Pay Costs:	**71,681**	**74,707**	**74,522**	**- 185**
Travel (21.0)	1,108	1,235	1,235	---
Transportation of things (22.0)	36	7	7	---
Rental payments to Others (23.2)	2	508	534	+ 026
Communication, utilities, and misc. charges (23.3)	447	880	1,296	+ 416
Printing and reproduction (24.0)	1,674	1,222	1,227	+ 005
Other Contractual Services: Advisory and assistance services (25.1)	26,747	26,067	26,067	---
Other services (25.2)	169,252	156,379	152,494	- 3,885
Purchase Goods & Services Government Accounts (25.3)	39,662	33,432	33,432	---
Operation and maintenance of facilities (25.4)	1,604	301	301	---
Research and Development Contracts (25.5)	-	870	870	---
Operation and maintenance of equipment (25.7)	229	293	293	---
Subtotal Other Contractual Services:	**237,495**	**217,342**	**213,457**	**- 3,885**
Supplies and materials (26.0)	184	238	238	---
Subtotal Non-Pay Costs	**240,946**	**221,431**	**217,993**	**- 3,438**
Total Salary and Expenses	**312,627**	**296,139**	**292,515**	**- 3,623**
Rental Payments to GSA (23.1)	6,481	9,558	12,153	+ 2,595
Grand Total, Salaries & Expenses and Rent	**319,109**	**305,697**	**304,669**	**- 1,028**
Direct FTE	519	535	525	- 10

Substance Abuse and Mental Health Services Administration
Salaries and Expenses Tables
PHS Evaluation Funds – Object Class
(Dollars in thousands)

Object Class[1]	FY 2014 Final	FY 2015 Enacted Level	FY 2016 President's Budget	FY 2016 +/- FY 2015
Personnel compensation: Full-time permanent (11.1)	6,519	10,166	11,033	+ 868
Other than full-time permanent (11.3)	362	431	642	+ 211
Other personnel compensation (11.5)	48	57	82	+ 025
Military personnel (11.7)	651	894	1,127	+ 233
Subtotal personnel compensation	**7,581**	**11,548**	**12,885**	**+ 1,337**
Civilian benefits (12.1)	1,971	3,055	3,384	+ 330
Military benefits (12.2)	365	500	647	+ 147
Subtotal Pay Costs:	**9,917**	**15,103**	**16,916**	**+ 1,814**
Travel (21.0)	21	183	183	---
Transportation of things (22.0)	9	---	---	---
Communication, utilities, and misc. charges (23.3)	---	174	174	---
Printing and reproduction (24.0)	930	328	328	---
Other Contractual Services: Advisory and assistance services (25.1)	---	3,492	3,492	---
Other services (25.2)	114,558	109,589	149,318	+ 39,729
Purchase Goods & Services Government Accounts (25.3)	6,044	3,492	3,492	---
Operation and maintenance of equipment (25.7)	3	---	---	---
Subtotal Other Contractual Services:	**120,605**	**116,573**	**156,302**	**+ 39,729**
Supplies and materials (26.0)	5	129	---	- 129
Equipment (31.0)	18	15	---	- 015
Subtotal Non-Pay Costs	121,570	117,387	156,987	+ 39,600
Total Salary and Expenses	**131,487**	**132,490**	**173,904**	**+ 41,414**
Rental Payments to GSA (23.1)	---	---	---	---
Grand Total, Salaries & Expenses and Rent	**131,487**	**132,490**	**173,904**	**+ 41,414**
Reimbursable FTE (1)	67	100	110	+ 10

[1] Does not include Other reimbursable FTE's (30) and associated Object Class Cost.

Detail of Full Time Equivalent Employee (FTE)

	2014 Actual Civilian	2014 Actual Military	2014 Actual Total	2015 Est. Civilian	2015 Est. Military	2015 Est. Total	2016 Est. Civilian	2016 Est. Military	2016 Est. Total
Health Surveillance and Program Support									
Direct	446	33	479	458	37	495	449	34	483
Reimbursable	24	10	34	31	11	42	37	15	52
Total	470	43	513	489	48	537	486	49	535
Mental Health Services									
Direct	9	1	10	10	0	10	10	0	10
Reimbursable	18	2	20	21	3	24	21	3	24
Total	27	3	30	31	3	34	31	3	34
Substance Abuse Prevention									
Direct	-	-	-	-	-	-	-	-	-
Reimbursable	17	3	20	17	3	20	17	3	20
Total	17	3	20	17	3	20	17	3	20
Substance Abuse Treatment									
Direct	29	1	30	29	1	30	31	1	32
Reimbursable	21	1	22	42	2	44	43	1	44
Total	50	2	52	71	3	74	74	2	76
OPDIV FTE Total	**564**	**51**	**615**	**608**	57	665	608	57	665

FY2012	13 Step 7
FY2013	13 Step 7
FY2014	13 Step 7
FY2015	13 Step 7
FY2016	13 Step 8

Detail of Positions

	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget
Executive Level IV	1	1	1
Subtotal	**1**	**1**	**1**
Total - Exec Level Salaries	**$155,500**	**$155,500**	**$155,500**
SES	13	13	15
Subtotal	**13**	**13**	**15**
Total, SES salaries	**$2,843,080**	**$2,871,510**	**$3,346,414**
GM/GS-15/EE	77	79	79
GM/GS-14	138	138	138
GM/GS-13	210	210	208
GS-12	56	62	62
GS-11	22	25	25
GS-10	1	1	1
GS-09	12	16	16
GS-08	23	25	25
GS-07	18	23	23
GS-06	8	10	10
GS-05	3	5	5
GS-04	0	0	0
GS-03	0	0	0
GS-02	0	0	0
Subtotal	**568**	**594**	**592**
Total, GS salaries	**$58,124,967**	**$63,892,084**	**$64,286,423**
CC-08/09	1	1	1
CC-07	0	0	0
CC-06	14	15	15
CC-05	16	16	16
CC-04	18	18	18
CC-03	6	7	7
CC-02	0	0	0
Subtotal	**55**	**57**	**57**
Total, CC salaries	**$4,636,488**	**$5,273,870**	**$5,259,500**
Total Positions (1)	**637**	**665**	**665**
Average ES level	ES	ES	ES
Average ES salary	$155,500	$155,500	$155,500
Average ES level	SES	SES	SES
Average ES salary	$218,698	$220,885	$223,094
Average GS grade	13.7	13.7	13.8
Average GS salary	$102,333	$107,562	$108,592
Average CC level	4.6	4.8	4.8
Average CC salaries	$84,300	$92,524	$92,272

(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 2016 Budget Request. Termination of this program allows SAMHSA to redirect approximately $38.2 million from the FY 2015 Enacted Level for substance abuse treatment programs that have a demonstrated record of success or that hold significant promise for increasing accountability and improving behavioral health outcomes. Following the table is a brief summary of the program and rationale for its elimination.

Program	FY 2015 Enacted (in Millions)
Access to Recovery	$38.2

Access to Recovery (-$38.2 million)[73]

SAMHSA is proposing eliminating the Access to Recovery (ATR) program in FY 2016. Many of the clinical services provided under ATR will now be covered by public and private insurance. In addition, states are able to support recovery support services and client choice with Substance Abuse Prevention and Treatment Block Grant funding. Since 2004, ATR has served over 650,000 clients through 75 grantees. SAMHSA has been able to identify successful substance abuse treatment and recovery-oriented systems of care models and will continue to offer technical assistance to states that would like to continue this activity.

[73] The Access to Recovery program was previously proposed for elimination in the FY 2015 President's Budget request.

FTEs Funded by the Affordable Care Act

Substance Abuse and Mental Health Services Administration

(Dollars in thousands)

Program	Section	FY 2012			FY 2013			FY 2014			FY 2015			FY 2016		
		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
Suicide 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

Physicians' Comparability Allowance (PCA) Worksheet

Substance Abuse and Mental Health Services Administration

(Whole dollars)

		PY 2014 (Actuals)	CY 2015 (Estimates)	BY 2016[1] (Estimates)
1) Number of Physicians Receiving PCAs		4	5	5
2) Number of Physicians with One-Year PCA Agreements		---	---	---
3) Number of Physicians with Multi-Year PCA Agreements		4	5	5
4) Average Annual PCA Physician Pay (without PCA payment)		$149,703	$152,016	$152,016
5) Average Annual PCA Payment		$18,500	$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	5	5

[1] FY 2016 data will be approved during the FY 2017 Budget cycle.

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 currently has two medical officer vacancies. The GS position was created on 6/29/2014 and the SES position was vacated on 10/3/2014. SAMHSA is currently going through the recruitment process for both positions. The job vacancy announcement for GS position closed on 12/26/2014 and a selection is anticipated to be made in early 2015. The SES slot request package is currently being drafted for Departmental approval.

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 because our salaries are not competitive with the private sector (e.g., we might offer 75% of a physician's salary on the outside). In addition, physicians of interest to SAMHSA often have income from consulting as well. The PCA is the only way to raise the government income so as to make the offer acceptable.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

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Substance Abuse and Mental Health Services Administration
SIGNIFICANT ITEMS IN SENATE REPORT

FY 2015 Consolidated Senate Report Language
(OMNIBUS - PL 113-235)

General Items

Item – Page 58

Access to Mental Health Services for Veterans **-** Many localities have successfully used customized web portals to assist veterans struggling with mental health and substance abuse issues. SAMHSA is encouraged to promote locally-customized web portals in order to expand their use nationwide.

Action taken or to be taken

SAMHSA encourages all grantees to address the behavioral health needs of returning veterans and their families in designing and developing their programs and to consider prioritizing this population for services where appropriate. SAMHSA will encourage its grantees to utilize and provide technical assistance regarding locally-customized web portals that assist veterans and their families with finding behavioral health treatment and support. SAMHSA is requesting $4.0 million to expand the Mental Health First Aid program to reach 55,000 individuals who work with veterans, military service members and their families

Item – Page 58

Primary and Behavioral Healthcare Integration **-** The agreement directs SAMHSA to ensure that new Integration grants awarded for FY 2015 are funded under the authorities in section 520K of the PHS Act.

Action taken or to be taken

SAMHSA will ensure that new Primary and Behavioral Healthcare Integration grants awarded for FY 2015 are funded under the authorities in section 520K of the PHS Act.

Item – Page 60

Addiction Technology Transfer Centers **-** The agreement rejects the administration request to reduce funding for the ATTCs. SAMHSA is directed to ensure that ATTCs maintain a primary focus on addiction treatment and recovery services.

Action taken or to be taken

FY 2015 funding for the Addiction Technology Transfer Centers is maintained at the FY 2014 level. The ATTCs will continue to maintain primary focus on addiction treatment and recovery.

Item – Pages 60-61

Criminal Justice Activities - SAMHSA is directed to ensure that all Drug Treatment Court funding is allocated to serve people diagnosed with a substance use disorder as their primary condition. SAMHSA is further directed to ensure that all drug treatment court grant recipients work directly with the corresponding state substance abuse agency in the planning, implementation, and evaluation of the grant. SAMHSA is further directed to expand training and technical assistance to drug treatment court grant recipients to ensure evidence-based practices are fully implemented. SAMHSA is directed to make Criminal Justice funding available for competitive grants to community-based providers through the Offender Reentry Program to implement overdose prevention programs for incarcerated and recently released individuals. The Administrator is directed to ensure an equitable amount of grant opportunities are available to grantees that serve those currently in custody, prior to release from incarceration, and continue for at least two months post-release into community-based services as part of a transition plan.

Action taken or to be taken

SAMHSA's FY 2015 Drug Treatment Court grant funding will be utilized to provide services for individuals diagnosed with a substance use disorder as their primary condition. Additionally, Drug Treatment Court applicants are required to include a letter of support from the state Substance Abuse Agency (SSA) Director or designated representative that provides support for the application and confirms that the proposal conforms to the framework of the state strategy of substance abuse treatment. SAMHSA requires that applications received without this letter will not be reviewed or funded. In terms of technical assistance, the FY 2015 Clinical Technical Assistance contract, when awarded, will be increased to expand services to SAMHSA Drug Treatment Court grantees. Finally, the FY 2015 Request for Application for the Offender Reentry Program will require that applicants provide, as part of their service delivery for both soon-to-be released and released individuals, overdose prevention programs, including an educational component that contains SAMHSA's Opioid Overdose Prevention Toolkit.

Item – Pages 61-62

Opioid Treatment Education and Training Programs - SAMHSA is directed to update all of its professional education and training programs for opioid treatment programs (OTPs), office-based opioid treatment programs (OBOTs) and other addiction treatment settings, such that evidence-based innovations in counseling, recovery support, and abstinence-based relapse prevention medication assisted treatments, are fully incorporated.

Action taken or to be taken

SAMHSA is taking concrete steps to update its workforce education and training initiatives. The opioid treatment program (OTP) training curriculum is being revised to take into account the Federal Opioid Treatment Program Guidelines. These Guidelines were last modified in 2007. The revisions will incorporate new information on recovery support, relapse prevention, counseling, overdose prevention and medications such as extended release injectable naltrexone. The buprenorphine training curriculum is also undergoing changes and an Advisory on clinical updates related to buprenorphine is in development. In January, SAMHSA released *Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide* and plans to release another guide focused on the use of Extended-Release Injectable Naltrexone for alcohol abuse treatment.

Item – Page 62

Prescription Drug and Heroin Treatment **-** The agreement directs the Center for Substance Abuse Treatment (CSAT) to ensure that these grants include as an allowable use the support of medication assisted treatment and other clinically appropriate services. These grants should be made available to states with the highest rates of primary treatment admissions for heroin and opioids per capita, and should target those states that have demonstrated a dramatic increase in admissions for the treatment opioids and heroin in recent years.

Action taken or to be taken

SAMHSA will release a Request for Application for grants to states to expand medication assisted treatment (MAT) services for persons with opioid use disorder. The program will target those states experiencing the highest rates of primary treatment admissions for heroin and opioids per capita and a dramatic increase in admissions for treatment of opioids and heroin in recent years. This program will increase the number of states from 11 to 22 that receive funding to expand services that address prescription drug misuse and heroin use in high-risk communities. This new funding is expected to serve an additional 24 high-risk communities.

Item – Page 62

Screening, Brief Intervention, and Referral to Treatment **-** SAMHSA is directed 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. These grants will have MAT as an allowable use. In FY 2016, the Budget includes a $13.0 million increase for this activity, more than doubling funding to $25.0 million within the Targeted Capacity Expansion-General program.

Action taken or to be taken

The SBIRT program requires grant recipients to implement the SBIRT model at all levels of primary care and medical facilities, including hospitals, trauma centers, Federally Qualified Health Centers, and other relevant settings. Research and clinical experience support the use of

SBIRT to intervene early with alcohol and other substance use disorders, which leads to early referral and treatment. SBIRT also identifies individuals with more serious conditions and diverts them from costly emergency services to general practitioners. Funds may be used for screening of substance use and co-occurring disorders, evidence-based client-centered brief interventions such as motivational interviewing, and brief treatment and referral to specialty care for individuals exhibiting signs of dependency. Evaluation findings also indicate that the value of SBIRT is that it makes an "invisible" clinical issue visible by providing the tools to identify and address alcohol and drug use disorders at every point in public health, from primary care to specialty care.

Item – Page 62

Overdose Fatality Prevention - The agreement reflects strong concerns about the increasing number of unintentional overdose deaths attributable to prescription and nonprescription opioids. SAMHSA is urged to take steps to encourage and support the use of Substance Abuse and Prevention Block Grant funds for opioid safety education and training, including initiatives that improve access for licensed healthcare professionals, to include paramedics, to emergency devices used to rapidly reverse the effects of opioid overdoses. Such initiatives should incorporate robust evidence-based intervention training, and facilitate linkage to treatment and recovery services.

Action taken or to be taken

Addressing the issue of prescription drug abuse and misuse as well as preventing opioid overdose deaths is a top priority for SAMHSA. In terms of grants to prevent prescription drug/opioid overdose related deaths, SAMHSA proposes for FY 2016 a $12.0 million grant program that has the potential to significantly reduce the number of opioid-related overdose deaths. Funding will help states purchase naloxone, equip first responders in high-risk communities, support education on the use of naloxone and other overdose death prevention strategies, provide the necessary materials to assemble overdose kits, as well as cover expenses incurred from dissemination efforts. SAMHSA's Opioid Overdose Prevention Toolkit should be used as the guide for the development of a comprehensive strategy that will include evidence based programs to intervene and prevent the likelihood of drug overdose recurrence. The Centers for Disease Control and Prevention (CDC) will evaluate this grant program for its efficacy in reducing overdose deaths from opioids.

In addition, state agencies that administer the Substance Abuse Block Grant (SABG) may use SABG funds (other than primary prevention set-aside funds) to purchase naloxone and the necessary materials to assemble overdose kits and to cover the costs associated with the dissemination of such kits. At the state's discretion, a portion of a states' allocation for the block grant may be used to purchase naloxone.

Item – Page 64

Strategic Prevention Framework State Incentive Grant (SPFSIG) and Partnerships for Success (PFS) - These two programs shall continue to focus exclusively on: addressing state and community-level indicators of alcohol, tobacco, and drug use; targeting and implementing appropriate universal prevention strategies; building infrastructure and capacity; and preventing substance use and abuse. The agreement does not approve of SAMHSA's proposal to use $1,500,000 from the SPFSIG to expand the focus of community coalitions to include mental health promotion and mental illness prevention. SAMHSA is directed not to use any SPFSIG funds for this initiative.

Action taken or to be taken

SAMHSA will not use any SPF-SIG funds for the Building Behavioral Health Coalitions initiative. The SPF-SIG PFS program will continue to address the nation's top emerging substance abuse priorities, such as prescription opioid drugs and other opioids, underage drinking, marijuana, and intoxicative inhalants using appropriate prevention strategies as well as providing support for grantees to strengthen substance abuse prevention infrastructure and capacity using the strategic prevention framework. Applicants for the FY 2015 PFS cohort will also be encouraged to address these issues or other emergent, data driven substance abuse prevention targets. SAMHSA will not use any SPF-SIG funds for the Building Behavioral Health Coalitions initiative.

Item – Pages 64-65

STOP Act - All funds appropriated for STOP Act community based coalition enhancement grants shall be used for making grants to eligible communities and not for any other purposes or activities.

Action taken or to be taken

SAMHSA ensures that the Sober Truth on the Prevention of Underage Drinking Act (STOP Act) grant program's funds are used for making grants to eligible communities and not for any other purpose or activities.

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SAMHSA
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SAMHSA-Specific Requirements

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. The Center for Substance Abuse Prevention (CSAP) provides funding for substance abuse prevention services and HIV testing programs. The Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS) funded projects that support substance abuse/mental health treatment services, HIV testing and referral to quality HIV care.

In 2011, SAMHSA joined with the Department of Health and Human Services' (HHS) Office of HIV/AIDS and Infectious Disease Policy and other HHS agencies to better coordinate a national response to the HIV epidemic under the "HHS 12 Cities Project". Consistent with this coordinated effort, SAMHSA funded 11 cooperative agreements from FY 2011-FY 2014 under the Minority AIDS Initiative-Targeted Capacity Expansion: Integrated Behavioral Health/Primary Care Network Cooperative Agreements (MAI-TCE Program). The purpose of this program is to facilitate 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 12 Metropolitan Statistical Areas (MSAs) and Metropolitan Divisions (MDs) most impacted by HIV/AIDS.

In FY 2014, SAMHSA's CMHS, CSAP, and CSAT supported a pilot HIV Continuum of Care grant program. The purpose of this jointly funded program is to integrate care (behavioral health treatment, prevention, and HIV medical care services) for racial/ethnic minority populations at high risk for behavioral health disorders and high risk for or living with HIV. This includes substance abuse primary prevention/treatment service programs, community mental health programs, and HIV integrated programs that can either co-locate or have fully integrated HIV prevention and medical care services within them. Also, this program provides substance abuse and HIV primary prevention services in local communities served by the behavioral health program. In addition, because of the significant co-morbidity 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, five percent of the allocated funds were 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 FY 2014, SAMHSA awarded 34 HIV Continuum of Care grants and a technical assistance contract. SAMHSA also awarded a contract to evaluate the MAI program. This contract evaluates both the process and the impact of programs that integrate mental health promotion, substance abuse prevention and treatment, HIV prevention, testing, and counseling activities, linkage to services, and medical treatment, and care (as programmatically appropriate) for people most at risk for HIV infection and living with HIV/AIDS.

In FY 2015, SAMHSA will fund the continuation of 34 HIV Continuum of Care grants, a technical assistance contract, and award a new HIV Consolidated Evaluation.

The primary purpose of the HIV Consolidated Evaluation is to conduct a comprehensive process and outcome evaluation of all SAMHSA HIV programs that entails in-depth evaluation development and implementation of a cooperative agreement for a period of four years. The evaluation results will be used to inform program development and refine the approach used in SAMHSA's HIV portfolio.

Expected outcomes for the HIV Continuum of Care programs include: 1) increased HIV testing to identify behavioral health clients who are unaware of their HIV status; 2) increased diagnosis of HIV among behavioral health clients; 3) increased number of clients who are linked to HIV medical care; 4) increased number of behavioral health clients who are retained in care; 5) increased number of behavioral health clients who are receiving antiretroviral therapy (ART); 6) improved adherence to behavioral treatment and ART; 7) increased number of behavioral health clients who have sustained viral suppression; and 8) increased adherence and retention in behavioral health (both substance use and mental disorders) treatment.

SAMHSA expects that data generated from the FY 2014 pilot HIV Continuum of Care grant program will help to inform SAMHSA efforts to continue the co-location and integrated HIV/primary care within either substance abuse or community mental health treatment programs that focus on 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. By integrating HIV care into behavioral health settings, people living with HIV/AIDS and mental and substance use disorders (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/AIDS, 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 viral 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.

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