DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2019

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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Letter from the Assistant Secretary

I am pleased to present the Substance Abuse and Mental Health Services Administration (SAMHSA) fiscal year (FY) 2019 Budget Request. SAMHSA is requesting a total of $3.5 billion. In addition, the Budget provides $1.2 billion in additional opioids allocation resources to SAMHSA for a variety of new and expanded efforts to fight the opioid crisis. When accounting for these resources, the total for SAMHSA is $4.8 billion. As a primary federal agency responsible for addressing substance abuse and mental health services, SAMHSA proudly leads public health efforts to advance the behavioral health of the nation. Now, more than ever, we must ensure individuals living with substance use and mental disorders gain access to high quality prevention, treatment, and recovery services.

Consistent with the goals of the *21st Century Cures Act*, SAMHSA's budget demonstrates a commitment to addressing the nation's pressing public health challenges, including the opioid crisis and serious mental illness (SMI). This budget aligns with the Administration's priorities to address behavioral health for children, adults, families, and communities. Through a sustained focus on implementing evidence-based practices, SAMHSA's budget aims to improve the lives of people across the nation.

SAMHSA's FY 2019 budget request includes investments to:

- Expand access to care for opioid use disorders though the continued investment of in Medication - Assisted Treatment (MAT) and strategies to prevent opioid abuse through evidence-based prevention approaches, including the use of the life-saving drug, naloxone
- Prioritize ensuring individuals with SMI gain access to care over incarceration through increased investments in evidence-based programs, such as Assertive Community Treatment (ACT), jail diversion programs, including mental health courts, and a focus on addressing the needs of high utilizers of services through the Community Mental Health Services Block Grant
- Make critical data from national surveys and health surveillance available to support innovation and improve patient outcomes

SAMHSA provides strategic investments that foster flexibility and leverage change across the nation. In FY 2019, SAMHSA maintains a strong commitment to enhancing the delivery of clinically sound, evidence-based, effective services. SAMHSA continues to streamline its business operations, including the provision of technical assistance and training, to ensure an optimization of service provision across America's communities.

The work SAMHSA does is vital to the health of this country. I am confident this budget supports SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities.

/S/ Elinore F. McCance-Katz

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use

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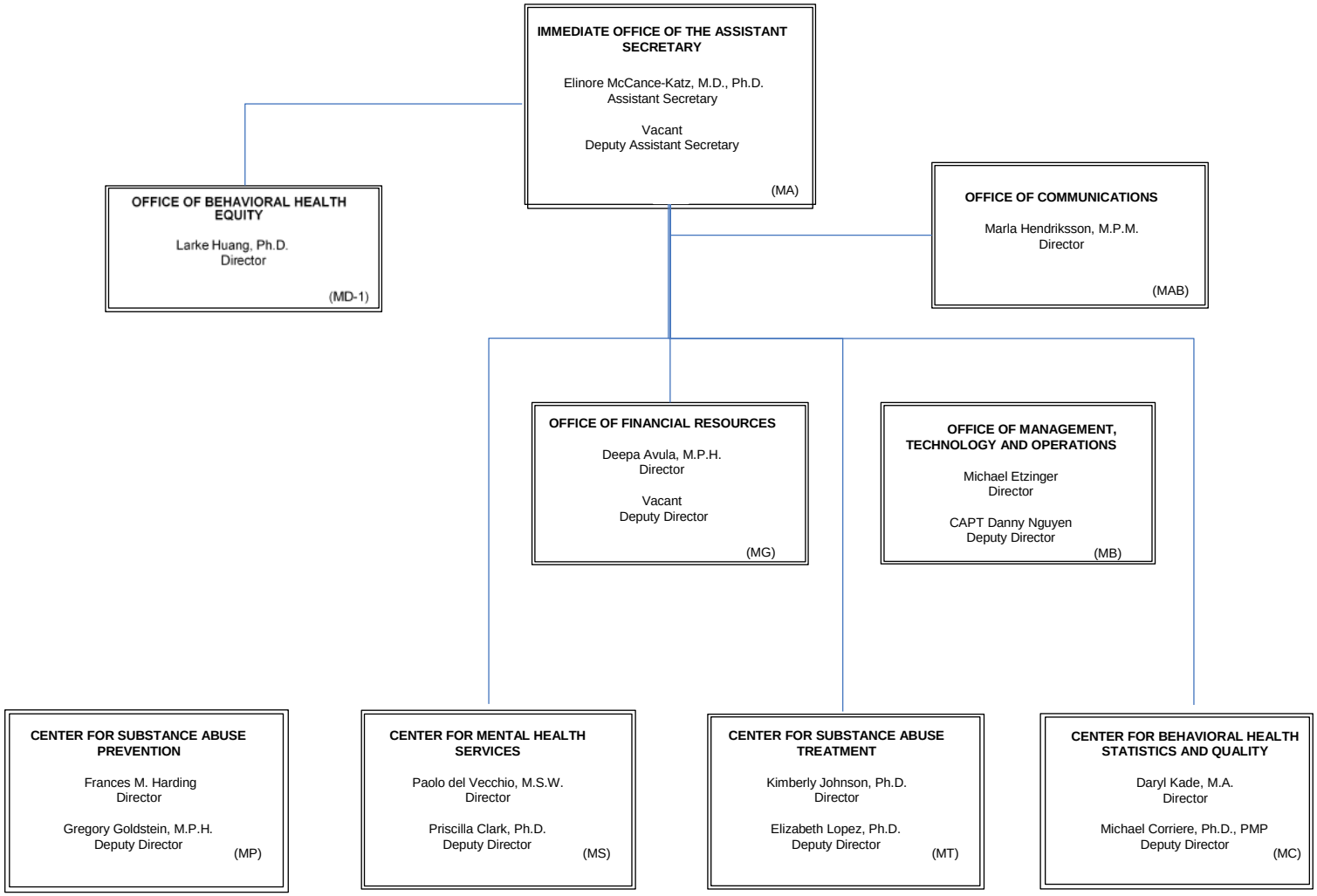
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Table of Contents

Fiscal Year 2019 Budget **Page**

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



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Performance Budget Overview

Introduction

The need to face mental health and substance abuse is critical to the nation's future. Prevention, treatment, and support to help people recover from mental and/or substance use disorders are essential strategies for the health and prosperity of individuals, families, communities, and the country. Unfortunately, the majority of those who need treatment do not receive it. Only 43.1 percent of the 44.7 million adults with diagnosable mental health problems received treatment in the past year. The unmet treatment need for those who needed substance use treatment (19.9 million adults) is even greater with only 1 in 9 individuals receiving specialty treatment in the past year. The nation can do better. SAMHSA has a unique responsibility to focus on these preventable and treatable problems, which, if unaddressed, lead to significant individual, societal, and economic consequences.

Mission

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes this mission through providing leadership and devoting its resources, including programs, policies, information and data, contracts, and grants to help demonstrate that:

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

Overview of Budget Request

The Fiscal Year (FY) 2019 President's Budget provides a program level of $3.5 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), which is a reduction of $688.4 million below the FY 2018 Continuing Resolution. In addition, the Budget provides $1.2 billion to SAMHSA for a variety of new and expanded efforts to fight the opioid crisis. When accounting for these resources, the total for SAMHSA is $4.8 billion, which is an increase of $551.6 million above the FY 2018 Continuing Resolution. This budget request seeks to advance SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. The budget request aims to address critical national priorities including combating the nation's opioid crisis, addressing serious mental illness, and developing and implementing strategies to prevent suicide.

Key Budget Highlights:

Additional Opioids Allocation

The FY 2019 President's Budget Request includes $10.0 billion in new resources to combat the opioid epidemic and address serious mental illness. In FY 2019, an initial allocation provides $1.2 billion in SAMHSA for a variety of new and expanded efforts to fight the opioid crisis. Of that amount, $1.0 billion is included to expand the State Targeted Response to the Opioid Crisis important program that addresses the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid addiction. The SAMHSA allocation also includes $150.0 million to reduce opioid-related injection drug use and related HIV/AIDS and Hepatitis C infection rates. In addition, also within SAMHSA, $90.0 million will be used to expand access to the overdose-reversing drug naloxone for first responders, expand the use of drug courts, and expand services to pregnant and postpartum women.

Substance Abuse Prevention and Treatment Block Grant

The FY 2019 President's Budget Request is $1.9 billion. This funding serves as a safety net for substance abuse prevention and treatment services. The states and jurisdictions have the flexibility to plan, carry out, and evaluate substance abuse prevention, treatment, and recovery services that address the needs of individuals, families, and communities. Recognizing that prevention is an integral component to reduce the effects of substance abuse on America's communities, the statute requires that twenty percent of the SABG state allocation must be spent on primary prevention services.

Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT PDOA)

The FY 2019 President's Budget Request is $56.0 million. MAT refers to the use of the Food and Drug Administration-approved pharmacotherapies (i.e., buprenorphine products, methadone, and naltrexone products) in combination with evidence-based psychosocial interventions for treatment of opioid addiction. MAT is a safe and effective strategy for decreasing the frequency and quantity of opioid abuse and reducing the risk of overdose and death. MAT PDOA addresses treatment needs of individuals who have an opioid addiction by expanding/enhancing treatment system capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based MAT and recovery support services. Recovery support services include linking patients and

families to social, legal, housing, and other supports to improve the probability of positive outcomes.

Grants to Prevent Prescription Drug and Opioid Overdose-related Deaths

The FY 2019 President's Budget Request is $12.0 million. The Grants to Prevent Prescription Drug and Opioid Overdose-related Deaths program helps states identify communities of high need and provide education, training, and resources to meet their specific needs. The grant funds can be used for purchasing overdose-reversing drugs, equipping first responders with these medications, providing training on their use, disseminating other overdose-related death prevention strategies, and providing materials to assemble and disseminate overdose kits.

First Responder Training

The FY 2019 President's Budget Request is $12.0 million. Under Section 202 of the Comprehensive Addiction and Recovery Act (CARA), SAMHSA is authorized to support additional efforts to prevent opioid overdose-related deaths by providing grants to states, local governments, and tribes to train first responders. The purpose of this program is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals at risk for opioid abuse. Grantees will train first responders and members of other key community sectors at the local government and tribal levels to implement secondary prevention strategies, such as the administration of naloxone through FDA-approved delivery devices to reverse the respiratory depression associated with opioid overdose.

Strategic Prevention Framework for Prescription Drugs (SPF Rx)

The FY 2019 President's Budget Request is $10.0 million. SAMHSA implemented the Strategic Prevention Framework for Prescription Drugs to raise awareness about the dangers of sharing medications and to work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program focuses on raising community awareness and bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients.

Community Mental Health Services Block Grant

The FY 2019 President's Budget Request is $562.6 million. This funding continues to serve as a safety net for mental health services for some of the nation's most at-risk populations. By statute, MHBG funds must be used to address the needs of adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). SAMHSA will maintain the ten percent set- aside for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The set-aside funds help reduce costs to society, as intervening early helps prevent deterioration of functioning in individuals experiencing a first episode of serious mental illness.

Suicide Prevention Activities

The FY 2019 President's Budget Request is $69.0 million. Suicide is a critical public health issue involving multiple psychological and social factors. It is one of the ten leading causes of death in the United States. SAMHSA supports a full complement of programs, which address the nation's alarming rates of suicide. These include: the National Strategy for Suicide Prevention, which focuses on adult suicide prevention, the Garrett Lee Smith State and Campus Suicide Programs,

which address youth and young adult suicide, and the Tribal Training and Technical Assistance Center, which aims to provide needed training and TA to tribal communities to develop comprehensive suicide prevention strategies.

Assertive Community Treatment (ACT) for Adults with SMI

The FY 2019 President's Budget Request is $15.0 million. This program is authorized under the 21st Century Cures Act. ACT is an evidence-based practice considered one of the most effective approaches to deliver services to people with SMI[1] and has been disseminated by SAMHSA for widespread use through its Evidence-Based Toolkit series[2] beginning in 2008. ACT was developed to reduce re-hospitalization and improve outcomes in community settings. ACT is designed as an integrated care approach to provide a comprehensive array of services, including medication management and other supportive services, directly rather than through an integrated team rather than referrals. The ACT team is composed of 10-12 multidisciplinary behavioral health staff, including psychiatrists, nurses, social workers, addition counselors, and peer specialists. These practitioners work together to deliver comprehensive, individualized, and recovery-oriented treatment and case management services to people with SMI in community settings.

Criminal and Juvenile Justice Programs

The FY 2019 President's Budget Request is $14.3 million. SAMHSA supports treatment and recovery efforts for people in criminal and juvenile justice systems with mental and/or substance use disorders. SAMHSA has created an array of programs, technical assistance centers, resources, and policy initiatives that take both public safety and behavioral health issues into consideration. Programs support judges and staff of specialty and other courts within a jurisdiction to work together to divert adults with mental illness or co-occurring mental and substance use disorders from the criminal justice system. 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 program supports community behavioral health services as an integral alternative to incarceration.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3589962/

[2] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Drug Free Communities

The FY 2019 President's Budget Request is $100.0 million. This activity was funded at $96.3 million in the Office of National Drug Control Policy (ONDCP) under the FY 2018 Annualized CR. SAMHSA has administered this program for several years on behalf of ONDCP. The FY 2019 Budget proposes to directly appropriate these funds to SAMHSA to streamline program management and create administrative efficiencies. Funding will be used to continue both the DFC and DFC-Mentoring programs. The goal of the program is to establish and strengthen collaboration among communities, public and private non-profit agencies, as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance abuse among youth. In addition, the program aims to reduce substance abuse among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse.

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 learn the extent to which strategies work or need improvement. SAMHSA seeks to identify the conditions that foster success, address barriers, enable collaboration across programs, and promote overall efficiency.

SAMHSA collects performance data on both output and outcome measures. Data on services programs include: abstinence from substance use, mental health functioning, overall physical health, criminal justice involvement, stable housing, social connectedness, and employment. Additionally, SAMHSA collects data on the numbers of people served, the numbers trained, and the number of training events held.

SAMHSA also maintains its commitment to utilize these performance data to manage and monitor its portfolio of grants. In FY 2017, SAMHSA reconfigured its approach to uniform data collection with the successful launch and implementation of SAMHSA's Performance Accountability and Reporting System (SPARS). This system provides a common data and reporting system for all SAMHSA discretionary grantees and allows for programmatic technical assistance on use of the data to enhance grantee performance monitoring and improve quality of service delivery.

In FY 2018, SAMHSA built upon this effort to further streamline its data collection efforts and ensure critical data elements, such as client diagnosis, were accurately captured. Additionally, in FY 2018, SAMHSA closely examined data across its discretionary grant programs to ensure that only critical data elements were being reported in an effort to streamline data collection and reporting and reduce grantee burden.

In FY 2019, SAMHSA will continue its efforts to improve upon data collection to better inform service delivery, needs, and program effectiveness.

All-Purpose Table

(Dollars in thousands)

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Mental Health				
Programs of Regional and National Significance	**$395,659**	**$394,868**	**$282,544**	**-$112,324**
Prevention and Public Health Fund (non-add)	*12,000*	*10,835*	--	*-10,835*
Children's Mental Health Services	119,026	118,218	119,026	+808
Set-Aside for Youth in Prodrome Phase of Psychosis (non-add).	*11,903*	*11,822*	*11,903*	*+81*
Projects for Assistance in Transition from Homelessness	64,635	64,196	64,635	+439
Protection and Advocacy for Individuals with Mental Illness	36,146	35,901	36,146	+245
Community Mental Health Services Block Grant	562,571	558,751	562,571	+3,821
Budget Authority (non-add)	*541,532*	*537,854*	*541,532*	*+3,678*
PHS Evaluation Funds (non-add)	*21,039*	*20,896*	*21,039*	*+143*
Total, Mental Health	**1,178,037**	**1,171,933**	**1,064,922**	**-107,011**
Budget Authority (non-add)	*1,144,998*	*1,140,202*	*1,043,883*	*-96,319*
Prevention and Public Health Fund (non-add)	*12,000*	*10,835*	--	*-10,835*
PHS Evaluation Funds (non-add)	*21,039*	*20,896*	*21,039*	*+143*
Substance Abuse Prevention				
Programs of Regional and National Significance	221,869	221,703	120,885	-100,818
Drug Free Communities[1]	--	--	100,000	100,000
Total, Substance Abuse Prevention	**221,869**	**221,703**	**220,885**	**-818**
Substance Abuse Treatment				
Programs of Regional and National Significance	350,427	352,020	255,318	-96,702
PHS Evaluation Funds (non-add)	*2,000*	*1,986*	--	*-1,986*
State Targeted Response to the Opioid Crisis Grants	500,000	496,605	--	-496,605
Substance Abuse Prevention and Treatment Block Grant	1,858,079	1,845,461	1,858,079	+12,618
Budget Authority (non-add)	*1,778,879*	*1,766,799*	*1,778,879*	*+12,080*
PHS Evaluation Funds (non-add)	*79,200*	*78,662*	*79,200*	*+538*
Total, Substance Abuse Treatment	**2,708,506**	**2,694,085**	**2,113,397**	**-580,688**
SAT Budget Authority (non-add)	*2,627,306*	*2,613,437*	*2,034,197*	*-579,240*
SAT PHS Evaluation Funds (non-add)	*81,200*	*80,648*	*79,200*	*-1,448*
Health Surveillance and Program Support				
Health Surveillance and Program Support	**124,258**	**123,414**	**121,885**	**-1,529**
PHS Evaluation Funds (non-add)	*30,428*	*30,221*	*19,428*	*-10,793*
Public Awareness and Support	13,000	12,912	11,572	-1,340
Performance and Quality Information Systems	10,000	9,932	12,893	+2,961
Behavioral Health Workforce Data and Development	1,000	993	998	+5
PHS Evaluation Funds (non-add)	*1,000*	*993*	*998*	+5
Data Request and Publications User Fees	1,500	1,490	1,500	+10
Total, Health Surveillance and Program Support	**149,758**	**148,741**	**148,848**	**+107**
HSPS Budget Authority (non-add)	*116,830*	*116,037*	*126,922*	*+10,885*
HSPS PHS Evaluation Funds (non-add)	*31,428*	*31,215*	*20,426*	*-10,789*
Data Request and Publications User Fees (non-add)	*1,500*	*1,490*	*1,500*	*+10*
TOTAL, SAMHSA Program Level	**4,258,170**	**4,236,462**	**3,548,052**	**-688,410**
Additional Opioids Allocation[2]				
State Targeted Response to the Opioid Crisis	--	--	1,000,000	+1,000,000
Reducing Injection Drug Use, HIV/AIDS, and Hepatitis			150,000	+150,000
Opioid Overdose Reversal Expansion	--	--	50,000	+50,000
Drug Courts Expansion	--	--	20,000	+20,000
Treatment for Pregnant and Post-Partum Women	--	--	20,000	+20,000
Total, Additional Opioids Allocation	--	--	**1,240,000**	**+1,240,000**
TOTAL, SAMHSA with Additional Opioids Allocation	**4,258,170**	**4,236,462**	**4,788,052**	**+551,590**
Less Funds from Other Sources:				
Additional Opioids Allocation (non-add)	--	--	*-1,240,000*	*-1,240,000*
Prevention and Public Health Fund (non-add)	*-12,000*	*-10,835*	--	*+10,835*
PHS Evaluation Funds	*-133,667*	*-132,759*	*-120,665*	*+12,094*
Data Request and Publications User Fees	*-1,500*	*-1,490*	*-1,500*	*-10*
TOTAL, SAMHSA Budget Authority	**$4,111,003**	**$4,091,378**	**$3,425,887**	**-$665,491**
FTEs[3]	**590**	**614**	**635**	**21**

[1] Drug Free Communities was funded in the Office of National Drug Control Policy at $97.0 million in FY 2017 and at $96.3 million under the FY 2018 Annualized CR.

[2] This funding is part of the FY 2019 President's Budget for $10.0 billion in new resources to combat the opioid epidemic and address mental illness. The Additional Opioids Allocation funding request is displayed in its entirely on page 259.

[3] This figure accounts for the staff needed to ensure the full functioning of the 21st Century Cures Act Mental Health and Substance Use Policy Laboratory. It also represents the staffing needed to administer the $1.2 billion in discretionary funding. It differs from the reported figure in MAX, which does not include these elements.

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SAMHSA
Budget Exhibits
Table of Contents

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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, $1,043,883,000: 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 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 up to 10 percent of the amounts made available to carry out the Children's Mental Health Services program may be used to carry out demonstration grants or contracts for early interventions with persons not more than 25 years of age at clinical high risk of developing a first episode of psychosis: Provided further, That none of the funds provided for section 1911 of the PHS Act shall be subject to section 241 of such Act: Provided further, That of the funds made available under this heading, $15,000,000 shall be to carry out section 224 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 42 U.S.C. 290aa 22 note).

SUBSTANCE ABUSE TREATMENT

For carrying out titles III and V of the PHS Act with respect to substance abuse treatment and title XIX of such Act with respect to substance abuse treatment and prevention, $2,034,197,000: Provided, That in addition to amounts provided herein, $79,200,000 shall be available under section 241 of the PHS Act to supplement funds otherwise available for substance abuse treatment activities and to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX: Provided further, That none of the funds provided for section 1921 of the PHS Act shall be subject to section 241 of such Act.

SUBSTANCE ABUSE PREVENTION

For carrying out titles III and V of the PHS Act with respect to substance abuse prevention and for the Drug-Free Communities Support Program authorized by the Drug-Free Communities Act of 1997, as amended, $220,885,000, of which $2,000,000 shall be made available as directed by section 4 of Public Law 107–82, as amended by Public Law 109–469 (21 U.S.C. 1521 note) and $3,000,000, to remain available until expended, shall be for activities authorized by section 103 of Public Law 114–198.

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, the Drug-Free Communities Act of 1997, as amended, and the Protection and Advocacy for Individuals with Mental Illness Act in the Substance Abuse and Mental Health Services Administration ("SAMHSA"), $126,922,000: Provided, That in addition to amounts provided herein, $20,426,000 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(o) of the PHS Act shall remain available through September 30, 2020: 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 Assistant Secretary for Mental Health and Substance Use may transfer discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated for the current fiscal year for SAMHSA in this Act 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.

Note.—A full-year 2018 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Act, 2018 (Division D of P.L. 115–56, as amended). The amounts included for 2018 reflect the annualized level provided by the continuing resolution.

Language Analysis

Language Provision	Explanation
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, $1,043,883,000: 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:	Identifies the purpose for which funds can be used
Provided further, That in addition to amounts provided herein, $21,039,000 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:	Sets the amount of Public Health Service 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.
Provided further, That up to 10 percent of the amounts made available to carry out the Children's Mental Health Services program may be used to carry out demonstration grants or contracts for early interventions with persons not more than 25 years of age at clinical high risk of developing a first episode of psychosis:	This provision permits SAMHSA to set aside up to 10 percent of CMHS for a demonstration with flexibility which would help address youth (which addresses 75 percent of first time psychotic episodes) instead of only children (which represent less than 50 percent of first time psychotic episodes) in the prodrome phase, which evidence indicates may prevent the further development of serious emotional disturbances and ultimately serious mental illness.

Language Analysis (continued)

Language Provision	Explanation
Provided further, That none of the funds provided for section 1911 of the PHS Act shall be subject to section 241 of such Act: Provided further, That of the funds made available under this heading, $15,000,000 shall be to carry out section 224 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 42 U.S.C. 290aa 22 note).	Identifies the purpose for which funds can be used
For carrying out titles III and V of the PHS Act with respect to substance abuse treatment and title XIX of such Act with respect to substance abuse treatment and prevention, $2,034,197,000:	Sets out the budget authority for the Substance Abuse Treatment appropriation.
Provided, That in addition to amounts provided herein, $79,200,000 shall be available under section 241 of the PHS Act to supplement funds otherwise available for substance abuse treatment activities and to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX: Provided further, That none of the funds provided for section 1921 of the PHS Act shall be subject to section 241 of such Act.	Sets the amount of Public Health Service 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. These evaluation efforts will enable the gathering and dissemination of best practices.
For carrying out titles III and V of the PHS Act with respect to substance abuse prevention and for the Drug-Free Communities Support Program authorized by the Drug-Free Communities Act of 1997, as amended, $220,885,000, of which $2,000,000 shall be made available as directed by section 4 of Public Law 107–82, as amended by Public Law 109–469 (21 U.S.C. 1521 note) and $3,000,000, to remain available until expended, shall be for activities authorized by section 103 of Public Law 114–198.	Identifies the purpose for which funds can be used. The FY 2019 Budget funds the Drug-Free Communities Support Program in SAMHSA. In previous years this activity was funded in the Office of National Drug Control Policy.

Language Analysis (continued)

Language Provision	Explanation
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, the Drug-Free Communities Act of 1997, as amended, and the Protection and Advocacy for Individuals with Mental Illness Act in the Substance Abuse and Mental Health Services Administration ("SAMHSA"), $126,922,000:	Identifies the purpose for which funds can be used to supplement activities funded in the other three appropriations
Provided, That in addition to amounts provided herein, $20,426,000 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:	Identifies the purpose for which funds can be used
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:	Provides authority to collect user fees
Provided further, That amounts made available in this Act for carrying out section 501(o) of the PHS Act shall remain available through September 30, 2020:	The 21st Century Cures Act authorizes funds for this program to be available for two years. However, recent appropriations acts have limited funds to annual periods of availability except as expressly provided within the appropriations acts themselves (which would not include the PHS Act). This proviso is that express authority.

Language Analysis (continued)

Language Provision	Explanation
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 Assistant Secretary for Mental Health and Substance Use may transfer discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated for the current fiscal year for SAMHSA in this Act 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 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
General Fund Discretionary Appropriation:			
Appropriation	$4,111,003,000	$4,119,353,000	$3,425,887,000
Across-the-board reductions	---	27,975,000	---
Subtotal, Appropriation	4,111,003,000	4,091,378,000	3,425,887,000
Rescission	---	---	---
Subtotal, adjusted appropriation	4,111,003,000	4,091,378,000	3,425,887,000
Prevention Fund Resource[1]	---	10,835,000	
Additional Opioids Allocation	---	---	1,240,000,000
Total, Discretionary Appropriation	**4,111,003,000**	**4,102,213,000**	**4,665,887,000**
Mandatory Appropriation:			
Mandatory PPHF	12,000,000	---	---
Subtotal, adjusted mandatory appropriation.	12,000,000	---	---
Offsetting collections from:			
Federal Source	133,667,000	132,759,000	120,665,000
Data Request and Publications User Fees	1,500,000	1,490,000	1,500,000
Unobligated balance, start of year	---	---	---
Unobligated balance, end of year	---	---	---
Unobligated balance, lapsing	---	---	---
Total obligations	**$4,258,170,000**	**$4,236,462,000**	**$4,788,052,000**

[1] Source of funds displayed consistent with prior year presentations and the assumptions for the FY 2019 Budget.

Summary of Changes

(Whole dollars)

2018	
Total estimated budget authority	$4,091,378,000
(Obligations)	4,091,378,000
2019	
Total estimated budget authority	3,425,887,000
(Obligations)	3,425,887,000
Net Change	**-$665,491,000**

	FY 2019 PB FTE	FY 2019 PB BA	FY 2019 +/- FY 2018 FTE	FY 2019 +/- FY 2018 BA
Increases:				
A. Built-in:				
1. Annualization of 2018 commissioned corps pay increase..		$8,297,308		+$206,320
2. Annualization of 2018 civilian pay increase		87,383,119		+$413,108
Subtotal, Built-in Increases		**95,680,427**		**+619,428**
A. Program:				
1. Health Surveillance		29,414,000		+12,698,000
5. Performance and Quality Information Systems		12,893,000		+2,962,000
Subtotal, Program Increases		**42,307,000**		**+15,660,000**
Total Increases	---	---	---	**+16,279,428**
Decreases:				
A. Built-in:				
1. Absorption of built-in increases				-619,428
Subtotal, Built-in Decreases				**-619,428**
A. Program:				
1. Mental Health		1,043,883,000		-96,319,000
2. Program Support		73,043,000		-3,434,000
3. Public Awareness and Support		11,572,000		-1,340,000
2. Substance Abuse Prevention PRNS		220,885,000		-818,000
3. Substance Abuse Treatment		2,034,197,000		-579,240,000
Subtotal, Program Decreases		**1,128,498,000**		**-681,151,000**
Total Decreases	---	---	---	**-681,770,428**
Net Change	---	$---	$---	**-$665,491,000**

Budget Authority by Activity

(Dollars in thousands)

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Mental Health			
Programs of Regional and National Significance	**$395,659**	**$394,868**	**$282,544**
Prevention and Public Health Fund (non-add)	*12,000*	*10,835*	--
Children's Mental Health Services	119,026	118,218	119,026
Projects for Assistance in Transition from Homelessness	64,635	64,196	64,635
Protection and Advocacy for Individuals with Mental Illness	36,146	35,901	36,146
Community Mental Health Services Block Grant	562,571	558,751	562,571
Budget Authority (non-add)	*541,532*	*537,854*	*541,532*
PHS Evaluation Funds (non-add)	*21,039*	*20,896*	*21,039*
Total, Mental Health	**1,178,037**	**1,171,933**	**1,064,922**
Substance Abuse Prevention			
Programs of Regional and National Significance	221,869	221,703	120,885
Drug Free Communities[1]	--	--	100,000
Total, Substance Abuse Prevention	**221,869**	**221,703**	**220,885**
Substance Abuse Treatment			
Programs of Regional and National Significance	**350,427**	**352,020**	**255,318**
PHS Evaluation Funds (non-add)	*2,000*	*1,986*	--
State Targeted Response to the Opioid Crisis Grants /2	500,000	496,605	--
Substance Abuse Prevention and Treatment Block Grant	1,858,079	1,845,461	1,858,079
Budget Authority (non-add)	*1,778,879*	*1,766,799*	*1,778,879*
PHS Evaluation Funds (non-add)	*79,200*	*78,662*	*79,200*
Total, Substance Abuse Treatment	**2,708,506**	**2,694,085**	**2,113,397**
Health Surveillance and Program Support			
Health Surveillance and Program Support	**124,258**	**123,414**	**121,885**
PHS Evaluation Funds (non-add)	*30,428*	*30,221*	*19,428*
Public Awareness and Support	13,000	12,912	11,572
Performance and Quality Information Systems	10,000	9,932	12,893
Data Request and Publications User Fees	1,500	1,490	1,500
Behavioral Health Workforce Data and Development	1,000	993	998
PHS Evaluation Funds (non-add)	*1,000*	*993*	*998*
Total, Health Surveillance and Program Support	**149,758**	**148,741**	**148,848**
TOTAL, SAMHSA Program Level	**4,258,170**	**4,236,462**	**3,548,052**
Additional Opioids Allocation[2]	--	--	1,240,000
TOTAL, SAMHSA with Additional Opioids Allocation	**4,258,170**	**4,236,462**	**4,788,052**
Less Funds from Other Sources:			
Additional Opioids Allocation (non-add)	--	--	*-1,240,000*
Prevention and Public Health Fund (non-add)	*-12,000*	*-10,835*	--
PHS Evaluation Funds	*-133,667*	*-132,759*	*-120,665*
Data Request and Publications User Fees	*-1,500*	*-1,490*	*-1,500*
TOTAL, SAMHSA Budget Authority	**$4,111,003**	**$4,091,378**	**$3,425,887**
FTEs[3]	**590**	**614**	**635**

[1] Drug Free Communities was funded in the Office of National Drug Control Policy at $97.0 million in FY 2017 and at $96.3 million under the FY 2018 Annualized CR.

[2] This funding is part of the FY 2019 President's Budget for $10.0 billion in new resources to combat the opioid epidemic and address mental illness. The Additional Opioids Allocation funding request is displayed in its entirely on page 259.

[3] This figure accounts for the staff needed to ensure the full functioning of the 21st Century Cures Act Mental Health and Substance Use Policy Laboratory. It also represents the staffing needed to administer the $1.2 billion in discretionary funding. It differs from the reported figure in MAX, which does not include these elements.

Authorizing Legislation

(Whole dollars)

Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Authorization	FY Auth. Expires or Expired	Nature of Expiration
	(i.e.: PHS Act, Section xx)		(i.e.: Bill name or Public Law number)	(identify amounts authorized)	(Indicate the last year for which the program is authorized or has the appropriation. Response should indicate either a FY or "permanent.")	Program Authority
Grants for the Benefit of Homeless	PHS Act, Section 506	(42 U.S.C. 290aa–5)	Pub. L. 114–255	$ 41,304,000	FY 2022	
Residential Treatment Programs for Pregnant and Postpartum Women	PHS Act, Section 508	(42 U.S.C. 290bb–1)	Pub. L. 114–198	$ 16,900,000	FY 2021	
Priority Substance Abuse Treatment Needs of Regional and National Significance	PHS Act, Section 509	(42 U.S.C. 290bb–2)	Pub. L. 114–255	$ 333,806,000	FY 2022	
Substance Abuse Treatment Services for Children and Adolescents	PHS Act, Section 514	(42 U.S.C. 290bb–7)	Pub. L. 114–255	$ 29,605,000	FY 2022	
Priority Substance Abuse Prevention Needs of Regional and National Significance	PHS Act, Section 516	(42 U.S.C. 290bb–22)	Pub. L. 114–255	$ 211,148,000	FY 2022	
Programs to Reduce Underage Drinking	PHS Act, Section 519B	(42 U.S.C. 290bb–25b)	Pub. L. 114–255	$ 10,000,000	FY 2022	
Priority Mental Health Needs of Regional and National Significance	PHS Act, Section 520A	(42 U.S.C. 290bb–32)	Pub. L. 114–255	$ 394,550,000	FY 2022	
Suicide Prevention Technical Assistance Center	PHS Act, Section 520C	(42 U.S.C. 290bb–34)	Pub. L. 114–255	$ 5,988,000	FY 2022	
Youth Suicide Early Intervention and Prevention Strategies	PHS Act, Section 520E	(42 U.S.C. 290bb–36)	Pub. L. 114–255	$ 30,000,000	FY 2022	
Mental Health and Substance Use Disorder Services on Campus	PHS Act, Section 520E-2	(42 U.S.C. 290bb–36b)	Pub. L. 114–255	$ 7,000,000	FY 2022	
National Suicide Prevention Lifeline Program	PHS Act, Section 520E-3	(42 U.S.C. 290bb–36c)	Pub. L. 114–255	$ 7,198,000	FY2022	
Grants for Jail Diversion Programs	PHS Act, Section 520G	(42 U.S.C. 290bb–38)	Pub. L. 114–255	$ 4,269,000	FY 2022	
Promoting Integration of Primary and Behavioral Health Care	PHS Act, Section 520K	(42 U.S.C. 290bb–42)	Pub. L. 114–255	$ 51,878,000	FY 2022	
Adult Suicide Prevention	PHS Act, Section 520L	(42 U.S.C. 290bb–43)	Pub. L. 114–255	$ 30,000,000	FY 2022	
Assertive Community Treatment Grant Program	PHS Act, Section 520M	(42 U.S.C. 290bb–44)	Pub. L. 114–255	$ 5,000,000	FY 2022	
Projects for Assistance in Transition From Homelessness	PHS Act, Section 535(a)	(42 U.S.C. 290cc–35(a))	Pub. L. 114–255	$ 64,635,000	FY 2022	
First Responder Training	PHS Act, Section 546	(42 U.S.C. 290ee-2)	Pub. L. 114–198	$ 12,000,000	FY 2021	
Building Communities of Recovery	PHS Act, Section 547	(42 U.S.C. 290ee-2)	Pub. L. 114–198	$ 1,000,000	FY 2021	
Community Mental Health Services for Children with Serious Emotional Disturbances	PHS Act, Section 565(f)(1)	(42 U.S.C. 290ff-4)	Pub. L. 114–255	$ 119,026,000	FY 2022	
Children and Violence	PHS Act, Section 581.29	(42 U.S.C. 290hh)	Pub. L. 106–310	Such Sums as Necessary	FY 2003	Appropriation in Authorizing Legislation
Grants for Persons who Experience Violence Related Stress	PHS Act, Section 582	(42 U.S.C. 290hh–1)	Pub. L. 114–255	$ 46,887,000	FY 2022	
Community Mental Health Services Block Grants	PHS Act, Section 1911	(42 U.S.C. 300x)	Pub. L. 114–255	$ 532,571,000	FY 2022	
Substance Abuse Prevention and Treatment Block Grants	PHS Act, Section 1921	(42 U.S.C. 300x-21)	Pub. L. 114–255	$ 1,858,079,000	FY 2022	
Assisted Outpatient Treatment Grant Program for Individuals With Serious Mental Illness	Section 224 of the Protecting Access to Medicare Act of 2014	(42 U.S.C. 290aa note)	Pub. L. 114–255	$ 19,000,000	FY 2022	
Protection and Advocacy for Individuals with Mental Illness	Section 117 of the Proection and Advocacy of Mentally Ill Inidivduals Act of 1986	(42 U.S.C. 10827)	Pub. L. 99-319	$ 19,500,000	FY 2003	Appropriation in Authorizing Legislation
Heath Surveillance	PHS Act, Section 501, 505	(42 U.S.C. 290aa, 290aa–4)	Pub. L. 114–255	Indefinite		
Public Awareness and Support	PHS Act, Section 501, 509, 516, 520A	(42 U.S.C. 290aa, 290bb-2, 290bb-22, 290bb-32)	Pub. L. 114–255	Indefinite		
Performance and Quality Improvement Systems	PHS Act, Section 501, 509, 516, 520A	(42 U.S.C. 290aa, 290bb-2, 290bb-22, 290bb-32)	Pub. L. 114–255	Indefinite		

Appropriations History

(Whole dollars)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
FY 2010					
General Fund Appropriation:					
Base	$3,393,882,000	$3,429,782,000	$3,419,438,000	$3,431,116,000	1/
P.L. 111-117					
Subtotal	$3,393,882,000	$3,429,782,000	$3,419,438,000	$3,431,116,000	
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	2/
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	3/
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	4/
S.R. 113-071					
Subtotal	$3,347,951,097	---	$3,529,944,000	$3,434,935,000	

1/ Reflects a $508 thousand transfer to HHS.

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

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

4/ Reflects the whole year appropriation.

Appropriations History (continued)

(Whole dollars)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
FY 2015					
General Fund Appropriation:					
Base	$3,297,669,000	---	$3,431,878,000	$3,474,045,000	5/
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	$3,642,710,000	$3,314,817,000	$3,634,269,000	6/
P.L. 114-113					
Subtotal	$3,395,663,000	$3,642,710,000	$3,314,817,000	$3,634,269,000	
FY 2017					
General Fund Appropriation:					
21st Century Cures Act				$500,000,000	7/
Base	$3,488,783,000	$4,211,603,000	$3,739,577,000	$4,111,003,000	8/
P.L. 115-31					
Subtotal	$3,488,783,000	$4,211,603,000	$3,739,577,000	$4,111,003,000	
FY 2018					
General Fund Appropriation:					
21st Century Cures Act				$496,605,000	7/
Base	$3,770,668,000	$4,193,936,000	$4,131,925,000	$4,091,378,000	9/
Subtotal	$3,770,668,000	$4,193,936,000	$4,131,925,000	$4,091,378,000	
FY 2019					
General Fund Appropriation:					
Base	$3,425,887,000				
Subtotal	$3,425,887,000				

5/ Reflects the whole year appropriation.

6/ Reflects the whole year appropriation.

7/ Reflects the additional amount provided to the Secretary of Health and Human Services to carry out the authorizations in the 21st Century Cures Act

8/ Reflects the whole year appropriation.

9/ Reflects the Annualized Continuing Resolution.

SAMHSA
Mental Health
Table of Contents

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Mental Health Appropriation

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Programs of Regional and National Significance….....	$395,659	$394,868	$282,544	-112,324
Prevention and Public Health Fund (non-add).....	*12,000*	*10,835*	---	*-10,835*
Children's Mental Health Services.....	119,026	118,218	119,026	808
Projects for Assistance in Transition From Homelessness...	64,635	64,196	64,635	439
Protection and Advocacy For Individuals with Mental Illness……	36,146	35,901	36,146	245
Community Mental Health Services Block Grant.....	562,571	558,751	562,571	3,820
PHS Evaluation Funds (non-add).....	*21,039*	*20,896*	*21,039*	*143*
Total, Mental Health.....	**$1,178,037**	**$1,171,933**	**$1,064,922**	**-$107,011**

The Mental Health FY 2019 President's Budget request is $1.1 billion, a decrease of $107.0 million from the FY 2018 Annualized CR. The request includes $1.1 billion in Budget Authority and $21.0 million in Public Health Service (PHS) Evaluation funds.

Programs of Regional and National Significance (PRNS)
Mental Health Appropriation

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Capacity:				
National Child Traumatic Stress Network	$48,887	$48,555	$48,887	$332
Project AWARE	68,964	71,475	---	-71,475
Project AWARE State Grants (non-add)	*54,001*	*56,614*	---	*-56,614*
Mental Health First Aid (non-add)	*14,963*	*14,861*	---	*-14,861*
Healthy Transitions	*19,951*	*19,816*	*19,951*	*135*
Children and Family Programs	7,229	7,180	7,229	49
Consumer and Family Network Grants	4,954	4,920	4,954	34
Project LAUNCH	23,605	23,445	23,605	160
Mental Health System Transformation and Health Reform	3,779	3,753	3,779	26
Primary and Behavioral Health Care Integration	*49,877*	*49,538*	---	*-49,538*
Suicide Prevention	69,032	67,479	69,032	1,553
National Strategy for Suicide Prevention (non-add)	*11,000*	*10,925*	*11,000*	*75*
Zero Suicide (non-add)	*9,000*	*8,939*	*9,000*	*61*
Zero Suicide -AI/AN (non-add)	*2,000*	*1,986*	*2,000*	*14*
Suicide Lifeline (non-add)	*7,198*	*7,149*	*7,198*	*49*
GLS - Youth Suicide Prevention - States (non-add)	*35,427*	*34,103*	*35,427*	*1,324*
Prevention & Public Health Fund (non-add)	*12,000*	*10,835*	---	*-10,835*
GLS - Youth Suicide Prevention - Campus (non-add)	*6,488*	*6,444*	*6,488*	*44*
GLS - Suicide Prevention Resource Center (non-add)	*5,988*	*5,947*	*5,988*	*41*
AI/AN Suicide Prevention Initiative (non-add)	*2,931*	*2,911*	*2,931*	*20*
Homelessness Prevention Programs	30,696	30,488	30,696	208
Minority AIDS	9,224	9,161	---	-9,161
Criminal and Juvenile Justice Programs	4,269	4,240	14,269	10,029
Seclusion and Restraint	1,147	1,139	1,147	8
Assisted Outpatient Treatment for Individuals with SMI	15,000	14,898	15,000	102
Assertive Community Treatment for Individuals with SMI	---	---	15,000	15,000
Tribal Behavioral Health Grants	15,000	14,898	15,000	102
Subtotal, Capacity	**371,614**	**370,986**	**268,549**	**-102,438**
Science and Service:				
Primary and Behavioral Health Care Integration TTA	1,991	1,977	---	-1,977
Practice Improvement and Training	7,828	7,775	7,828	53
Consumer and Consumer-Supporter TA Centers	1,918	1,905	1,918	13
Disaster Response	1,953	1,940	1,953	13
Homelessness	2,296	2,280	2,296	16
Minority Fellowship Program	8,059	8,004	---	-8,004
HIV/AIDS Education	---	---	---	---
Subtotal, Science and Service	**24,045**	**23,882**	**13,995**	**-9,887**
Total, PRNS	**$395,659**	**$394,868**	**$282,544**	**-$112,324**

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities……..……States, Federally Recognized,
American Indian/Alaska Native tribes or tribal organizations,
Indian Health Service-operated and contracted health facilities
and programs, other public and private nonprofit entities

National Child Traumatic Stress Network

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
National Child Traumatic Stress Network.....	$48,887	$48,555	$48,887	$332

Authorizing Legislation .....Section 582 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....States, Local Governments, Tribes, Institutions of Higher Education, and Community Organizations

Program Description and Accomplishments

Child traumatic stress is a pervasive and potentially life changing experience that affects tens of thousands of children each year. Child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations that overwhelm their ability to cope with what they have experienced. Child traumatic stress can interfere with a wide range of childhood developmental capabilities, including social and educational functioning. There is strong evidence that the negative impact of child trauma progresses into adulthood and increases the likelihood of later adverse physical and behavioral health outcomes if not recognized and addressed early in life.[3,4] Studies show that 25 percent to 80 percent or more of children and adolescents are exposed to traumatic events, with many exposed to multiple traumatic events.[5] While the effects of trauma and exposure to violence are found in all service sectors, it is particularly prominent among youth with mental illness and/or drug/alcohol addiction involved in the child welfare, and juvenile justice systems. Studies show that youth in foster care can have rates of Post-Traumatic Stress Disorder that are nearly double those of combat veterans.[6]

Established in 2000, the National Child Traumatic Stress Initiative (NCTSI) aims to improve behavioral health services and interventions for children and adolescents exposed to traumatic events. SAMHSA 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 225 funded and affiliate centers located

[3] Putnam, K.T., Harris, W.W., Putnam, F.W. (2013). Synergistic childhood adversities and complex adult psychopathology. Journal of Traumatic Stress, 26(4), 435-442.
[4] Kerker, B.D., Zhang, J., Nadeem, E., Stein, R.E., Hurlburt, M.S., Heneghan, A., Landsverk, J., McCue Horwitz S (2015). Adverse childhood experiences and mental health, chronic medical conditions, and development in young children. Academy of Pediatrics, 13(15), 00173-00174.
[5] Fairbank, J.A. (2008). The epidemiology of trauma, and trauma related disorders in children and youth. PTSD Research Quarterly, (19), 1050-1835.
[6] Pecora, P.J., Kessler, R.C., Williams, J., O'Brien, K., Downs, A.C., English, E., Holmes, K. (2005). Improving family foster care: Findings from the northwest foster care alumni study. Casey Family Programs. Retrieved from http://www.casey.org/resources/publications/ImprovingFamilyFosterCare.htm

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 evidence-based services for children experiencing trauma, their families, and communities. A component of this work has been the development of resources and delivery of training and consultation to support the development of trauma-informed child-serving systems. Network members work together within and across diverse settings, including a wide variety of governmental and non-governmental organizations.

Data collected in FY 2017 demonstrate that the current NCTSN grantees have provided evidence- based treatment to over 28,000 children, adolescents, and family members. Seventy- five percent reported positive functioning at six months, far exceeding the target of 65 percent. In addition, thousands more youth and families have benefited indirectly from the training and consultation provided by NCTSN grantees to organizations not receiving direct NCTSN funding enabling these organizations to deliver evidence-based trauma interventions.

The NCTSN continues to be a principal source of child-trauma information and training for the nation. In FY 2017, NCTSN grantee sites provided trauma-informed training to over 200,000 individuals. Since its inception, the NCTSN has provided training on best practices and other aspects of child trauma to over one million participants throughout the country. The NCTSI's newly created Helping Kids Recover and Thrive Campaign generated 100 online social media touches (e.g., Facebook, Twitter, etc.). This campaign informed the public about the efforts and resources available through the NCTSI.

In FY 2016, SAMHSA awarded 82 new five-year NCTSI grants for the program. SAMHSA will continue to ensure that grantees disseminate information regarding evidence-based interventions for the prevention and treatment of childhood trauma so more children can benefit from proven practices. In FY 2017, SAMHSA awarded four new grants and supported 82 grant continuations. Under the FY 2018 Annualized CR level, SAMHSA would continue to support 86 grant continuations.

Funding History

Fiscal Year	Amount
FY 2015	$45,887,000
FY 2016	$46,887,000
FY 2017	$48,887,000
FY 2018	$48,555,000
FY 2019	$48,887,000

Budget Request

The FY 2019 President's Budget request is $48.9 million, an increase of $332,000 from the FY 2018 Annualized CR. SAMHSA requests funding to continue support for 86 continuation grants for the improvement of mental disorder treatment, services, and interventions for children and adolescents exposed to traumatic events and plans to provide trauma-informed services for children and adolescents as well as provide training.

Outputs and Outcomes Table

Program: National Child Traumatic Stress Network

NOTE: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.2.02a Increase the percentage of children receiving trauma informed services who report positive functioning at 6 month follow-up (Outcome)	FY 2017: 74.8 % Target: 77 % (Target Not Met)	74.8 %	74.8 %	Maintain
3.2.23 Increase the unduplicated count of the number of children and adolescents receiving trauma-informed services (Outcome)	FY 2017: 28,419 Target: 48,872 (Target Not Met)	28,419	28,419	Maintain
3.2.24 Increase the number of child-serving professionals trained in providing trauma-informed services (Outcome)	FY 2017: 215,289 Target: 225,710 (Target Not Met but Improved)	225,710	225,710	Maintain

Project AWARE

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Project AWARE.....	$68,964	$71,475	$---	-$71,475
*Project AWARE State Grants (non-add).....	*54,001*	*56,614*	---	*-56,614*
*Mental Health First Aid (non-add).....	*14,963*	*14,861*	---	*-14,861*

Authorizing Legislation .....Sections 501, 520A, and 520J of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....State and Local Education Agencies, Local Governmental Entities, Community Organizations and Provider Organizations, Community Colleges, Networks, National Non-Profit Organizations, States and Tribes

Program Description and Accomplishments

Project AWARE is made up of three components: Project AWARE State Educational Agency (SEA) grants, Mental Health First Aid Grants, and Resilience in Communities After Stress and Trauma Grants. Project AWARE State Educational Agency grants are awarded to State Education Authorities (SEAs) to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services. Mental Health First Aid grants provide supports to teachers and other individuals who work with youth to help schools and communities understand, recognize, and respond to signs of mental illness or drug/alcohol addiction in children and youth. Resiliency in Communities After Stress and Trauma (ReCAST) program assists high-risk youth and families and promotes resilience in communities that have recently faced civil unrest through implementation of evidence-based violence prevention, and community youth engagement programs as well as linkages to trauma-informed behavioral health services.

Project AWARE supports several strategies for addressing mental health in schools: supports for mental wellness in education settings, building awareness of mental health issues, and early intervention with coordinated supports. In FY 2017, AWARE grantees trained nearly 60,000 teachers, parents, first responders, school resource officers, and other adults who interact with youth to recognize and respond to the signs of mental health and substance use issues. To date, over 300,000 at-risk youth have been identified and referred.

In FY 2017, SAMHSA supported the continuation of 96 grants (19 AWARE SEA grants, 70 MHFA Community grants, and 7 ReCAST grants), a new cohort of two ReCAST grants, and contracts for technical assistance and evaluation activities.

Under the FY 2018 Annualized CR level, SAMHSA would support the continuation of 16 grants (eight AWARE SEA grants and eight ReCAST grants), a new cohort of 102 grants (12 AWARE SEA grants and 90 MHFA grants), which will include program implementation and direct TA.

Funding History

Fiscal Year	Amount
FY 2015	$54,865,000
FY 2016	$64,865,000
FY 2017	$68,964,000
FY 2018	$71,475,000
FY 2019	---

Budget Request

The FY 2019 President's Budget request is $0.0, a decrease of $71.5 million from FY 2018 Annualized CR. SAMHSA is eliminating the program. SAMHSA has developed significant knowledge and evidence for states to begin implementing and bringing to scale these efforts. SAMHSA will continue to ensure this knowledge is disseminated.

Outputs and Outcomes Table

Program: Project AWARE

NOTE: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.2.39 Increase the number of individuals who have received training in prevention or mental health promotion (Outcome)	FY 2017: 59,186 Target: 145,356 (Target Not Met)	59,186	59,186	Maintain

Healthy Transitions

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Healthy Transitions.....	$19,951	$19,816	$19,951	$136

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Tribes

Program Description and Accomplishments

Youth and young adults with Serious Mental Illness (SMI), along with those with co-occurring mental illness and drug/alcohol addiction, face a more difficult transition to adulthood than do their peers. Nearly 20 percent of young adults aged 18 to 25 living in U.S. households had a diagnosable mental health condition in the past year. Of these, more than 1.3 million had a disorder so serious, such as schizophrenia, bipolar disorder, and major depression, that it compromised their ability to function. Compared to their peers, these young people were significantly more likely to experience homelessness,[7] be arrested,[8] drop out of school,[9] and be unemployed.[10] It is important to identify these young people, develop appropriate outreach and engagement processes, and facilitate access to effective clinical and supportive interventions. Outreach and engagement are essential to these youth and young adults, and their families, as many are disconnected from social and other community supports.

FY 2016 data demonstrated positive outcomes for individuals in the program. For example, at six-month follow-up, 59 percent reported positive functioning, 38 percent reported having a permanent place to live in the community, and 66 percent reported being employed.

In FY 2016, SAMHSA supported 17 Healthy Transitions continuation grants and technical assistance and evaluation contracts. In FY 2017, SAMHSA continued to support 16 continuation grants, the technical assistance, and evaluation contracts. Under the FY 2018 Annualized CR

[7] Embry, L. E., Vander Stoep, A., Evens, C., Ryan, K. D., & Pollock, A. (2009). Risk factors for homelessness in adolescents released from psychiatric residential treatment. Journal of the American Academy of Child and Adolescent Psychiatry, 39(10), 1293-1299.
[8] Davis, M., Banks, S. M., Fisher, W. H., Gershenson, B.,& Grudzinskas, A. J. (2007). Arrests of adolescents clients of a public mental health system during adolescence and young adulthood. Psychiatric Services, 58(11), 1454-1460.
[9] Planty, M., Hussar, W., Snyder, T., Provasnik, S., Kena, G., Dinkes, R., Kemp, J. (2008). The condition of education 2008 (NCES 2008-031).
[10] Newman, L., Wagner, M., Cameto, R., & Knokey, A. M. (2009). *The post-high school outcomes of youth with disability up to 4 years after high school: A report from the national longitudinal transition study-2 (NLTSC)* (NCSER 2009-3017). Menlo Park, CA: SRI International.

level, SAMHSA would continue support for 14 continuation grants, four new grants, and technical assistance and evaluation activities.

Funding History

Fiscal Year	Amount
FY 2015	$19,951,000
FY 2016	$19,951,000
FY 2017	$19,951,000
FY 2018	$19,816,000
FY 2019	$19,951,000

Budget Request

The FY 2019 President's Budget request is $20.0 million, an increase of $135,500 from the FY 2018 Annualized CR to improve access to mental disorder treatment and related support services for young people aged 16 to 25 who either have, or are at risk of developing, a serious mental health condition. SAMHSA's budget request will support four continuation grants and a new cohort of 14 grants and evaluation and technical assistance activities.

Outputs and Outcomes Table

Program: Healthy Transitions

NOTE: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.2.34 Increase the percentage of clients receiving services who report positive functioning at six-month follow-up. (Outcome)	FY 2017: 66.1 % Target: 64.0 % (Target Exceeded)	66.1 %	66.1 %	Maintain
3.2.35 Increase the percentage of clients receiving services who had a permanent place to live in the community at six-month follow-up. (Outcome)	FY 2017: 45.4 % Target: 36.0 % (Target Exceeded)	45.4 %	45.4 %	Maintain
3.2.36 Increase the percentage of clients receiving services who are currently employed at six-month follow-up. (Outcome)	FY 2017: 66.8 % Target: 56.0 % (Target Exceeded)	66.8 %	66.8 %	Maintain

Children and Family Programs

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Children and Family Programs.....	$7,229	$7,180	$7,229	$49

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Competitive Grants/Contracts/ Interagency Agreements
Eligible Entities..... Tribes

Program Description and Accomplishments

Without early identification, intervention, treatment, and support, children with Serious Emotional Disturbance (SED) are likely to face challenges at home, in school, and in their psychosocial development. It is a public health priority that these children and their families have access to effective, evidence-based services, and support.

SAMHSA's Children and Family Programs provide funding for the Circles of Care grant program. Initially funded in 1998, the Circles of Care Program is a three-year infrastructure/planning grant which seeks to promote mental disorder treatment equity by providing American Indian/Alaska Native (AI/AN) communities with tools and resources to design and sustain their own culturally competent system of care approach for children. The Circles of Care program reflects the unique history and needs of individual AI/AN communities and promotes the idea of building on cultural strengths. The program increases capacity and community readiness to address the mental health issues of children and their families through the provision of evidence based treatment services and supports. This grant program is of critical importance as there are significant mental health needs in AI/AN communities. For example, suicide is the second leading cause of death for Indian youth ages 15 to 24. Through Circles of Care, SAMHSA has improved the availability, accessibility, and acceptability of behavioral health services for native youth. For example, data from the previous cohort of grantees show that over 3,000 consumer/family members were involved in ongoing mental health related planning activities and there were 4,300 peer-to-peer collaborations.

Rehabilitation Research and Training Centers (RRTCs) seek to advance the current knowledge base by supporting research, training, technical assistance, and knowledge translation activities that help youth and young adults with serious mental health conditions, including youth and young adults from high-risk, disadvantaged backgrounds, achieve their life goals. SAMHSA's Children and Family Program supports two RRTC programs that are co-funded with the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR). The first program, RRTC on Transition to Employment for Youth and Young Adults with Serious Mental Health Conditions, will conduct research and evaluative studies that contribute to improved employment outcomes for youth and young adults with serious mental health conditions, including those from

high-risk, disadvantaged backgrounds. The second program, RRTC on Community Living and Participation for Youth and Young Adults with Serious Mental Health Conditions, will conduct research and evaluative studies that contribute to improved community participation for youth and young adults with serious mental health conditions. Unemployment rates for youth with mental disorders are significantly higher than those for youth with no disabilities. Unemployed young adults are three times more likely to suffer from depression, and youth without jobs are at higher risk to use alcohol and other drugs, and engage in risky behaviors that have negative health outcomes.[11]

In FY 2016, SAMHSA provided continuation support for 11 three-year Circles of Care grants to AI/AN communities and two RRTCs.

In FY 2017, SAMHSA awarded 13 new Circles of Care grants and the continuation of two RRTCs. Under FY 2018 Annualized CR level, SAMHSA would support the continuations of the program.

Funding History

Fiscal Year	Amount
FY 2015	$6,458,000
FY 2016	$6,458,000
FY 2017	$7,229,000
FY 2018	$7,180,000
FY 2019	$7,229,000

Budget Request

The FY 2019 President's Budget request is $7.2 million, an increase of $49,000 from the FY 2018 Annualized CR. SAMHSA requests funding to enhance and improve the quality of existing services and promote the use of culturally competent services and support for children and youth with, or at risk for, serious mental health conditions and their families. This funding will be used to support the continuation of 13 Circles of Care grants, and two RRTCs.

The output and outcome measures for Children and Family Programs are part of the Mental Health - Other Capacity Activities Outputs and Outcomes table shown on page 78.

[11] McGee RE, Thompson NJ. Unemployment and Depression Among Emerging Adults in 12 States, Behavioral Risk Factor Surveillance System, 2010. Prev Chronic Dis 2015; 12:140451.

Consumer and Family Network Grants

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Consumer and Family Network Grants.....	$4,954	$4,920	$4,954	$34

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....Community Organizations

Program Description and Accomplishments

Across the healthcare arena, there is growing recognition and evidence that patient-centered care positively influences an individual's health outcomes, improves quality and efficacy of care received, and provides feedback to drive service and systems improvements. As with other health disciplines, people with SMI and their family members should have meaningful involvement in all aspects of their health care and treatment, including behavioral health care.

The Consumer and Family Network Programs provide consumers, families, and youth with opportunities to participate meaningfully in the development of policies, programs, and quality assurance activities related to mental health systems across the United States. The Consumer and Family Network Programs support two primary grant activities: the Statewide Consumer Network Program and the Statewide Family Network Program.

The Statewide Consumer Network Grant Program focuses on the needs of adults (18 years and older) with SMI by strengthening the capabilities of statewide consumer-run organizations. These entities serve an important role in engaging consumers of mental health services, 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. This is accomplished by: 1) strengthening organizational relationships and business management skills; 2) fostering leadership skills among families of children and adolescents with SED; and 3) identifying and addressing the technical assistance needs of children and adolescents with SED and their families. The Statewide Family Network Program focuses on families, parents, and the primary caregivers of children, youth, and young adults.

In FY 2017, SAMHSA supported 17 Statewide Consumer Network continuations, 26 Statewide Family Network continuations, one new Statewide Consumer Network grant, and one new Statewide Family Network grant, technical assistance activities, and a Statewide Peer Network Development activity demonstrating collaboration between the addiction recovery network and the consumer and family networks.

Under the FY 2018 Annualized CR level, SAMHSA would support ten Statewide Consumer Network continuations and nine new grants, 21 Statewide Family Network continuations and five new grants which will support program implementation and direct TA.

Funding History

Fiscal Year	Amount
FY 2015	$4,954,000
FY 2016	$4,954,000
FY 2017	$4,954,000
FY 2018	$4,920,000
FY 2019	$4,954,000

Budget Request

The FY 2019 Presidents Budget request is $4.9 million, an increase of $34,000 from the FY 2018 Annualized CR. SAMHSA requests funding to continue support for 16 grants that promote consumer, family, and youth participation in the development of policies, programs, and quality assurance activities related to mental health systems reform across the United States. SAMHSA will also fund a new cohort of 30 Family and Consumer Network grant programs.

The output and outcome measures for Consumer and Family Network Programs are part of the Mental Health - Other Capacity Activities Outputs and Outcomes table shown on page 78.

Project LAUNCH

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Project LAUNCH	$23,605	$23,445	$23,605	$160

Authorizing Legislation……. Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....States and Tribes

Program Description and Accomplishments

Researchers estimate that between 9.5 percent and 14.2 percent of children from birth to age five experience an emotional or behavioral disturbance. Studies also show that half of all lifetime cases of mental illness begin before age 14.[12] The preschool expulsion rate of these children is more than three times the expulsion rate of students in kindergarten through 12th grade. Boys are more than four times as likely to be expelled than girls. African American preschoolers are almost twice as likely to be expelled than Caucasian preschoolers.[13] School suspensions and expulsions have shown to increase the likeliness of later life negative outcomes. Research has shown that prevention and early treatment of mental disorders is more beneficial and cost-effective than waiting to address these issues later in life. Integrating behavioral health into primary care and early childcare settings, increasing screening for developmental and social/emotional issues, and training people who interact with young children to help them feel safe and secure are all critical elements to ensure children start life with the tools and skills needed to succeed.

Established in 2008, Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) is a national initiative that has funded 55 sites, including states, tribes, territories, communities, and the District of Columbia. The purpose of the Project LAUNCH initiative is to promote the wellness of young children from birth to eight years of age by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Project LAUNCH pays particular attention to the social and emotional development of young children and works to ensure that the systems that serve them (including early childcare and education, home visiting, and primary care) are equipped to promote and monitor healthy social and emotional development. The program also ensures that the systems intervene to prevent mental, emotional, and behavioral disorders in early childhood and into the early elementary grades.

As of 2017, performance data for the program found that:

- Approximately 197,000 children and parents have been screened or assessed for behavioral health concerns across a range of diverse settings (e.g., primary care, child care, and home visiting);
- Approximately 126,000 families have been served through home visiting programs with an added focus on the social/emotional and behavioral health needs of children and parents;

- Approximately 79,000 community providers have been trained on social/emotional development and behavioral health for young children;
- Nearly 159,000 individuals received evidence-based mental health-related services, and
- Nearly 9,100 new organizations are collaborating, coordinating, and sharing resources to implement prevention/promotion strategies for young children and their families.

The multi-site evaluation of Project LAUNCH is ongoing. Phase one of the evaluation used a meta-analytical approach to assess the implementation of the program. The findings indicate that grantees successfully achieved three goals: 1) improvements to the local child services system in the LAUNCH communities; 2) improvements to the state child services system; and 3) 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 assess the impact of Project LAUNCH more effectively.

In FY 2016, SAMHSA supported 36 five-year continuation grants, a new cohort of grants, and a technical assistance and evaluation contract. 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. Project LAUNCH Expansion grantees, funded in FY 2016, have been successfully implementing Project LAUNCH strategies in 15 additional communities across their five states. In FY 2017, SAMHSA awarded 25 continuation grants and a technical assistance and evaluation contract.

Under the FY 2018 Annualized CR level, SAMHSA would award a new cohort of eight grants. In addition, funding will be provided to support the continuation of 18 grants, and technical assistance activities.

[12] Brauner, Cheryl, and Cheryll Stephens. "Estimating the Prevalence of Early Childhood Serious Emotional/Behavioral Disorders: Challenges and Recommendations." Public Health Reports 121.3 (2006): 303-10.
[13] Gilliam, W. (2005). Pre-kindergarteners left behind: Expulsion rates in state prekindergarten systems. Foundation for Child Development.

Funding History

Fiscal Year	Amount
FY 2015	$34,555,000
FY 2016	$34,555,000
FY 2017	$23,605,000
FY 2018	$23,445,000
FY 2019	$23,605,000

Budget Request

The FY 2019 President's Budget request is $23.6 million, an increase of $160,000 from FY 2018 Annualized CR. This funding will support eight continuation grants, 18 new grants, and contract activities that will improve health outcomes for young children and support children at high risk for mental illness and their families in order to prevent future disability. This funding request will provide services for over 14,421 individuals, training to 8,765 people, and screening for mental health or related intervention to 18,554 children up to eight years old.

Outputs and Outcomes Table

Program: Mental Health-Project LAUNCH

Note: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
2.3.94 Increase the number of persons served. (Output)	FY 2017: 14,421 Target: 38,594 (Target Not Met)	14,421	14,421	Maintain
2.3.95 Increase the number of persons trained in mental illness prevention or mental health promotion. (Outcome)	FY 2017: 8,765 Target: 13,102 (Target Not Met)	8,765	8,765	Maintain
2.4.00 Increase the number of 0-8 year old children screened for mental health or related interventions. (Outcome)	FY 2017: 18,554 Target: 44,775 (Target Not Met)	18,554	18,554	Maintain
2.4.01 Increase the number of 0-8 year old children referred to mental health or related interventions. (Outcome)	FY 2017: 3,652 Target: 9,114 (Target Not Met)	3,652	3,652	Maintain

Mental Health System Transformation and Health Reform

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Mental Health System Transformation and Health Reform	$3,779	$3,753	$3,779	$26

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Tribes

Program Description and Accomplishments

There is a significant gap between the number of people with SMI, such as schizophrenia, bipolar disorder, and major depression, who want to work (66 percent) and the number of people who are actually employed (less than 20 percent). The benefits of steady competitive employment are substantial and include increased income, improved adherence with treatment for mental illness, enhanced self-esteem, reduced use of substances, and improved quality of life.[14] The Transforming Lives through Supported Employment Grant program is the remaining component of the Mental Health System Transformation program. This program was implemented to help states foster the adoption and implementation of permanent transformative changes in how public mental health services are organized, managed, and delivered throughout the United States.

The program began in FY 2014 as a focused effort to enhance state and community capacity to provide evidence-based supported employment programs for adults and youth with SMI/SED. These grants help people with SMI build paths to self-sufficiency and recovery rather than disability and dependence. They also support treatment and service providers and employers to develop and maintain sustained competitive employment opportunities for people with SMI. The grant program helps states to identify and implement the structural and financing changes that are essential to make supported employment programs sustainable and statewide. FY 2017 program data show that 55 percent of individuals were employed at six-month follow-up; additionally, 74 percent reported positive functioning and 66 percent had a permanent place to live.

In FY 2017 and under the FY 2018 Annualized CR, SAMHSA would support the continuation of these grants and related technical assistance activities.

[14] IPS Supported Employment: The Evidence-Based Practice for Employment. (n.d.). Retrieved August 4, 2015.

Funding History

Fiscal Year	Amount
FY 2015	$3,779,000
FY 2016	$3,779,000
FY 2017	$3,779,000
FY 2018	$3,753,000
FY 2019	$3,779,000

Budget Request

The FY 2019 President's Budget request is $3.8 million, an increase of $26,000 from the FY 2018 Annualized CR. SAMHSA requests funding to support a new cohort of seven Transforming Lives Through Supported Employment grants to enhance state and community capacity to provide evidence-based supported employment programs for adults and youth with SMI/SED and technical assistance to the grantees.

Outputs and Outcomes Table

Program: Mental Health System Transformation and Health Reform

Note: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.2.11 Increase the 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 2017: 5,262 Target: 4,303 (Target Exceeded)	5,262	5,262	Maintain
1.2.21 Increase the percentage of clients receiving services who report positive functioning at six- month follow-up. (Outcome)	FY 2017: 74 % Target: 57 % (Target Exceeded)	74 %	74 %	Maintain
1.2.22 Increase the percentage of clients receiving services who had a permanent place to live in the community at six-month follow-up. (Outcome)	FY 2017: 66 % Target: 77 % (Target Not Met but Improved)	77 %	77 %	Maintain
1.2.23 Increase the percentage of clients receiving services who are currently employed at six-month follow-up. (Outcome)	FY 2017: 55 % Target: 32 % (Target Exceeded)	55 %	55 %	Maintain

Primary and Behavioral Health Care Integration

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Primary and Behavioral Health Care Integration.....	$49,877	$49,538	$---	-$49,538
Primary and Behavioral Health Care Integration TTA…..	1,991	1,977	---	-1,977
Total PBHCI	**$51,868**	**$51,516**	**$---**	**-$51,516**

Authorizing Legislation……..……Section 520K of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Competitive Grants/Cooperative Agreements
Eligible Entities.....Qualified Community Mental Health Programs (FY 2017 Authorization), States or State Agency

Program Description and Accomplishments

Adults with SMI, such as schizophrenia, bipolar disorder, and major depression, experience high rates of morbidity and mortality. These rates are due, in large part, to elevated incidence and prevalence of cardiovascular disease, obesity, diabetes, hypertension, and dyslipidemia in people with SMI.[15] Physical health problems among people with SMI affect an individual's 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.[16]

The Primary and Behavioral Health Care Integration (PBHCI) program began in FY 2009 to address specifically this intersection between primary care and treatment for mental illness and co- occurring drug/alcohol addiction. The program supports two activities: grants to community mental health centers and States and the PBHCI Training and Technical Assistance (TTA) Center, which is co-funded through a competitive cooperative agreement with the Health Resources and Services Administration (HRSA). These two activities collectively support the coordination and integration of primary care services and publicly funded community behavioral health services for individuals with SMI or co-occurring mental illness and drug/alcohol addiction served by the public mental health system. PBHCI seeks to improve health outcomes for people with SMI and co-occurring mental illness and drug/alcohol addiction by encouraging grantees to engage in necessary collaboration, expand infrastructure, and increase the availability of primary healthcare and wellness services for individuals with SMI or co-occurring mental illness and drug/alcohol addiction. Through FY 2017, SAMHSA has awarded 214 PBHCI grants.

PBHCI activities also include the braided Minority AIDS Initiative HIV Continuum of Care pilot program, which supports behavioral health screening, primary prevention, and treatment for

[15] Forman-Hoffman, Muhuri, Novak, Pemberton, Ault, and Mannix (August 2014) CBHSQ Data Review: Psychological Distress and Mortality among Adults in the U.S. Household Population.
[16] E. Chesney et al., Risks of all-cause and suicide mortality in mental disorders: a meta-review, World Psychiatry; 2014: 13:1153-160.

racial/ethnic minority populations with or at high risk for mental illness and drug/alcohol addiction and HIV/AIDS. This includes HIV/AIDS integrated programs that either co-locate or have fully integrated HIV/AIDS prevention and medical care services with behavioral health services.

In FY 2017, SAMHSA supported 61 continuation grants and awarded three new grants to states based on new requirements in the 21st Century Cures Act. These new awards to states reflect a change in the eligibility requirements and provide up to $2.0 million per grant per year. In line with the 21st Century Cures Act changes, the FY 2017 state grantees were allowed to expand the populations to be served to include children with SED, individuals with drug/alcohol addiction and adults with mental illness, as well as continue to support adults with SMI.

Under the FY 2018 Annualized CR level, SAMHSA would continue to support 61 continuation grants and award a new cohort of 10 grants to states. Support will continue to all grantees through the training and technical assistance center.

Funding History

Fiscal Year	Amount
FY 2015	$51,868,000
FY 2016	$51,868,000
FY 2017	$51,868,000
FY 2018	$51,516,000
FY 2019	---

Budget Request

The FY 2019 President's Budget request is $0.0, a decrease of $51.5 million from the FY 2018 Annualized CR. SAMHSA has eliminated this program due to other funding sources available for integrated care. SAMHSA will continue to disseminate the lessons learned from this program.

Outputs and Outcomes Table

Program: Primary & Behavioral Health Care Integration (PBHCI)

Note: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.2.41 Increase the percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2017: 54.6 % Target: 55.9 % (Target Not Met)	54.6 %	54.6 %	Maintain
3.2.42 Increase the percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2017: 24.1 % Target: 23.8 % (Target Exceeded)	24.1 %	24.1 %	Maintain
3.2.43 Increase the percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2017: 71 % Target: 69.1 % (Target Exceeded)	71.0 %	71.0 %	Maintain

Suicide Prevention Programs

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Suicide Prevention.....	$69,032	$67,479	$69,032	$1,552
*Suicide Lifeline (non-add).....	*7,198*	*7,149*	*7,198*	*49*
GLS - Youth Suicide Prevention - States (non-add)	*35,427*	*34,103*	*35,427*	*1,324*
*Budget Authority (non-add).....	*23,427*	*23,268*	*35,427*	*12,159*
*Prevention & Public Health Fund (non-add)...	*12,000*	*10,835*	---	*-10,835*
GLS - Youth Suicide Prevention - Campus (non-add)	*6,488*	*6,444*	*6,488*	*44*
GLS - Suicide Prevention Resource Center (non-add)	*5,988*	*5,947*	*5,988*	*41*
*AI/AN Suicide Prevention Initiative (non-add)...	*2,931*	*2,911*	*2,931*	*20*
National Strategy for Suicide Prevention (non-add)	*11,000*	*10,925*	*11,000*	*75*
*Zero Suicide (non-add).....	*9,000*	*8,939*	*9,000*	*61*
*Zero Suicide -AI/AN (non-add).....	*2,000*	*1,986*	*2,000*	*14*

Program Description and Accomplishments

SAMHSA supports the goals and objectives of the National Strategy for Suicide Prevention (NSSP) through the Suicide Prevention Programs highlighted below. 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 NSSP supports this type of comprehensive approach and is an important step toward reducing suicide.

Approximately 44,193 Americans died by suicide in 2015. One American dies by suicide every 11.9 minutes. In 2008, suicide became the 10th leading cause of death in the United States and has remained so through 2015, the most recent year for which there are available mortality data. The 2015 National Survey on Drug Use and Health reported that approximately 1.4 million Americans age 18 and over attempted suicide, 9.7 million seriously considered suicide, and 2.7 million made a plan. While youth have the highest rate of suicide attempts, middle-aged adults have the highest number of deaths by suicide nationwide, and middle aged and older adult males have the highest rates of death by suicide. The nation's suicide prevention efforts must address the issues of suicidal thoughts, plans, attempts, and deaths among adults and youth to reduce suicide in America.

National Strategy for Suicide Prevention

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
National Strategy for Suicide Prevention.....	$11,000	$10,925	$11,000	$75
Zero Suicide (non-add).....	*9,000*	*8,939*	*9,000*	*61*
Zero Suicide -AI/AN (non-add).....	*2,000*	*1,986*	*2,000*	*14*

Authorizing Legislation ..... Section 520L of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Competitive Grants
Eligible Entities..... Community –based primary care or behavioral health entity, Federally Recognized, American Indian/Alaska Native tribe or tribal organizations, State mental health or public health agency

Program Description and Accomplishments

Suicide has been increasing in the United States, particularly in adults and older adults. Suicide is the fifth leading cause of death among middle-aged adults (ages 35 to 64 years).[17] In 2013, suicide among working-aged adults (25 to 64) accounted for almost 70 percent of all suicides, and from 1999 to 2010, the suicide rate among individuals age 35 to 64 increased by nearly 30 percent.[18] Additionally, the highest rates of suicide are seen among men who are 80 or older. With the rising rates of suicide among adults, particularly middle-aged and older adults, focusing on preventing suicide among adults is urgently required in order to reduce suicide nationally. The baby boomer generation is the group that has had high rates of suicide throughout its lifecycle and is entering the stage of life that has historically had the highest rate of suicide. There is a risk that without significant targeted intervention toward adults, the number of suicides in the United States could continue to increase.

The 2012 National Strategy for Suicide Prevention (NSSP) seeks to reduce the overall suicide rate and number of suicides in the U.S. nationally. The NSSP grant program supports states' efforts to implement the NSSP. While the NSSP addresses all age groups and populations with specific needs, the goals and objectives of the NSSP grants are focused on preventing suicide and suicide attempts among adults over the age of 25 who comprised more than 38,000 of the more than 44,000 suicides in the United States in 2015. In FY 2014, SAMHSA awarded four new grants to support states in implementing the NSSP goals and objectives. States use NSSP funding to support efforts such as raising suicide awareness, establishing emergency room referral processes, and improving clinical care practice standards. These grants focus on preventing suicide and suicide attempts

[17] Centers for Disease Control and Prevention (CDC) Vital Signs: Suicide among adults aged 35–64 years – United States, 1999–2010. MMWR Morbidity Mortality Weekly Report. 2013; 62 (17):321–325.
[18] Centers for Disease Control and Prevention (CDC) Vital Signs: Suicide among adults aged 35–64 years – United States, 1999–2010. MMWR Morbidity Mortality Weekly Report. 2013; 62 (17):321–325.

among working-aged adults 25 to 64 years old. In FY 2015 and FY 2016, SAMHSA provided continuation funds for these four grants.

In FY 2017, Congress appropriated $9.0 million, to implement Zero Suicide in health care systems including a $2.0 million tribal set aside. The Zero Suicide model is a comprehensive, multi-setting approach to suicide prevention in health systems. The purpose of this program is to implement suicide prevention and intervention programs for individuals who are 25 years of age or older by systematically applying evidence-based approaches to screening and risk assessment, developing care protocols, including collaborative safety planning, providing evidence-based treatments, maintaining continuity of care during high risk periods, and improving care and outcomes for such individuals who are at risk for suicide being seen in health care systems. In FY 2017, SAMHSA awarded three new Zero Suicide grants and five new NSSP grants. Under the FY 2018 Annualized CR level, SAMHSA would support the continuation of five NSSP grants and award a new cohort of three Zero Suicide grants.

Funding History

Fiscal Year	Amount
FY 2015	$2,000,000
FY 2016	$2,000,000
FY 2017	$11,000,000
FY 2018	$10,925,000
FY 2019	$11,000,000

Budget Request

The FY 2019 President's Budget request is $11.0 million, an increase of $75,000 from the FY 2018 Annualized CR. Funding will support the continuation of five NSSP grants, three continuation Zero Suicide grants, and evaluation and technical assistant activities. The grants support states in implementing the NSSP goal to prevent suicide. States use NSSP funding to support efforts such as raising suicide awareness, establishing emergency room referral processes, and improving clinical care practice standards.

Garrett Lee Smith Youth Suicide Prevention – State/Tribal and Campus

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
GLS - Youth Suicide Prevention - States.....	$35,427	$34,103	$35,427	$1,324
*Prevention & Public Health Fund (non-add).....	*12,000*	*10,835*	---	*-10,835*
GLS - Youth Suicide Prevention - Campus.....	6,488	6,444	6,488	44

Authorizing Legislation ..... Sections 520E and 520E-2 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... States and Tribes

Program Description and Accomplishments

In the fall of 2003, Garrett Lee Smith, son of Sen. Gordon and Sharon Smith, died by suicide in his apartment in Utah where he attended college. He was one day shy of 22 years old. Like most suicides, Garrett's came unexpectedly. As many families have tragically experienced, depression is not rare or peculiar, but can be deadly. It affects one in six Americans at some point. Hardly a family goes untouched.[19]

The Garrett Lee Smith (GLS) Memorial Act authorizes SAMHSA to manage two significant youth suicide prevention programs and one resource center. The GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program has awarded 180 grants to 50 states and the District of Columbia, 47 tribes or tribal organizations, and one territory. These grants develop and implement youth suicide prevention and early intervention strategies involving public-private collaboration among youth-serving institutions. The GLS Campus Suicide Prevention program has awarded 190 grants to 175 institutions of higher education, including tribal colleges and universities, to prevent suicide and suicide attempts.

Grantees use their funds to prevent suicide in their communities, often through providing trainings and events. By the end of FY 2017, 1,304,600 individuals had participated in 35,301 training events or educational seminars provided by grantees and over 86,000 youth had been screened for suicide risk. Grantees have identified almost 60,600 youth at risk for suicide and ensured that they receive appropriate services. Grantees' efforts are reducing the likelihood of at-risk youth falling through the gaps in the system.

Results from the congressionally mandated cross-site evaluation have shown that counties who implemented GLS supported activities had lower suicide rates than matched counties that did not in the first year following suicide prevention activities.

[19] http://www.jaredstory.com/garrett_smith.html

In FY 2016, SAMHSA provided continuation funds for 38 GLS State/Tribal grants, 37 GLS Campus grants, 4 new GLS State/Tribal grants and 18 new GLS Campus grants as well as the National Suicide Prevention Evaluation.

In FY 2017, SAMHSA provided continuation funds for 42 GLS State/Tribal grants, three new GLS State/Tribal grants, 40 GLS Campus grants, 17 new GLS Campus grants, and the National Suicide Prevention evaluation. The 17 new GLS Campus grantees utilized funding in accordance with changes made in the 21st Century Cures Act.

Under the FY 2018 Annualized CR level, SAMHSA would support the continuation for 45 GLS State/Tribal grants, 35 GLS Campus grants, 18 new GLS Campus grants, and continuation of the National Suicide Prevention evaluation.

Funding History

Fiscal Year	Amount
FY 2015	$41,915,000
FY 2016	$41,915,000
FY 2017	$41,915,000
FY 2018	$40,547,000
FY 2019	$41,915,000

Budget Request

The FY 2019 President's Budget request is $41.9 million, an increase of $1.4 million from the FY 2018 Annualized CR. SAMHSA requests funding for 19 State/tribal grant continuations, 53 Campus continuations, and a new cohort of 26 State/tribal grants to continue developing and implementing youth suicide prevention and early intervention strategies involving public-private collaboration among youth serving institutions. In addition, the funding will support prevention of suicide and suicide attempts at institutions of higher education and the National Suicide Prevention Evaluation.

Garrett Lee Smith Suicide Prevention Resource Center

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
GLS - Suicide Prevention Resource Center.....	$5,988	$5,947	$5,988	$41

Authorizing Legislation ..... Section 520C of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
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 the above 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, and 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 2015, SAMHSA awarded a new five-year SPRC grant. In FY 2016 and FY 2017, SAMHSA supported the continuation of this grant and provided supplemental funding to support technical assistance to the new Zero Suicide Grantees. Under the FY 2018 Annualized CR level, SAMHSA would support the continuation of this grant.

Funding History

Fiscal Year	Amount
FY 2015	$5,988,000
FY 2016	$5,988,000
FY 2017	$5,988,000
FY 2018	$5,947,000
FY 2019	$5,988,000

Budget Request

The FY 2019 President's Budget request is $6.0 million, an increase of $41,000 from the FY 2018 Annualized CR. Funding will support one grant continuation to promote the implementation of

the NSSP and enhance the nation's mental health infrastructure. The Suicide Prevention Resource Center will provide states, tribes, government agencies, private organizations, colleges and universities, and suicide survivors and mental health consumer groups with access to information and resources that support program development, intervention implementation, and adoption of policies that prevent suicide.

Suicide Lifeline

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Suicide Lifeline.....	$7,198	$7,149	$7,198	$49

Authorizing Legislation .....Section 520E-3 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Tribes, Community Organizations

Program Description and Accomplishments

To prevent death and injury as the result of suicide attempts, individuals need rapid access to suicide prevention and crisis intervention services. In FY 2015, the National Suicide Prevention Lifeline answered calls from over 1.5 million Americans. This helped provide rapid access at any time of the day or night to crisis intervention, and when needed, emergency response.

Launched in FY 2005, the National Suicide Prevention Lifeline (Lifeline), 1-800-273-TALK, coordinates a network of 164 crisis centers across the United States by providing suicide prevention and crisis intervention services for 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 156,418 calls per month for a total of 1,877,020 calls answered in FY 2017. 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?" 82 percent responded "a lot" (59 percent) or "a little" (22 percent).

Since FY 2007, SAMHSA has collaborated with the Department of Veterans Affairs (VA) to ensure that veterans, service members, and their families who call the Lifeline and "press 1" have 24/7 access to the VA's Veterans Crisis Line. In FY 2017, year to date more than 54,000 callers per month pressed "1" and were connected to the Veterans Crisis Line.

The Lifeline Evaluation is a part of the National Suicide Prevention Evaluation (NSPE), which includes many of the programs in SAMHSA's suicide prevention portfolio. The NSPE is an

evaluation that will assess the impact of SAMHSA's suicide prevention initiatives on reducing suicidal behavior, attempts, and mortality. The NSPE also provides 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, imminent risk protocols, emergency intervention, and follow-up procedures and have advanced improvements in practice that are lifesaving.

In FY 2016, SAMHSA awarded six new Crisis Center follow-up grants and the continuation of the Lifeline grant. In FY 2017, SAMHSA continued to support grant continuations of Crisis Center Follow-up grants and the Suicide Lifeline grant.

Under the FY 2018 Annualized CR level, SAMHSA would award a new Suicide Lifeline grant and support the continuation of six Crisis Center Follow-up grants.

Funding History

Fiscal Year	Amount
FY 2015	$7,198,000
FY 2016	$7,198,000
FY 2017	$7,198,000
FY 2018	$7,149,000
FY 2019	$7,198,000

Budget Request

The FY 2019 President's Budget Request is $7.2 million, an increase of $49,000 from the FY 2018 Annualized CR. SAMHSA is requesting funding to the continuation of 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 six new National Suicide Prevention Lifeline Crisis Center Follow-up grants to focus on providing follow-up to suicidal people discharged from emergency rooms and inpatient units, and will support a crisis chat system.

American Indian/Alaska Native Suicide Prevention Initiative

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
American Indian/Alaska Native Suicide Prevention Initiative……	$2,931	$2,911	$2,931	$20

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
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, substance abuse, and suicide among American Indian/Alaska Native (AI/AN) youth. These plans mobilize tribal communities' existing social and educational resources to meet their goals. From 2015 to 2017, 126 tribal communities have received specialized technical assistance and support in suicide prevention and related areas. In addition, more than 10,860 members of these communities received training in prevention and mental health promotion.

In FY 2016, SAMHSA supported the continuation of this five-year contract. In FY 2017, SAMHSA continued support for this activity through the existing contract. Under the FY 2018 Annualized CR level, SAMHSA would award a new contract to support this activity.

Funding History

Fiscal Year	Amount
FY 2015	$2,931,000
FY 2016	$2,931,000
FY 2017	$2,931,000
FY 2018	$2,911,000
FY 2019	$2,931,000

Budget Request

The FY 2019 President's Budget Request is $2.9 million, an increase of $20,000 from the FY 2018 Annualized CR. SAMHSA requests funding to support comprehensive, broad, focused, and intensive training and technical assistance to federally recognized tribes and other AI/AN communities in order to address and prevent mental illness and alcohol/other drug addiction, prevent suicide, and promote mental health through the contract continuation.

Outputs and Outcomes Table

Program: Suicide Prevention

Note: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Enacted. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
2.3.59 Increase the total number of individuals trained in youth suicide prevention (Outcome)	FY 2017: 77,306 Target: 160,082 (Target Not Met)	77,306	77,306	Maintain
2.3.60 Increase the total number of youth screened (Output)	FY 2017: 62,542 Target: 3,337 (Target Exceeded)	62,542	62,542	Maintain
2.3.61 Increase the number of calls answered by the suicide hotline (Output)	FY 2017: 1,877,020 Target: 1,308,825 (Target Exceeded)	1,877,020	1,877,020	Maintain
3.1.01 Increase the number of individuals screened for mental health or related interventions (Intermediate Outcome)	FY 2017: Result Expected December 31, 2018 Target: Set Baseline (Pending)			Maintain
3.1.02 Increase the number of individuals referred to mental health or related services (Intermediate Outcome)	FY 2017: Result Expected December 31, 2018 Target: Set Baseline (Pending)			Maintain
3.1.03 Increase the number of organizations that establish management information/information technology system links across multiple agencies (Intermediate Outcome)	FY 2017: Result Expected December 31, 2018 Target: Set Baseline (Pending)			Maintain
3.1.04 Increase the number of organizations or communities that demonstrate improved readiness to change their systems (Intermediate Outcome)	FY 2017: Result Expected December 31, 2018 Target: Set Baseline (Pending)			Maintain
3.2.37 Increase the number of youth referred to mental health or related services (Output)	FY 2017: 13,950 Target: 9,177 (Target Exceeded)	13,950	13,950	Maintain

Homelessness Prevention Programs

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Homelessness Prevention Programs.....	$30,696	$30,488	$30,696	$208
Homelessness.....	2,296	2,280	2,296	16

Authorizing Legislation ..... Sections 520A and 506 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States, Domestic Public and Community Organizations, Private Nonprofit Entities, and Community-based Public or Nonprofit Entities

Program Description and Accomplishments

While significant progress has been made over the last decade to reduce homelessness in specific communities and with specific populations, the number of people experiencing homelessness has remained high. Many factors contribute to homelessness, including lack of affordable housing, foreclosures, rising housing costs, job loss, underemployment, mental illness, and addiction. Services are needed to link individuals to permanent housing and coordinate benefits, treatment, and supportive services. According to the U.S. Department of Housing and Urban Development, 549,928 individuals experienced homelessness on a given night in 2016 in the United States, about 14 percent (77,486) of the homeless population is considered "chronically homeless," and about seven percent (39,471) of individuals who are homeless are veterans.[20] Almost 20 percent of individuals experiencing homelessness have an SMI and 17 percent struggle with chronic substance use and misuse.[21]

In FY 2011, SAMHSA initiated the Cooperative Agreements to Benefit Homeless Individuals (CABHI) program, jointly funded by the Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT) (Treatment for Homeless line) to support treatment services and the development and expansion of local systems that provide permanent housing and supportive services. This includes integration of treatment and other critical services for individuals with SMI or co-occurring mental illness and drug/alcohol addiction.

CABHI also supports coordination and planning at the local level with state or local Public Housing Authorities; local mental health, substance abuse treatment, and primary care provider organizations; the local Department of Housing and Urban Development-supported Continuum of

[20] The 2016 Annual Homeless Assessment Report (AHAR) to Congress . (November 2016.). Retrieved August 9, 2017, from https://www.hudexchange.info/resources/documents/2016-AHAR-Part-1.pdf
[21] The U.S. Department of Housing and Urban Development, 2016 CoC Homeless Populations and Subpopulations Reports. Available at https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/

Care (CoC) program; the state Medicaid Office; and the state Mental Health and Substance Abuse Authorities. This program expanded to include states as the eligible entity in 2013.

In FY 2016, SAMHSA supported a national evaluation to compare the effectiveness of the CABHI program and various models of service delivery that are used across homeless service programs managed by states, local governments, and community-based organizations. Recent data show that at six-month follow-up, 73.4 percent of individuals reported positive functioning, 23.1 percent were employed, and 62.1 percent had a permanent place to live. SAMHSA also supported a technical assistance contract to provide training and support to its homeless service providers and grantees.

In FY 2017, SAMHSA supported 39 continuation grants, and awarded 16 new grants to states, local governments, and community-based organizations, and a technical assistance and evaluation contract.

Under the FY 2018 Annualized CR level, SAMHSA would support 46 continuation grants, a new cohort of 10 grants, technical assistance, and evaluation.

Funding History

Fiscal Year	Amount
FY 2015	$32,992,000
FY 2016	$32,992,000
FY 2017	$32,992,000
FY 2018	$32,768,000
FY 2019	$32,992,000

Budget Request

The FY 2019 President's Budget Request is $33.0 million, an increase of $224,000 from the FY 2018 Annualized CR. SAMHSA plans to support 26 CABHI continuation grants, award a new cohort of 30 grants, and support TA and evaluation activities.

Minority AIDS

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Minority AIDS.....	$9,224	$9,161	$---	-$9,161

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
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

Minority 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.[22] African Americans accounted for 45 percent and Hispanics accounted for 23 percent of all HIV/AIDS cases diagnosed in 2013.[23] Psychiatric and psychosocial complications are frequently not diagnosed nor addressed at the time of HIV diagnosis or through the course of the disease process. When untreated, these complications are associated with increased morbidity and mortality, impaired quality of life, and numerous medical issues such as non-adherence with the treatment regimen.

The Minority AIDS program enhances and expands the provision of effective, culturally competent, HIV/AIDS-related mental health services in racial and ethnic minority communities for people living with or at high risk for HIV/AIDS. More than 4,600 individuals received services in FY 2017.

In FY 2016 and FY 2017, SAMHSA supported the continuation of 34 HIV Continuum of Care grants, and evaluation and technical assistance contracts. Under the FY 2018 Annualized CR level, SAMHSA would award a new cohort of 34 grants focused on individuals with mental disorders and/or co-occurring disorders living with or at risk for HIV/AIDS.

[22] Centers for Disease Control and Prevention. HIV Surveillance Report. (2013); vol. 25. Published February 2015. Accessed May 8, 2015 from http://www.cdc.gov/hiv/library/reports/surveillance.
[23] Centers for Disease Control and Prevention. HIV Surveillance Report. (2013); vol. 25. Published February 2015. Accessed May 8, 2015 from http://www.cdc.gov/hiv/library/reports/surveillance.

Funding History

Fiscal Year	Amount
FY 2015	$9,995,000
FY 2016	$9,995,000
FY 2017	$9,224,000
FY 2018	$9,161,000
FY 2019	----

Budget Request

The FY 2019 President's Budget request is $0.0 million, a decrease of $9.2 million from the FY 2018 Annualized CR. SAMHSA has discontinued this program because they overlap with other federal activities.

States will be able to provide services to reduce injection drug use and related HIV/AIDS and Hepatitis C infection rates through $150 million in new funding proposed as part of the Additional Opioid Allocation described on page 259.

The output and outcome measures for the Minority AIDS Initiative are part of the Mental Health - Other Capacity Activities Outputs and Outcomes table shown on page 78.

Criminal and Juvenile Justice Programs

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Criminal and Juvenile Justice Programs.....	$4,269	$4,240	$14,269	$10,029

Authorizing Legislation……Sections 520A and 520G of the Public Health Service Act
FY 2019 Authorization ..... Permanent
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, and Local Governmental Unit

Program Description and Accomplishments

Data indicate that a significant number of individuals that come in contact with law enforcement and the criminal justice system have a mental or substance use disorder. More than half of all prison and jail inmates (i.e., people in state and federal prisons and local jails) meet criteria for having a mental health problem; 6 in 10 meet criteria for a substance abuse problem; and more than one-third meet criteria for having both a substance abuse and mental health problem.[24] Approximately 250,000 individuals with serious mental illness (SMI) are incarcerated at any given time—about half arrested for non-violent offenses, such as trespassing or disorderly conduct. In addition, during street encounters, police officers are almost twice as likely to arrest someone who appears to have a mental illness. A Chicago study of thousands of police encounters found that 47 percent of people with a mental illness were arrested, while only 28 percent of individuals without a mental illness were arrested for the same behavior.[25] The costs associated with incarceration are high: state corrections budgets alone account for $39.0 billion in taxpayer costs.[26,27] There is a clear and largely unmet need for effective behavioral health services and supports that are accessible before, during, and after incarceration and continue in the community as needed for this high-risk, population.

In FY 2014, SAMHSA supported a second cohort of four-year Behavioral Health Treatment Court Collaborative grants (BHTCC) in the Mental Health and Substance Abuse Treatment

[24] U.S. Department of Justice, Office of Justice Programs. (2006) *Mental health problems of prison and jail inmates*. Retrieved, March 25, 2011, from http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf
[25] The Role of Mental Health Courts in System Reform. The Bazelon Center for Mental Health Law. http://heinonline.org/HOL/LandingPage?handle=hein.journals/udclr7&div=10&id=&page=
[26] Pew Center on the States. (2011). State of recidivism: The revolving door of America's prisons. Washington, DC: The Pew Charitable Trusts. http://www.pewtrusts.org/en/research-and-analysis/reports/0001/01/01/state-of-recidivism
[27] Henrichson, C., & Delaney, R. (2012). The price of prisons: What incarceration costs taxpayers. New York: Vera Institute of Justice.

appropriations. BHTCC supports judges and staff of specialty (e.g., drug court) and other courts within a jurisdiction to work together to divert adults with mental illness or co-occurring mental and substance use disorders from the criminal justice system. 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 the diversion of adults with mental illness and co-occurring mental illness and drug/alcohol addiction, from the criminal justice system and includes alternatives to incarceration. The program supports community behavioral health services and includes a focus on veterans involved with the criminal justice system.

In FY 2017, SAMHSA provided continuation support for 17 grants, continued technical assistance, and awarded a new evaluation contract. The BHTCC evaluation focuses on examining the clinical and functional outcomes of program participants with behavioral health issues. The evaluations also build on the findings from the first cohort and more thoroughly examine both the features of successful collaborations between the courts and community services as well as the clinical and functional outcomes of program participants.

Under the FY 2018 Annualized CR level, SAMHSA would award a new cohort of eight grants that divert adults with an SMI or a co-occurring disorder form the criminal justice system to community-based services prior to arrest and booking. In addition, SAMHSA will continue support for the technical assistance and evaluation contracts.

Recent Evaluation Results

SAMHSA completed an evaluation of the first cohort of BHTCC grantees in September 2014. Findings of the evaluation demonstrate that grantees built multi-agency workgroups or collaboratives to oversee programs. Because of the grant funding, all grant recipients expanded access to specialty courts. Most grant recipients anticipated continuing new screening and assessment processes addressing a broader array of behavioral health needs after grant funding ended. Program innovations were divided into four main groups, including court and treatment provider collaboration, court and community case management, unified cross-court screening and referral, and meaningful peer involvement. BHTCC served over 2,997* individuals, with 77 percent of them identified as having co-occurring mental illness and drug/alcohol addiction and with nearly two thirds reporting violence or trauma exposure in their lives. Based on performance data reporting, alcohol and other drug use by program participants declined by 53 percent at six months**. Nearly 79 percent of participants either maintained good physical health or reported physical health improvements in the same time period***. In addition, employment rates increased from 29 percent to 45 percent over the first six months, with monthly mean income increasing by $217.

*Cohort 2 data through November 15, 2017.
**Calculated as the change in percentage of individuals reporting alcohol or drug use from baseline to six-month follow-up.
***Calculated as the percentage of individuals who either maintained a health status of excellent to good, or who had an improvement in health status from baseline to six-month.

Funding History

Fiscal Year	Amount
FY 2015	$4,296,000
FY 2016	$4,269,000
FY 2017	$4,269,000
FY 2018	$4,240,000
FY 2019	$14,269,000

Budget Request

The FY 2019 President's Budget Request is $14.3 million, an increase of $10.0 million from the FY 2018 Annualized CR. SAMHSA will award a new cohort of 27 grants that targets additional resources to address the needs of those with SMI.

The output and outcome measures for Criminal and Juvenile Justice Programs are part of the Mental Health - Other Capacity Activities Outputs and Outcomes table shown on page 78.

Practice Improvement and Training

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Practice Improvement and Training.....	$7,828	$7,775	$7,828	$53

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... 105 Nationally Recognized Historically Black Colleges and Universities

Program Description and Accomplishments

SAMHSA facilitates health integration by engaging in activities that support mental health system transformation. 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.

The purpose of the HBCU-CFE program is to network the 105 HBCUs throughout 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 substance use disorder treatment and mental health

professions. The comprehensive focus of the HBCU-CFE program simultaneously expands service capacity on campuses and in other treatment venues.

In FY 2017, SAMHSA awarded one new HBCU-Center for Excellence grant to a consortium of HBCUs with a lead university.

Rehabilitation Research and Training Centers (RRTCs) seek to advance the current knowledge base by supporting research, training, technical assistance, and knowledge translation activities that help adults with serious mental health illness achieve their life goals. The RRTCs are funded in partnership with the Administration for Community Living's National Institute on Disability, Independent Living, and Rehabilitation Research. Currently, there are two RRTCs funded for up to five years. The first program, RRTC on Improving Employment Outcomes for Persons with Mental Illness will conduct research activities and evaluation studies on improving employment outcomes of individuals with SMI. The second program, RRTC on Self-Directed Care to Promote Recovery, Health and Wellness for Individuals with SMI, will conduct research and evaluation studies to develop, adapt, and enhance self-directed models of medical, mental health, and nonmedical services designed to improve health, recovery and employment outcomes for individuals with SMI.

In FY 2017, SAMHSA continued funding for two RRTCs and will continue this funding in FY 2018.

Under the FY 2018 Annualized CR level, SAMHSA would award a new HBCU grant program. In addition, SAMHSA will award a Clinical Support Services TA Center dedicated to addressing issues for individuals living with SMI.

Funding History

Fiscal Year	Amount
FY 2015	$7,828,000
FY 2016	$7,828,000
FY 2017	$7,828,000
FY 2018	$7,775,000
FY 2019	$7,828,000

Budget Request

The FY 2019 President's Budget Request is $7.8 million, an increase of $53,000 from the FY 2018 Annualized CR. Funding will support the continuation of the expanded HBCU program. It will also support the continuation of the Clinical Support Services TA Center for SMI.

The output and outcome measures for Practice Improvement and Training are part of the Mental Health - Science and Service Activities Outputs and Outcomes table shown on page 79.

Consumer and Consumer-Supporter TA Centers

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Consumer and Consumer-Supporter Technical Assistance Centers.....	$1,918	$1,905	$1,918	$13

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants
Eligible Entities.....Community Organizations

Program Description and Accomplishments

Consumer-centered services and supports, such as peer specialists, are vital to improving the quality and outcomes of health and behavioral healthcare services for people with mental disorders including SMI. First funded in 1992, the purpose of Consumer and Consumer-Supporter Technical Assistance (TA) Centers is to provide technical assistance to facilitate quality improvement of the mental health system by specific promotion of consumer-directed approaches for adults with SMI.

Such approaches maximize consumer self-determination, promote long-term recovery, and assist individuals with SMI to increase their community involvement through work, school, and social connectedness. This program also improves collaboration among consumers, families, providers, and administrators. It helps to transform community mental health services into a more consumer and family driven model.

In the first six months of FY 2017, Consumer and Consumer-Supporter TA Centers provided training to nearly 8,500 people. These trainings covered a range of topics that including peer support, the Wellness Recovery Action Plan, financial literacy, and collaborative leadership. In addition, the Consumer and Consumer-Supporter TA Centers provided support and expertise to consumer organizations that led to these organizations obtaining over $700,000 in funding for consumer-directed activities and the program is responsible for nearly 400 consumers and family members holding positions within consumer or family organizations participated in mental health-related planning and systems improvement.

In FY 2017 and under the FY 2018 Annualized CR, SAMHSA supported the continuation of five grants.

Funding History

Fiscal Year	Amount
FY 2015	$1,918,000
FY 2016	$1,918,000
FY 2017	$1,918,000
FY 2018	$1,905,000
FY 2019	$1,918,000

Budget Request

The FY 2019 President's Budget request is $1.9 million, an increase of $13,000 from the FY 2018 Annualized CR. SAMHSA's funding request will continue support of five grants to provide technical assistance to facilitate the quality improvement of the mental health system by promoting consumer-directed approaches for adults with SMI.

The output and outcome 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 79.

Disaster Response

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Disaster Response.....	$1,953	$1,940	$1,953	$13

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....Domestic Public or Private Non-Profit Entities

Program Description and Accomplishments

Disasters like Superstorm Sandy, Hurricanes Harvey, Irma, and Maria, the Oregon and Washington mudslides, the Iowa and Oklahoma tornados, and the Pulse nightclub shooting strike without warning. These unexpected disasters leave individuals, families, and whole communities struggling to rebuild.

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 Disaster Behavioral Health. These programs use appropriated 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 assists individuals and communities in recovering from presidentially declared disasters through the provision of community-based behavioral health outreach and psycho-educational services. SAMHSA provides technical assistance, program guidance and monitoring, and 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 provides Disaster Behavioral Health expertise around emerging public health initiatives to develop and disseminate innovative consultation and to technologies to communities, federal partners, and other stakeholders.

SAMHSA's Disaster Distress Helpline is a toll-free, multilingual crisis systems service available 24/7 via telephone (1-800-985-5990) and Short Message Service (SMS) (text 'TalkWithUs' to 66746) to residents in the United States and its territories who are experiencing emotional distress resulting from disasters. In FY 2017, SAMHSA responded to nearly 14,000 calls and received over 31,000 text messages through these services. In FY 2014, SAMHSA's first Disaster app was created on Apple and Android platforms. The Disaster App provided evidence-informed and evidence-based resources in the Disaster Kit, along with additional partner resources and information on local mental health and substance use treatment facilities. It has the ability to share content anonymously and can function with limited Internet connectivity.

In addition to these activities, SAMHSA funded a new cooperative agreement, Networking, Certifying and Training Suicide Prevention Hotlines and a National and a National Disaster Distress Helpline in FY 2015. This jointly funded cooperative agreement manages, enhances, and strengthens the National Suicide Prevention Lifeline and supports the Disaster Distress Helpline. SAMHSA continued to support for these activities in FY 2016 and FY 2017, and would maintain this support under the FY 2018 Annualized CR level.

Funding History

Fiscal Year	Amount
FY 2015	$1,953,000
FY 2016	$1,953,000
FY 2017	$1,953,000
FY 2018	$1,940,000
FY 2019	$1,953,000

Budget Request

The FY 2019 President's Budget request is $2.0 million, an increase of $13,000 from the FY 2018 Annualized CR. SAMHSA is requesting funding to continue the support of a nationally available disaster distress crisis counseling telephone line and the Disaster Technical Assistance Center.

The output and outcome measures for Disaster Response are part of the Mental Health - Science and Service Activities Outputs and Outcomes table shown on page 79.

Seclusion and Restraint

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Seclusion and Restraint	$1,147	$1,139	$1,147	$8

Authorizing Legislation ..... Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Contracts
Eligible Entities ..... Not Applicable

Program Description and Accomplishments

People die because of the inappropriate use of seclusion and restraint practices; countless others are injured; and many are traumatized by coercive practices. Children with emotional and behavioral issues 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, evidence-based approaches to care have been developed, proven effective, and implemented to reduce or eliminate the use of traumatizing practices. 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 to individuals with mental illness and/or drug/alcohol addiction. This initiative focuses on the mental health delivery system and other service sectors, including criminal justice systems, schools, and child welfare organizations, that may use coercive practices with people who have mental illness and/or drug/alcohol addiction.

SAMHSA awarded a five-year contract 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 the elimination of restraint, seclusion, and other coercive practices. The second objective is to develop and implement training and technical assistance on SAMHSA's concept of trauma,[28] key principles, and practice guidance for a trauma-informed approach,[29] and enhance recognition that both organizational and cultural changes are necessary to sustain efforts to eliminate the use of seclusion and restraints. In addition, the contract facilitates dissemination of

[28] https://www.integration.samhsa.gov/clinical-practice/trauma
[29] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

trauma-informed practices across multiple service settings. FY 2017, SAMHSA supported the continuation of this contract.

Under the FY 2018 Annualized CR level, SAMHSA would utilize funding to contribute to a regionally-based TA effort focusing on issues related to the provision of services and supports for those living with mental disorders and/or SMI.

Funding History

Fiscal Year	Amount
FY 2015	$1,147,000
FY 2016	$1,147,000
FY 2017	$1,147,000
FY 2018	$1,139,000
FY 2019	$1,147,000

Budget Request

The FY 2019 President's Budget request is $1.1 million, an increase of $8,000 from the FY 2018 Annualized CR. SAMHSA's funding request will provide support for the continuation of regionally-based TA activities.

Assisted Outpatient Treatment for Individuals with Serious Mental Illness

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Assisted Outpatient Treatment for Individuals with Serious Mental Illness.....	$15,000	$14,898	$15,000	$102

Authorizing Legislation ..... Section 224 of the Protecting Access to Medicare Act of 2014,
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Communities

Program Description and Accomplishments

Recent data show that one in 25 Americans live with a SMI, such as schizophrenia, bipolar disorder and major depression. Less than half of adults with diagnosable mental disorders receive the treatment they need. Without access to and receipt of evidence-based mental health services, mental health issues can negatively affect all areas of a person's life.

In an effort to increase access to evidence-based mental health services for individuals with SMI, in April 2014, Congress passed the Protecting Access to Medicare Act of 2014 (PAMA), which authorized a four-year pilot program to award grants for Assisted Outpatient Treatment (AOT) programs for individuals with SMI. This authorization was extended in the 21st Century Cures Act. AOT is the practice of delivering outpatient treatment under court order to adults with SMI who meet specific criteria, such as a prior history of repeated hospitalizations or arrest. AOT involves petitioning local courts through a civil process to order individuals to enter and remain in treatment within the community for a specified period of time. This program will help to identify evidence-based AOT practices that support improved outcomes, including outreach and engagement, clinical treatment and supportive services, and due process protections.

In FY 2016, SAMHSA implemented an AOT grant program and awarded 17 grants to eligible entities, such as a county, city, mental health system, mental health court, or any other entity with authority under the law of the state in which the grantee is located. This four-year pilot program is intended to implement and evaluate new AOT programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a SMI. This program is designed to work with families and courts to allow these individuals to obtain treatment while continuing to live in the community and their homes. Grants were awarded to applicants that have not previously implemented an AOT program.

SAMHSA has partnered with the Assistant Secretary for Planning and Evaluation to implement a cross-site evaluation which will assess the effectiveness and impact of the AOT grant program. Additional program outcomes that will be evaluated will include, but are not be limited to, the

rates of incarceration, employment, healthcare utilization, mortality, suicide, substance use, hospitalization, homelessness, and use of services.

SAMHSA will continue to consult with the National Institute of Mental Health, the Attorney General, and the Administration for Community Living on this pilot program. In addition, SAMHSA will work with families and courts in the implementation of this program.

In FY 2017 and under the FY 2018 Annualized CR, SAMHSA would provide funding for the continuation of 17 grants, technical assistance, and the evaluation of this program.

Funding History

Fiscal Year	Amount
FY 2015	---
FY 2016	$15,000,000
FY 2017	$15,000,000
FY 2018	$14,898,000
FY 2019	$15,000,000

Budget Request

The FY 2019 President's Budget request is $15.0 million, an increase of $102,000 from the FY 2018 Annualized CR. This funding will support 17 grant continuations to improve the health and social outcomes for individuals with SMI by providing continuation funding for the AOT grants, and the evaluation, and technical assistance contracts.

Outputs and Outcomes Table

Program: Assisted Outpatient Treatment for Individuals with Serious Mental Illness
NOTE: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.4.06 Increase the percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2017: 74.6 % Target: 55.7 % (Target Exceeded)	74.6 %	74.6 %	Maintain
3.4.07 Increase the percentage of clients receiving services who are maintained at six-month follow-up. (Outcome)	FY 2017: 81.8 % Target: 70.5 % (Target Exceeded)	81.8%	81.8%	Maintain
3.4.08 Increase the number of people in the mental health and related workforce trained in mental health-related practices/activities.(Outcome)	FY 2017: 2,519 Target: 756 (Target Exceeded)	2,519	2,519	Maintain
3.4.09 Increase the number of consumers/family members who provide mental health-related services.(Outcome)	FY 2017: 103 Target: 52 (Target Exceeded)	103	103	Maintain

Outputs and Outcomes Table

Program: Mental Health – Other Capacity Activities [1]

NOTE: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.2.05 Increase the percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2017: 55.2 % Target: 55.7 % (Target Not Met)	55.2 %	55.2 %	Maintain
1.2.82 Increase the percentage of clients receiving services who had a permanent place to live in the community at six-month follow-up. (Outcome)	FY 2017: 66.9 % Target: 70.5 % (Target Not Met but Improved)	70.5 %	70.5 %	Maintain
1.2.83 Increase the percentage of clients receiving services who are currently employed at six-month follow-up. (Outcome)	FY 2017: 25.0 % Target: 25.3 % (Target Not Met)	25.0 %	25.0 %	Maintain
1.2.88 Increase the number of individuals screened for mental health or related interventions. (Outcome)	FY 2017: 77,818 Target: 29,813 (Target Exceeded)	77,818	77,818	Maintain

[1] includes the following: Children and Family, Consumer and Family Network, Minority AIDS Initiative, and Criminal and Juvenile Justice programs.

Outputs and Outcomes Table

Program: Mental Health - Science and Service Activities

Note: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.4.06 Increase the number of people trained by CMHS Science and Service Programs. (Output)	FY 2017: 40,070 Target: 20,000 (Target Exceeded)	40,070	40,070	Maintain
1.4.14 Increase the number of calls answered by the Disaster Distress Hotline. (Output)	FY 2017: 13,889 Target: 6,000 (Target Exceeded)	13,889	13,889	Maintain
1.4.15 Increase the number of text messages answered by the Disaster Distress Hotline. (Output)	FY 2017: 31,644 Target: 10,000 (Target Exceeded)	31,644	31,644	Maintain

Tribal Behavioral Health Grants

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Tribal Behavioral Health Grants.....	$15,000	$14,898	$15,000	$102

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
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 eight to 24 years.[30] Further, AI/AN high school students report higher rates of suicidal behaviors than the general population of U.S. high school students.[31] These behaviors include serious thoughts of suicide, suicide plans, suicide attempts, and medical attention for a suicide attempt. However, the risk of suicide is not the same in all AI/AN youth demographic groups. For instance, AI/AN youth raised in urban settings have a smaller risk of having thoughts of suicide than AI/AN youth raised on tribal reservations (21 percent and 33 percent, respectively).[32]

Consistent with the goals of the Tribal Behavioral Health Agenda, the Tribal Behavioral Health Grant (TBHG) program addresses the high incidence of substance use and suicide among AI/AN populations. Starting in FY 2014, this program supports tribal entities with the highest rates of suicide by providing effective and promising strategies that address substance abuse, trauma, and suicide and by promoting the mental health of AI/AN young people.

In FY 2014, SAMHSA's Center for Mental Health Services awarded five-year TBHG grants of up to $0.2 million annually to 20 tribes or tribal organizations with high rates of suicide. These five-year grants 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 Training and Technical Assistance Center (http://www.samhsa.gov/tribal-ttac) provides training and education to AI/AN grantees and organizations serving AI/AN populations to support their ability to achieve their goals. An evaluation component allows grantees and SAMHSA to work collaboratively to monitor progress and learn from each other.

[30] 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.
[31] 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.
[32] Freedenthal, S. & Stiffman, A. R. (2004). Suicidal Behavior in Urban American Indian Adolescents: A Comparison with Reservation Youth in a Southwestern State. Suicide and Life-Threatening Behavior, 34(2), 160-171.

In FY 2016, SAMHSA expanded the TBHG program to include a Native youth initiative focused on removing possible barriers to success for Native youth. This initiative takes a comprehensive, culturally appropriate approach to help improve the lives of and opportunities for AI/AN youth. In addition to the Department of Health and Human Services, 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 AI/AN youth. This funding allows SAMHSA to expand activities through the braided TBHG ($15.0 million in the Substance Abuse Prevention appropriation and $15.0 million in Mental Health appropriation) to allow tribes the flexibility to implement community-based strategies to address trauma, prevent substance abuse, and promote mental health and resiliency among youth in tribal communities. The additional FY 2016 funding expanded these activities to approximately 90 tribes and tribal entities. With the expansion of the TBHG program, SAMHSA's goal is to reduce substance use and the incidence of suicide attempts among AI/AN youth and to address behavioral health conditions that affect learning in the Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion, including trauma-informed strategies, and substance use prevention activities for high-risk AI/AN youth and their families, enhance early detection of mental illness and drug/alcohol addiction among AI/AN youth, and increase referral to treatment. In FY 2017, SAMHSA provided funding to support 81 grant continuations, 13 new grants, and the evaluation and technical assistance activities.

Under the FY 2018 Annualized CR level, SAMHSA would support 81 grant continuations, 36 new grants, evaluation, and technical assistance activities.

Funding History

Fiscal Year	Amount
FY 2015	$4,988,000
FY 2016	$15,000,000
FY 2017	$15,000,000
FY 2018	$14,898,000
FY 2019	$15,000,000

Budget Request

The FY 2019 President's Budget request is $15.0 million, an increase of $102,000 from the FY 2018 Annualized CR. This request, combined with $15.0 million in the Substance Abuse Prevention will award 18 new grants and continue support for 100 grants that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families.

As a braided activity, SAMHSA will track separately any amounts spent or awarded under Tribal Behavioral Health Grants through the distinct appropriations and ensure that funds are used for purposes consistent with legislative direction and intent of these appropriations.

Outputs and Outcomes Table

Program: Tribal Behavioral Health

Note: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
2.4.12 Increase the percentage of youth age 10 - 24 who received mental health or related services after screening, referral or attempt. (Output)	FY 2017: 56.0% Target: 20.0% (Target Exceeded)	56.0%	56.0%	Maintain
2.4.13 Increase the number of programs/organizations that implemented specific mental-health related practices/activities as a result of the grant. (Outcome)	FY 2017: 5,670 Target: 296 (Target Exceeded)	5,670	5,670	Maintain

Minority Fellowship Program

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Minority Fellowship Program.....	$8,059	$8,004	$---	-$8,004

Authorizing Legislation ..... Section 597 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Grants/Contracts
Eligible Entities..……Organizations that represent individuals obtaining post-baccalaureate training (including for master's and doctoral degrees) for mental and substance use disorder treatment professionals, including in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling

Program Description and Accomplishments

SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance use disorder treatment services for minority populations that are underserved. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, the program expanded to include marriage and family therapists and later added professional counselors. Professional guilds receive competitively awarded grants, and then competitively award the stipends to post-graduate students pursuing a degree in that professional field. The MFP program has had a variety of foci including youth and addiction counselors.

Under the FY 2018 Annualized CR level, SAMHSA would award a new cohort of 11 MFP grants and a technical assistance and evaluation contract.

Funding History

Fiscal Year	Amount
FY 2015	$8,059,000
FY 2016	$8,059,000
FY 2017	$8,059,000
FY 2018	$8,004,000
FY 2019	---

Budget Request

The FY 2019 President's Budget request is $0.0 million, a decrease of $8.0 million from the FY 2018 Annualized CR. SAMHSA is eliminating this program because it overlaps with other federal activities.

Assertive Community Treatment for Adults with SMI

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Assertive Community Treatment for Adults with SMI..	$---	$---	$15,000	$15,000

Authorizing Legislation .....Sections 520M of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, local governments, Indian tribes or tribal organizations, mental health systems, or health care facilities

Program Description and Accomplishments

The Assertive Community Treatment (ACT) for Adults with SMI program is authorized under the 21st Century Cures Act. ACT is an evidence-based practice considered one of the most effective approaches to deliver services to people with SMI[33] and has been disseminated by SAMHSA for widespread use through its Evidence Based Toolkit series[34] beginning in 2008. ACT was developed to reduce re-hospitalization and improve outcomes in community settings. ACT is designed as an integrated care approach to provide a comprehensive array of services, including medication management and other supportive services, directly rather than through referrals. The ACT team is composed of 10-12 multidisciplinary behavioral health staff, including psychiatrists, nurses, social workers, addition counselors, and peer specialists. These practitioners work together to deliver comprehensive, individualized, and recovery-oriented treatment and case management services to approximately 100 people with SMI in community settings. Caseloads are approximately one staff member to every 10 individuals. The services are provided 24 hours, 7 days a week and as long as needed, wherever they are needed. Teams often find they can anticipate and avoid crises.

[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3589962/
[34] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Funding History

Fiscal Year	Amount
FY 2015	---
FY 2016	---
FY 2017	---
FY 2018	---
FY 2019	$15,000,000

Budget Request

The FY 2019 President's Budget request is $15.0 million, an increase of $15.0 million from the FY 2018 Annualized CR. Funding will support approximately 20 grants to advance the ACT approach to address the needs of those living with SMI and technical assistance and evaluation activities.

SAMHSA/Mental Health
PRNS Mechanism Table Summary

(Dollars in thousands)

Program Activity	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Programs of Regional & National Significance						
Grants/Cooperative Agreements						
Continuations	624	$269,694	489	$214,054	368	$141,234
New/Competing	83	54,983	259	117,232	198	93,492
Subtotal	707	324,676	748	331,285	566	234,725
Contracts						
Continuations	22	65,221	15	51,596	12	41,754
New/Competing	2	5,762	6	11,987	6	6,065
Subtotal	24	70,983	21	63,583	18	47,819
Total, Mental Health PRNS	**731**	**$395,659**	**769**	**$394,868**	**584**	**$282,544**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Capacity:						
National Child Traumatic Stress Network						
Grants						
Continuations	82	$43,280	86	$45,222	86	$45,215
New/Competing	4	1,901	---	---	---	---
Subtotal	86	45,181	86	45,222	86	45,215
Contracts						
Continuations	---	2,959	---	3,333	---	3,673
New/Competing	---	748	---	---	---	---
Subtotal	---	3,706	---	3,333	---	3,673
Total ,National Child Traumatic Stress Network	**86**	**48,887**	**86**	**48,555**	**86**	**48,887**
Project AWARE						
Grants						
Continuations	96	56,420	16	24,755	---	---
New/Competing	2	2,317	102	37,630	---	---
Subtotal	98	58,737	118	62,385	---	---
Contracts						
Continuations	3	10,227	2	8,333	---	---
New/Competing	---	---	1	757	---	---
Subtotal	3	13,227	3	9,090	---	---
Total, Project AWARE	**101**	**68,964**	**121**	**71,475**	**---**	**---**
Healthy Transitions						
Grants						
Continuations	16	16,832	14	13,932	4	3,368
New/Competing	---	---	4	2,983	14	15,132
Subtotal	16	16,832	18	16,915	18	18,500
Contracts						
Continuations	---	3,119	---	2,901	---	1,451
New/Competing	---	---	---	---	---	---
Subtotal	---	3,119	---	2,901	---	1,451
Total, Healthy Transitions	**16**	**19,951**	**18**	**19,816**	**18**	**19,951**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Children and Family Programs						
Grants						
Continuations	---	---	13	5,028	13	5,093
New/Competing	13	5,115	---	---	---	---
Subtotal	13	5,115	13	5,028	13	5,093
Contracts						
Continuations	---	2,114	---	1,355	---	2,136
New/Competing	---	---	---	796	---	---
Subtotal	---	2,114	---	2,151	---	2,136
Total, Children and Family Programs	**13**	**7,229**	**13**	**7,180**	**13**	**7,229**
Consumer and Family Network Grants						
Grants						
Continuations	43	4,169	32	3,026	16	1,500
New/Competing	2	190	14	1,473	30	2,950
Subtotal	45	4,359	46	4,499	46	4,451
Contracts						
Continuations	---	595	---	421	---	503
New/Competing	---	---	---	---	---	---
Subtotal	---	595	---	421	---	503
Total, Consumer and Family Network Grants	**45**	**4,954**	**46**	**4,920**	**46**	**4,954**
Project LAUNCH						
Grants/Cooperative Agreements						
Continuations	25	19,289	18	12,851	8	4,457
New/Competing	---	---	8	4,457	18	14,170
Subtotal	25	19,289	26	17,309	26	18,627
Contracts						
Continuations	2	2,398	2	4,402	2	4,978
New/Competing	1	1,918	1	1,734	---	---
Subtotal	3	4,316	3	6,136	2	4,978
Total, Project LAUNCH	**28**	**23,605**	**29**	**23,445**	**28**	**23,605**
Mental Health System Transformation and Health Reform						
Grants						
Continuations	7	2,230	7	2,642	---	---
New/Competing	---	---	---	---	7	2,687
Subtotal	7	2,230	7	2,642	7	2,687
Contracts						
Continuations	---	1,549	---	1,111	---	1,092
New/Competing	---	---	---	---	---	---
Subtotal	---	1,549	---	1,111	---	1,092
Total, Mental Health System Transformation and Health Reform	**7**	**3,779**	**7**	**3,753**	**7**	**3,779**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Primary and Behavioral Health Care Integration						
Grants						
Continuations	61	22,575	61	23,968	---	---
New/Competing	3	23,988	10	22,734	---	---
Subtotal	64	46,562	71	46,702	---	---
Contracts						
Continuations	---	3,315	---	2,836	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	3,315	---	2,836	---	---
Total, PBHCI	**64**	**49,877**	**71**	**49,538**	**---**	**---**
National Strategy for Suicide Prevention						
Grants						
Continuations	---	---	5	1,884	8	9,882
New/Competing	8	10,447	3	7,948	---	---
Subtotal	8	10,447	8	9,832	8	9,882
Contracts						
Continuations	---	---	---	122	---	1,118
New/Competing	---	553	---	972	---	---
Subtotal	---	553	---	1,094	---	1,118
Total, National Strategy for Suicide Prevention	**8**	**11,000**	**8**	**10,925**	**8**	**11,000**
GLS - Youth Suicide Prevention - States						
Grants						
Continuations	42	28,479	45	29,665	19	12,205
New/Competing	5	2,208	---	---	26	18,145
Subtotal	47	30,686	45	29,665	45	30,350
Contracts						
Continuations	1	4,741	1	4,438	---	3,077
New/Competing	---	---	---	---	1	2,000
Subtotal	1	4,741	1	4,438	1	5,077
Total, GLS - States	**48**	**35,427**	**46**	**34,103**	**46**	**35,427**
GLS - Youth Suicide Prevention - Campus						
Grants						
Continuations	40	3,665	35	3,404	53	5,250
New/Competing	17	1,656	18	1,847	---	---
Subtotal	57	5,320	53	5,251	53	5,250
Contracts						
Continuations	---	1,168	---	1,193	---	738
New/Competing	---	---	---	---	1	500
Subtotal	---	1,168	---	1,193	1	1,238
Total, GLS - Campus	**57**	**6,488**	**53**	**6,444**	**54**	**6,488**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
GLS - Suicide Prevention Resource Center						
Grants						
Continuations	1	5,634	1	5,607	1	5,552
New/Competing	---	---	---	---	---	---
Subtotal	1	5,634	1	5,607	1	5,552
Contracts						
Continuations	---	354	---	341	---	436
New/Competing	---	---	---	---	---	---
Subtotal	---	354	---	341	---	436
Total, GLS - Suicide Prevention Resource Center	**1**	**5,988**	**1**	**5,947**	**1**	**5,988**
Suicide Lifeline						
Grants						
Continuations	7	5,961	6	687	1	5,302
New/Competing	---	---	1	5,302	6	687
Subtotal	7	5,961	7	5,989	7	5,989
Contracts						
Continuations	---	1,237	---	488	---	1,209
New/Competing	---	---	---	672	---	---
Subtotal	---	1,237	---	1,161	---	1,209
Total, Suicide Lifeline	**7**	**7,198**	**7**	**7,149**	**7**	**7,198**
AI/AN Suicide Prevention Initiative						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	2,931	---	---	1	2,931
New/Competing	---	---	1	2,911	---	---
Subtotal	1	2,931	1	2,911	1	2,931
Total, AI/AN	**1**	**2,931**	**1**	**2,911**	**1**	**2,931**
Homelessness Prevention Programs						
Grants						
Continuations	39	19,068	46	14,605	26	15,585
New/Competing	16	4,928	10	10,393	30	9,678
Subtotal	55	23,996	56	24,998	56	25,263
Contracts						
Continuations	2	6,001	2	5,490	1	3,833
New/Competing	---	700	---	---	1	1,600
Subtotal	2	6,700	2	5,490	2	5,433
Total, Homelessness Prevention Programs	**57**	**30,696**	**58**	**30,488**	**58**	**30,696**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Minority AIDS						
Grants						
Continuations	32	7,091	---	---	---	---
New/Competing	---	---	32	7,622	---	---
Subtotal	32	7,091	32	7,622	---	---
Contracts						
Continuations	---	2,133	---	1,136	---	---
New/Competing	---	---	---	402	---	---
Subtotal	---	2,133	---	1,539	---	---
Total, Minority AIDS	**32**	**9,224**	**32**	**9,161**	**---**	**---**
Criminal and Juvenile Justice Programs						
Grants						
Continuations	17	2,249	---	---	8	2,950
New/Competing	---	---	8	2,698	27	9,148
Subtotal	17	2,249	8	2,698	35	12,098
Contracts						
Continuations	2	2,020	---	1,542	---	2,171
New/Competing	---	---	---	---	---	---
Subtotal	2	2,020	---	1,542	---	2,171
Total, Criminal and Juvenile Justice Programs	**19**	**4,269**	**8**	**4,240**	**35**	**14,269**
Seclusion and Restraint						
Grants						
Continuations	---	$---	---	$---	---	$---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	1,147	---	65	1	1,147
New/Competing	---	---	1	1,074	---	---
Subtotal	1	1,147	1	1,139	1	1,147
Total, Seclusion and Restraint	**1**	**1,147**	**1**	**1,139**	**1**	**1,147**
Assertive Community Treatment for Individuals with Serious Mental Illness						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	20	13,720
Subtotal	---	---	---	---	20	13,720
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	1	1,280
Subtotal	---	---	---	---	1	1,280
Total, Assertive Community Treatment for Individuals with Serious Mental Illness	**---**	**---**	**---**	**---**	**21**	**15,000**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Assisted Outpatient Treatment for Individuals with Serious Mental Illness						
Grants						
Continuations	17	13,315	17	13,305	17	13,305
New/Competing	---	---	---	---	---	---
Subtotal	17	13,315	17	13,305	17	13,305
Contracts						
Continuations	---	1,685	1	1,593	1	1,595
New/Competing	---	---	---	---	---	100
Subtotal	---	1,685	1	1,593	1	1,695
Total, Assisted Outpatient Treatment for Individuals with Serious Mental Illness	**17**	**15,000**	**18**	**14,898**	**18**	**15,000**
Tribal Behavioral Health Grants						
Grants						
Continuations	81	7,737	81	8,519	100	7,855
New/Competing	13	2,733	36	2,871	20	3,624
Subtotal	94	10,470	117	11,390	120	11,479
Contracts						
Continuations	1	4,235	1	3,508	1	3,521
New/Competing	---	295	---	---	---	---
Subtotal	1	4,530	1	3,508	1	3,521
Total, Tribal Behavioral Health Grants	**95**	**15,000**	**118**	**14,898**	**121**	**15,000**
Subtotal, Capacity	**702**	**$371,614**	**742**	**$370,987**	**569**	**$268,549**
Science and Service:						
Primary and Behavioral Health Care Integration TA						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	1,991	---	113	---	---
New/Competing	---	---	1	1,864	---	---
Subtotal	1	1,991	1	1,977	---	---
Total, PBHCI TA	**1**	**1,991**	**1**	**1,977**	**---**	**---**
Practice Improvement & Training						
Grants						
Continuations	2	2,042	1	3,158	3	1,935
New/Competing	---	---	2	1,721	---	2,687
Subtotal	7	2,042	10	4,879	10	4,623
Contracts						
Continuations	6	5,267	4	2,896	3	2,620
New/Competing	1	519	---	---	1	585
Subtotal	7	5,786	4	2,896	4	3,205
Total, Practice Improvement & Training	**9**	**7,828**	**7**	**7,775**	**07**	**7,828**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Consumer and Consumer-Supporter TA Centers						
Grants						
Continuations	5	1,749	5	1,796	5	1,779
New/Competing	---	---	---	---	---	---
Subtotal	5	1,749	5	1,796	5	1,779
Contracts						
Continuations	---	169	---	109	---	139
New/Competing	---	---	---	---	---	---
Subtotal	---	169	---	109	---	139
Total, CCSTAC	**5**	**1,918**	**5**	**1,905**	**5**	**1,918**
Disaster Response						
Grants						
Continuations	---	923	---	---	---	---
New/Competing	---	---	---	810	---	863
Subtotal	---	923	---	810	---	863
Contracts						
Continuations	1	---	1	1,130	1	1,090
New/Competing	---	1,030	---	---	1	---
Subtotal	1	1,030	1	1,130	2	1,090
Total, Disaster Response	**1**	**1,953**	**1**	**1,940**	**2**	**1,953**
Homelessness						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	2,296	1	2,280	1	2,296
New/Competing	---	---	---	---	---	---
Subtotal	1	2,296	1	2,280	1	2,296
Total, Homelessness	**1**	**2,296**	**1**	**2,280**	**1**	**2,296**
Minority Fellowship Program						
Grants						
Continuations	11	6,488	---	---	---	---
New/Competing	---	---	11	6,742	---	---
Subtotal	11	6,488	11	6,742	---	---
Contracts						
Continuations	1	1,571	---	458	---	---
New/Competing	---	---	1	803	---	---
Subtotal	1	1,571	1	1,262	---	---
Total, Minority Fellowship Program	**12**	**8,059**	**12**	**8,004**	**---**	**---**
Subtotal, Science and Service	**29**	**24,045**	**27**	**23,882**	**15**	**13,995**
Total, Mental Health PRNS	**731**	**$395,659**	**769**	**$394,868**	**584**	**$282,544**

Grant Awards Table

(Whole dollars)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	707	748	566
Average Awards	$459,231	$442,895	$414,709
Range of Awards	$15,000 - $6,000,000	$15,000 - $6,000,000	$15,000 - $6,000,000

Children's Mental Health Services

(Dollars in thousands)

Programs of Regional and National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Children's Mental Health Services.....	$119,026	$118,218	$119,026	$808

Authorizing Legislation ..... Sections 561 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities…….States, Tribes, Communities, Territories

Program Description and Accomplishments

It is estimated that over 7.4 million children and youth in the United States have a serious mental disorder. Unfortunately, only 41 percent of those in need of mental health services actually receive treatment.[35] Created in 1992, SAMHSA's Children's Mental Health Initiative (CMHI) addresses this gap by supporting "systems of care" (SOC) for children and youth with serious emotional disturbances and their families to increase their access to evidence-based treatment and supports. The 21st Century Cures Act reauthorized the CMHI through FY 2022. Approximately 9-13 percent of America's youth are estimated to have a serious emotional disturbance (SED), the term analogous to serious mental illness when applied to children. CMHI provides grants to assist states, local governments, tribes, and territories in their efforts to deliver services and supports to meet the needs of children and youth with SED.

CMHI supports the development, implementation, expansion, and sustainability of comprehensive, community-based services that use the SOC approach. 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 throughout the U.S. The SOC approach helps prepare children and youth for successful transition to adulthood and 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 with an appropriate, effective, and youth-guided approach. This approach has demonstrated improved outcomes for children at home, at school, and in their communities. For example, CMHI grantee data show that suicide attempt rates decreased over 50 percent within 12 months after children and youth accessed CMHI-related SOC services. In addition, school suspensions/expulsions decreased over 50

[35] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 144863. Rockville, MD: Substance Abuse and Mental Health Services Administration.

percent and unlawful behavior decreased over 50 percent after 18 months of children and youth beginning SOC-related services and supports.[36]

In addition, the CMHI program seeks to address behavioral health disparities for children and youth with SED/Serious Mental Illness (SMI) from racial and ethnic minorities by promoting clear and culturally competent strategies to improve their access, use of services, and outcomes.

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 ensuring collaboration between the CMHI SOC and other child-and youth- serving systems (e.g., Child Welfare, Juvenile Justice, and Education). SAMHSA also strongly encourages efforts by CMHI SOC grantees to coordinate with other SAMHSA programs, such as those supported by the Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG).

CMHI has an ongoing 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 SOC; and 3) critical and emerging issues in children's and youth's mental health. The evaluation includes an SOC assessment that describes the infrastructure and an assessment of outcomes derived from direct SOC services. A service experience study evaluates: 1) change in service use patterns of children and their families; 2) differences in client satisfaction between groups of children (and their families) in the SOC communities who receive an evidence- based treatment and those who do not; and 3) retention in services.

National program evaluation data reported annually to Congress indicate that CMHI SOCs 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.

In FY 2016, SAMHSA supported 47 continuation grants, 53 new grants, and five contracts. In FY 2017, SAMHSA supported 63 continuation grants, 11 new grants, and four contracts. Under the FY 2018 Annualized CR level, SAMHSA would seek to develop and implement a services research demonstration effort based on the North American Prodrome Longitudinal Study funded by the National Institute of Mental Health. During the prodrome phase, a disease process has begun but is not yet diagnosable or inevitable. The demonstration will address whether community-based intervention during this phase can prevent the further development of serious

[36] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, (2015). *The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program, Report to Congress.* Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf.

emotional disturbances and ultimately serious mental illness. The project will examine the extent to which evidence-based early intervention for young people at clinical high risk for psychosis can be scaled up to mitigate or delay the progression of mental illness, reduce disability, and/or maximize recovery. The new effort will be funded from a 10 percent set-aside of the base program, and will focus on youth and young adults who are identified to be at clinical high risk for developing a first episode of psychosis. Funding of this new effort will not affect continuation funding of any CMHI-base funded program. The grantees will focus on this population in order to support the development and implementation of evidence-based programs providing community outreach and psychosocial interventions for youth and young adults in the prodrome phase of psychotic illness.

Funding History

Fiscal Year	Amount
FY 2015	$117,026,000
FY 2016	$119,026,000
FY 2017	$119,026,000
FY 2018	$118,218,000
FY 2019	$119,026,000

Budget Request

The FY 2019 President's Budget request is $119.0 million, an increase of $808,000 from the FY 2018 Annualized CR. In FY 2019, the budget request will support continuation of the 10 percent set-aside prodromal activity and will also support funding for 57 continuation grants and TA and evaluation activities. This funding will provide training to 5,100 people in the mental health and related workforce and serve 13,595 children with serious emotional disturbances.

SAMHSA/Mental Health
Mechanism Table

(Dollars in thousands)

Program Activity	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Children's Mental Health Services						
Grants/Cooperative Agreements						
Continuations	63	$76,628	62	$91,743	55	$81,914
New/Competing	11	20,910	12	11,326	19	20,074
Subtotal	74	97,538	74	103,069	74	101,989
Contracts						
Continuations	2	11,435	1	9,824	1	11,712
New/Competing	---	305	---	---	---	---
Subtotal	2	11,739	1	9,824	1	11,712
Technical Assistance	2	9,749	1	5,325	1	5,325
Total, Children's Mental Health Services	**78**	**$119,026**	**76**	**$118,218**	**76**	**$119,026**

Outputs and Outcomes Table

Program: Children's Mental Health Initiative

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 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 2017: 10,187 Target: 7,830 (Target Exceeded)	10,187	10,187	Maintain
3.2.25 Increase the percentage of children receiving services who report positive social support at six-month follow-up. (Outcome)	FY 2017: 84.2 % Target: 87.6 % (Target Not Met)	84.2 %	84.2 %	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 2017: 57.8% Target: 62.7 % (Target Not Met)	57.8 %	57.8 %	Maintain
3.2.27 Increase the 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 2017: 81,925 Target: 48,818 (Target Exceeded)	81,925	81,925	Maintain

Grant Awards Table

(Whole dollars)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	74	74	74
Average Awards	$1,318,079	$1,392,824	$1,378,225
Range of Awards	$330,000 - $2,000,000	$330,000 - $2,000,000	$330,000 - $2,000,000

Projects for Assistance in Transition from Homelessness

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Projects for Assistant in the Transition from Homeless	$64,635	$64,196	$64,635	$439

Authorizing Legislation ..... Section 535(a) of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Formula Grants
Eligible Entities..... States and Territories

Program Description and Accomplishments

On an average night, an estimate of 578,424 individuals experience homelessness.[37] Data suggest that approximately 26 percent of individuals experiencing homelessness have a serious mental illness (SMI), and that 30 percent of the chronically homeless population (individuals or families with a disabling condition who have been experiencing homelessness for longer than one year or more than four times in the past three years) have a serious mental illness.[38,39,40] Mental illness affects individuals' abilities to maintain stable relationships, perform daily living activities, and maintain stable employment. Symptoms of mental disorders also often cause individuals to become estranged from family members and caregivers, leaving them without a support system. As a result, individuals with a mental illness are more likely to experience homelessness than those without mental illness and experience homelessness longer than the rest of the homeless population.[41]

Data show that the PATH program's efforts to identify primary care, behavioral disorder treatment, and housing for individuals who are chronically homeless is two to three times more cost effective than having them in the criminal justice system or treating them via other costly healthcare settings (e.g., emergency rooms, critical care units).

In 1990, the Stewart B. McKinney Homeless Assistance Amendments Act authorized the PATH program to provide services to individuals who are experiencing homelessness and SMI. The

[37] The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2014). The 2014 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. Available at: https://www.hudexchange.info/resources/documents/2014-AHAR-Part1.pdf
[38] The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2010). The 2010 Annual Homeless Assessment Report (AHAR) to Congress. Available at: https://www.hudexchange.info/resources/documents/2010HomelessAssessmentReport.pdf
[39] National Alliance on Mental Illness. Mental Health by the Numbers. Available at: https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
[40] Office of National Drug Control Policy. Integrate Treatment for Substance Use Disorders into Mainstream Health Care and Expand Support for Recovery. Available at: https://www.whitehouse.gov/ondcp/chapter-integrate-treatment-for-substance-use-disorders
[41] National Alliance on Mental Illness (2004). Homelessness. Available at: http://www2.nami.org/Content/ContentGroups/Policy/Fact_Sheets/homelessnessPFS.pdf

PATH program supports 56 grants to the 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 illness and substance abuse treatment services, case management, assistance with accessing housing, and other supportive services. PATH helps to engage people with SMI into mental disorder treatment. PATH outreach workers specialize in engaging those who are most vulnerable in their communities and who are least likely to seek out services on their own. PATH's primary goal is to bring the most vulnerable into the service system and to connect them with the mainstream resources and supportive services that they need in order to access and sustain stable housing, build social connections, and access treatment and services to support their recovery.

In FY 2016, the PATH program outreached to 181,336 individuals experiencing homelessness and enrolled 60 percent of individuals with SMI into the PATH program (90,054 individuals). Additionally, 53 percent of enrolled individuals were experiencing a co-occurring drug/alcohol addiction. Of those enrolled in PATH, 56,405 individuals received community mental health services. In addition, 10,372 individuals received substance abuse treatment through PATH, while 17,318 individuals were referred by PATH to substance abuse treatment services in the community. In addition, PATH assisted 17,232 individuals with addressing complex housing needs and referred 25,911 individuals to housing assistance agencies in their communities. The services provided by the PATH program fill gaps in existing community resources and play a crucial role in communities' strategic plans to end homelessness. In FY 2017 and under the FY 2018 Annualized CR level, SAMHSA continued support for this program.

Funding History

Fiscal Year	Amount
FY 2015	$64,635,000
FY 2016	$64,635,000
FY 2017	$64,635,000
FY 2018	$64,196,000
FY 2019	$64,635,000

Budget Request

The FY 2019 President's Budget request is $64.6 million, an increase of $439,000 from the FY 2018 Annualized CR. This formula-based funding to all states will continue PATH services in over 500 communities that the states provide funding to in order to support outreach workers and mental health specialists that engage with individuals who are living with SMI or those living with both SMI and drug/alcohol addiction and are homeless or at imminent risk of becoming homeless. The services provided by the program help ensure that these individuals have an opportunity to access stable housing, improve their health and wellness, lead self-directed lives, and achieve their full potential.

Outputs and Outcomes Table

Program: Projects for Assistance in Transition from Homelessness

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 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. (Intermediate Outcome)	FY 2016: 54 % Target: 66 % (Target Not Met)	66 %	66 %	Maintain
3.4.16 Increase the number of homeless persons contacted. (Outcome)	FY 2016: 174,978 Target: 191,926 (Target Not Met)	174,978	174,978	Maintain
3.4.17 Increase the percentage of contacted homeless persons with serious mental illness who become enrolled in services. (Outcome)	FY 2016: 57 % Target: 58 % (Target Not Met)	57 %	57 %	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 2016: 1,800 Target: 2,296 (Target Not Met but Improved)	2,296	2,296	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

State/Territory	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Alabama	$612,850	$608,363	$610,179	$1,816
Alaska	300,000	300,000	300,000	---
Arizona	1,348,828	1,338,952	1,342,948	3,996
Arkansas	303,838	301,614	302,514	900
California	8,810,100	8,745,597	8,771,696	26,099
Colorado	1,018,772	1,011,313	1,014,331	3,018
Connecticut	799,100	793,249	795,616	2,367
Delaware	300,000	300,000	300,000	---
District of Columbia	300,000	300,000	300,000	---
Florida	4,332,860	4,301,137	4,313,973	12,836
Georgia	1,669,441	1,657,218	1,662,164	4,946
Hawaii	300,000	300,000	300,000	---
Idaho	300,000	300,000	300,000	---
Illinois	2,704,272	2,684,472	2,692,483	8,011
Indiana	1,011,159	1,003,755	1,006,751	2,996
Iowa	334,444	331,996	332,986	990
Kansas	377,262	374,500	375,617	1,117
Kentucky	468,743	465,312	466,700	1,388
Louisiana	732,795	727,430	729,601	2,171
Maine	300,000	300,000	300,000	---
Maryland	1,271,101	1,261,794	1,265,560	3,766
Massachusetts	1,558,333	1,546,924	1,551,541	4,617
Michigan	1,728,977	1,716,318	1,721,440	5,122
Minnesota	810,710	804,774	807,176	2,402
Mississippi	300,000	300,000	300,000	---
Missouri	893,474	886,933	889,580	2,647
Montana	300,000	300,000	300,000	---
Nebraska	300,000	300,000	300,000	---
Nevada	615,728	611,220	613,044	1,824
New Hampshire	300,000	300,000	300,000	---

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

State/Territory	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
New Jersey	2,137,423	2,121,774	2,128,106	6,332
New Mexico	300,000	300,000	300,000	---
New York	4,221,694	4,190,784	4,203,291	12,507
North Carolina	1,379,141	1,369,043	1,373,129	4,086
North Dakota	300,000	300,000	300,000	---
Ohio	1,985,819	1,971,280	1,977,163	5,883
Oklahoma	452,678	449,364	450,705	1,341
Oregon	630,795	626,177	628,046	1,869
Pennsylvania	2,366,093	2,348,769	2,355,779	7,010
Rhode Island	300,000	300,000	300,000	---
South Carolina	679,989	675,010	677,025	2,015
South Dakota	300,000	300,000	300,000	---
Tennessee	909,460	902,801	905,496	2,695
Texas	4,993,867	4,957,303	4,972,098	14,795
Utah	591,275	586,945	588,697	1,752
Vermont	300,000	300,000	300,000	---
Virginia	1,471,713	1,460,937	1,465,297	4,360
Washington	1,328,716	1,318,988	1,322,924	3,936
West Virginia	300,000	300,000	300,000	---
Wisconsin	836,367	830,243	832,721	2,478
Wyoming	300,000	300,000	300,000	---
Puerto Rico	890,817	884,294	886,933	2,639
Guam	50,000	50,000	50,000	---
Virgin Islands	50,000	50,000	50,000	---
American Samoa	50,000	50,000	50,000	---
Northern Mariana Islands	50,000	50,000	50,000	---

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Protection and Advocacy for Individuals with Mental Illness (PAIMI)

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
PAIMI	$36,146	$35,901	$36,146	$245

Authorizing Legislation ..... The PAIMI Act, 42 U.S.C. 10801 et seq.
FY 2019 Authorization ..... Permanent
Allocation Method ..... Formula Grants
Eligible Entities..... States and Territories

Program Description and Accomplishments

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) program ensures that the most vulnerable individuals with serious 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 while receiving appropriate mental disorder treatment and discharge planning services.

The Protection and Advocacy for Individuals with Mental Illness Act of 1986, as amended by the Children's Health Act of 2000, extended the protections of the Developmental Disabilities (DD) Assistance Act of 1975 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 supports legal-based advocacy services that are provided by the 57 governor-designated P&A systems, which include states, territories, and the District of Columbia. 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.

In FY 2016, the 57 state PAIMI Programs:

- Served 11,197 PAIMI-eligible individuals/clients: 2,520 children and youth (ages 0 to 18), 7,987 adults (ages 19 to 64), and 690 older adults (age 65 and older). These individuals filed 9,344 complaints alleging abuse, neglect, and/or rights violations.

- Resolved 91 percent of abuse allegations, 89 percent of neglect allegations, and 92 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 disorder treatment; safer, cleaner facility environment; discharge into an appropriate community-based setting; and discharge from a nursing facility.

In FY 2016 and FY 2017, SAMHSA continued to fund 57 annual grants to states and territories as well as continued technical assistance activities and support for grantees. Under the FY 2018 Annualized CR level, SAMHSA would continue to support for this program.

Funding History

Fiscal Year	Amount
FY 2015	$36,146,000
FY 2016	$36,146,000
FY 2017	$36,146,000
FY 2018	$35,901,000
FY 2019	$36,146,000

Budget Request

The FY 2019 President's Budget Request is $36.1 million, an increase of $245,000 from the FY 2018 Annualized CR. Funding will support the continuation of the PAIMI grants in order to serve the same number of individuals, approximately 11,000-15,000, as in past years. This program will continue to assist individuals with serious mental illness increase access to treatment. These grantees protect and advocate for the rights of individuals with mental illness and investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.

Outputs and Outcomes Table

Program: Protection and Advocacy for Individuals with Mental Illness

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.4.12 Increase the number of people served by the PAIMI program. (Outcome)	FY 2016: 11,197 Target: 15,925 (Target Not Met)	11,197	11,197	Maintain
3.4.19 Increase the number attending public education/ constituency training and public awareness activities. (Output)	FY 2016: 98,441 Target: 139,427 (Target Not Met but Improved)	139,427	139,247	Maintain
3.4.21 Increase percentage of complaints of alleged abuse, neglect, and rights violations substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, elimination of other barriers to personal decision-making, as a result of Protection and Advocacy for Individuals with Mental Illness (PAIMI) involvement (Outcome)	FY 2016: 91 % Target: 87 % (Target Exceeded)	91 %	91 %	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA # 93.138

State/Territory	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Alabama	$453,952	$455,298	$457,437	$2,139
Alaska	428,000	425,100	428,000	3
Arizona	626,682	629,701	638,466	8,765
Arkansas	428,000	425,100	428,000	3
California	3,140,635	3,079,038	3,062,888	-16,150
Colorado	438,159	440,297	448,981	8,684
Connecticut	428,000	425,100	428,000	3
Delaware	428,000	425,100	428,000	3
District of Columbia	428,000	425,100	428,000	3
Florida	1,738,714	1,749,217	1,775,184	25,967
Georgia	925,906	927,473	928,540	1,067
Hawaii	428,000	425,100	428,000	3
Idaho	428,000	425,100	428,000	3
Illinois	1,066,670	1,043,625	1,039,118	-4,507
Indiana	600,047	588,521	590,481	1,960
Iowa	428,000	425,100	428,000	3
Kansas	428,000	425,100	428,000	3
Kentucky	428,000	425,100	428,000	3
Louisiana	428,000	425,100	428,000	3
Maine	428,000	425,100	428,000	3
Maryland	466,105	463,731	463,294	-437
Massachusetts	507,663	499,407	501,833	2,426
Michigan	887,795	872,732	871,730	-1,002
Minnesota	445,887	443,077	447,152	4,075
Mississippi	428,000	425,100	428,000	3
Missouri	537,097	538,451	543,537	5,086
Montana	428,000	425,100	428,000	3
Nebraska	428,000	425,100	428,000	3
Nevada	428,000	425,100	428,000	3
New Hampshire	428,000	425,100	428,000	3

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA # 93.138

State/Territory	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
New Jersey	678,311	670,834	671,532	698
New Mexico	428,000	425,100	428,000	3
New York	1,522,109	1,496,525	1,503,131	6,606
North Carolina	909,472	906,431	912,834	6,403
North Dakota	428,000	425,100	428,000	3
Ohio	1,019,483	1,012,261	1,015,748	3,487
Oklahoma	428,000	425,100	428,000	3
Oregon	428,000	425,100	428,000	3
Pennsylvania	1,058,552	1,044,467	1,048,220	3,753
Rhode Island	428,000	425,100	428,000	3
South Carolina	457,957	456,991	462,608	5,617
South Dakota	428,000	425,100	428,000	3
Tennessee	588,878	585,671	590,456	4,785
Texas	2,278,953	2,305,423	2,391,127	85,704
Utah	428,000	425,100	428,000	3
Vermont	428,000	425,100	428,000	3
Virginia	671,652	669,292	675,772	6,480
Washington	573,587	573,276	577,268	3,992
West Virginia	428,000	425,100	428,000	3
Wisconsin	494,807	489,789	493,300	3,511
Wyoming	428,000	425,100	428,000	3
Puerto Rico	528,202	525,206	510,845	-14,361
American Samoa	229,300	227,800	229,300	---
Guam	229,300	227,800	229,300	---
American Indian Consortium	229,300	227,800	229,300	---
Northern Mariana Islands	229,300	227,800	229,300	---
Virgin Islands	229,300	227,800	229,300	---

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Community Mental Health Services Block Grant (MHBG)

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Community Mental Health Services Block Grant.....	$562,571	$558,751	$562,571	$3,820
PHS Evaluation Funds (non-add).....	*21,039*	*20,896*	*21,039*	*143*

Authorizing Legislation…….Sections 1920 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Formula Grant
Eligible Entities.....States, Territories, Freely Associated States, and District of Columbia

Program Description and Accomplishments

Serious mental illnesses are more common in the United States than is generally realized. According to the 2015 Behavioral Health Barometer: United States, approximately 4.1 percent of U.S. adults (an estimated 9.8 million individuals) reported having a serious mental illness (SMI) within the year prior to being surveyed.[42,43] Nearly a third of these individuals did not receive any services in the year before being surveyed.[44]

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.[45] The MHBG distributes funds for a variety of services and for planning, administration, and educational activities. By statute, these services and activities must support community-based mental health services for children with serious emotional disturbances and adults with serious mental illness. MHBG services include: outpatient 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; wraparound services for children and families; jail diversion programs; and services for at-risk populations (e.g., individuals, who are homeless, those in rural and frontier areas, military families, and veterans). Through the

[42] Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51)
[43] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: United States, 2015.* HHS Publication No. SMA–16–Baro–2015. Rockville, MD: Substance Abuse and Mental Health Services Administration,
[44] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: United States, 2015.* HHS Publication No. SMA–16–Baro–2015. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
[45] Territories include Guam, Puerto Rico, the Northern Mariana Islands, U.S. Virgin Islands and American Samoa. Freely Associated States, which have signed Compacts of Free Association with the United States, include the Republic of Palau, Federated States of Micronesia and Republic of the Marshall Islands. See http://www.doi.gov//oia/islands/index.cfm. Further information about the Block Grant program can be found on SAMHSA's Web site at http://www.samhsa.gov/grants/block-grants

administration of the MHBG, SAMHSA supports implementation of practices demonstrated and proven effective in the Mental Health Programs of Regional and National Significance (PRNS) portfolio.

The MHBG continues to represent a significant "safety net" source of funding for mental health services for some of the most at-risk populations across the country. Together, SAMHSA's block grants support the provision of services and related support activities to approximately seven million individuals with mental and substance use conditions in any given year. The Block Grant's flexibility and stability have made it a vital support for public mental health systems.

States rely on the MHBG for delivery of services and for an array of non-clinical coordination and support services that are not supported by Medicaid or other third party insurance to strengthen their service systems. The MHBG statute provides for a five percent administrative set-aside that allows 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. States also use block grant funds, with other funding sources, to support training for staff and implementation of evidence-based practices and other promising practices for the treatment of mental disorders, improved business practices, use of health information technology, and integration of physical and behavioral health services.

SAMHSA's MHBG and Substance Abuse Prevention and Treatment Block Grant (SABG) applications align with changes in federal/state environments and statutes. SAMHSA offers states the opportunity to complete a combined application for mental health and substance abuse services, submit a biennial versus an annual plan, and provide information regarding their efforts to respond to various changes in federal and state law.[46,47] Permitting MHBG recipients to submit the application/plan biennially reduces the burden on states.

There are many individuals, both adolescent and adult, with co-occurring mental illness and drug/alcohol addiction. In recognition of this, SAMHSA strongly encourages coordination between MHBG programs and those supported by the Substance Abuse Prevention and Treatment Block Grant (SABG) as well as other SAMHSA-funded efforts such as the systems of care for children and adolescents supported through the Children's Mental Health Initiative.

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 2016 show that:

- For the 58 states and territories that reported data in the Employment Domain, 24.5 percent of the mental health consumers were in competitive employment;

[46] 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).
[47] State Plan (Sec. 1932 (b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x-32(b)).

- For the 58 states and territories that reported data in the Housing Domain, 82.5 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 approximately 22.73 people per 1,000 population;
- For the 50 states and territories that reported data in the Retention Domain, only 8.8 percent of the patients returned to a state psychiatric hospital within 30 days of state hospital discharge; and
- For the 48 states and territories that reported data in the Perception of Care Domain, 71.8 percent of adult mental health consumers improved functioning as a direct result of the mental health services they received.

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

Starting in FY 2014, 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."[48] SAMHSA is collaborating with the National Institute of Mental Health and states to implement this provision.

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, incarceration, disruption of employment, substance abuse, increased hospitalizations, and reduced prospects for long-term recovery.

The five percent set-aside allocated to states totaling approximately $24.2 million per year in FY 2014 and FY 2015 supported implementation of evidenced-based 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 living with psychotic illness. In FY 2016, Congress increased the set-aside to 10 percent; through this funding, the number of states with fully implemented operating first-episode treatment programs is 39 and SAMHSA continues to monitor and ensure that the set-aside program is solely used to address first-episode psychosis. Beginning in September 2016, SAMHSA, in partnership with NIMH, initiated a 3-year evaluation study of such programs funded through the MHBG set-aside to ensure that funds are only used for programs showing strong evidence of effectiveness and target first episode of psychosis. In FY 2017, SAMHSA continued support for the MHBG and maintained the ten percent set-aside. Under the FY 2018 Annualized CR level, SAMHSA would continue support for the MHBG and maintain the ten percent set-aside.

[48] http://www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

The table below identifies activities, which have been implemented with the 10 percent set-aside.

State	FY 2017 10% Set Aside Allotment	Program Description
Alabama	$776,624	Statewide EASA (Early Assessment and Support Alliance) program model is being developed and implemented.
Alaska	$113,049	A CSC (Coordinated Specialty Care) Program model is in the process of being developed and implemented.
American Samoa	$10,392	Training 2-4 peer support specialists to begin FEP outreach.
Arizona	$1,291,492	An EPICENTER FEP program is operational in Phoenix and in Tucson.
Arkansas	$481,445	Developing portions of CSC model in thirteen locations.
California	$7,418,311	Forty-one CSC programs, from several different models, are in various states of development throughout CA. Thirty-seven are fully operational.
Colorado	$884,527	Implementing four CSC (OnTRACKUSA) programs, three in the Denver area and one in the rural northeastern portion of the state.
Connecticut	$559,824	State is implementing two programs based on two distinct CSC models (Potential and STEP).
District of Columbia	$122,338	As part of the implementation of a CSC program. Training staff on Cognitive Behavioral Therapy for individuals experiencing psychosis.
Delaware	$161,013	A statewide program, CORE (Community Outreach, Referral and Early Intervention), has been implemented.
Florida	$3,671,016	State has implemented five CSC programs. All of these programs are based on the Navigate model.
Georgia	$1,762,259	State has implemented six CSC programs. All programs are based on the LIGHT-ETP model.
Guam	$30,690	Staff have begun providing services in the I Fine'na program, which is based on OnTrackNY.
Hawaii	$298,296	State has implemented a program in Honolulu based on the OnTRACK model.
Idaho	$257,357	Three CSC programs have been implemented.
Illinois	$2,052,910	State has implemented CSC programs in 11 locations throughout the state.
Indiana	$953,262	State is establishing four programs based on the PARC model and making use of a "hub and spoke" design.
Iowa	$427,942	State has two functioning CSC programs and is in the process of contracting for four additional locations/programs.
Kansas	$402,649	State has one fully functional CSC program in Kansas City and is operationalizing a second program in Topeka.

State	FY 2017 10% Set Aside Allotment	Program Description
Kentucky	$696,021	Six EASA CSC program sites are operational and two more are being developed. State is also developing data infrastructure to track outcomes.
Louisiana	$653,029	Three sites are in the process of being implemented. These programs are using the Navigate CSC model.
Maine	$214,240	State has implemented one program based on the PIER Model. The state has also contracted with the PIER program to train staff at two other providers to provide FEP services.
Marshall Islands	$13,531	Marshall Islands is using the set-aside block grant funding to develop first episode outreach practices and protocols for individuals experiencing FEP.
Maryland	$913,003	The state has implemented four CSC programs, two in Baltimore, one in Gaithersburg and one in Catonsville. They are continuing to develop staff expertise in the FEP approaches.
Massachusetts	$1,063,752	Massachusetts has developed two CSC programs, one in Boston and a second in western Mass. They are using the PREP model of CSC.
Michigan	$1,650,729	The State has implemented three CSC programs and are in the process of developing three additional locations. They are using the NAVIGATE CSC model.
Federated States of Micronesia	$20,145	Funds are being used to train staff on the OnTrack CSC model in four locations.
Minnesota	$797,688	State has implemented three CSC teams (across two programs) in the Twin Cities area and has issued an RFP for a CSC program in a rural part of the state.
Mississippi	$488,430	State is fully implementing the NAVIGATE CSC programs to provide training and technical assistance to two CSC teams.
Missouri	$895,085	State has established eight CSC sites spread throughout the state.
Montana	$163,298	The state is implementing the NAVIGATE model in one site for the state.
Nebraska	$246,923	Nebraska has implemented OnTrackUSA in two of the six behavioral health service regions of the state.

State	FY 2017 10% Set Aside Allotment	Program Description
Nevada	$569,929	Nevada has implemented one CSC program in the Reno area and a second program in the Las Vegas area using the RAISE TEAM approach.
New Hampshire	$191,588	The state is using a NAVIGATE training team to train Community Mental Health Centers to establish CSC teams that will continue to expand beyond the training period, using a staged approach.
New Jersey	$1,478,105	New Jersey has implemented three CSC teams adhering to the RAISE CSC model.
New Mexico	$325,382	New Mexico is expanding access to the NAVIGATE model for specialty coordinated care for individuals with FEP through the already implemented University of New Mexico EARLY program.
New York	$3,314,087	New York is spending set-aside funds to expand its existing OnTrackNY program to two new sites with a goal of having 22 sites by the end of 2017. These sites will include rural and less-populated areas.
North Carolina	$1,515,525	North Carolina supports three CSC sites currently operated in the state, including one that started accepting clients in July 2017. The state will also fully implement a Quality Assurance Database developed by the UNC OASIS (Outreach and Support Intervention Services) technical assistance program, which will be utilized by all FEP sites funded through the MHBG (Mental Health Block Grant).
North Dakota	$93,964	The state is using the set-aside funds to identify and contract with a vendor for the implementation of CSC services.
Northern Mariana Islands	$9,814	The Community Guidance Center is implementing a psychoeducation group in FY 2016 geared toward family education, which will help families and the community better identify FEP symptoms in their family or community leading to earlier treatment of the client.
Ohio	$1,679,337	State has implemented 14 CSC programs and is currently installing three more.

State	FY 2017 10% Set Aside Allotment	Program Description
Oklahoma	$579,240	Oklahoma has implemented two NAVIGATE CSC programs in Oklahoma City and Tulsa. The state has implemented the program Transition to Independence (TIP) in five to six CMHCs in Oklahoma, Okmulgee, and Washington Counties by funding training, outreach activities and an employment/education coach.
Oregon	$727,381	The state has implemented 31 CSC programs that currently serve all 36 counties.
Palau	$5,000	One CSC team will be supported in a population area of roughly 20,000 with 1 percent need annually.
Pennsylvania	$1,876,252	Pennsylvania selected ten program sites for fiscal year 2017-2018, including two new sites that are intended to serve rural populations.
Puerto Rico	$690,214	Puerto Rico has implemented two CSC programs, including the PORTI programs in San Juan and Mayagüez.
Rhode Island	$196,114	Rhode Island is using the entire set-aside amount to serve individuals ages 16-25 experiencing a first episode of psychosis by enhancing the two existing treatment teams so that they will be able to serve an additional ten clients.
South Carolina	$791,804	South Carolina is funding two programs, the existing, or Traditional Program, will be evaluated against the CSC Program in terms of clinical and social outcomes.
South Dakota	$114,445	State has implemented two CSC programs in Sioux Falls and Rapid City. They have been trained by OnTrackNY.
Tennessee	$1,089,250	Tennessee used the additional funds to expand OnTrackTN to two additional sites (for a total of three), create a statewide FEP learning collaborative consisting of all three sites, improve outcomes, provide rapid access to services including services that are linguistically and culturally competent, increase awareness and early detection, provide statewide training for providers and the community, and increase statewide capacity to provide FEP services. In September 2017, the state held a conference for all providers in the state to learn about the CSC model and FEP in general.
Texas	$4,347,182	Texas is in the process of expanding to eight additional locations in rural and urban areas across the state. These new sites will be able to serve both indigent and Medicaid eligible populations.

State	FY 2017 10% Set Aside Allotment	Program Description
Utah	$419,638	State has implemented three CSC programs.
Vermont	$95,607	Vermont is continuing to partner with the Vermont Cooperative for Practice Improvement and Innovation to facilitate the initiative including targeted research, implementation, workforce development, outreach and education.
Virgin Islands	$19,857	Virgin Islands intends to establish a CSC program according to the NAVIGATE model.
Virginia	$1,187,835	State has established eight CSC programs that are operated through the state's community service boards (CSBs). The existing programs will continue to receive training and technical assistance to strengthen their clinical service delivery skills and to ensure fidelity to the model.
Washington	$1,257,951	Washington has established three CSC programs adhering to the NAVIGATE CSC Model. In addition, the state is currently establishing two more CSC programs.
West Virginia	$305,198	State has established one CSC program in the Wheeling area.
Wisconsin	$873,289	Wisconsin is continuing to fund the CSC model PROPS program operated by JMHC in Madison and five rural counties north of Madison. In addition, the state is funding a CSC program in Milwaukee.
Wyoming	$64,221	The state is piloting two CSC programs that are currently serving clients.

Funding History

Fiscal Year	Amount
FY 2009	420,774,000
FY 2010	420,774,000
FY 2011	419,933,000
FY 2012	459,756,000
FY 2013	436,809,376
FY 2014	482,571,000
FY 2015	482,571,000
FY 2016	532,571,000
FY 2017	562,571,000
FY 2018	558,751,000
FY 2019	562,571,000

Budget Request

The FY 2019 President's Budget request is $562.6 million, an increase of $3.8 million from the FY 2018 Annualized CR. With this funding, SAMHSA will continue to address the needs of individuals with SMI and SED and will continue to maintain the ten percent set-aside for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The set-aside funds help reduce costs to society, as intervening early helps prevent deterioration of functioning in individuals experiencing a first episode of serious mental illness.

Outputs and Outcomes Table

Program: Mental Health Block Grant

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Enacted and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
2.3.11 Increase the number of evidence based practices (EBPs) implemented. (Output)	FY 2016: 4.6 per State Target: 4.5 per State (Target Exceeded)	4.6 per State	4.6 per State	Maintain
2.3.14 Increase the number of people served by the public mental health system. (Output)	FY 2016: 7,399,821 Target: 7,620,000 (Target Not Met)	7,339,821	7,339,821	Maintain
2.3.15 Increase the rate of consumers (adults) reporting positively about outcomes. (Outcome)	FY 2016: 75.7 % Target: 71.8 % (Target Exceeded)	75.7 %	75.7 %	Maintain
2.3.16 Increase the rate of family members (children/adolescents) reporting positively about outcomes. (Outcome)	FY 2016: 73.5 % Target: 66.1 % (Target Exceeded)	73.5 %	73.5 %	Maintain
2.3.81 Increase the percentage of service population receiving any evidence based practice. (Outcome)	FY 2016: 11.7 % Target: 6.2 % (Target Exceeded)	11.7 %	11.7 %	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Alabama	$7,766,238	$7,689,598	$7,751,758	$62,160
Alaska	1,130,485	1,108,020	1,094,747	-13,273
Arizona	12,914,921	12,990,602	14,302,111	1,311,509
Arkansas	4,814,450	4,785,464	4,668,655	-116,809
California	74,183,108	73,493,945	72,171,883	-1,322,062
Colorado	8,845,273	8,895,443	10,266,813	1,371,370
Connecticut	5,598,243	5,539,388	5,208,078	-331,310
Delaware	1,610,133	1,601,498	1,244,331	-357,167
District Of Columbia	1,223,382	1,242,006	1,249,876	7,870
Florida	36,710,162	36,929,628	35,028,428	-1,901,200
Georgia	17,622,593	17,618,691	17,166,833	-451,858
Hawaii	2,982,957	2,971,526	2,806,140	-165,386
Idaho	2,573,572	2,569,413	3,041,895	472,482
Illinois	20,529,098	20,161,517	19,323,751	-837,766
Indiana	9,532,616	9,402,339	9,491,586	89,247
Iowa	4,279,421	4,225,546	4,186,060	-39,486
Kansas	4,026,493	3,984,903	3,889,390	-95,513
Kentucky	6,960,209	6,873,537	6,945,506	71,969
Louisiana	6,530,287	6,612,667	7,642,645	1,029,978
Maine	2,142,401	2,124,838	2,116,680	-8,158
Maryland	9,130,026	9,098,670	10,541,659	1,442,989
Massachusetts	10,637,515	10,534,113	10,929,640	395,527
Michigan	16,507,285	16,226,414	15,851,241	-375,173
Minnesota	7,976,879	7,863,935	8,033,726	169,791
Mississippi	4,884,299	4,823,605	4,882,520	58,915
Missouri	8,950,847	8,845,118	8,976,420	131,302
Montana	1,632,975	1,621,121	1,596,734	-24,387
Nebraska	2,469,225	2,450,810	2,407,736	-43,074
Nevada	5,699,289	5,744,659	5,605,524	-139,135
New Hampshire	1,915,877	1,900,322	1,885,122	-15,200

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
New Jersey	14,781,050	14,661,166	15,015,386	354,220
New Mexico	3,253,819	3,190,825	3,142,979	-47,846
New York	33,140,871	32,543,235	31,623,473	-919,762
North Carolina	15,155,252	15,184,367	15,389,201	204,834
North Dakota	939,644	865,685	810,698	-54,987
Ohio	16,793,371	16,472,626	16,629,951	157,325
Oklahoma	5,792,397	5,656,138	5,623,520	-32,618
Oregon	7,273,805	7,454,720	8,220,871	766,151
Pennsylvania	18,762,518	18,377,069	17,675,837	-701,232
Rhode Island	1,961,141	1,936,810	2,018,420	81,610
South Carolina	7,918,037	7,925,945	8,022,467	96,522
South Dakota	1,144,445	1,137,677	1,127,968	-9,709
Tennessee	10,892,496	10,783,368	10,231,427	-551,941
Texas	43,471,820	43,597,726	45,054,899	1,457,173
Utah	4,196,380	4,224,023	4,710,898	486,875
Vermont	956,073	943,609	925,272	-18,337
Virginia	11,878,348	11,873,403	13,332,181	1,458,778
Washington	12,579,513	12,614,800	12,492,829	-121,971
West Virginia	3,051,982	2,969,962	2,919,126	-50,836
Wisconsin	8,732,888	8,600,323	9,260,142	659,819
Wyoming	642,205	634,739	616,825	-17,914
American Samoa	103,920	103,408	104,460	1,052
Guam	306,899	307,858	334,211	26,353
Northern Marianas	98,137	99,605	105,179	5,574
Puerto Rico	6,902,140	6,847,260	6,831,465	-15,795
Palau	50,000	50,000	50,000	---
Marshall Islands	135,308	137,371	146,935	9,564
Micronesia	201,449	200,214	209,699	9,485
Virgin Islands	198,568	197,089	215,287	18,198

SAMHSA

Substance Abuse Prevention
Table of Contents

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Substance Abuse Prevention Appropriation

(Dollars in thousands)

Program Activities	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Programs of Regional and National Significance.....	$221,869	$221,703	$120,885	-$100,818
Drug Free Communities[1]	---	---	$100,000	+$100,000
Total, Substance Abuse Prevention	**$221,869**	**$221,703**	**$220,885**	**-$818**

[1] Drug Free Communities was funded in the Office of National Drug Control Policy at $97.0 million in FY 2017 and at $96.3 million under the FY 2018 Annualized CR.

The Substance Abuse Prevention FY 2019 President's Budget Request is $220.9 million, a decrease of $0.8 million from the FY 2018 Annualized CR.

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

(Dollars in Thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Capacity:				
Strategic Prevention Framework.....	$119,484	$118,673	$58,426	-$60,247
Strategic Prevention Framework Rx (non-add).....	*10,000*	*9,932*	*10,000*	*68*
Federal Drug-Free Workplace.....	4,894	4,861	4,894	33
Comprehensive Addiction and Recovery Act.....	12,000	11,919	12,000	81
MinorityAIDS.....	40,405	40,925	---	-40,925
Sober Truth on Preventing Underage Drinking Act (STOP Act)……..	7,000	6,952	7,000	48
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths……	12,000	11,919	12,000	81
Tribal Behavioral Health Grants……	14,450	14,898	15,000	102
Subtotal, Capacity	**210,233**	**210,146**	**109,320**	**-100,826**
Science and Service:				
Center for the Application of Prevention Technologies	7,493	7,442	7,493	51
SAP Minority Fellowship Program.....	71	71	---	-71
Science and Service Program Coordination.....	4,072	4,044	4,072	28
Subtotal, Science and Service	**11,636**	**11,557**	**11,565**	**8**
Total, PRNS	**$221,869**	**$221,703**	**$120,885**	**-$100,818**

Authorizing Legislation .....……Sections 516 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities……States, political subdivisions of States, Federally Recognized American Indian/Alaska Native tribe or tribal organizations, Indian Health Service-operated and contracted health facilities and programs, public or private nonprofit entities

Strategic Prevention Framework

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Strategic Prevention Framework.....	$119,484	$118,673	$58,426	-$60,247
Strategic Prevention Framework Rx (non-add)..	*10,000*	*9,932*	*10,000*	*68*

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities..... States, Tribes, and Territories

Program Description and Accomplishments

Strategic Prevention Framework (SPF)

Drug and alcohol use are significant public health problems. Youth and adolescents who use alcohol and drugs face an increased risk of poor school performance, criminal justice involvement, the development of a drug/alcohol addiction, risky sexual behavior, illnesses such as HIV and hepatitis, depression and anxiety, and injury and death. The immediate and long-term risks and negative outcomes associated with adolescent drug and alcohol use underscore the need for effective prevention and treatment programs.

Youth and adolescents use a variety of substances. In 2015, 27.1 million people aged 12 or older used an illicit drug in the past 30 days, which corresponds to about 1 in 10 Americans (10 percent). The illicit drug use estimate for 2015 continues to be driven primarily by marijuana use and the misuse of prescription pain relievers, with 22.2 million individuals who currently use marijuana aged 12 or older (i.e., past 30 day use) and 3.8 million people aged 12 or older who reported current misuse of prescription pain relievers.[49]

The Strategic Prevention Framework – Partnerships for Success program addresses underage drinking among youth and young adults age 12 to 20 and allows states to prioritize State-identified top data driven substance abuse target areas.

Data show that states and communities receiving Partnerships for Success funding have made improvements in reducing the impact of substance abuse. The 2015 National Survey on Drug Use and Health (NSDUH) shows that underage alcohol use (i.e., people aged 12 to 20) and binge and heavy drinking use among young adults aged 18 to 25, have declined over time but remain a concern. In 2015, 20.3 percent of underage people reported current use of alcohol, 13.4 percent

[49] Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/

reported binge drinking, and 3.3 percent reported heavy alcohol use. The binge-drinking rate declined from 14.2 percent to 13.4 percent, and the rate of heavy drinking declined from 3.7 percent to 3.3 percent. In 2015, 7.0 percent of adolescents aged 12 to 17 were currently using marijuana. This means that approximately 1.8 million adolescents used marijuana in the past month. [50]

In 2016, the program specifically addressed underage drinking and prescription drug misuse among youth and young adults and also encouraged grantees to address issues related to marijuana and heroin use.

The cross-site evaluation for the Partnerships For Success program addresses the following questions:

1) Was the implementation of Partnerships for Success program associated with a reduction in underage drinking and/or prescription drug misuse?
2) Did variability in the total level of funding from all sources relate to outcomes? Did variability in the total level of Partnerships for Success funding relate to outcomes, above and beyond other funding available to communities?
3) What intervention type, combinations of interventions, and dosages of 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 other interventions?
5) How does variability in factors (strategy selection and implementation, infrastructure, geography, demography, sub-recipient selection, Training/Technical Assistance, barriers to implementation) relate to outcomes across funded communities?

In FY 2017, SAMHSA funded 74 Strategic Prevention Framework grant continuations. Under the FY 2018 Annualized CR, SAMHSA plans to support 48 Strategic Prevention Framework grant continuations and 18 new grants. SPF PFS addresses the Nation's top substance abuse prevention priorities including underage drinking. Our nation is at a turning point in how it addresses substance-related issues. SAMHSA's Talk. They Hear You.® media Campaign (TTHY®) recommends that messaging about underage drinking and substance use prevention begin by age 9 in order to shape children's attitudes and behaviors about substance use.[51] The SPF PFS program addresses underage drinking among persons aged 9 to 20. Additionally, states/tribes may use grant funds to target up to two additional, data-driven substance abuse prevention priorities targeting individuals ages 9 and above. Through expanded partnerships targeting populations in non-traditional settings, the SPF-PFS is designed to ensure that prevention strategies and messages reach the populations disproportionately impacted by the consequences of substance use.

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[50] Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data.

[51] September 6, 2017 Substance Abuse and Mental Health Services Administration, expanded prevention messaging (moving beyond underage drinking) for the *Talk. They Hear You*. media campaign.

Strategic Prevention Framework for Prescription Drugs (SPF Rx)

Drug overdose death rates have increased five-fold since 1980.[52] Since 2000, the drug overdose death rates have more than doubled.[53] In 2009, drug overdose deaths outnumbered deaths due to motor vehicle crashes for the first time. In the U.S., misuse of prescription drugs, including opioid-analgesic pain relievers, is responsible for much of the recent increase in drug-poisoning deaths.[54]

Funding for SAMHSA and the Centers for Disease Control and Prevention (CDC) in FY 2016 was 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, SAMHSA and CDC partnered to ensure alignment with HHS's policy and plan for prevention of opioid-related overdoses and deaths. CDC provided funding to states to address opioid prescribing on multiple fronts, and SAMHSA provided funding to states for the prevention of prescription drug misuse in high priority age groups (including young and middle-aged adults) and the public through the Strategic Prevention Framework – Partnerships for Success program.

In FY 2016, SAMHSA implemented the Strategic Prevention Framework for Prescription Drugs to assist grantees in developing capacity and expertise in the use of data from state run prescription drug monitoring programs (PDMP). Grantees will also 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 focuses on raising community awareness and bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients. SAMHSA tracks reductions in opioid overdoses and the incorporation of prescription drug monitoring data into needs assessments and strategic plans as indicators of program success. SAMHSA awarded 25 grants in FY2016 and FY 2017. SAMHSA would support 25 grant continuations under the FY 2018 Annualized CR level.

Funding History

Fiscal Year	Amount
FY 2015	$109,484,000
FY 2016	$119,484,000
FY 2017	$119,484,000
FY 2018	$118,673,000
FY 2019	$58,426,000

[52] 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.

[53] Centers for Disease Control and Prevention. NCHS Data on Drug Poisoning Deaths. NCHS Fact Sheet. June 2015. Hyattsville, MD: National Center for Health Statistics. 2015. Available at http://www.cdc.gov/nchs/data/factsheets/factsheet_drug_poisoning.pdf.

[54] Paulozzi LJ. Prescription drug overdoses: A review. J. Safety Res 43(4):283–9. 2012.

Budget Request

The FY 2019 President's Budget Request is $58.4 million, a decrease of $60.2 million from the FY 2018 Annualized CR. Funding for the SPF Rx program will be maintained in its entirety ($10.0 million). Funding will support 25 Strategic Prevention Framework continuation grants at a reduced rate, technical assistance, and evaluation to build capacity to address prescription drug misuse and overdose prevention efforts, in conjunction with other state and local partners.

Outputs and Outcomes Table

Program: Partnerships for Success

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
2.3.79 Increase the number of EBPs implemented by sub-recipient communities (Output)	FY 2016: 531 Target: 650 (Target Not Met but Improved)	531	531	Maintain
2.3.80 Increase the number of sub-recipient communities that improved on one or more targeted NOMs indicators. (Outcome)	FY 2016: 552 Target: 142 (Target Exceeded)	552	552	Maintain

Program: Strategic Prevention Framework Rx

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.3.11 Increase the percent of funded states that incorporate PDMP data into their needs assessments in developing their strategic plans. (Outcome)	FY 2016: 72% Target: 100 % (Target Not Met))	85 %	85 %	Maintain
3.3.12 Increase the percent of funded states reporting reductions in opioid overdoses. (Outcome)	FY 2016: 52% Target: 55 % (Target Not Met)	55 %	55 %	Maintain

Federal Drug-Free Workplace

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Federal Drug-Free Workplace.....	$4,894	$4,861	$4,894	$33

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Inter-Agency Agreements/Contracts
Eligible Entities..... Federal Agencies, Regulated Entities (e.g., Department of Transportation, Nuclear Regulatory Commission), HHS- Certified Laboratories

Program Descriptions and Accomplishments

Alcohol and other drug misuse are widespread and have a variety of negative consequences, particularly in the workplace. Employers with successful drug-free workplace programs report decreases in absenteeism, accidents, downtime, turnover, and theft; increases in productivity; and overall improved morale. They also report better health status among many employees and family members and decreased use of medical benefits. Some organizations with drug-free workplace programs qualify for incentives, for example, decreased premium costs for certain kinds of insurance, such as Workers' Compensation.

In 1986, the President signed an Executive Order mandating that all Federal agencies be drug-free. In 1988, Congress passed the Drug-Free Workplace Act.

The Federal Drug-Free Workplace Programs (DFWP) ensure employees in national security, public health, and public safety positions are tested for the use of illegal drugs and the misuse of prescription drugs and ensure the laboratories that perform this drug testing are inspected and certified by HHS. Through this program, the federal government is able to avoid lost productivity and reduce absenteeism, injuries, and fatalities.

SAMHSA implements the Federal Drug-Free Workplace Programs, which consist of two principal activities mandated by Executive Order (E.O.) 12564 and Public Law (P.L.) 100-71. These include: 1) oversight of the Federal Drug-Free Workplace Programs, aimed at the elimination of the use of illegal drugs and the misuse of prescription drugs within Executive Branch agencies and the federally-regulated industries, and 2) oversight of the National Laboratory Certification Program (NLCP), which certifies laboratories to conduct forensic drug testing for federal agencies and federally-regulated industries; the private sector also uses the HHS-Certified Laboratories.

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 the use of

illegal substances and the misuse of prescription drugs by federal employees in safety-sensitive positions.

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 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.

Since FY 2014, SAMHSA has funded the Drug-Free Workplace drug testing activities. These activities will continue in FY 2018 under the NLCP contract. The NLCP oversees the certification of the labs that perform drug testing under the Drug-Free Workplace Programs. The Drug Testing Advisory Board (DTAB) provides recommendations to the Assistant Secretary for Mental Health and Substance Use based on an ongoing review of the direction, scope, balance, and emphasis of SAMHSA's drug testing activities and the NLCP.

On January 10, 2012, SAMHSA approved the DTAB's recommendations to revise the mandatory guidelines 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). On August 7, 2015, SAMHSA approved the DTAB's recommendations to pursue hair as an alternative specimen in the Mandatory Guidelines for Federal Workplace Drug Testing Programs.

CSAP's Workplace Helpline supports the drug-free workplace program. The helpline is a toll- free telephone service (800-WORKPLACE) that answers questions from the public and private sectors about drug testing in the workplace.

Continued funding for the Federal Drug-Free Workplace Programs has ensured the testing of federal employees in national security, public health, and public safety positions for the use of illegal drugs, the misuse of prescription drugs, and the inspection certification of HHS-certified laboratories for the past four years.

Funding History

Fiscal Year	Amount
FY 2015	$4,894,000
FY 2016	$4,894,000
FY 2017	$4,894,000
FY 2018	$4,861,000
FY 2019	$4,894,000

Budget Request

The FY 2019 President's Budget Request is $4.9 million, an increase of $33,000 from the FY 2018 Annualized CR. In FY 2019, SAMHSA will continue oversight of the Executive Branch Agencies' Federal Drug-Free Workplace Programs. This includes review of Federal Drug-Free Workplace plans from those federal agencies that perform federal employee testing, random testing of those designed testing positions of national security, public health, and public safety, and testing for illegal drug use and the misuse of prescription drugs. SAMHSA will continue its oversight role for the inspection and certification of the HHS-certified laboratories.

SAMHSA will continue/add the below items to its drug testing portfolio:

- DTAB continued evaluation of the scientific supportability of hair as an alternative specimen to urine and oral fluids in the Mandatory Guidelines for Federal Workplace Drug Testing Programs;
- Continued use of subject matter experts and partnering with other federal agencies to establish the scientific standards set out in the mandatory guidelines;
- Implementation of the final Urine Specimen Mandatory Guidelines and provide guidance on the implementation;
- Research of alternative specimens for scientific supportability and inclusion in the Mandatory Guidelines;
- Technical and scientific leadership for federal agencies on marijuana testing; and
- Updates to the DFWP website.

Minority AIDS

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Minority AIDS.....	$40,405	$40,925	$---	-$40,925

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities.....Local Government Entities, Community-based Organization, Minority Serving Institutions, and Institutions of Higher Education

Program Description and Accomplishments

The update to the 2010 National HIV/AIDS Strategy for the United States reports that there is still an HIV epidemic, which remains a major health issue for the United States. It also notes that people across the nation deserve access to tools and education to prevent HIV transmission. In 1995, 44 percent of the public indicated that HIV/AIDS was the most urgent health problem facing the U.S., compared to only six percent in 2009. Approximately 40,000 people become infected with HIV each year.[56] In addition, because HIV and viral hepatitis share common modes of transmission, one third of HIV infected individuals are also infected with hepatitis C.[57] Hepatitis C cases are also increasing because of the use of injection drugs.

The Minority AIDS program supports activities that assist grantees in building a solid foundation for delivering and sustaining quality and accessible state-of-the-science substance misuse and HIV prevention services. The program aims to engage community-level domestic public and private non-profit entities, tribes, and tribal organizations in order to prevent and reduce the onset of substance misuse and transmission of HIV/AIDS among at-risk populations, including racial/ethnic minority youth and young adults, ages 13 to 24. SAMHSA works with college and university clinics/wellness centers and community-based providers that can provide comprehensive substance abuse and HIV prevention strategies. These strategies combine education and awareness programs, social marketing campaigns, and HIV and viral hepatitis testing services in non-traditional settings with substance misuse and HIV prevention programming for the population of focus. Because of the high rate of HIV/AIDS and hepatitis co- morbidity, this program includes viral hepatitis prevention and education training.

[56] Centers for Disease Control and Prevention. Trends in U.S. HIV Diagnoses, 2005-2014. February, 2016; https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/hiv-data-trends-fact-sheet-508.pdf.
[57] Action Plan for the Prevention, Care and Treatment of Viral Hepatitis, http://www.hhs.gov/ash/initiatives/hepatitis/

SAMHSA helps to prevent HIV and hepatitis infection acquired through substance misuse and other means. SAMHSA's Minority AIDS programs address. SAMHSA HIV/AIDS prevention programs have included a focus on community-based organizations and minority serving institutions and a focus on the continuum of care.

Funding History

Fiscal Year	Amount
FY 2015	$41,205,000
FY 2016	$41,205,000
FY 2017	$40,405,000
FY 2018	$40,925,000
FY2019	---

Budget Request

The FY 2019 President's Budget Request is $0.0 million, a decrease of $40.9 million from the FY 2018 Annualized CR. SAMHSA is eliminating this program because it overlaps with other federal activities.

States will be able to provide services to reduce injection drug use and related HIV/AIDS and Hepatitis C infection rates through $150 million in new funding proposed as part of the Additional Opioid Allocation described on page 259.

Outputs and Outcomes Table

Program: Minority AIDS

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
2.3.56 Increase the number of program participants exposed to substance abuse prevention education services. (Output)	FY 2016: 3,332 Target: 2,580 (Target Exceeded)	2,580	2,580	Maintain
2.3.83 Increase the percent of program participants who report no use of alcohol at pre-test who remain non-users at post-test (all ages). (Outcome)	FY 2016: 84% Target: 91.2% (Target Not Met)	85.7%	85.7%	Maintain
2.3.85a Increase the number of persons tested for HIV through the Minority AIDS Initiative prevention activities. (Outcome)	FY 2016: 23,280 Target: 35,074 (Target Not Met)	21,137	21,137	Maintain

Sober Truth on Preventing Underage Drinking Act (STOP Act)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Sober Truth on Preventing Underage Drinking Act (STOP Act)…….....	$7,000	$6,952	$7,000	$48

Authorizing Legislation .....Section 519B of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Current and former Drug-Free Communities grantees

Program Description and Accomplishments

Underage drinking continues to be a national concern. It disrupts the lives of individuals and families and imposes great costs on communities. Alcohol-related consequences include impairments in cognitive abilities (e.g., decision-making and impulse control) and motor skills (e.g., balance and hand-eye coordination), death, injury, physical and sexual assault, unsafe sex, health problems, suicide attempts, memory loss, and more.[58] Those who report being intoxicated at least once a week have a higher likelihood of becoming injured and needing medical treatment, causing injury in traffic crashes, and being taken advantage of sexually.[59] Twenty-five percent of college students report academic consequences of their drinking, including missing class, falling behind in class, doing poorly on exams, and receiving lower grades overall.[60]

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 the age of 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. The STOP Act was reauthorized in the 21st Century Cures Act.

Strong prevention efforts are necessary to continue to address underage drinking. These efforts have proven effective. Over the past decade, a large number of evaluation studies have demonstrated the far-reaching effects of prevention interventions in reducing alcohol, tobacco, and other drug abuse as well as delinquent behaviors; violence; and other mental, emotional, and behavioral health problems.[61]

[58] Chaloupka, Grossman, & Saffer, 2002; O'Brien et al., 2013; White & Hingson, 2013.
[59] White & Hingson, 2013.
[60] White & Hingson, 2013.
[61] e.g., Calear & Christensen, 2010; Lemstra et al., 2010; Ttofi & Farrington, 2011.

In both FY 2011 and FY 2012, SAMHSA conducted program evaluations of the STOP Act grant program. The findings indicated that the program was accomplishing its intended goal of enhancing underage drinking prevention efforts in coalition communities around the country.

In mid-2014, SAMHSA began conducting a retrospective national cross-site evaluation of the STOP Act grant program.

In 2015, there were 138.3 million Americans aged 12 or older who reported current use of alcohol, including 66.7 million who reported binge alcohol use in the past month and 17.3 million who reported heavy alcohol use in the past month. Individuals with past month binge drinking and heavy alcohol use represented 24.9 and 6.5 percent of people aged 12 or older, respectively.

FY 2016 data showed that 82 percent of coalitions report at least 5 percent improvement in the 30-day use of alcohol in at least two grades.

In FY 2017, SAMHSA provided funding for 81 STOP Act grant continuations and 17 new grants. Under the FY 2018 Annualized CR level, SAMHSA would continue these grants.

Funding History

Fiscal Year	Amount
FY 2015	$7,000,000
FY 2016	$7,000,000
FY 2017	$7,000,000
FY 2018	$6,952,000
FY2019	$7,000,000

Budget Request

The FY 2019 President's Budget Request is $7.0 million, an increase of $48,000 from the FY 2018 Annualized CR. In FY 2019, SAMHSA will support 95 STOP Act grant continuations. This funding will continue to strengthen SAMHSA's commitment to reduce and prevent underage drinking.

Outputs and Outcomes Table

Program: Sober Truth on Preventing Underage Drinking (STOP Act)
NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.3.01 Increase the percent of coalitions that report at least 5 percent improvement in the past 30-day use of alcohol in at least two grades. (Outcome)	FY 2016: 63.6 % Target: 62.0 % (Target Exceeded)	62.0 %	62.0 %	Maintain
3.3.02 Increase the percent of coalitions that report improvement in youth perception of risk from alcohol in at least two grades. (Outcome)	FY 2016: 72.7 % Target: 68 % (Target Exceeded)	70.0 %	70.0 %	Maintain

Center for the Application of Prevention Technologies

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Center for the Application of Prevention Technologies	$7,493	$7,442	$7,493	$51

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Contracts
Eligible Entities..... Domestic and Public Entities

Program Description and Accomplishments

SAMHSA's 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. The program 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 program 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. Through FY 2016, the CAPT continued to develop comprehensive training and technical assistance products. These products focus on shared risk and protective factors to promote collaboration across substance abuse and mental health disciplines within the behavioral health field.

The program is increasing emphasis on virtual or distance forms of service delivery and relying more heavily on webinars and online training. The CAPT program 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 FY 2015, the CAPT supported the organizational capacity of high-need communities to address health disparities and achieve benchmarks identified in SAMHSA's Partnerships for Success program. CAPT continues 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. Data show that over 8,400 participants were trained and 94 percent agreed or strongly agreed that the TA increased their capacity to do substance abuse prevention work.

In FY 2016, CAPT expanded its scope of work by providing technical assistance to new SAMHSA grantees in the SPF Rx program as well as Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths program.

In FY 2017, funding continued to support the delivery of technical assistance and workforce development to the prevention field.

Under the FY 2018 Annualized CR level, funding would continue to provide technical assistance through a robust approach to regional Centers for Applied Prevention TA delivery to the prevention field.

Funding History

Fiscal Year	Amount
FY 2015	$7,493,000
FY 2016	$7,493,000
FY 2017	$7,493,000
FY 2018	$7,442,000
FY2019	$7,493,000

Budget Request

The FY 2019 President's Budget Request is $7.5 million, an increase of $51,000 from the FY 2018 Annualized CR. The program will continue to provide regionally based technical assistance and training to over 9,000 individuals in the prevention field.

Outputs and Outcomes Table

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

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.4.11 Prevention: increase the number of individuals trained by the CAPT. (Output)	FY 2016: 8,874 Target: 5,216 (Target Exceeded)	9,000	9,000	Maintain
1.4.12 Increase the 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 2016: 94.0 % Target: 90.0 % (Target Exceeded)	90.0%	90.0%	Maintain
1.4.13 Increase the 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 2016: 98 Target: 92 (Target Exceeded)	95	95	Maintain

Science and Service Program Coordination

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Science and Service Program Coordination.....	$4,072	$4,044	$4,072	$28

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Contracts
Eligible Entities..... Domestic and Public Entities

Program Description and Accomplishments

SAMHSA has made prevention of underage drinking a priority because of its potential impact on the health and well-being of young people and their communities. Over the past decade, there has been a steady decline in past month or current drinking by adolescents and young adults. Trend data report similar declines in underage binge and heavy drinking. In fact, among 8th to 12th grade students, rates of current, binge, and heavy drinking have declined to record lows.[62] Yet, alcohol remains the drug of choice for individuals between the ages of 12 to 20 years, and risky and heavy drinking among college-age youth students remains unacceptably high. [63]

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 program supports the Tribal Training and Technical Assistance Center and the Underage Drinking Prevention Education Initiatives (UADPEI).

The Tribal Training and Technical Assistance 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, substance abuse, and suicide among American Indian/Alaska Native (AI/AN) youth, in support of the HHS Tribal Health and Well-Being Coordination. These plans mobilize tribal communities' existing social and educational resources to meet their goals.

The Underage Drinking Prevention Education Initiatives engage 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

[62] Johnston, L. D., O'Malley, P. M., Miech, R. A., Bachman, J. G., & Schulenberg, J. E. (2017). *Monitoring the Future national survey results on drug use, 1975-2016: Overview, key findings on adolescent drug use.* Ann Arbor: Institute for Social Research, the University of Michigan.
[63] Center for Behavioral Health Statistics and Quality. (2016). *2015 National Survey on Drug Use and Health: Detailed Tables.* Substance Abuse and Mental Health Services Administration, Rockville, MD.

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 FY 2016, community-based organizations registered to host 1,500 events. These events were held in all 50 states, the District of Columbia, and three territories. Approximately 870 individuals attended live online training webinars and SAMHSA responded to 3,000 requests for technical assistance in planning, promoting, hosting, and evaluating events. SAMHSA will continue to fund two contracts to support these activities.

Funding History

Fiscal Year	Amount
FY 2015	$4,072,000
FY 2016	$4,072,000
FY 2017	$4,072,000
FY 2018	$4,044,000
FY 2019	$4,072,000

Budget Request

The FY 2019 President's Budget Request is $4.1 million, an increase of $28,000 from the FY 2018 Annualized CR. These funds will support SAMHSA's substance abuse prevention efforts and include a focus on preventing underage drinking and providing technical assistance and training to American Indians/Alaska Native communities.

Tribal Behavioral Health Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Tribal Behavioral Health Grants.....	$14,450	$14,898	$15,000	$102

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... 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 eight to 24 years.[64] Further, AI/AN high school students report higher rates of suicidal behaviors than the general population of U.S. high school students.[65] These behaviors include serious thoughts of suicide, suicide plans, suicide attempts, and medical attention for a suicide attempt. However, the risk of suicide is not the same in all AI/AN youth demographic groups. For instance, AI/AN youth raised in urban settings have a smaller risk of having thoughts of suicide than AI/AN youth raised on tribal reservations (21 percent and 33 percent, respectively).[66]

Consistent with the goals of the Tribal Behavioral Health Agenda, the Tribal Behavioral Health Grant (TBHG) program addresses the high incidence of substance use and suicide among AI/AN populations. Starting in FY 2014, this program supports tribal entities with the highest rates of suicide by providing effective and promising strategies that address substance abuse, trauma, and suicide and by promoting the mental health of AI/AN young people.

In FY 2014, SAMHSA's Center for Mental Health Services awarded five-year TBHG grants of up to $0.2 million annually to 20 tribes or tribal organizations with high rates of suicide. These five-year grants 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 Training and Technical Assistance Center (http://www.samhsa.gov/tribal-ttac) provides training and education to AI/AN grantees and organizations serving AI/AN populations to support their ability to achieve their goals. An evaluation component allows grantees and SAMHSA to work collaboratively to monitor progress and learn from each other.

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[64] 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.
[65] 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.
[66] Freedenthal, S. & Stiffman, A. R. (2004). Suicidal Behavior in Urban American Indian Adolescents: A Comparison with Reservation Youth in a Southwestern State. Suicide and Life-Threatening Behavior, 34(2), 160-171.

In FY 2016, SAMHSA expanded the TBHG program to include a Native youth initiative focused on removing possible barriers to success for Native youth. This initiative takes a comprehensive, culturally appropriate approach to help improve the lives of and opportunities for AI/AN youth. In addition to the Department of Health and Human Services, 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 AI/AN youth. This funding allows SAMHSA to expand activities through the braided TBHG ($15.0 million in the Substance Abuse Prevention appropriation and $15.0 million in Mental Health appropriation) to allow tribes the flexibility to implement community-based strategies to address trauma, prevent substance abuse, and promote mental health and resiliency among youth in tribal communities. The additional FY 2016 funding expands these activities to approximately 90 tribes and tribal entities. With the expansion of the TBHG program, SAMHSA's goal is to reduce substance use and the incidence of suicide attempts among AI/AN youth and to address behavioral health conditions that affect learning in the Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion, including trauma-informed strategies, and substance use prevention activities for high-risk AI/AN youth and their families, enhance early detection of mental illness and drug/alcohol addiction among AI/AN youth, and increase referral to treatment.

In FY 2017, SAMHSA provided funding to support 61 grant continuations and 15 new grant awards.

Under the FY 2018 Annualized CR level, SAMHSA would continue to support 76 grant continuations, evaluation, and technical assistance activities.

Funding History

Fiscal Year	Amount
FY 2015	---
FY 2016	$15,000,000
FY 2017	$14,450,000
FY 2018	$14,898,000
FY 2019	$15,000,000

Budget Request

The FY 2019 President's Budget Request is $15.0 million, an increase of $102,000 from the FY 2018 Annualized CR. This request, combined with $15.0 million in the Center of Mental Health Services will continue support 93 grants that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families.

As a braided activity, SAMHSA will track separately any amounts spent or awarded under Tribal Behavioral Health Grants through the distinct appropriations and ensure that funds are used for purposes consistent with legislative direction and intent of these appropriations.

Outputs and Outcomes Table

Program: Tribal Behavioral Health

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
2.4.12 Increase the percentage of youth age 10 - 24 who received mental health or related services after screening, referral or attempt (Output)	FY 2017: 56 % Target: 20 % (Target Exceeded)	56 %	56 %	Maintain
2.4.13 Increase the number of programs/organizations that implemented specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2017: 5,670 Target: 296 (Target Exceeded)	5670	5670	Maintain

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Grants to Prevent Prescription Drug/ Opioid Overdose Related Deaths.....	$12,000	$11,919	$12,000	$81

Authorizing Legislation ..... Section 516 and Section 546 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants, Contracts
Eligible Entities.....States, local government entities, Federally Recognized American Indian/Alaska Native tribe or tribal organizations

Program Description and Accomplishments

Opioid overdose is a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids (including synthetics such as fentanyl).[67] Opioids include illegal drugs such as heroin, as well as prescription medications used to treat pain. These prescription 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 overuse.

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

As the rates of prescription drug abuse, heroin abuse, illicit synthetic opioid abuse, overdoses, and opioid-related overdose deaths increase, communities are searching for ways to reduce the death rate from opioid-related overdoses.

[67] National Institute on Drug Use (NIDA). America's Addiction to Opioids: Heroin and Prescription Drug Abuse. (2014) Available from URL: http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2015/americas-addiction-to-opioids-heroin-prescription-drug-abuse#_ftnref4

In FY 2016, SAMHSA awarded 12 grants to states for the Grants to Prevent Prescription Drug and Opioid Overdose-related Deaths program helps 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 can be used for purchasing overdose reversing drugs, equipping first responders with them, providing training on their use, and developing other overdose-related death prevention strategies, and providing materials to assemble and disseminate overdose kits. These grantees are also required to develop a dissemination plan and a training course tailored to meet the needs of first responders in the communities within their state. The course uses SAMHSA's Opioid Overdose Prevention Toolkit as a guide and includes a comprehensive prevention program that will focus on prevention, treatment, and recovery services in order to decrease the likelihood of drug overdose recurrence.

In FY 2017 and under the FY 2018 Annualized CR level, SAMHSA would provide funding to continue the 12 grants.

Funding History

Fiscal Year	Amount
FY 2015	---
FY 2016	---
FY 2017	$12,000,000
FY 2018	$11,919,000
FY 2019	$12,000,000

Budget Request

The FY 2019 President's Budget Request is $12.0 million, an increase of $81,000 from the FY 2018 Annualized CR. This funding will provide continuation grants to 12 states to reduce the number of opioid overdose-related deaths. Funding will help states purchase overdose reversing drugs, equip first responders in high-risk communities, support education on the use of naloxone and other overdose-related death prevention strategies, provide the necessary materials to assemble overdose kits, and cover expenses incurred from dissemination efforts.

First Responder Training for Opioid Overdose Reversal Drugs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
First Responder Training (CARA)	$12,000	$11,919	$12,000	$81

Authorizing Legislation ..... Section 546 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method…….....Competitive Grants
Eligible entities…….States, local government entities, Federally Recognized American Indian/Alaska Native tribe or tribal organizations

Program Description and Accomplishments

Under Section 202 of the Comprehensive Addiction and Recovery Act (CARA), SAMHSA is authorized to support additional efforts to prevent opioid overdose-related deaths by providing grants to train first responders. In FY 2017, SAMHSA funded 21 grants for the First Responder CARA grant program (FR-CARA). The purpose of this program is to allow first responders and members of other key community sectors to administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose. Grantees will train and provide resources to first responders and members of other key community sectors at the state, tribal, and local governmental levels on carrying and administering a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose. Grantees will also establish processes, protocols, and mechanisms for referral to appropriate treatment and recovery communities. This program includes a broader eligibility than the previously referenced state-based Grants to Prevent Opioid Overdose-related Death program. The program allows for much needed services to reach local and tribal areas. Additionally, in FY 2017, the First Responder Training program also included a set-aside to address the critical needs of rural populations.

Training, technical assistance, and evaluation activities are also being supported to assist grantees, determine best practices, and assess program outcomes. Under the FY 2018 Annualized CR level, funding would support continuation grants to 21 grantees to address the opioid crisis in this country.

Funding History

Fiscal Year	Amount
FY 2015	---
FY 2016	---
FY 2017	$12,000,000
FY 2018	$11,919,000
FY 2019	$12,000,000

Budget Request

The FY 2019 President's Budget Request is $12.0 million, an increase of $81,000 from the FY 2018 Annualized CR. This funding will provide continuation grants to 20 grantees and support the continuation of training, technical assistance and evaluation activities to address the opioid crisis in this country.

Minority Fellowship Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Minority Fellowship Program.....	$71	$71	$---	-$71

Authorizing Legislation ..... Section 597 of the PHS Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Grants/Contracts
Eligible Entities..... Organizations that represent individuals obtaining post-baccalaureate training (including for master's and doctoral degrees) for mental and substance use disorder treatment professionals, including in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling

Program Description and Accomplishments

SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance use disorder treatment services for minority populations that are underserved. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, the program expanded to include marriage and family therapists and later

added professional counselors. Professional guilds receive competitively awarded grants, and then competitively award the stipends to post-graduate students pursuing a degree in that professional field. In FY 2016 and FY 2017, SAMHSA funded six continuation grants.

Funding History

Fiscal Year	Amount
FY 2015	$71,000
FY 2016	$71,000
FY 2017	$71,000
FY 2018	$71,000
FY 2019	---

Budget Request

The FY 2019 President's Budget Request is $0.0 million, a decrease of $71,000 from the FY 2018 Annualized CR. The program is being discontinued because it overlaps with other federal activities.

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Drug Free Communities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Drug Free Communities[1]	$---	$---	$100,000	$100,000

[1] Drug Free Communities was funded in the Office of National Drug Control Policy at $97.0 million in 2017 and at $96.3 million under the FY 2018 Annualized CR.

Authorizing Legislation .....Drug-Free Communities Act of 1997 (Public Law 105-20)
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities..... States, Tribes, and Territories

Program Description and Accomplishments

The Drug-Free Communities (DFC) Act of 1997 created the DFC Support Program (Public Law 105-20). By statute, the DFC Support Program has two goals:

- Establish and strengthen collaboration among communities, public and private non-profit agencies, as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance abuse among youth.
- Reduce substance abuse among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse.

The goal of the program is to establish and strengthen collaboration among communities, public and private non-profit agencies, as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance abuse among youth. In addition, the program aims to reduce substance abuse among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse. Five- year grants of up to $125,000 are awarded to new recipients each year. Recipients are eligible to apply for funding for a second five-year period, which is designated as a competing continuation grant.

The program also includes the Drug Free Communities Mentoring (DFC-M) Program. The purpose of this program is to provide grant funds to existing DFC recipients so they may serve as mentors to newly-formed and/or developing coalitions that have never received a DFC grant. It is the intent of the DFC-M Program that, at the end of the Mentoring grant, each Mentee coalition will meet all of the statutory eligibility requirements of the DFC Support Program and be fully prepared to compete for a DFC grant on their own. DFC-M grants are awarded for two years for up to $75,000. Eligible applicants are coalitions that have been in existence for at least five years, have an active DFC grant at the time of the award, and are in good standing.

Funding History

Fiscal Year	Amount
FY 2015	---
FY 2016	---
FY 2017	---
FY 2018	---
FY 2019	$100,000,000

Budget Request

The FY 2019 President's Budget Request is $100.0 million. This activity was funded at $96.3 million in the Office of National Drug Control Policy (ONDCP) under the 2018 Annualized CR. SAMHSA has administered this program for several years on behalf of ONDCP. The FY 2019 Budget proposes to directly appropriate these funds to SAMHSA to streamline program management and create administrative efficiencies. Funding will be used to continue both the DFC and DFC-Mentoring programs.

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table Summary

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Grants						
Continuations	385	$154,652	385	$119,446	291	$85,222
New/Competing	85	$22,391	64	63,453	---	---
Subtotal	470	177,044	449	182,899	291	85,222
Contracts						
Continuations	31	$32,604	20	34,105	24	35,663
New	6	12,221	2	4,699	---	---
Subtotal	37	44,825	22	38,804	24	35,663
Total, Substance Abuse Prevention PRNS	**507**	**$221,869**	**471**	**$221,703**	**315**	**$120,885**

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Capacity:						
Strategic Prevention Framework						
Grants						
Continuations	99	$104,032	73	$55,174	88	$48,022
New/Competing	---	---	18	50,896	---	---
Supplements	---	---	---	---	---	---
Subtotal	99	104,032	91	106,070	88	48,022
Contracts						
Continuations	14	15,452	6	12,603	7	10,404
New	---	---	---	---	---	---
Subtotal	14	15,452	6	12,603	7	10,404
Total, Strategic Prevention Framework	**113**	**119,484**	**97**	**118,673**	**95**	**58,426**
Federal Drug-Free Workplace						
Contracts						
Continuations	4	4,894	3	769	4	4,894
New	---	---	1	4,092	---	---
Subtotal	4	4,894	4	4,861	4	4,894
Total, Federal Drug-Free Workplace	**4**	**4,894**	**4**	**4,861**	**4**	**4,894**
Minority AIDS						
Grants						
Continuations	131	29,147	105	25,488	---	---
New/Competing	32	6,290	45	12,490	---	---
Subtotal	163	35,437	150	37,979	---	---
Contracts						
Continuations	4	4,138	---	2,343	---	---
New	1	830	1	603	---	---
Subtotal	5	4,968	1	2,946	---	---
Total, Minority AIDS	**168**	**40,405**	**151**	**40,925**	**---**	**---**
Sober Truth on Preventing Underage Drinking Act						
Grants						
Continuations	81	3,791	98	4,567	95	4,504
New/Competing	17	766	---	---	---	---
Subtotal	98	4,557	98	4,567	95	4,504
Contracts						
Continuations	1	1,384	2	2,385	2	2,496
New	1	1,060	---	---	---	---
Subtotal	2	2,443	2	2,385	2	2,496
Total, Sober Truth on Preventing Underage Drinking	**100**	**7,000**	**100**	**6,952**	**97**	**7,000**

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Grants to Prevent Prescription Drug/Opioid Overdose						
Grants						
Continuations	12	10,650	12	10,687	12	10,254
New	---	---	---	---	---	---
Subtotal	12	10,650	12	10,687	12	10,254
Contracts						
Continuations	2	1,350	1	1,232	2	1,746
New	---	---	---	---	---	---
Subtotal	2	1,350	1	1,232	2	1,746
Total, Grants to Prevent Prescription Drug/ Opioid	**14**	**12,000**	**13**	**11,919**	**14**	**12,000**
Tribal Behavioral Health Grants						
Grants						
Continuations	61	7,012	76	12,451	76	12,315
New/Competing	15	4,100	---	---	---	---
Subtotal	76	11,111	76	12,451	76	12,315
Contracts						
Continuations	3	3,339	3	2,447	3	2,685
New/Competing	---	---	---	---	---	---
Subtotal	3	3,339	3	2,447	3	2,685
Total, Tribal Behavioral Health Grants	**79**	**14,450**	**79**	**14,898**	**79**	**15,000**
First Responder Training (CARA)						
Grants						
Continuations	---	-45,333	21	11,079	20	10,127,232
New/Competing	21	$11,236	---	---	---	---
Subtotal	21	$11,191	21	11,079	20	$10,127
Contracts						
Continuations	---	---	1	839	2	1,873
New/Competing	1	809	---	---	---	---
Subtotal	1	809	1	839	2	1,873
Total, First Responder Training (CARA)	**22**	**12,000**	**22**	**11,919**	**22**	**12,000**
Subtotal, Capacity	**478**	**$198,233**	**444**	**$198,228**	**289**	**$97,320**

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Science and Service:						
Center for the Application of Prevention Technologies						
Contracts						
Continuations	---	$429	1	$7,442	1	$7,493
New/Competing	1	7,064	---	---	---	---
Subtotal	1	7,493	1	7,442	1	7,493
Technologies	1	7,493	1	7,442	1	7,493
SAP Minority Fellowship Program						
Grants						
Continuations	1	66	---	---	---	---
New/Competing	---	---	1	66	---	---
Subtotal	1	66	1	66	---	---
Contracts						
Continuations	---	5	---	---	---	---
New/Competing	---	---	---	4	---	---
Subtotal	---	5	---	4	---	---
Total, SAP Minority Fellowship Program	**1**	**71**	**1**	**71**	---	---
Science & Service Program Coordination						
Contracts						
Continuations	3	1,614	3	4,044	3	4,072
New	2	2,458	---	---	---	---
Subtotal	5	4,072	3	4,044	3	4,072
Total, Science & Service Program Coordination	**5**	**4,072**	**3**	**4,044**	**3**	**4,072**
Subtotal, Science and Service	**7**	**11,636**	**5**	**11,557**	**4**	**11,565**
Total, Substance Abuse Prevention	**507**	**$221,869**	**471**	**$221,703**	**315**	**$120,885**

Grant Awards Table

(Whole dollars)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	470	449	291
Average Award	$376,689	$407,348	$292,858
Range of Awards	$50,000 - $2,300,000	$50,000 - $2,300,000	$50,000 - $2,300,000

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SAMHSA
Substance Abuse Treatment
Table of Contents

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Substance Abuse Treatment Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Programs of Regional and National Significance.....	$350,427	$352,020	$255,318	-$96,702
PHS Evaluation Funds (non-add).....	*2,000*	*1,986*	---	*-1,986*
State Targeted Response to the Opioid Crisis Grants.....	500,000	496,605	---	-496,605
Substance Abuse Prevention and Treatment Block Grant	1,858,079	1,845,461	1,858,079	12,618
Budget Authority (non-add).....	*1,778,879*	*1,766,799*	*1,778,879*	*12,080*
PHS Evaluation Funds (non-add).....	*79,200*	*78,662*	*79,200*	*538*
Total, Substance Abuse Treatment.....	**$2,708,506**	**$2,694,085**	**$2,113,397**	**-$580,688**

The Substance Abuse Treatment FY 2019 President's Budget Request is $2.1 billion, a decrease of $580.7 million from the FY 2018 Annualized CR. The request includes $2.0 billion in Budget Authority and $79.2 million in Public Health Service (PHS) Evaluation funds.

Programs of Regional and National Significance (PRNS)
Substance Abuse Treatment Appropriation

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Capacity:				
Opioid Treatment Programs/Regulatory Activities	$8,724	8,665	$8,724	$59
Screening, Brief Intervention and Referral to Treatment	30,000	29,796	---	-29,796
Budget Authority (non-add)	*28,000*	*27,810*	---	*-27,810*
PHS Evaluation Funds (non-add)	*2,000*	*1,986*	---	*-1,986*
Targeted Capacity Expansion-General	67,192	66,736	67,192	456
Other Targeted Capacity Expansion	*11,192*	*11,116*	*11,192*	*76*
MAT for Prescription Drug and Opioid Addiction (non-add)	*56,000*	*55,620*	*56,000*	*380*
Pregnant and Postpartum Women	19,931	19,796	19,931	135
Comprehensive Addiction and Recovery Act (non-add)	*4,000*	*3,973*	*4,000*	*27*
Recovery Community Services Program	2,434	2,417	2,434	17
Improving Access to Overdose Treatment (IATOT)	1,000	993	1,000	7
Building Communities of Recovery (BCOR)	3,000	2,980	3,000	20
Children and Families	29,605	29,404	29,605	201
Treatment Systems for Homeless	36,386	36,139	36,386	247
Minority AIDS	65,570	65,125	---	-65,125
Criminal Justice Activities	74,000	77,470	78,000	530
Other Criminal Justice Activities (non-add)	*18,000*	*17,878*	*18,000*	*122*
Drug Court Activities (non-add)	*56,000*	*59,593*	*60,000*	*407*
Subtotal, Capacity	**337,842**	**339,520**	**246,272**	**-93,248**
Science and Service:				
Addiction Technology Transfer Centers	9,046	8,985	9,046	61
SAT Minority Fellowship Programs	3,539	3,515	---	-3,515
Subtotal, Science and Service	**12,585**	**12,500**	**9,046**	**-3,454**
Total, PRNS	**$350,427**	**$352,020**	**$255,318**	**-$96,702**

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities…… …… ……..States, local governments, Communities, Federally Recognized American Indian/Alaska Native tribes or tribal organizations, Indian Health Service-operated and contracted health facilities and programs, public or private nonprofit entities

Opioid Treatment Programs/Regulatory Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Opioid Treatment Programs/Regulatory Activities.....	$8,724	$8,665	$8,724	$59

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
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 Association

Program Description and Accomplishments

The misuse of prescription opioid pain relievers and illicit opioids, such as heroin, is causing suffering, sickness, overdose, and death in the United States at epidemic levels.[68] Communities across the nation also face the risk that individuals who inject opioids will contract and spread Human Immunodeficiency Virus (HIV) and hepatitis C.[69] The underlying cause of these problems is increasing rates of opioid abuse.[70,71]

With increasing incidence of opioid abuse, there is a corresponding increase in admissions for treatment of opioid abuse.[72] Medication-assisted treatment (MAT) refers to the use of the Food and Drug Administration (FDA) approved pharmacotherapies (i.e., buprenorphine products, methadone, and naltrexone products) in combination with evidence-based psychosocial interventions for treatment of opioid use disorders. MAT is a safe and effective strategy for decreasing the frequency and quantity of opioid use and reducing the risk of overdose and death.

[68] U.S. Department of Health and Human Services. Addressing prescription drug abuse in the United States: current activities and future opportunities. 2013. Retrieved from www.cdc.gov/drugoverdose/pdf/hhs_prescription_drug_abuse_report_09.2013.pdf
[69] Substance Abuse and Mental Health Services Administration. Associations of nonmedical pain reliever use and initiation of heroin use in the United States. 2013. Retrieved from https://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm
[70] Johnson EM, Lanier WA, Merrill RM, et al. Unintentional prescription opioid-related overdose deaths: description of decedents by next of kin or best contact, Utah, 2008-2009. J Gen Intern Med. 2013;28(4): 522-9.
[71] Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA.* 2011;305(13):1315-1321. doi:10.1001/jama.2011.370.
[72] Paulozzi LJ, Jones CM, Mack KA, Rudd RA. Vital signs: overdoses of prescription opioid pain relievers – United States, 1999-2008. MMWR Morb Mortal Wkly Rep. 2011;60(43): 1487-92.

Approximately one million Americans need, but do not access, treatment for an opioid addiction.[73] A search of SAMHSA's behavioral health treatment locator reveals only 20 percent of surveyed facilities offer MAT for individuals with opioid addiction. The majority of the roughly 1,500 opioid treatment programs (OTPs) which provide supervised dosing of methadone and buprenorphine are at or near capacity.

OTPs are the only means of providing medication-assisted treatment (MAT) with methadone. Buprenorphine can be prescribed in an office setting by physicians who have received a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000) provision of the Controlled Substances Act. Most physicians with a waiver to prescribe buprenorphine do not treat the maximum allowable number of patients. On July 8, 2016, SAMHSA/HHS published a final rule, "Medication Assisted Treatment for Opioid Use Disorders," which allows practitioners who have had a waiver to prescribe buprenorphine for up to 100 patients for a year or more, to now obtain a waiver to treat up to 275 patients.

SAMHSA is responsible for regulating and certifying approximately 1,500 OTPs to use opioid agonist treatment medications and processing waivers for physicians and mid-level practitioners, such as nurse practitioners and physician assistants, who wish to treat opioid abuse with buprenorphine. SAMHSA reviews new and renewal applications for OTPs and oversees their accreditation. OTPs are required to be accredited as a condition of certification. SAMHSA's regulation of OTPs plays a critical role in expanding access and maintaining quality. Accrediting organizations must be approved by SAMHSA to fulfill this function and this approval must be renewed every five years. SAMHSA monitors the accrediting bodies for quality assurance and improvement by making 10 to 20 site visits to recently-accredited programs each year; additionally, SAMHSA conducts unannounced OTP site visits to investigate complaints.

SAMHSA implements DATA 2000 in coordination with the Drug Enforcement Administration. This includes approving waivers for qualified practitioners to provide medication-assisted treatment in office-based settings. More than 37,000 practitioners have been granted waivers since 2001. Waiver processing is conducted under a contract entitled DATA Waiver Processing and Support Project. From August 2016 through March 2017, SAMHSA processed over 7,365 waiver applications and certified 3,211 physicians to treat up to 30 patients, 1,107 to treat up to 100 patients, and 3,047 to treat up to 275 patients.

In November 2016, the implementation of Section 303 of the Comprehensive Addiction and Recovery Act (CARA) enabled the Department of Health and Human Services (HHS) to announce that nurse practitioners (NPs) and physician assistants (PAs) could immediately begin taking the 24 hours of required training to prescribe buprenorphine for the treatment of opioid addiction. CARA expanded prescribing privileges to NPs and PAs for five years (until October 1, 2021).

[73] Jones, C. M. (2013). Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers, United States, 2002-2004 and 2008-2010. Drug and Alcohol Dependence, 132(1-2):95-100.

NPs and PAs who complete the required training and seek to prescribe buprenorphine for up to 30 patients were able to begin applying for a waiver in February 2017. As of November 2017, SAMHSA had approved 4,070 mid-level practitioners to begin prescribing buprenorphine. SAMHSA supports a cooperative agreement, the Providers Clinical Support Services for Medication-Assisted Treatment (PCSS-MAT), which provides education, training and mentors to behavioral healthcare providers.

SAMHSA developed the MATx, a public domain app for healthcare practitioners to support medication-assisted treatment of opioid use disorder. This is a significant step forward in efforts to improve access to MAT, making it easier for patients living with addiction to access effective, evidence-based treatment. This public domain app puts the most critical information to support the delivery of MAT in one place - the latest on treatment approaches, medications, and clinical support tools, plus helplines and access to SAMHSA's Treatment Locators (https://www.findtreatment.samhsa.gov/).

Under the FY 2018 Annualized CR level, SAMHSA would support one continuation grant, one supplemental grant, and technical assistance efforts.

Funding History

Fiscal Year	Amount
FY 2015	$8,724,000
FY 2016	$8,724,000
FY 2017	$8,724,000
FY 2018	$8,665,000
FY 2019	$8,724,000

Budget Request

The FY 2019 President's Budget Request is $8.7 million, an increase of $59,000 from the FY 2018 Annualized CR. SAMHSA intends to continue to support the Secretary's five-prong strategy to address the opioid crisis priorities through regulatory activities, ongoing training, certification, and technical assistance to provider groups and communities impacted by the opioid crisis.

Screening, Brief Intervention, and Referral to Treatment

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Screening Brief Intervention and Referral to Treatment	$30,000	$29,796	$---	-$29,796
Budget Authority (non-add)	*28,000*	*27,810*	---	*-27,810*
PHS Evaluation Funds (non-add)	*2,000*	*1,986*	---	*-1,986*

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Single State Authority and Health Departments in States, Territories, the District of Columbia, Federally Recognized American Indian/Alaska Native Tribes or Tribal Organizations, Domestic Public and Private Non-Profit Entities, and Public and Private Universities Colleges

Program Description and Accomplishments

Among individuals age 12 or older, 27.1 million (10.1 percent) use illicit drugs, 66.7 million (24.9 percent) binge drink, and 17.3 million (6.5 percent) drink heavily.[74] This imposes a great cost on society by compromising individual health and potentially causing injury to others. The National Institute on Drug Abuse found that misuse of illicit drugs and alcohol costs society $488.0 billion each year.[75] Of the individuals who need treatment for substance abuse, only 10.8 percent receive treatment in a specialty treatment facility.[76] The vast majority of those meeting criteria for having a drug/alcohol addiction have not been diagnosed.

In 2003, SAMHSA started the Screening, Brief Intervention and Referral to Treatment (SBIRT) program, which is intended to help primary care physicians identify individuals who misuse substances and help them intervene early with education, brief treatment, or referral to specialty treatment. The program's goal is to increase the number of individuals who receive treatment and reduce the rate of substance misuse. Studies have shown that this approach is effective in helping reduce harmful alcohol consumption.[77,78,79]

The SBIRT program seeks to increase the use of SBIRT in medical settings by promoting wide dissemination and adoption of the practice across the spectrum of primary care services. To achieve this, SAMHSA awards state implementation grants to encourage adoption of SBIRT by healthcare providers in each state. SAMHSA also supports the SBIRT Student Training grant programs.

The SBIRT program requires state grant recipients to implement the model in all primary care settings, as well as hospitals, trauma centers, federally qualified health centers, and other relevant health care settings. Recipients may use funds to screen for substance use and co-occurring mental illness and drug/alcohol addiction. They can support evidence-based client-centered interventions, such as Motivational Interviewing, brief treatment, and referral to specialty care for individuals exhibiting addiction symptoms.

The SBIRT training program helps train a wide range of medical providers to incorporate SBIRT as part of their ongoing practice. This includes physicians, nurses, counselors, social workers, health promotion advocates, health educators, and others. A SAMHSA-funded cross-site evaluation found that allied health professionals, rather than the physicians themselves, were more likely to implement SBIRT with their patients.[80] The SBIRT Student Training and Health Professionals Training grant programs support SBIRT training efforts for medical students, medical residents, nurses, social workers, psychologists, pharmacists, dentists, and physician assistants. These efforts aim to develop further the primary healthcare workforce in substance abuse treatment and services.

SAMHSA has demonstrated the effectiveness of SBIRT and continues to disseminate SBIRT practices. As of 2016, SAMHSA data show roughly 2.7 million individuals have received screening and/or intervention through the SBIRT initiative.[81] Of those screened, roughly, 11.5 percent were determined to be at risk, another 1.9 percent were referred for brief treatment, and an additional 2.2 percent were referred to specialty treatment.[82]

In FY 2017, SAMHSA funded three continuation state cooperative agreements and continued funding for eight state cooperative agreements and 69 training grant continuations.

Under the FY 2018 Annualized CR level, SAMHSA would support seven new and eight continuation SBIRT state grants to support program implementation and direct TA, as needed, and 12 SBIRT continuation training grants.

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[74]Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/

[75] National Institute on Drug Abuse (2016), *Trends and Statistics,* http://www.drugabuse.gov/related-topics/trends-statistics.

[76] Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/

[77] Bertholet, N., Daeppen, J.-B., Wietlisbach, V., Fleming, M., & Burnand, B. (2005). *Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis*. Archives of Internal Medicine 165, 986–995.

[78] Kahan, M., Wilson, L., & Becker, L. (1995). *Effectiveness of physician-based interventions with problem drinkers: A review.* Canadian Medical Association Journal, *152*, 851–859.

[79] Wilk, A.I., Jensen, N.M., and Havighurst, T.C. (1997*). Meta-analysis of randomized control trails addressing brief interventions in heavy alcohol drinkers.* Journal of General Medicine, 12 (5), 274-283.

[80] RTI International (2009). *RTI International to Evaluate Comprehensive Substance Abuse Intervention Programs for SAMHSA.*

[81] *Services Accountability Improvement System*, (2016). http://www.samhsa-gpra.samhsa.gov/

[82] *Services Accountability Improvement System*, (2016). http://www.samhsa-gpra.samhsa.gov/

Funding History

Fiscal Year	Amount
FY 2015	$46,889,000
FY 2016	$46,889,000
FY 2017	$30,000,000
FY 2018	$29,796,000
FY 2019	---

Budget Request

The FY 2019 President's Budget Request is $0.0 million, a decrease of $29.8 million from the FY 2018 Annualized CR. The SBIRT program is being eliminated in FY 2019 as significant knowledge has been developed and disseminated for this program. SBIRT has been brought to scale in hundreds of communities across the nation. SAMHSA will continue to disseminate SBIRT program information through its national TA efforts.

Outputs and Outcomes Table

Program: Screening, Brief Intervention, and Referral to Treatment

NOTE: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.2.40 Increase the number of clients served (Output)	FY 2017: 182,851 Target: 300,000 (Target Not Met)	182,851	182,851	Maintain
1.2.41 Increase the percentage of clients receiving services who had no past month substance use (Outcome)	FY 2017: 34.8 % Target: 36 % (Target Not Met but Improved)	34.8 %	34.8 %	Maintain

Targeted Capacity Expansion-General

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Targeted Capacity Expansion General.....	$67,192	$66,736	$67,192	$456
Other Targeted Capacity Expansion.....	*11,192*	*11,116*	*11,192*	*76*
MAT for Prescription Drug and Opioid Addiction (non-add)	*56,000*	*55,620*	*56,000*	*380*

Authorizing Legislation ..... Sections 509 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Domestic Public and Private Non-Profit Entities, States, Opioid Medication-Assisted SPF Rx Treatment Service Providers, Outpatient Substance Abuse Providers, Community Mental Health Centers, Federally Qualified Health Centers, SAMHSA Certified Opioid Treatment Programs, and Licensed Outpatient Substance Abuse Treatment Programs

Program Description and Accomplishments

Urgent, unmet, and emerging substance abuse treatment and recovery support service capacity needs remain a critical issue for the nation. In an effort to assist communities in overcoming these barriers, SAMHSA initiated the Targeted Capacity Expansion (TCE) program. The program provides rapid, strategic, comprehensive, and integrated community-based responses to gaps in and capacity for substance abuse treatment and recovery support services. Examples of such needs include limited or no access to medication-assisted treatment (MAT) for opioid use disorders; lack of resources needed to adopt and implement health information technology (HIT) in substance abuse treatment settings; and short supply of trained and qualified peer recovery coaches to assist individuals in the recovery process.

Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT PDOA)

MAT refers to the use of the Food and Drug Administration-approved pharmacotherapies (i.e., buprenorphine products, methadone, and naltrexone products) in combination with evidence- based psychosocial interventions for treatment of opioid addiction. MAT is a safe and effective strategy for decreasing the frequency and quantity of opioid abuse and reducing the risk of overdose and death.

Drug overdose death continues to increase in the U.S., with 63,600 lethal drug overdoses in 2016, a record number of overdose deaths and an increase from 52,404 in 2015; among these deaths, 42,249 (66 percent) involved an opioid, an increase from 33,091 (63 percent) in 2015. Opioid addiction is driving this alarming trend, with 19,413 overdose deaths related to synthetic opioids

other than methadone, and 15,469 overdose deaths related to heroin in 2016.[83] The rate of drug overdose deaths involving synthetic opioids other than methadone doubled between 2015 and 2016. Heroin overdose death rates have more than tripled since 2010, from 1.0 per 100,000 in 2010 to 4.9 per 100,000 in 2016. Despite these troubling statistics, significant gaps persist between treatment needs and capacity. In 2012, 48 states and the District of Columbia reported levels of opioid addiction that were higher than their rates of MAT capacity. Furthermore, 38 states reported that at least 75 percent of their opioid treatment programs (OTPs) were operating at 80 percent or greater capacity. [84]

MAT PDOA addresses treatment needs of individuals who have an opioid addiction by expanding/enhancing treatment system capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based MAT and recovery support services. Recovery support services include linking patients and families to social, legal, housing, and other supports to improve the probability of positive outcomes.

In FY 2016, SAMHSA funded 11 continuation state grants, 11 new state grants, as well as one contract. The 22 grantees in FY 2016 represent all 10 HHS regions. As of August 2017, approximately 2,470 individuals with opioid addiction are being served through the grant program; at six-month follow-up, 61 percent of individuals served reported abstinence from illicit drug use, exceeding the 60 percent target. In FY 2017, SAMHSA multi-year funded five grants and annually funded one new grant, 23 continuations and one continuing technical assistance contract.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund 20 new MAT PDOA and 12 continuation MAT-PDOA grants, which will support program implementation and direct TA.

Targeted Capacity Expansion-Technology Assisted Care (TCE-TAC)

Access to treatment remains inadequate for underserved populations living with drug/alcohol addiction and/or co-occurring mental illness and drug/alcohol addiction, such as those living in rural areas. A key component of this access challenge relates to a lack of dependable transportation and many organizations experience significant financial constraints in serving these rural populations. SAMHSA believes that behavioral healthcare providers who use health information technology (HIT) can help patients improve their access to necessary care and prevention services. For example, tele-health and tele-psychiatry can bring addiction medicine providers to clients in areas without local specialists. Web-based tools can improve communication and help deliver much-needed support and education. Health information technology approaches can also enable providers to document and coordinate better mental and substance abuse treatment services directly or via tele-psychiatry or telemedicine with families and other providers and specialists.

SAMHSA established the TCE-TAC grant program to address the lack of resources in the field necessary to adopt and implement health information technologies, including electronic health records (EHRs), smart phones, tablets, web-based technologies and applications to support

[83] Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017.
[84] Jones, C. M., Campopiano, M., Baldwin, G., McCance-Katz, E. (2015). National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health*, 105(8), e55-c63.

tele- psychiatry and telemedicine. The program also addresses the behavioral healthcare providers' need to expand and/or enhance their ability to communicate effectively with individuals in treatment, as well as monitor their health to ensure treatment and prevention services are available when and where needed.

TCE-TAC and its predecessor program, Targeted Capacity Expansion-Health Information Technology (TCE-HIT), have improved care delivery in 48 behavioral healthcare organizations across 23 states. In FY 2017, the TCE-TAC program included 12 additional grantees bringing the total number of grantees since 2011 to 60 behavioral healthcare organizations. Grantees have deployed all of the above-mentioned technologies to provide substance abuse treatment services directly or via remote service delivery (i.e., tele-psychiatry and telemedicine). In FY 2017, the TCE-TAC and TCE- HIT programs served roughly 882 individuals. Health information technology clearly holds great potential for increasing access to treatment services and providing reliable exposure to meaningful health information for underserved individuals with mental illness and alcohol/drug addiction. Providing the means to sustain this technology is likely to be an ongoing challenge for these and similarly situated organizations.

In FY 2016, SAMHSA funded 13 new TCE-TAC grants to enhance or expand the capacity of treatment providers to serve individuals who are traditionally underserved and to help achieve and maintain recovery and to improve the overall quality of life for those being served. In FY 2017, SAMHSA supported continued funding for the 13 TCE-TAC grant awards. These awards support the continuous development and deployment of unique advanced technology solutions to serve more clients with fewer resources.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund 13 continuation TCE-TAC grants for implementation and direct TA.

Targeted Capacity Expansion-Peer to Peer (TCE-PTP)

Peer support is built on the premise that individuals in recovery from drug/alcohol addiction can be of great value through the sharing of their recovery experiences with those attempting to achieve and sustain recovery. Peer recovery support services, as an adjunct to clinical treatment, extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery from drug/alcohol addiction. Peer support and peer recovery support services have been shown to reduce healthcare costs. Additionally, the overall message from limited research studies conducted to date is that recovery support service adjuncts appear to be helpful over and above treatment alone.

There is currently a short supply of adequately trained peer support providers to work both in treatment and in community-based settings. There is also a growing need to train and certify existing peer providers to address the increasing demand and diverse settings in which peer providers are employed. Since 2002, SAMHSA has awarded over 105 grants to community-based organizations to provide peer recovery support services to individuals in or seeking recovery from drug/alcohol addiction and their families. The primary objective of these services is to help individuals and families in search of recovery to obtain much needed support, sustain clinical treatment gains, engage in healthy community living, and improve overall quality of life. This

grant program incorporates a peer-to-peer model, which capitalizes on the expertise of those individuals with similar lived experience.

The TCE-PTP program has reached over 5,800 individuals and their families. Significant strides have been made in increasing abstinence, work and educational opportunities, social connectedness, housing stability, housing support, and decreasing criminal justice involvement. In FY 2016, the percentage of people who were employed or currently attending school increased from 27.5 percent at intake to 47.1 percent at six-month follow-up and abstinence in the past 30 days from alcohol and drug use improved from 63.6 percent at intake to 82.1 percent at six-month month follow-up. In addition, the percentage of individuals reporting stability in housing improved from 45.2 percent at intake to 55.6 percent at six-month follow-up. In FY 2017, SAMHSA funded 17 continuation TCE peer-to-peer grants and TA activities.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund 17 continuation TCE PTP grants to support program implementation and direct TA.

The output and outcome measures for Targeted Capacity Expansion-General are part of the Treatment - Other Capacity Activities Outputs and Outcomes table shown on page 202.

Funding History

Fiscal Year	Amount
FY 2015	$23,223,000
FY 2016	$36,303,000
FY 2017	$67,192,000
FY 2018	$66,736,000
FY 2019	$67,192,000

Budget Request

The FY 2019 President's Budget Request is $67.2 million, an increase of $456,000 from the FY 2018 Annualized CR. SAMHSA intends to fund 32 continuation MAT PDOA grants, 13 new TCE-TAC grants, and 17 TCE-PTP new grants.

Outputs and Outcomes Tables

Program: Treatment Prescription Drug and Opioid Addiction

NOTE: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.3.01 Increase the number of admissions for Medication Assisted Treatment (Output)	FY 2017: 2,230 Target: 1,400 (Target Exceeded)	2,230	2,230	Maintain
1.3.02 Increase number of clients receiving integrated care (Output)	FY 2017: 1,301 Target: 1,100 (Target Exceeded)	1,301	1,301	Maintain
1.3.03 Decrease illicit drug use at 6-month follow-up (Outcome)	FY 2017: 62 % Target: 60 % (Target Exceeded)	62 %	62 %	Maintain

Pregnant and Postpartum Women

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Pregnant and Postpartum Women.....	$19,931	$19,796	$19,931	$135
Comprehensive Addiction and Recovery Act (non-add).	*4,000*	*3,973*	*4,000*	*27*

Authorizing Legislation…….Section 508 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

From 1992 to 2012, a steady four percent of women admitted to treatment for drug/alcohol addiction were pregnant. From FY 2003 through FY 2015, 28.4 percent of pregnant and postpartum women who had custody of their children at intake reported illegal drug use in the past 30 days.[85] Since many traditional substance abuse treatment programs do not allow for the inclusion of children, a woman may be torn between the need to care for her dependent children and her need for treatment.[86] The nation's opioid crisis has also added to this challenge for many pregnant and parenting women. The proportion of pregnant women entering treatment who reported any prescription opioid misuse increased substantially from two percent in 1992 to 28 percent in 2012, an increase of 173 percent, from 351 to 6,087 women.[87] The proportion of pregnant women who entered treatment and reported prescription opioids as their primary substance use increased from one percent in 1992 to 19 percent in 2012, an increase of 344 percent, from 124 to 4,268 women.[88]

Since 2003, SAMHSA has supported comprehensive residential substance abuse treatment, prevention, and recovery support services for pregnant and postpartum women, their minor children, and services for other family members (e.g., fathers of the children) through the Pregnant and Postpartum Women program (PPW). SAMHSA has successfully implemented a family-centered approach in the PPW program, which has evolved over time. This approach includes partnering with others to leverage diverse funding streams, encouraging the use of evidence-based practices, supporting innovation, and developing workforce capacity to meet the needs of these families.

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[85] Internal SAMHSA performance data
[86] Center for Substance Abuse Treatment. *Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series 51*. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.
[87] Martin, C. E., Longinaker, N., & Terplan, M. (2015). *Recent trends in treatment admissions for prescription opioid abuse during pregnancy.* Journal of substance abuse treatment, 48(1), 37-42.
[88] Ibid.

The PPW family-centered approach includes a variety of services and case management for women, children, and families. Services provided to women include: outreach; engagement; pre-treatment; screening and assessment; detoxification; substance misuse education; treatment; 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, education, testing, and counseling; and treatment of hepatitis, HIV/AIDS, and other sexually transmitted diseases. Services available to children include screening and developmental diagnostic assessments addressing social, emotional, cognitive, and physical well-being; 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 also supports tobacco use counseling and interventions, screening and assessment for Fetal Alcohol Syndrome Disorders, and a trauma-informed approach.

The PPW program provides services not covered under most public and private insurance. Based on an in-depth review of cross-site evaluation and performance data in FY 2014, SAMHSA built the current PPW program model on an evidence-based approach for serving pregnant and post-partum women in need of residential substance abuse treatment.

In FY 2016, SAMHSA funded two new residential treatment grants, 25 residential treatment grant continuations, and one Addiction Technology Transfer Center (ATTC) supplement grant continuation. That same year SAMHSA convened a PPW Family-Centered Summit. The Summit's purpose was to elicit recommendations from experts in the area of women's substance abuse treatment services and family-centered care to inform the expansion of CSAT's PPW program to incorporate a wider range of family-centered services for pregnant and postpartum women and their minor children. This includes the expansion of treatment modalities to go beyond residential treatment and include intensive outpatient and outpatient treatment with or without housing components. SAMHSA has reviewed the recommendations from the Summit and is taking them into consideration in determining the future direction of the PPW Program, including the development of service requirements for the PPW program expansion effort to support wide-scale adoption of the family-centered approach.

In FY 2017, SAMHSA funded 18 new residential treatment grants, seven residential treatment grant continuations, and three contracts.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund five new PPW residential grants and 28 continuation PPW grants for program implementation and direct TA.

Pregnant and Postpartum Women Pilot

An aim of the Comprehensive Addiction and Recovery Act (CARA) is to address substance abuse and addiction across the country through the implementation of prevention, treatment, and recovery programs. In FY 2017, SAMHSA received funding to support three of these programs through its Substance Abuse Treatment Appropriation.

Historically, the PPW program has only supported the provision of residential treatment services. In order to ensure increased accessibility and availability of services for pregnant women, CARA

authorizes the provision of outpatient and intensive outpatient services for pregnant women through the PPW Pilot program.

In FY 2017, SAMHSA funded three new state PPW pilot grants to: 1) support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid disorders; 2) help state substance abuse agencies address the continuum of care, including services provided to women in nonresidential-based settings; and 3) promote a coordinated, effective and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery. An evaluation of this program is underway to determine the effectiveness of the pilot.

Under the FY 2018 Annualized CR level, SAMHSA plans to fund three continuation state PPW pilot grants for program implementation and direct TA, and one continuation evaluation contract.

The output and outcome measures for Pregnant and Postpartum Women are part of the Treatment - Other Capacity Activities Outputs and Outcomes table shown on page 202.

Funding History

Fiscal Year	Amount
FY 2015	$15,931,000
FY 2016	$15,931,000
FY 2017	$19,931,000
FY 2018	$19,796,000
FY 2019	$19,931,000

Budget Request

The FY 2019 President's Budget Request is $19.9 million, an increase of $135,000 from the FY 2018 Annualized CR. SAMHSA intends to fund two new residential treatment PPW grants and 26 continuation PPW grants. These funds also support the continuation of the three PPW Pilot grants ($4.0 million) to provide an array of services and supports to pregnant women and their children.

The FY 2019 President's Budget requests additional funds Pregnant and Postpartum Women through the Additional Opioids Allocation funding and is described on page 259.

Recovery Community Services Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Recovery Community Services Program.....	$2,434	$2,417	$2,434	$17

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
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 Tribal Organizations

Program Description and Accomplishments

An estimated 23 million people in the United States are in recovery from addiction to alcohol and other drugs.[89] As public education increases, there is broader acknowledgement of addiction as a treatable condition that needs to be managed over the course of a lifetime. More people in recovery are now willing to be open about their own recovery and to share their experience to help others attempting to achieve recovery. Through the use of their lived experience, individuals in recovery can provide support and hope to those newly seeking recovery.

Since 1998, SAMHSA has recognized the value of supporting recovery through peers and other recovery supports, and has provided funding through the Recovery Community Services Program (RCSP). RCSP was designed to assist recovery communities strengthen their infrastructure and provide peer recovery support services to those in or seeking recovery from alcohol/other drug addiction across the nation. The delivery of recovery support services by people in recovery is known as peer recovery support services (PRSS). PRSS are a strong component in helping individuals and families address substance abuse in the context of chronic disease management, especially when delivered by a Peer (often known as a Recovery Coach, Peer Specialist, or Peer Mentor). SAMHSA initiated RCSP to help build an infrastructure for PRSS programs to support the development and expansion of peer recovery services. These peer services are most frequently offered by Recovery Community Organizations (RCOs), that now number over one hundred in the U.S. alone.

Though the RCSP was a services program from 2002-2010, it was evident that this approach needed to be taken system-wide to have a larger effect. Many states recognize the value of addiction peer recovery services; however, further efforts are required to realize the potential of these services and supports at a system-wide level. The infusion of these services into state

[89] Partnership for Drug Free Kids, March, 20152012. Retrieved from http://www.drugfree.org/newsroom/survey-ten-percent-of-american-adults-report-being-in-recovery-from-substance-abuse-or-addiction

systems ensures the wide scale adoption of peer recovery support. By developing a workforce of trained and certified peers and engaging recovery community organizations in the full continuum of treatment and recovery services, states have the ability to enhance their systems to ensure holistic approaches to care. SAMHSA supports this state system development effort through the RCSP Statewide Network grant program. Since the inception of the RCSP, over 120 grants have been awarded to RCOs to expand PRSS locally and lay the groundwork for a national network of PRSS programs.

Recovery Community Services Program Statewide Network (RCSP-SN)

The RCSP-SN grant program supports a statewide approach to enhance the presence of people with lived experience in recovery from drug/alcohol addiction as key partners in state systems, as well as building a peer workforce. Activities include collaborating on local and state workforce development, developing linkages with other organizations that promote recovery throughout the state, and participating in policy, planning, and program development discussions at the state, community, and local level. Involving recovery community leaders and key stakeholders in decision-making helps states to design peer services and PRSS programs that are authentic to the recovery experience, complementary to clinical practice, demonstrate strong recovery outcomes, and are sustainable over time. Additionally, the statewide networks help to ensure the development of a trained, qualified, and effectively supervised peer workforce.

Workforce outcomes for the program include the amount of training provided, the number of people trained, trainee satisfaction, and the usefulness of information presented. Other key outcomes include: the number of RCOs that have been linked across the state; the number of state-sponsored events where participation of the statewide network occurred; the effects of linkages with behavioral health and other health systems; the outcomes of program activities on raising awareness about addiction peer recovery support; and the number of policy/program discussions which included addiction peer recovery support as a result of project efforts.

In FY 2017, SAMHSA funded a new cohort of 10 RCSP-SN grants, two contracts, as well as a statewide peer network development activity to foster collaboration between the addiction recovery and mental health consumer and family network communities. This effort is also supported by a contract designed to strengthen the development and expansion of the recovery support work of the RCSP-SN grantees and other related SAMHSA recovery support efforts.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund 10 RCSP-SN continuation grants.

The output and outcome measures for Recovery Community Services Program are part of the Treatment - Other Capacity Activities Outputs and Outcomes table shown on page 202.

Funding History

Fiscal Year	Amount
FY 2015	$2,434,000
FY 2016	$2,434,000
FY 2017	$2,434,000
FY 2018	$2,417,000
FY 2019	$2,434,000

Budget Request

The FY 2019 President's Budget Request is $2.4 million, an increase of $17,000 from the FY 2018 Annualized CR. SAMHSA intends to fund the continuation of 10 RCSP Statewide Network grants and TA activities to continue the efforts of building addiction recovery networks throughout the nation and the collaboration among peer-run organizations.

Children and Families

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Children and Families	$29,605	$29,404	$29,605	$201

Authorizing Legislation ..... Sections 509 and 514 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Single States Agencies in States, Territories, District of Columbia, public and private non-profit entities, Federally Recognized American Indian/Alaska Native Tribes Tribal Organizations, and health facilities or programs operated by or in accordance with a contract or grant with the Indian Health Service

Program Description and Accomplishments

Substance abuse plays a significant role in the lives of many children and youth (ages 12 to 25) throughout the nation. In 2015, approximately nine percent of adolescents between the ages of 12 and 17 and 22 percent of youth between the ages of 18 and 25 reported current illicit drug use. Three percent of adolescents between the ages of 12 and 17, and 11 percent of youth between the ages of 18 and 25 met the criteria for an alcohol use disorder. Many of these youth have co- occurring mental and substance use disorders. In 2015, six percent of youth ages 18-15 had

co-occurring mental illness and substance use disorders.[90] Most substance abuse begins during adolescence, making this developmental period a critical time for intervention. Approximately four percent of admissions to substance abuse treatment facilities were adolescents in 2015.[91] Sixty-one percent of infants and 41 percent of older children involved in the child welfare system have at least one parent who is using alcohol or other drugs.[92] On average, 32 percent of children are removed from home care as a result of parental alcohol or other drug use.[93]

SAMHSA's Children and Families program makes appropriate treatment available to youth and their families/caregivers to reduce the impact of substance abuse and/or co-occurring mental and substance abuse on communities in the U.S.

Substance Abuse Treatment for Youth

In 2015, less than 7 percent of adolescents ages 12 to 17 and 8 percent of youth ages 18 to 25 who needed treatment received the needed treatment at a specialty facility. Youth have psychological, developmental, and emotional needs that are distinct from adults. The neurological and developmental differences between youth and adults require tailored treatment and recovery approaches for youth with alcohol/other drug addiction.

SAMHSA's programs to treat youth with addiction and/or co-occurring substance abuse and mental disorders address gaps in service delivery by providing services for youth and their families and primary caregivers using effective evidence-based, family-centered practices. SAMHSA supports a youth treatment grant initiative at the state, territorial, and tribal levels. The populations of focus for the initiatives are adolescents (ages 12 to 17), transition-aged youth (ages 18 to 25), and their families and caregivers.

This initiative helps to further the use of, and access to, effective evidence-based family-centered treatment approaches for youth with alcohol/other drug addiction. It supports training across participating states and collaboration between local community-based providers and their state, tribal, or territorial infrastructure. The services provided include evidence-based assessment and treatment interventions appropriate for adolescents and transition age youths.

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[90] Center for Behavioral Health Statistics and Quality. (2016). 2015 National Survey on Drug Use and Health: Detailed Tables.

[91] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *Treatment Episode Data Set (TEDS): 2005-2015. National Admissions to Substance Abuse Treatment Services.* BHSIS Series S-91, HHS Publication No. (SMA) 17-5037. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

[92] Wulczyn, F., Ernst, M., & Fisher, P. (2011). *Who are the infants in out-of-home care? An epidemiological and developmental snapshot.* Chicago: Chapin Hall at the University of Chicago. Retrieved from http://www.chapinhall.org/sites/default/files/publications/06_08_11_Issue%20Brief_F_1.pdf

[93] US Department of Health and Human Services. Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.(2016). The AFCARS report: Preliminary FY 2015 estimates as of June 2016 (No. 23). Washington, DC: Author. *Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services.*

In FY 2016, SAMHSA funded 32 grant continuations and five contracts. SAMHSA also funded two new youth treatment implementation grants to support treatment for youth with SUD.

In FY 2017, SAMHSA funded 12 new youth treatment implementation grants and one new contract. SAMHSA also funded 14 grant continuations and two continuing contracts.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund 18 new youth treatment grants and to provide funding for 13 continuation grants for program implementation and direct TA. New grant funding will include an emphasis on tribes.

Addressing Child Abuse and Neglect

SAMHSA and the Administration for Children and Families collaborate to address child abuse and neglect by supporting a National Center on Substance Abuse and Child Welfare (NCSACW). NCSACW works across agencies to provide technical assistance and training to professionals in order to meet the needs of families affected by parental substance abuse. From September 2016 through March 2017, NCSACW disseminated nearly 8000 informational materials, which include reports, guidance documents, presentations from conferences and webinars, research articles, toolkits, and grantee site-specific tools. NCSACW facilitated 30 events, attended by an estimated 4,000 participants, with an average of 130 attendees per event. NCSACW monitored and provided support to trainees on web-based tutorials. Since 2007, 71,141 users have completed the NCSACW's tutorials and the current completion rate is 97 percent. The content of the tutorials was updated in 2015 to infuse the latest research and evidence-based practices and to offer a more interactive and engaging user experience. NCSACW's activities have assisted professionals throughout the nation in improving cross-system collaboration and being better prepared to meet child welfare mandates requirements for timely child permanency decisions.

NCSACW continues to provide support and technical assistance and training to tribes, state agencies, and communities to develop collaborative approaches to the treatment of pregnant women with opioid addiction. Since August 2016, NCSACW has disseminated SAMHSA's "A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers" to child welfare, substance abuse treatment, dependency court, and medical professionals. The publication has been downloaded 13,000 times from the NCSACW website. Since the passage of the Comprehensive Addiction and Recovery Act of 2016 (CARA), Section 503, Infant Plan of Safe Care Act, NCSACW has responded to 440 TA requests on Plans of Safe Care and the provisions on prenatal substance exposure in the Child Abuse and Prevention Treatment Act (CAPTA). Launched in September 2014, NCSACW provides the Substance Exposed Infant In-Depth Technical Assistance Program (SEI-IDTA) to strengthen collaboration linkages across child welfare, substance abuse treatment, and the courts, as well as medical communities, early care and education systems, home visiting, and other key partners to improve outcomes for infants and their families. In FY 2017, SAMHSA funded a new NCSACW technical assistance contract.

Under the FY 2018 Annualized CR level, SAMHSA would plan to provide continuation support for the NCSACW technical assistance contract.

The output and outcome measures for Children and Families are part of the Treatment - Other Capacity Activities Outputs and Outcomes table shown on page 202.

Funding History

Fiscal Year	Amount
FY 2015	$29,605,000
FY 2016	$29,605,000
FY 2017	$29,605,000
FY 2018	$29,404,000
FY 2019	$29,605,000

Budget Request

The FY 2019 President's Budget Request is $29.6 million, an increase of $201,000 from the FY 2018 Annualized CR. SAMHSA intends to fund eight new youth treatment grants and 27 youth treatment grants continuations. These funds will continue to address the gaps in substance abuse treatment by providing services for youth, their families, and caregivers.

Treatment Systems for Homeless

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Treatment Systems for Homeless	$36,386	$36,139	$36,386	$247

Authorizing Legislation ..... Section 506 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Competitive Grants/Contracts
Eligible Entities..... States, Domestic Public and Community Organizations, Private Nonprofit Entities, and Community-based Public or Nonprofit Entities

Program Description and Accomplishments

SAMHSA's Treatment Systems for Homeless portfolio supports services for those with alcohol/other drug addiction and who are experiencing homelessness, including veterans, and those experiencing chronic homelessness.

Between 2007 and 2014, homelessness in the United States declined by 11 percent, while chronic homelessness declined by 31 percent.[95] Chronic homelessness is defined as individuals or families with a disabling condition who have been without housing for longer than one year or more than four times in the past three years. Despite this progress, the number of people experiencing homelessness remains at unacceptably high levels. On a given night in January 2015, 564,708 individuals were experiencing homelessness. Of these individuals, 96,275 were experiencing chronic homelessness, 104,083 had severe mental illness, 103,888 were affected by chronic substance abuse, and 47,725 were veterans.[96]

Many factors contribute to the problem of homelessness, including lack of affordable housing, foreclosures, rising housing costs, job loss, underemployment, mental illness, and drug/alcohol addiction. The progress made to date in reducing homelessness points to improvement in services, as well as the effectiveness of collaboration across all levels, from the federal government to state governments and community systems. The U.S. Interagency Council on Homelessness, in which HHS participates, has set aggressive goals to prevent and end homelessness. These goals include: preventing and ending homelessness among veterans; preventing and ending chronic homelessness; preventing and ending homelessness for families, youth, and children; and setting a path to ending homelessness for all individuals. The services and support offered through SAMHSA's Treatment Systems for Homeless programs are crucial to achieving these goals. SAMHSA manages the following Treatment Systems for Homelessness grant programs:

Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States)

In FY 2013, SAMHSA initiated the CABHI-States program, funded jointly by CSAT and CMHS, which builds on the CABHI program by working with states to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services. CABHI-States supports services for individuals with serious mental illness and/or alcohol/other drug addiction who experience chronic homelessness and/or veterans who experience homelessness. It also provides peer supports and enhancement or development of a statewide plan to ensure sustained collaboration across public health and housing systems that will result in short-term and long-term strategies to support behavioral health services for individuals who experience chronic homelessness. The grantees work with state and local Public Housing Authorities and state Medicaid agencies to develop systematic, cost-effective, and integrated approaches to housing and behavioral disorder treatment and services for individuals with mental illness and/or alcohol/other drug addiction experiencing homelessness. This program was further enhanced in FY 2015 with the implementation of CABHI State Enhancement grants, which enabled CABHI-States grantees to build upon their programs.

[95] The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2014). The 2014 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. Retrieved from https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf

[96] U.S. Department of Housing and Urban Development (HUD) 2014 Continuum of Care (CoC) Homeless Assistance Programs-Homeless Populations and Subpopulations Report. Retrieved from https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2015.pdf

Grants for the Benefit of Homeless Individuals (GBHI)

In FY 2017, CSAT funded the GBHI program (last funded in FY 2010). The purpose of this program is to support the development and/or expansion of local implementation of a community infrastructure that integrates behavioral health treatment and services for alcohol/other drug addiction and co-occurring mental illness and alcohol/other drug addiction, permanent housing, and other critical services for individuals (including youth) and families experiencing homelessness.

Based on FY 2017 data for CSAT funded programs, 52.7 percent of clients in Treatment Systems for Homeless-supported programs report abstinence from substance use at a six-month follow- up, while approximately 20.7 percent of clients report being employed or engaged in productive activities and 64.4 percent of clients report having a permanent place to live in the community.[97]

In FY 2017, SAMHSA funded 16 new CABHI grants, 17 new GBHI grants, and 46 continuation grants (30 CABHI, seven GBHI-SSH, and nine CABHI-States) as well as two contracts for national evaluation and technical assistance.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund 32 new homelessness treatment grants (nine CABHI and 23 GBHI) and 63 continuation grants (46 CABHI and 17 GBHI).

The output and outcome measures for Treatment Systems for Homeless are part of the Treatment- Other Capacity Activities Outputs and Outcomes table shown on page 202.

Funding History

Fiscal Year	Amount
FY 2015	$41,386,000
FY 2016	$41,304,000
FY 2017	$36,386,000
FY 2018	$36,139,000
FY 2019	$36,386,000

Budget Request

The FY 2019 President's Budget Request is $36.4 million, an increase of $247,000 from the FY 2018 Annualized CR. SAMHSA intends to fund 65 continuation grants (17 CABHI and 48 GBHI). SAMHSA also plans to award 37 new CABHI grants. Additional funds will support two contracts including the continuation of cross-center contracts for national evaluation and technical assistance.

[97] SPARS. (2017). Retrieved from www.samhsa-gpra.samhsa.gov.

Outputs and Outcomes Table

Program: Treatment System for Homelessness (GBHI)

NOTE: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.4.23 Increase the number of clients served (Output)	FY 2017: 6,544 Target: 5,100 (Target Exceed)	6,544	6,544	Maintain
3.4.24 Increase the percentage of homeless clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2017: 22 % Target: 30 % (Target Not Met)	22 %	22 %	Maintain
3.4.25 Increase the percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2017: 61.6% Target: 33% (Target Exceeded)	61.6 %	61.6 %	Maintain

Minority AIDS

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Minority AIDS	$65,570	$65,125	$---	-$65,125

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

Three of SAMHSA's Minority AIDS Initiative (MAI) programs address HIV and hepatitis infection by facilitating the development and expansion of culturally competent and effective community-based treatment systems for substance drug/alcohol addiction and co-occurring mental illness and substance abuse treatment within racial and ethnic minority communities. The goals of the MAI program are to reduce the impact of behavioral health issues, reduce the risk for and incidence of HIV and hepatitis, and increase access to HIV and hepatitis testing and treatment for these individuals in states with the highest HIV prevalence rates (at or above 299.5 per 100,000). By region, the prevalence rates were highest in the Northeast at 419.5 per 100,000 and the South at 352.5 per 100,000.[98]

SAMHSA has implemented a number of HIV programs with varying foci including minority women, at risk populations, and the continuum of care for individuals with both mental and substance use disorders.

The output and outcome measures for Minority AIDS are part of the Treatment - Other Capacity Activities Outputs and Outcomes table shown on page 202.

[98] Centers for Disease Control and Prevention. (2016). *HIV in the United States by Geographic Distribution.* Retrieved from https://www.cdc.gov/hiv/pdf/statistics/cdc-hiv-geographic-distribution.pdf

Funding History

Fiscal Year	Amount
FY 2014	$65,570,000
FY 2015	$65,570,000
FY 2016	$65,570,000
FY 2017	$65,125,000
FY 2018	---

Budget Request

The FY 2019 President's Budget Request is $0.0 million, a decrease of $65.1 million from the FY 2018 Annualized CR. This program is being discontinued in FY 2019 because it overlaps with other federal activities.

States will be able to provide services to reduce injection drug use and related HIV/AIDS and Hepatitis C infection rates through $150 million in new funding proposed as part of the Additional Opioid Allocation described on page 259.

Criminal Justice Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Criminal Justice Activities	$74,000	$77,470	$78,000	$530
Other Criminal Justice Activities (non-add)	*18,000*	*17,878*	*18,000*	*122*
Drug Court Activities (non-add)	*56,000*	*59,593*	*60,000*	*407*

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
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, Government with Direct Involvement with Adult Criminal Courts, Tribal Organizations and Individual Adult Tribal Healing to Wellness Courts, and Individual Juvenile Treatment Drug Courts

Program Description and Accomplishments

SAMHSA's Criminal Justice portfolio includes several grant programs that focus on diversion, alternatives to incarceration, drug courts, and re-entry from incarceration for adolescents and adults with drug/alcohol addiction and/or co-occurring drug/alcohol addiction and mental illness.

Drug Courts

According to a 2006 Bureau of Justice Statistics report, approximately 74 percent of state prisoners, 63 percent of federal prisoners, and 76 percent of jail inmates met the criteria for a mental disorder. An estimated 42 percent of state prisoners and 49 percent of jail inmates met the criteria for both a mental illness and drug/alcohol addiction.[99] For youth in the juvenile justice system, 50 to 70 percent met criteria for a mental disorder and 60 percent met criteria for a substance use disorder. Of those youth with co-occurring mental illness ad drug/alcohol addiction, almost 30 percent experienced severe disorders that impaired their ability to function.[100]

[99] James, D. J., & Glaze, L. E. (2006). *Highlights mental health problems of prison and jail inmates*. Retrieved from https://www.bjs.gov/index.cfm?ty=pbdetail&iid=789

[100] Teplin, Linda et al, (2005) Major mental disorders, substance use disorders, comorbidity and HIV-AIDS risk behaviors in juvenile detainees. *Psychiatric Services,* 56,(7): pp 823-28.

The criminal justice system was the major source of referrals to substance abuse treatment, with probation or parole referrals representing the largest proportion of criminal justice system referrals to treatment.[101] Most probation or parole referrals to treatment were males between the ages of 18 and 44. The most common substances reported by these referrals were alcohol, marijuana, and methamphetamine.[102]

Drug courts are designed to combine the sanctioning power of courts with effective treatment services for a range of populations with circumstances, such as alcohol and/or other drug use, child abuse/neglect or criminal behavior, veterans or people with mental illness. Drug courts represent the coordinated efforts of the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities to intervene and break the cycle of substance misuse, addiction, and crime. Stakeholders work together to give individual clients the opportunity to improve their lives, including recovery from substance drug/alcohol addiction, and develop the capacity and skills to become fully-functioning parents, employees, and citizens.

Many drug courts lack sufficient funding or the ability to implement evidence-based practices for substance abuse treatment and recovery services.[103] Through its Treatment Drug Court grant programs, SAMHSA seeks to reduce this gap in treatment services while also improving treatment services by requiring that evidence-based practices be used. SAMHSA's interest is to support and shape treatment drug courts that serve clients with drug/alcohol addiction in the respective problem-solving court models as long as the court meets all the elements required for drug courts. The intent is to meet the treatment needs of clients using evidence-based practices consistent with the disease model and the problem-solving model, rather than with the traditional court case-processing model. A long-term goal of this program is to build sustainable systems of care for individuals needing treatment drug court services.

SAMHSA's Adult Drug Court programs support a variety of services including direct treatment services for diverse populations, wraparound/recovery support services designed to improve access and retention, drug testing for illicit substances, education support, relapse prevention and long-term management, pharmacotherapy, and HIV testing conducted in accordance with state and local requirements. The program seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use, and outcomes among the racial and ethnic minority populations served.

These 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 in addition to Government Accountability Office reports. SAMHSA requires evidence-based practices from federal inventories to be used. SAMHSA also has regular

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[101] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set (TEDS): 2005-2015. National Admissions to Substance Abuse Treatment Services. BHSIS Series S-91, HHS Publication No. (SMA) 17-5037. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

[102] SAMHSA. (2015). *Criminal and Juvenile Justice*. Retrieved from http://www.samhsa.gov/criminal-juvenile-justice

[103] SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. (n.d.). *Adult Mental Health Treatment Courts Database*. Retrieved from http://gainscenter.samhsa.gov/judgescourts/courtsjudges.asp

communications with the National Association of Drug Court Professionals to obtain and incorporate the latest findings and field expertise.

Performance data show that these grant programs are effective in improving the lives of drug court participants. In FY 2015, 5,497 clients received services through the Drug Court Programs. Of these, 85.1 percent had no past month substance use, 91.8 percent had no involvement with the criminal justice system thirty days prior to intake, 58.9 percent of adult clients were either employed or engaged in productive activities, and 43.8 percent had a permanent place to live in the community.

In FY 2015, FY 2016 and FY 2017, SAMHSA's Adult Drug Court grant programs were required to ensure that drug courts funded by SAMHSA could not deny the use of Food and Drug Administration (FDA)-approved medications for opioid addiction to drug court clients. Drug court judges, however, retained judicial discretion in cases where specified conditions for pharmacotherapy provisions were not met.

In FY 2017, SAMHSA funded 51 new drug court grants, 122 drug court grant continuations, and four contracts.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund 101 drug court grants continuation, 58 new drug court grants, and three contracts.

Criminal Justice Other/Offender Reentry Program

In addition to the drug court portfolio, SAMHSA supports Offender Reentry Program (ORP) grants, as well as other criminal justice activities, such as evaluation and behavioral health contracts. Studies show that only about 10 percent of individuals involved with the criminal justice system who are in need of substance abuse treatment receive it as part of their justice system supervision. Approximately one-half of the institutional treatment provided is educational programming.[104] During the past decade, awareness of the need for a continuum of care of services for adult offenders has grown as states and local communities have struggled with the increasing number of these individuals returning to the community after release from correctional confinement. ORP grants provide screening, assessment, comprehensive treatment, and recovery support services for individuals reentering the community from incarceration. ORP services include screening, comprehensive individual assessment for substance use and/or co-occurring mental disorders, case management, program management, alcohol and other drug treatment, wraparound services, drug testing, relapse prevention and long-term support.

In FY 2017, SAMHSA funded 11 new ORP grants and 27 ORP grant continuations.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund 16 new ORP grants, 11 continuation OFR grants, and two contract activities.

[104] Taxman FS, Perdoni ML, Harrison LD. (2007). Drug treatment services for adult offenders: The state of the state. Journal of Substance Abuse Treatment 32(3), 239-254.

Behavioral Health Treatment Court Collaborative Program

In FY 2014, SAMHSA supported a second cohort of four-year Behavioral Health Treatment Court Collaborative grants (BHTCC) in the Mental Health and Substance Abuse Treatment appropriations. BHTCC supports judges and staff of specialty (e.g., drug court) and other courts within a jurisdiction to work together to divert adults with mental illness and/or alcohol/other drug addiction from the criminal justice system. 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 grant program focuses on adults with behavioral health problems, including serious mental illness, 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.

SAMHSA completed an evaluation of the first cohort of BHTCC grantees in September 2014. Findings of the evaluation demonstrate that grantees built multi-agency workgroups or collaboratives to oversee programs. Because of the grant funding, all grant recipients expanded access to specialty courts. Most grant recipients anticipated continuing new screening and assessment processes addressing a broader array of behavioral health needs after grant funding ended. Program innovations were divided into four main groups, including court and treatment provider collaboration, court and community case management, unified cross-court screening and referral, and meaningful peer involvement. Roughly 1,400 individuals were served through the BHTCC., Two-thirds of the grantees reported that they provided co-occurring mental illness and substance abuse treatment services, trauma-specific treatment, and peer support. Based on performance data reporting, program participants experienced improvements in mental health and reductions in substance use. Alcohol and other drug use declined by 60 percent in the first six months while mental health symptoms declined by 20 percent over the same period and 74 percent of participants reported physical health improvements at six months. In addition, employment rates increased from 36 percent to 45 percent over the first six months, with monthly median income increasing by $298.[105]

In FY 2017, SAMHSA funded 17 continuation grants and the evaluation contract.

Under the FY 2018 Annualized CR level, SAMHSA would plan to fund 16 new and 11 continuation ORP grants continue support for the technical assistance and evaluation contracts.

[105] Advocates for Human Potential. (2014). *Evaluation of the Adult Treatment Court Collaborative Program: Final evaluation report.* Albany, NY: Author.

Funding History

Fiscal Year	Amount
FY 2015	$78,000,000
FY 2016	$78,000,000
FY 2017	$74,000,000
FY 2018	$77,470,000
FY 2019	$78,000,000

Budget Request

The FY 2019 President's Budget Request is $78.0 million ($60.0 million for Drug Courts Activities and $18.0 million for Other Criminal Justice Activities), an increase of $530,000 from the FY 2018 Annualized CR. SAMHSA intends to support 44 new drug court grants, 115 drug court continuation grants, and three contracts. SAMHSA intends to fund 27 ORP continuation grants.

The FY 2019 President's Budget requests additional funds Drug Courts through the Additional Opioids Allocation funding and is described on page 259.

Outputs and Outcomes Table

Program: Criminal Justice - Drug Courts

NOTE: SAMHSA makes grant awards toward the end of the year and therefore bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.2.72 Increase the percentage of adult clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2017: 64.1 % Target: 55 % (Target Exceeded)	64.1 %	64.1 %	Maintain
1.2.73 Increase the percentage of adult clients receiving services who had a permanent place to live in the community (Outcome)	FY 2017: 46 % Target: 41 % (Target Exceeded)	46 %	46 %	Maintain
1.2.74 Increase the percentage of adult clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2017: 93.7 % Target: 91 % (Target Exceeded)	93.7 %	93.7 %	Maintain
1.2.76 Increase the percentage of adult clients receiving services who had no past month substance use (Outcome)	FY 2017: 86.1 % Target: 71 % (Target Exceeded)	86.1 %	86.1 %	Maintain
1.2.79 Increase the number of adult clients served (Output)	FY 2017: 8,597 Target: 5,500 (Target Exceeded)	8,597	8,597	Maintain

Outputs and Outcomes Table

Program: Criminal Justice - Offender Re-Entry Program

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.2.80 Increase the number of clients served (Outcome)	FY 2017: 1,212 Target: 2,000[106] (Target Not Met)	2,000	2,000	Maintain
1.2.81 Increase the percentage of clients who had no past month substance use (Outcome)	FY 2017: 69.1 % Target: 74 %[107] (Target Not Met)	74.0 %	74.0 %	Maintain
GH: 1.2.84 Increase the percentage of clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2017: 93.3 % Target: 94 % (Target Not Met but Improved)	93.3 %	93.3 %	Maintain

[106]Decrease in target from prior year level reflects a decrease in funding and changes in data trends.
[107]Decrease in target from prior year level reflects a decrease in funding and changes in data trends.

Outputs and Outcomes Table

Program: Treatment – Other Capacity

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final. The FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.2.25 Increase the percentage of adults receiving services who had no past month substance use (Outcome)	FY 2017: 65.6 % Target: 60 % (Target Exceeded)	65.6 %	65.6 %	Maintain
1.2.26 Increase the number of clients served (Output)	FY 2017: 20,310 Target: 30,000 (Target Not Met)	20,310	20,310	Maintain
1.2.27 Increase the percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2017: 45.6 % Target: 43 % (Target Exceeded)	45.6 %	45.6 %	Maintain
1.2.28 Increase the percentage of adults receiving services who had a permanent place to live in the community (Outcome)	FY 2017: 46.6 % Target: 47 % (Target Not Met but Improved)	47 %	47 %	Maintain
1.2.29 Increase the percentage of adults receiving services who had no involvement with the criminal justice system (Outcome)	FY 2017: 97.5 % Target: 93 % (Target Exceeded)	97.5 %	97.5 %	Maintain

Building Communities of Recovery

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Building Communities of Recovery.....	$3,000	$2,980	$3,000	$20

Authorizing Legislation . Section 302 of the Comprehensive Addiction and Recovery Act of 2016
FY 2019 Authorization $3,000,000
Allocation Method ..... Grants/Contracts
Eligible Entities..... Primary care, child welfare system, criminal justice system

Program Description and Accomplishments

Peer services play a vital role in assisting individuals in achieving recovery from substance use disorders. Recovery Community Organizations (RCOs) are central to the delivery of those services. In FY 2017, SAMHSA funded a new cohort of grant through the Comprehensive Addiction Recovery Act (CARA) Building Communities of Recovery program. The purpose of this program is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery support from drug/alcohol addiction. These grants are intended to support the development, enhancement, expansion, and delivery of recovery support services (RSS) as well as promotion of and education about recovery. Programs are designed to be overseen by people in recovery from SUDs who reflect the community served.

Grants support linkages between recovery networks and a variety of other organizations, systems, and communities, including: primary care, other recovery networks, child welfare system, criminal justice system, housing services and employment systems. Grantees will also work to reduce negative attitude, discrimination, and prejudice around addiction and addiction recovery.

Under the FY 2018 Annualized CR level, SAMHSA will support five continuation grants for program implementation and direct TA.

Funding History

Fiscal Year	Amount
FY 2015	---
FY 2016	---
FY 2017	$3,000,000
FY 2018	$2,980,000
FY 2019	$3,000,000

Budget Request

The FY 2019 President's Budget Request is $3.0 million, an increase of $20,000 from the FY 2018 Annualized CR. These funds will be used to support seven new grants and five continuation grants the Building Communities of Recovery Program to develop, expand, and enhance recovery support services.

Minority Fellowship Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
SAT Minority Fellowship Program.....	$3,539	$3,515	$---	-$3,515

Authorizing Legislation .....Section 597 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Grants/Contracts
Eligible Entities..... Organizations that represent individuals obtaining post-baccalaureate training (including for master's and doctoral degrees) for mental and substance use disorder treatment professionals, including in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling

Program Description and Accomplishments

SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance use disorder treatment services for minority populations that are underserved. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, the program expanded to include marriage and family therapists and later added professional counselors. Professional guilds receive competitively awarded grants, and then competitively award the stipends to post-graduate students pursuing a degree in that professional field. In FY 2016 and FY 2017, SAMHSA funded six continuation grants.

SAMHSA Minority Fellowship Programs have had a variety of foci including youth and addiction counselors.

In FY 2017, SAMHSA provided continuation funding for this cohort of grants.

Under the FY 2018 Annualized CR level, SAMHSA will award a new cohort of MFP grants.

Funding History

Fiscal Year	Amount
FY 2015	$2,920,045
FY 2016	$3,539,000
FY 2017	$3,539,000
FY 2018	$3,515,000
FY 2019	---

Budget Request

The FY 2019 President's Budget Request is $0.0 million, a decrease of $3.5 million from the FY 2018 Annualized CR. This program is being discontinued in FY 2019 because it overlaps with other federal activities.

Addiction Technology Transfer Centers

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Addiction Technology Transfer Centers.....	$9,046	$8,985	$9,046	$61

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

Misuse of, and addiction to alcohol, tobacco, and illicit drugs cost Americans more than $700 billion a year in increased healthcare costs, crime, and lost productivity.[108, 109] Recently, the nation's attention has been on the increase misuse of opioids. The majority of drug overdose deaths (more than six out of ten) involved an opioid.[110] Alcohol/other drug addiction is treatable and research has led to development of medications and evidence-based psychosocial interventions that help people achieve recovery and resume productive lives. One critical need is to help recruit, train, and support treatment providers in the use of evidence-based practices.

[108] National Institute for Drugs and Alcohol. (2015). *Trends and Statistics.* Retrieved from NIH/NIDA: http://www.drugabuse.gov/related-topics/trends-statistics
[109] National Institute for Drugs and Alcohol. (2015). *Trends and Statistics.* Retrieved from NIH/NIDA: http://www.drugabuse.gov/related-topics/trends-statistics
[110] Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep. ePub: 16 December 2016

The Addiction Technology Transfer Center Network (ATTC Network) is one of SAMHSA's proven models for building behavioral health capacity in health systems and communities through the sharing and transfer of expertise. SAMHSA supports the ATTC Network to develop and provide low or no cost training opportunities using evidence-based teaching, technologies, implementation, coaching, and information dissemination to behavioral health professionals. During the last cycle of the ATTC program (FY 2011 - 2016), the ATTC network supported the completion of over 430 events (technical assistance, webinars, onsite training, presentations etc.) benefiting over 128,000 health professionals. Overall, over 94 percent of participants reported satisfaction with the quality of the training or technical assistance they received from the ATTC Network. There is a critical and rising need for practitioners to reflect the diversity of their client population in terms of characteristics, such as age, race/ethnicity, and sexual orientation.

Existing diversity requires recruitment of new professionals from a variety of backgrounds.[111] Treating persons with drug/alcohol addiction is difficult and challenging. Pay and benefits often do not fully reflect the difficulty of this work. Burnout and turnover are significant challenges for providers and their employing organizations and may impede patient recovery.

Faced with an average annual staff turnover rate of 18.5 percent, substance use disorder treatment programs deal with significant challenges to fill open positions.[112] Common hurdles for many abuse treatment facilities include difficulty retaining and recruiting qualified individuals, the need for a diverse workforce capable of working in integrated settings, and the perception that drug/alcohol addiction is not a valid health issue (i.e., that addiction is a 'choice').[113]

To address the gaps in workforce, the ATTC Network supports national and regional activities focused on improving the skills of substance abuse treatment and other healthcare professionals. The ATTC Network decreases the gap in time between the release of new scientific findings and the adoption of these interventions by front-line substance abuse treatment clinicians. ATTC grantees develop evidence-based and promising practices for addiction treatment/recovery professionals, public health/mental health personnel, institutional and community corrections professionals, nurses, and other health professions. The ATTC Network dissemination models include technical assistance, training and an extensive array of web-based resources created to translate the latest science for adoption into practice by the substance abuse treatment workforce. Using a systems change approach, the goal is to improve organizations and systems of care, enhancing access, engagement, and outcomes in a continuous quality improvement framework.

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[111] Ryan, O., Murphy, D., Krom, L. (2012). Vital Signs: Taking the Pulse of the Addiction Treatment Workforce, A National Report, Version 1. Kansas City, MO: Addiction Technology Transfer Center National Office in residence at the University of Missouri-Kansas City. Retrieved from http://www.attcnetwork.org/documents/VitalSignsReport.pdf

[112] Ryan, O., Murphy, D., Krom, L. (2012). Vital Signs: Taking the Pulse of the Addiction Treatment Workforce, A National Report, Version 1. Kansas City, MO: Addiction Technology Transfer Center National Office in residence at the University of Missouri-Kansas City. Retrieved from http://www.attcnetwork.org/documents/VitalSignsReport.pdf

[113] Ryan, O., Murphy, D., Krom, L. (2012). Vital Signs: Taking the Pulse of the Addiction Treatment Workforce, A National Report, Version 1. Kansas City, MO: Addiction Technology Transfer Center National Office in residence at the University of Missouri-Kansas City. Retrieved from http://www.attcnetwork.org/documents/VitalSignsReport.pdf

In FY 2016, the ATTC Network included 10 Regional Centers, four National Focus Area Centers, and a Network Coordinating Office. In FY 2017, a new cohort of grants was awarded to 10 Regional Centers and one Coordinating Center.

Under the FY 2018 Annualized CR level, SAMHSA plans to fund one new AI/AN and eleven continuation grants in the ATTC program. Together, the members of the ATTC Network will continue to provide technical assistance, workforce training, support meetings, and the collaboration with other HHS agencies, the SAMHSA Regional Administrators, and other partners.

Funding History

Fiscal Year	Amount
FY 2015	$9,046,000
FY 2016	$9,046,000
FY 2017	$9,046,000
FY 2018	$8,985000
FY 2019	$9,046,000

Budget Request

The FY 2019 President's Budget Request is $9.0 million, an increase of $61,000 from the FY 2018 Annualized CR. SAMHSA plans to fund twelve continuation grants. Funding will allow the ATTC grantees to disseminate evidence-based, promising practices to addiction treatment and recovery professionals, public health and mental health personnel, institutional and community corrections professionals, and other related disciplines.

Improving Access to Overdose Treatment

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Improving Access to Overdose Treatment.....	$1,000	$993	$1,000	$7

Authorizing Legislation . Section 302 of the Comprehensive Addiction and Recovery Act of 2016
FY 2019 Authorization $1,000,000
Allocation Method ..... Grants/Contracts
Eligible Entities..... Primary care, child welfare system, criminal justice system

Program Description and Accomplishments

Drug overdose deaths and opioid-involved deaths continue to increase in the United States. In 2016, there were more than 63,600 drug overdose deaths in the United States. Opioids—prescription and illicit—are the main driver of drug overdose deaths. 116 Americans die every day from an opioid overdose. Opioid overdose deaths were five times higher in 2016 than 1999.[114] In 2013, SAMHSA released the Opioid Overdose Prevention Toolkit to help reduce the number of opioid-related overdose deaths and adverse events. The Improving Access to Overdose Treatment (CARA) grant program utilizes this toolkit and other resources to help grantees train and provide resources to health care providers and pharmacists on the prescribing of drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

Further, the Improving Access to Overdose Treatment (CARA) grant program addresses the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder (including prescription opioids as well as illicit drugs such as heroin).

SAMHSA awarded one (1) Improving Access to Overdose Treatment (CARA) grant in FY 2017. The grantee partners with other prescribers at the community level to develop best practices for prescribing and co-prescribing FDA-approved overdose reversal drugs. After developing best practices, the grantee will train other prescribers in key community sectors as well as individuals who support persons at high risk for overdose. This grant program also ensures the grantee establishes protocols to connect patients who have experienced a drug overdose with appropriate treatment, including medication-assisted treatment and appropriate counseling and behavioral therapies.

[114] (Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017/ CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov.

Funding History

Fiscal Year	Amount
FY 2015	---
FY 2016	---
FY 2017	$1,000,000
FY 2018	993,000
FY 2019	$1,000,000

Budget Request

The FY 2019 President's Budget Request is $1.0 million, an increase of $7,000 from the FY 2018 Annualized CR. In FY 2019, SAMHSA will support three grants to continue increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table Summary

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Grants/Cooperative Agreements:						
Continuations	420	$155,345	384	$176,300	320	$173,677
New/Competing	241	142,641	206	125,681	131	39,248
Subtotal	661	297,986	590	301,981	451	212,925
Contracts:						
Continuations	21	36,947	29	41,318	49	36,581
New/Competing	17	19,494	6	8,721	2	5,811
Subtotal	38	56,441	35	50,039	51	42,393
Total, Substance Abuse Treatment	**699**	**$350,427**	**625**	**$352,020**	**502**	**$255,318**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Capacity:						
Opioid Treatment Programs/Regulatory Activities						
Grants						
Continuations	1	$1,000	1	$1,393	---	$394
New/Competing	1	1,400	1	1,000	1	1,999
Subtotal	2	2,400	2	2,393	1	2,393
Contracts						
Continuations	4	4,645	3	4,078	4	4,840
New/Competing	3	1,679	2	2,194	1	1,492
Subtotal	7	6,324	5	6,272	5	6,331
Total, Opioid Treatment Programs/Regulatory Activities	**9**	**8,724**	**7**	**8,665**	**6**	**8,724**
Screening, Brief Intervention and Referral to Treatment						
Grants						
Continuations	80	25,298	20	16,607	---	---
New/Competing	---	---	7	6,853	---	---
Subtotal	80	25,298	27	23,461	---	---
Contracts						
Continuations	2	4,588	2	5,979	---	---
New/Competing	---	114	---	357	---	---
Subtotal	2	4,702	2	6,336	---	---
Total, Screening, Brief Intervention and Referral to Treatment	**82**	**30,000**	**29**	**29,796**	**---**	**---**
Targeted Capacity Expansion						
Grants						
Continuations	52	28,006	44	21,209	33	52,151
New/Competing	8	31,899	21	41,030	32	8,409
Subtotal	60	59,905	65	62,239	65	60,561
Contracts						
Continuations	2	5,094	1	4,000	1	6,352
New/Competing	1	2,193	1	497	---	279
Subtotal	3	7,287	2	4,497	1	6,631
Total, Targeted Capacity Expansion	**63**	**67,192**	**67**	**66,736**	**66**	**67,192**
Subtotal, Capacity	**154**	**105,916**	**103**	**105,197**	**72**	**75,916**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Capacity:						
Pregnant and Postpartum Women						
Grants						
Continuations	7	3,413	23	13,537	26	14,603
New/Competing	22	13,086	5	2,377	2	1,035
Subtotal	29	16,499	28	15,914	28	15,638
Contracts						
Continuations	2	2,326	5	3,541	5	3,866
New/Competing	2	1,106	---	340	---	427
Subtotal	4	3,432	5	3,881	5	4,293
Total, Pregnant and Postpartum Women	**33**	**19,931**	**33**	**19,796**	**33**	**19,931**
Recovery Community Services Program						
Grants						
Continuations	---	---	10	1,496	10	1,499
New/Competing	10	1,499	---	---	---	---
Subtotal	10	1,499	10	1,496	10	1,499
Contracts						
Continuations	---	132	2	789	2	831
New/Competing	2	803	---	133	---	104
Subtotal	2	935	2	922	2	935
Total, Recovery Community Services Program	**12**	**2,434**	**12**	**2,417**	**12**	**2,434**
Children and Families						
Grants						
Continuations	14	$9,684	13	$12,329	27	$18,884
New/Competing	12	11,741	18	12,017	8	4,529
Subtotal	26	21,425	31	24,346	35	23,413
Contracts						
Continuations	2	4,012	3	5,058	28	5,629
New/Competing	1	4,168	---	---	---	563
Subtotal	3	8,180	3	5,058	28	6,192
Total, Children and Families	**29**	**29,605**	**34**	**29,404**	**63**	**29,605**
Subtotal, Capacity	**228**	**157,886**	**182**	**156,814**	**180**	**127,886**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Capacity:						
Treatment Systems for Homeless						
Grants						
Continuations	46	20,910	63	21,312	65	22,815
New/Competing	33	11,638	32	11,177	37	8,586
Subtotal	79	32,548	95	32,489	102	31,401
Contracts						
Continuations	2	3,701	2	3,650	2	4,227
New/Competing	---	137	---	---	---	758
Subtotal	2	3,838	2	3,650	2	4,985
Total, Treatment Systems for Homeless	**81**	**36,386**	**97**	**36,139**	**104**	**36,386**
Minority AIDS						
Grants						
Continuations	82	29,090	82	40,598	---	---
New/Competing	59	29,181	36	17,678	---	---
Subtotal	141	58,271	118	58,276	---	---
Contracts						
Continuations	2	5,083	2	4,874	---	---
New/Competing	1	2,217	2	1,975	---	---
Subtotal	3	7,299	4	6,849	---	---
Total, Minority AIDS	**144**	**65,570**	**122**	**65,125**	**---**	**---**
Criminal Justice Activities						
Grants						
Continuations	130	35,837	112	36,816	142	54,118
New/Competing	75	26,354	74	30,500	44	13,238
Subtotal	205	62,191	186	67,316	186	67,355
Contracts						
Continuations	3	6,424	4	7,219	4	8,456
New/Competing	4	5,386	1	2,935	1	2,189
Subtotal	7	11,809	5	10,154	5	10,645
Total, Criminal Justice Activities	**212**	**74,000**	**191**	**77,470**	**191**	**78,000**
Subtotal, Capacity	**665**	**333,842**	**592**	**$335,548**	**475**	**242,272**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Improving Access to Overdose Treatment (IATOT)						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	---	3	993	3	1,000
New/Competing	3	1,000	---	---	---	---
Subtotal	3	1,000	3	993	3	1,000
Total, Improving Access to Overdose Treatment (IATOT)	**3**	**1,000**	**3**	**993**	**3**	**1,000**
Building Communities of Recovery (BCOR)						
Grants						
Continuations	---	---	5	2,533	5	$825
New/Competing	8	2,533	---	---	7	1,453
Subtotal	8	2,533	5	2,533	12	2,278
Contracts						
Continuations	---	---	---	171	---	722
New/Competing	---	467	---	276	---	---
Subtotal	---	467	---	447	---	722
Total, Building Communities of Recovery (BCOR)	**8**	**3,000**	**5**	**2,980**	**12**	**3,000**
Science and Service:						
Addiction Technology Transfer Centers						
Grants						
Continuations	---	---	11	8,470	12	8,388
New/Competing	11	8,515	1	---	---	---
Subtotal	11	8,515	12	8,470	12	8,388
Contracts						
Continuations	---	492	---	514	---	658
New/Competing	---	39	---	---	---	---
Subtotal	---	531	---	514	---	658
Total, Addiction Technology Transfer Centers	**11**	**9,046**	**12**	**8,985**	**12**	**9,046**
Subtotal, Science and Service	**11**	**9,046**	**12**	**8,985**	**12**	**9,046**
Minority Fellowship Program (MFP)						
Grants						
Continuations	8	2,107	---	---	---	---
New/Competing	2	796	11	3,048	---	---
Subtotal	10	2,903	11	3,048	---	---
Contracts						
Continuations	2	450	2	452	---	---
New/Competing	---	186	---	14	---	---
Subtotal	2	636	2	467	---	---
Total, Minority Fellowship Program (MF)	**12**	**3,539**	**13**	**3,515**	**---**	**---**
Subtotal, Science and Service:	**23**	**12,585**	**25**	**12,500**	**12**	**9,046**
Total, Substance Abuse Treatment PRNS	**699**	**350,427**	**625**	**352,020**	**502**	**255,318**

Grant Awards Table

(Whole Dollars)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	661	590	451
Average Award	$450,811	$511,832	$472,118
Range of Awards	$300,000-$600,000	$300,000-$600,000	$300,000-$600,000

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State Targeted Response to the Opioid Crisis

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
State Targeted Response to the Opioid Crisis Grants.	$500,000	$496,605	$---*	-$496,605

Authorizing Legislation .....Section 1003 of the 21st Century, Cures Act
FY 2019 Authorization ..... Permanent
Allocation Method .....Grants
Eligible Entities.....States/Territories
*Additional funding is proposed for this program as part of the Additional Opioids Allocation funding request. That funding request is displayed in its entirety on page 259.

Program Description and Accomplishments

Opioid abuse continues to cause a significant crisis across the nation. According to the CDC, opioid-overdose related deaths numbered approximately 64,000 in 2016. As misuse and abuse continues to rise, Americans are dealing with the devastating consequences that accompany this use including: loss of employment, social connectedness, increased criminal justice involvement, injury, and death.

The State Targeted Response to the Opioid Crisis Grant Program (Opioid STR) was authorized under Section 1003 of the 21st Century Cures Act. The program aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid addiction.

Grantees are required to: use epidemiological data to demonstrate the critical gaps in availability of treatment for opioid addiction in geographic, demographic, and service level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly address the gaps in their systems of care; implement prevention strategies; deliver evidence based treatment interventions including medication and psychosocial interventions; deliver recovery support services; and report progress toward increasing availability of treatment for opioid addiction and reducing opioid-related overdose deaths.

The Opioid STR grants have helped states target these resources to address the particular problems they are facing with respect to opioids. States have applied learn lessons from the first year of this program and are already identifying ways to maximize impact and efficiency. States have quickly implemented a wide range of evidence-based prevention, treatment, and recovery interventions that respond to the unique needs in their communities

In FY 2017, Opioid STR grants were awarded via formula to all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Northern Marianas, Micronesia, Palau, and American Samoa. Funds are also being used to support a cross-site evaluation to demonstrate program effectiveness and technical assistance activities.

Funding History

Fiscal Year	Amount
FY 2015	---
FY 2016	---
FY 2017	$500,000,000
FY 2018	$496,605,000
FY 2019	---

Budget Request

Section 1003 of the 21st Century Cures Act authorized $500.0 million to be appropriated to the HHS Secretary for use as grants to support state responses to opioid abuse in FY 2017 and FY 2018. There is no funding authorized under current law in FY 2019. The FY 2019 President's Budget request is $1.0 billion in the Additional Opioids Allocation funding and is described on page 259.

Substance Abuse Prevention and Treatment Block Grant

(Dollars in thousands)

Programs of Regional & National Significance	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Substance Abuse Prevention and Treatment Block Grant	$1,858,079	$1,845,461	$1,858,079	$12,618
Budget Authority (non-add)	*1,778,879*	*1,766,799*	*1,778,879*	*12,080*
PHS Evaluation Funds (non-add)	*79,200*	*78,662*	*79,200*	*538*

Authorizing Legislation .....Section 1935 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
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 authorizing legislation and implementing regulation governing the Substance Abuse Prevention and Treatment Block Grant (SABG) includes a number of prescriptive performance and expenditure requirements as well as explicit expenditure prohibitions. The states and jurisdictions have the flexibility to plan, carry out, and evaluate substance abuse treatment and recovery services that reflect comments received from individuals, families and communities during the development of their respective biennial plans and the results of such plans are reflected in their respective annual reports. The legislation and regulation prioritizes two populations to be served with SABG funds: (1) substance using pregnant women and women with dependent children; and (2) persons who inject drugs. Although the legislation and regulation prioritizes such individuals, the states and jurisdictions have the flexibility to prioritize other underserved populations as determined by anecdotal and empirical data. For example, most states and jurisdictions prioritize substance abuse treatment and recovery services for adolescents and transitional age youth. Some states and jurisdictions are also developing peer-to-peer recovery services to facilitate individuals' entry to substance abuse treatment services and to promote and support individuals in early recovery. States and jurisdictions frequently partner with other executive branch departments, e.g., education, human services, justice and public health, to coordinate services for individuals and families impacted by substance abuse.

The Substance Abuse Prevention and Treatment Block Grant (SABG) program distributes funds to 60 eligible states, territories and freely associated states[115], the District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota (referred to collectively as states) to plan, carry out, and evaluate substance abuse prevention, treatment, and recovery support services for individuals,

[115] Territories include Guam, Puerto Rico, the Northern Mariana Islands, U.S. Virgin Islands and American Samoa. Freely Associated States, which have signed Compacts of Free Association with the United States, include the Republic of Palau, Federated States of Micronesia and Republic of the Marshall Islands. Retrieved from http://www.doi.gov//oia/islands/index.cfm

families, and communities impacted by substance abuse. The SABG's overall goal is to support and expand substance abuse prevention and treatment services while providing maximum flexibility to grantees.

The SABG is critically important because it provides the states and their respective SABG sub-recipients, including, but not limited to, administrative service organizations, county and municipal governments, and prevention and treatment providers, 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.[116] 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. Block grant funds are being leveraged by states, along with other funding sources, to support training for staff and implementation of evidence-based practices for the prevention of substance misuse and the treatment of drug/alcohol addiction, improved business practices such as facilitating enrollment in appropriate health coverage and use of health information technology and integration of physical and behavioral health.[117] SAMHSA encourages states to use block grant resources to support and not supplant services that are covered through commercial and public insurer plans.

SAMHSA Block Grant funds are directed toward four purposes: to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; 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; to fund primary prevention for individuals not identified as needing treatment (universal programs that reach everyone in a group being served regardless of risk, selective interventions that serve people at elevated risk of substance misuse or a drug/alcohol addiction, and indicated prevention interventions that serve people who exhibit some symptoms of a clinical substance use disorder, but do not yet meet criteria for a diagnosis); and to collect performance and outcome data to determine the ongoing effectiveness of behavioral disorder 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: allow recovery to be pursued through personal choice and many pathways; encourage providers to assess performance based on outcomes that demonstrate client successes; and expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services.

In addition to the states' and jurisdictions' plans and reports, the authorizing legislation provides SAMHSA with significant resources to support targeted technical assistance to the SABG grantees and their respective sub-recipients, i.e., community- and faith-based organizations approved by the states and jurisdictions to provide substance abuse treatment and recovery services. SAMHSA's Knowledge Application Program (KAP) (http://www.samhsa.gov/kap) produces the Technical

[116] SABG State Agency Reported Expenditures by Target Activity Within Source of Funds, State/Jurisdiction Selection: All States/Jurisdictions (2015)

[117] Case Studies of Three Policy Areas and Early State Innovators: 2014 State Profiles of Mental Health and Substance Use Disorder Agencies. HHS Publication in Press. Rockville, MD: Substance Abuse and Mental Health Services Administration. (2015).

Assistance Public Series that provide practical guidance and information related to the delivery of substance abuse treatment services and related public health services to individuals and families. The KAP also produces the Treatment Improvement Protocol Series, a growing library of best practice guidelines, which are produced by a consensus-development process based on the experience and knowledge of clinical, research, and administrative experts.

Funding Allocations and Requirements

SABG funds are distributed[118] through a formula grant that provides funding based on specified economic and demographic factors and is administered by SAMHSA's Centers for Substance Abuse Treatment (CSAT) and Center for 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.

Maintenance of Effort: The SABG requires states to maintain its expenditures for certain substance abuse prevention and treatment activities at a level that is no less than the state's average expenditures for the previous two-years.

Funding Set-Asides and Other Requirements: The authorizing legislation and implementation regulation for the SABG includes specific funding set-asides, including 20 percent for primary prevention (see below), and five percent for early intervention service for HIV for designated states.[119] The statute 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.

Coordination of Efforts: SAMHSA emphasizes that Block Grant recipients should coordinate and partner with government agencies, nonprofit organizations, consumers and families and providers to support integrated and coordinated services and programs. SAMHSA provides targeted technical assistance for SABG grantees through a technical assistance contract.

Performance and Evaluation

SAMHSA is undertaking a series of agency-wide efforts designed to develop a set of common 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

[118] Block Grants and Formula Grants: A Guide for Allocation Calculations; 2007 Department of Health and Human Services, SAMHSA.
[119] Substance Abuse and Mental Health Services Administration. (2015). *Block Grant Laws and Regulations.* Retrieved from http://www.samhsa.gov/grants/block-grants/laws-regulations.

billing data systems, and state mental health and substance abuse treatment data systems), ensures consistency in the use of measures, and provides a more complete perspective of the delivery of mental illness and substance abuse treatment 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.[120] SAMHSA data show that the SABG has been successful in expanding treatment capacity by supporting approximately two million[121] 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 2015, at discharge, clients demonstrated high abstinence rates from both illegal drug (70 percent) and alcohol (83 percent) use. State substance abuse authorities reported the following outcomes for services provided during FY 2015, the most recent year for which data is available:

State substance abuse authorities reported the following outcomes for services provided during FY 2016, the most recent year for which data is available:

- For the 50[3] states and the District of Columbia that reported data concerning abstinence from alcohol use, all 51 identified improvements in client abstinence;
- Similarly, for the 50 states and D.C. that reported data concerning the abstinence from drug use, 50 of 51 identified improvements in client abstinence;
- For the 50 states and D.C. that reported employments data, 45 of 50 identified improvements in client employment;
- For the 50 states and D.C. that reported criminal justice data, 47 of 51 reported an increase in clients with no arrests based on data reported to TEDS;
- For the 50 states and D.C. that reported housing data, 48 of 51 identified improvements in stable housing for clients based on data reported to TEDS; and
- For the 50 states and D.C that reported recovery support data, 51 states out of 51 identified improvements in client engagement in recovery support programs. At intake clients who were engaged in recovery support programs increased from 29 percent to 44.8 percent at discharge.

20 Percent Prevention Set-Aside

SAMHSA is responsible for managing the 20 percent prevention set-aside of the SABG. The 20 percent set-aside requires SABG grantees to spend at least 20 percent of their SABG award to develop and implement a comprehensive prevention program, which includes a broad array of

[120] Substance Abuse and Mental health Administration. Retrieved from http://tie.samhsa.gov/SAPT2010.html#Evaluation.
[121] Substance Abuse and Mental Health Services Administration (2015). *Clients Level Data / TEDS.* Retrieved from http://www.samhsa.gov/data/client-level-data-teds
[3] Source: West Virginia numbers have been included in the text, but they appear lower than expected.

prevention strategies directed at individuals not identified to be in need of treatment.[122] The prevention set-aside is one of SAMHSA's main vehicles for supporting SAMHSA's Strategic Initiative for the Prevention of Substance Abuse and Mental Illness. The 20 percent set-aside is focused only on substance use prevention. States use these funds to develop infrastructure and capacity and to fund programs specific to primary 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.

States are encouraged to make prevention a top priority, taking advantage of recent science, best practices in community coordination, proven planning processes, and the findings articulated by the Institute of Medicine report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People.*[123] 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 Synar Amendment requires states to ensure tobacco is not sold to individuals under age 18.[124] 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.

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[122] Substance Abuse and Mental Health Services Administration (2015). *Substance Abuse Prevention and Treatment Block Grant.* Retrieved from http://www.samhsa.gov/grants/block-grants/sabg

[123] "Front Matter." *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* Washington, DC: The National Academies Press, 2009. Retrieved from http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx.

[124] Substance Abuse and Mental Health Services Administration (2015). *Synar Program.* Retrieved from http://www.samhsa.gov/synar

Funding History

Fiscal Year	Amount
FY 2010	1,454,713,000
FY 2011	1,782,528,000
FY 2012	1,800,332,000
FY 2013	1,710,306,376
FY 2014	1,815,443,000
FY 2015	1,819,856,000
FY 2016	1,858,079,000
FY 2017	1,858,079,000
FY 2018	1,845,460,786
FY 2019	1,858,079,000

Budget Request

The FY 2019 President's Budget request is $1.9 billion, an increase of $12.6 million from the FY 2018 Annualized CR. SABG funds will continue to serve as a source of safety net funding, including assistance to states in addressing the opioid epidemic, and will continue to support certain services (e.g., recovery support services) not covered by commercial insurance and non-clinical activities and services that address the critical needs of state substance abuse prevention and treatment service systems.

Substance Abuse and Mental Health Services Administration
FY 2019 DISCRETIONARY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

State/Territory	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Alabama	$23,089,756	$22,935,346	$22,983,552	$48,206
Alaska	5,889,143	5,849,760	5,969,752	119,992
Arizona	40,188,203	39,919,450	43,347,842	3,428,392
Arkansas	13,524,655	13,434,211	13,462,447	28,236
California	254,417,734	252,716,349	253,247,522	531,173
Colorado	28,777,682	28,585,235	31,004,115	2,418,880
Connecticut	18,212,438	18,090,645	18,128,669	38,024
Delaware	6,967,878	6,921,281	6,967,796	46,515
District Of Columbia	6,967,878	6,921,281	6,967,796	46,515
Florida	111,380,602	110,635,759	110,868,297	232,538
Georgia	57,152,886	56,770,684	56,890,007	119,323
Hawaii	8,515,901	8,458,952	8,476,731	17,779
Idaho	8,535,938	8,478,855	8,496,676	17,821
Illinois	67,646,569	67,194,191	67,335,422	141,231
Indiana	32,246,464	32,030,820	32,098,144	67,324
Iowa	13,093,501	13,005,940	13,033,276	27,336
Kansas	11,899,802	11,820,224	11,845,068	24,844
Kentucky	20,378,612	20,242,333	20,284,879	42,546
Louisiana	25,026,724	24,859,361	24,911,611	52,250
Maine	6,967,878	6,921,281	6,967,796	46,515
Maryland	34,080,384	33,852,476	33,923,628	71,152
Massachusetts	39,845,551	39,579,089	39,662,278	83,189
Michigan	56,053,510	55,678,660	55,795,687	117,027
Minnesota	24,102,321	23,941,140	23,991,460	50,320
Mississippi	13,803,724	13,711,413	13,740,232	28,819
Missouri	26,548,786	26,371,244	26,426,672	55,428
Montana	6,967,878	6,921,281	6,967,796	46,515
Nebraska	7,641,330	7,590,230	7,606,183	15,953
Nevada	16,890,245	16,777,294	16,812,557	35,263

Substance Abuse and Mental Health Services Administration
FY 2019 DISCRETIONARY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG) CFDA #93.959

State/Territory	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
New Hampshire	6,967,878	6,921,281	6,967,796	$46,515
New Jersey	48,064,756	47,743,329	47,843,678	100,349
New Mexico	9,565,226	9,501,260	9,521,230	19,970
New York	111,831,371	111,083,513	111,316,992	233,479
North Carolina	44,992,436	44,691,555	44,785,489	93,934
North Dakota	6,533,624	6,489,931	6,623,054	133,123
Ohio	64,536,492	64,104,913	64,239,651	134,738
Oklahoma	17,149,542	17,034,857	17,070,661	35,804
Oregon	20,578,587	20,440,970	22,030,242	1,589,272
Pennsylvania	59,100,893	58,705,664	58,829,054	123,390
Rhode Island	7,598,565	7,547,751	7,563,615	15,864
South Carolina	23,718,051	23,559,440	23,608,958	49,518
South Dakota	6,041,781	6,001,377	6,124,479	123,102
Tennessee	31,978,622	31,764,769	31,831,533	66,764
Texas	144,710,369	143,742,637	144,044,760	302,123
Utah	16,588,775	16,477,840	16,758,971	281,131
Vermont	6,459,950	6,416,750	6,548,372	131,622
Virginia	41,980,395	41,699,657	41,787,303	87,646
Washington	37,785,106	37,532,423	37,611,310	78,887
West Virginia	8,432,779	8,376,386	8,393,992	17,606
Wisconsin	27,198,302	27,016,417	27,073,201	56,784
Wyoming	4,197,608	4,169,537	4,255,064	85,527
Red Lake Indians	594,034	590,061	591,301	1,240
American Samoa	343,467	341,781	345,156	3,375
Guam	1,014,336	1,017,520	1,104,302	86,782
Northern Marianas	324,352	329,209	347,532	18,323
Puerto Rico	22,812,308	22,631,279	22,572,549	-58,730
Palau	133,476	133,743	141,245	7,502
Marshall Islands	447,206	454,034	485,502	31,468
Micronesia	665,810	661,739	692,887	31,148
Virgin Islands	656,290	651,412	711,354	59,942

Outputs and Outcomes Tables

Program: Synar Amendment

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
2.3.49 Increase the number of States (including Puerto Rico) whose retail sales violations is at or below 20% (Outcome)	FY 2016: 52 Target: 52 (Target Met)	52	52	Maintain
2.3.62 Increase the number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% (Outcome)	FY 2016: 30 Target: 33 (Target Not Met but Improved)	33	33	Maintain

Outputs and Outcomes Tables

Program: Prevention Set-Aside

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
2.3.63 Increase the 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 2014: 35.3% (Historical Actual)	22.0%	22.0%	Maintain
2.3.65 Increase the 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 2015: 73.0% Target: 67.5 %[125] (Target Exceeded)	67.5%	67.5%	Maintain
2.3.67 Increase the 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 2014: 49.0% Target: 59.0% (Target Not Met)	63.0%	63.0%	Maintain
2.3.68 Increase the 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 2014: 24.0% Target: 37.3% (Target Not Met)	43.0%	43.0%	Maintain

[125]Data not available for FY 15 and FY 16 for most measures because of the NSDUH redesign prevented data collection during these fiscal years.

Outputs and Outcomes Tables

Program: Treatment Activities

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
1.2.43 Increase the number of admissions to substance abuse treatment programs receiving public funding. (Output)	FY 2015: 1,806,941 Target: 1,937,960 (Target Not Met)	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 2016: 69.6 % Target: 74.0% (Target Not Met)	74.0%	74.0%	Maintain
1.2.49 Increase the percentage of clients reporting no alcohol use in the past month at discharge. (Outcome)	FY 2016: 83.1 % Target: 78.0% (Target Exceeded)	78.0%	78.0%	Maintain
1.2.50 Increase the percentage of clients reporting being employed/in school at discharge. (Outcome)	FY 2015: 35.7 % Target: 43.0% (Target Not Met)	40.0%	40.0%	Maintain
1.2.51 Increase the percentage of clients reporting no involvement with the Criminal Justice System. (Outcome)	FY 2015: 93.2 % Target: 92.0% (Target Exceeded)	92.0%	92.0%	Maintain
1.2.85 Increase the percentage of clients receiving services who had a permanent place to live in the community. (Outcome)	FY 2015: 88.9 % Target: 92.0% (Target Not Met)	92.0%	92.0%	Maintain

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SAMHSA
Health Surveillance and Program Support
Table of Contents

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Health Surveillance

(Dollars in thousands)

Program Activity	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Health Surveillance	$47,258	$46,937	$48,842	$1,905
Budget Authority (non-add)	*16,830*	*16,716*	*29,414*	*12,698*
PHS Evaluation Funds (non-add)	*30,428*	*30,221*	*19,428*	*-10,793*
Data Request and Publication User Fees	$1,500	$1,490	$1,500	$---

Authorizing Legislation ..... Sections 501 and 505 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Federal/Intramural, Contracts, Other
Eligible Entities..... Not Applicable

Program Description and Accomplishments

The Health Surveillance funding primarily supports the activities of the Center for Behavioral Health Statistics and Quality (CBHSQ). The detailed funding for each activity along with a detailed narrative description of each project follows.

Resources by Activity/Program

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Health Surveillance and Program Support Appropriation				
Health Surveillance				
Population Data Collection, Analysis, and Dissemination	$14,718	$11,890	$12,992	$1,102
National Survey on Drug Use and Health (NSDUH).....	*5,326*	*2,939*	*640*	*-2,300*
Community Behavioral Health Surveillance	3,000	3,000	---	-3,000
Community Early Warning and Monitoring System (CEM-S).....	*3,000*	*1,000*	---	*-1,000*
Evidence-Based Programs/Practices	2,258	1,191	---	-1,191
Emergency Department Data Collection, Analysis, and Dissemination	125	4,000	15,000	11,000
SAMHSA's Emergency Department Surveillance System (SEDSS).....	*125*	*4,000*	*15,000*	*11,000*
Treatment Services Data Collection, Analysis, and Dissemination	11,013	13,696	11,512	-2,184
Behavioral Health Services Information System (BHSIS).....	*11,013*	*13,696*	*11,512*	*-2,184*
Behavioral Health Research and Dissemination	3,903	3,142	929	-2,214
Substance Abuse and Mental Health Data Archive (SAMHDA).....	*425*	*177*	*177*	---
Analytic Support Center (ASC).....	*2,790*	*2,965*	*751*	*-2,214*
Center for Financing Reform & Innovations (CFRI).....	*688*	---	---	---
Performance Measurement/Systems	*1,756*	*441*	---	*-441*
SAMHSA Performance Accountability Reports System (SPARS).....	---	---	---	---
Program Evaluations	1,346	1,350	---	*-1,350*
Primary and Behavioral Health Care Integration (PBHCI).....	*1,346*	*1,350*	---	*-1,350*
Content Management	---	---	---	---
Innovation and Logistical Services Support	---	---	---	---
Support	9,140	8,227	8,409	182
Operations.....	*2,358*	*2,433*	*2,503*	*70*
Payroll.....	*5,350*	*5,794*	*5,906*	*112*
Total Health Surveillance	**$47,258**	**$46,937**	**$48,842**	**$1,905**

Overview

SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) is the government's lead agency for behavioral health statistics. As authorized by Section 6004 of the 21st Century Cures Act, which amends Section 505 of the Public Health Service Act, CBHSQ performs activities that: (1) coordinate SAMHSA's integrated data strategy, including by collecting data each year; (2) provide statistical and analytical support for SAMHSA's activities; (3) recommend a core set of performance metrics to evaluate activities supported by SAMHSA; (4) coordinate with the Assistant Secretary, the Assistant Secretary for Planning and Evaluation, and SAMHSA's Chief Medical Officer, as appropriate, to improve the quality of services and evaluations. CBHSQ activities are integrated and cross over multiple funding lines.

CBHSQ receives funding for Health Surveillance (HS) and Performance and Quality Information Systems (PQIS) within the Health Surveillance and Program Support appropriation (HSPS)

funding sources and the Substance Abuse Treatment appropriation from Block Grant Set Aside (BGSA) funding sources. Programs are often funded from several sources. (A table detailing All Funding Sources follows the PQIS section). Under Health Surveillance, CBHSQ work includes Population Data Collection, Analysis, and Dissemination; Treatment Services Data Collection, Analysis, and Dissemination; Emergency Services Data Collection, Analysis, and Dissemination; Behavioral Health Surveillance; and Behavioral Health Research and Dissemination. Under PQIS, CBHSQ activities include Performance Measurement/Systems, Program Evaluations, and Evidence-Based Programs/Practices.

The total funding amount for CBHSQ (from all sources) in FY 2018 Annualized CR is $113.1 million, including $57.9 million from Health Surveillance and Program Support (HSPS) Appropriation and $55.2 million from the Substance Abuse Treatment (SAT) Appropriation.

Population Data Collection, Analysis, and Dissemination

Section 505 of the Public Health Service Act (42 USC 290aa-4) requires SAMHSA, on an annual basis, to collect data on the prevalence of substance use and mental illness. To accomplish this, SAMHSA administers the National Survey on Drug Use and Health (NSDUH). NSDUH is an annual collection of behavioral health data on approximately 67,500 persons aged 12 or older of the U.S. civilian, non-institutionalized population. NSDUH is the nation's primary source of statistical information on the use of illegal drugs, alcohol, and tobacco, certain mental disorders, co-occurring drug/alcohol addiction and mental illness, and treatment for substance abuse and mental health problems. NSDUH data provide estimates at the national, state, and sub-state level. NSDUH can be used to determine the prevalence of substance abuse and mental illness among demographic or geographic subgroups and provides trend estimates over time. NSDUH data provide states the opportunity to focus on their leading public health challenges through the release of state-specific data. Each year, three simultaneous NSDUH activities are ongoing: planning for future surveys, collecting data on over 67,500 persons in the current year survey, and analysis and dissemination of data from previous collections.

The prevalence of substance use from the FY 2015 NSDUH estimates that 27.1 million Americans aged 12 or older, or 10.1 percent were current (past month) illicit drug users.[126] From the FY 2015 NSDUH, 17.9 percent of adults ages 18 and older had any mental illness in the past year (43.4 million) and 4 percent (9.8 million) of adults had serious mental illness.[127]

[126] Substance Abuse and Mental Health Services Administration, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. See: http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1- 2014.pdf.

[127] Substance Abuse and Mental Health Services Administration, *Behavioral Health Trends in the United States: Results from the 2015 National Survey on Drug Use and Health*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. See: http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1- 2014.pdf.

The FY 2015 NSDUH included changes to the data collection equipment, respondent contact materials, and survey questions. The changes made to the survey questions were intended to improve the quality of the data collected and address changing substance use (e.g., misuse of prescription drugs) and mental health policy and research needs. All of the FY 2015 NSDUH changes were evaluated in field tests during FY 2012 and FY 2013, with appropriate adjustments made to the FY 2015 NSDUH based on field test findings.[128] A contract was awarded in early FY 2017 for survey years FY 2018 through FY 2021.

CBHSQ has partnered with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Research Council (NRC) for guidance on how to collect data on other behavioral health issues (including trauma, recovery, and serious emotional disturbance among children) through extramural data collection initiatives. In FY 2018, SAMHSA will begin a NSDUH redesign to ensure the survey is clinically up-to-date through alignment of questions to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). Other potential areas for the next possible redesign include, but are not limited to, electronic cigarettes, synthetic marijuana, and alignment of treatment questions for substance abuse and mental health.

NSDUH data are disseminated through public-use files made available online on the Substance Abuse and Mental Health Data Archive (SAMHDA). Data are also disseminated through annual reports.[129,130,131] Collectively, in FY 2015 and FY 2016, approximately 200 reports and articles were written by external researchers using NSDUH, TEDS, N-SSATS, and DAWN data. In FY 2017, 30,000 NSDUH downloaded events are anticipated. CBHSQ staff also responded to over 600 requests for NSDUH data in FY 2016.

Treatment Services Data Collection, Analysis, and Dissemination

Section 505 of the Public Health Service Act (42.U.S.C. 290aa-4) requires SAMHSA to collect data on mental illness and substance abuse treatment services. For this purpose, SAMHSA's CBHSQ developed the Behavioral Health Services Information System (BHSIS). Data collected through the BHSIS provides information to the public on treatment services through the Behavioral Health Treatment Services Locator, a portion of the National Treatment Referral Service. The

[128] The following report provides a summary of the changes made to the 2014 NSDUH sample design and 2015 NSDUH redesign, including data collection equipment, respondent contact materials, and the survey questionnaire. http://www.samhsa.gov/data/sites/default/files/NSDUH-RedesignChanges-2015.pdf

[129] Substance Abuse and Mental Health Services Administration, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. See: http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1- 2014.pdf.

[130] Substance Abuse and Mental Health Services Administration. *Suicidal Thoughts and Behavior among Adults: Results from the 2014 National Survey on Drug Use and Health* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. See http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR2-2014/NSDUH-FRR2-2014.pdf

[131] Substance Abuse and Mental Health Services Administration. *Risk and Protective Factors and Initiation of Substance Use: Results from the 2014 National Survey on Drug Use and Health.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. See: http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR4-2014v1/NSDUH-DR-FRR4-2014.pdf

Locator provides accurate, timely, and regularly updated information on mental and substance abuse treatment facilities across the country. BHSIS includes multiple data collection programs and information resources to support the Locator. BHSIS data collections comprise: (1) the National Mental Health Services Survey (N-MHSS) which provides information on all specialty mental disorder treatment facilities in the United States; in FY 2016, the overall response rate was 92.1 percent; (2) the National Survey of Substance Abuse Treatment Services (N-SSATS) which provides information on all public and private substance abuse treatment facilities in the United States; in FY 2016, the overall response rate was 92.4 percent; (3) the Treatment Episode Data Set (TEDS) which provides demographic and services information on publicly funded admissions and discharges from substance abuse treatment; (4) the Mental Health Treatment Episode Data Set (MH-TEDS) and the Mental Health Client Level Data (MH-CLD) which provide demographic and services information on publicly funded admissions and discharges of clients in mental disorder treatment; and (5) the Uniform Reporting System (URS) which provides a set of standardized data tables submitted annually by states and territories as part of their Mental Health Block Grant (MHBG) annual implementation reports.

One important element of the BHSIS is the Inventory of Behavioral Health Services (I-BHS) which provides a listing of all known mental disorder and substance abuse treatment facilities. As of March 2017, I-BHS had identified 19,529 active substance abuse treatment facilities and 14,263 active mental disorder treatment facilities in the United States and its territories.

In FY 2015, the Behavioral Health Treatment Services Locator was accessed more than 2.8 million times by individuals, families, community groups, and organizations to identify appropriate treatment services. Also in FY 2016, for the months of May through October that SAMHDA was operational, researchers downloaded over 2,000 BHSIS public-use datasets, and it is projected, based on increasing downloads and an expanding repository of datasets available, that in FY 2017, researchers will download over 10,000 BHSIS public use datasets. CBHSQ staff responded to over 100 requests for BHSIS data. In February 2017, data users accessed over 380 web pages for URS tables.

In FY 2016, SAMHSA awarded a new BHSIS contract for four cycles of the annual N-SSATS and N-MHSS. The Behavioral Health Treatment Services Locator is part of the National Treatment Referral Routing Service, which is required through Section 9006 of the 21st Century Cures Act. In FY 2017, SAMHSA continued each of the BHSIS data programs and is coordinating with states to develop Mental Health-Treatment Episode Data Set/Mental Heath-Client Level Data (MH-TEDS/MH-CLD) further.

Emergency Department Data Collection, Analysis, and Dissemination

Section 505 of the Public Health Service Act (42.U.S.C. 290aa-4) requires SAMHSA to collect and publish data on Emergency departments (ED) visits related to the use of alcohol and drugs.

Emergency departments (EDs) are a robust source of information about substance abuse and mental disorder-related morbidity; an ongoing collection of data allows monitoring of patterns, trends, and the identification of emergent drugs of use.

In late FY 2011, SAMHSA began collaborating with the National Center for Health Statistics (NCHS) to obtain data from the National Hospital Care Survey (NHCS) on ED visits related to substance abuse and mental illness for the SAMHSA Emergency Department Surveillance System (SEDSS). The NHCS is a survey that describes national patterns of healthcare delivery in hospital-based settings, including inpatient, emergency, and outpatient departments. With SEDSS data, national level estimates of drug-related ED visits and mental illness can be published.

In FY 2017, efforts focused on challenges that include recruiting hospitals to participate in the survey, developing an infrastructure to collect electronic health record (EHR) data for surveillance purposes, and developing methods to identify information about drug-related ED visits in EHR data. SAMHSA also worked with NCHS to fund a NCHS research data center to help prepare for analysis of the EHR data.

SAMHSA FY 2018 Annualized CR funding is $4.0 million and SAMHSA will discontinue funding for SEDSS in FY 2019 with the plan to Implement the more robust Drug Abuse Warning Network.

Community Behavioral Health Surveillance

SAMHSA coordinates public health response data efforts to create opportunities for cross-agency and public-private partnerships to address critical public health questions and use existing or decreasing resources more effectively. Surveillance of health conditions is critical to track aberrations, changes over time, impact of public health interventions, and national and regional differences. Currently, no such surveillance system exists for behavioral health data; national surveillance systems do exist, though, for 52 infectious diseases.

In FY 2016, SAMHSA funded support for the Community Early Warning and Monitoring System (C-EMS), a cooperative initiative in which national level behavioral health indicators are being developed. In FY 2017, SAMHSA provided funding for a pilot program, establishing infrastructure and reporting mechanisms for data collection using this national behavioral health surveillance system. The pilot the results will be available for review.

In FY 2016 and FY 2017, SAMHSA supported and reported on field investigations by deploying staff to New Mexico, Baltimore, and Flint, Michigan to assess the capacity of the local community to respond to behavioral health public health concerns. Additionally, SAMHSA supported and reported on field investigations related to suicide, opioid-overdose deaths, and an opioid-related HIV outbreak in Indiana.

SAMHSA has also developed a community assessment tool (CAST)[132] that provides a modeled "gold standard" for local-level community behavioral health infrastructure compared to an on-the-ground asset mapping. CAST allows for a local-level evaluation of gaps and overages in programmatic coverage, and facilitates community level discussions about resource management. The CAST tool, within the context of public health, can be used as a preparation, mitigation, response, or recovery tool.

[132] Green B, Lyerla R, Stroup DF, Azofeifa A, High PM. A Tool for Assessing a Community's Capacity for Substance Abuse Care. Prev Chronic Dis 2016;13:160190. DOI: http://dx.doi.org/10.5888/pcd13.160190

SAMHSA FY 2018 Annualized CR funding is $3.0 million and SAMHSA will discontinue funding for C-EMS in FY 2019 with the plan to continue a partnership with state and territorial epidemiologists to explore the viability of this approach to collect local behavioral health indicators in future years.

Behavioral Health Research and Dissemination

OMB's Open Data Policy Memorandum (M-13-13) requires the Federal Government to make data it collects accessible and usable through dissemination activities. CBHSQ conducts epidemiological and health services research in the area of behavioral health. Results of these research studies inform policymakers, service providers, program developers, and the public about important behavioral health findings.

CBHSQ is completing a research framework to feed into a broader SAMHSA learning agenda for research, statistical studies, and program evaluation. CBHSQ categorizes its research activities into four major portfolio areas: substance use, mental health, community behavioral health surveillance, and methodological studies. Additionally, several portfolio topic areas, subsets of the portfolio areas, have been identified to represent a snapshot of current and past CBHSQ research endeavors. The portfolio topic areas allow CBHSQ to optimize resources and balance priorities.

From FY 2012 – FY 2016, CBHSQ produced 64 articles; these articles were across the four Portfolio areas in the CBHSQ Research Framework. CBHSQ is projected to produce 64 articles in FY 2017 and 16 articles in FY 2018. Additionally, CBHSQ disseminates information through short reports and data spotlights using CBHSQ and other data sources that focus on topics impacting the behavioral health of the nation. Short reports describe trends in substance use, mental health, and treatment topics with in-depth analysis by age, gender, substance use initiation, socioeconomic status, and national and state estimates. Spotlights focus on a single topic with one chart or graph and a descriptive paragraph delineating public health significance. These are published on the SAMHSA website and at the National Library of Medicine. During the period FY 2012 – FY 2016, CBHSQ staff authored over 200 such reports. CBHSQ staff is projected to produce approximately 50 short reports and spotlights in FY 2017.

The Analytical Support Contract will continue to provide support for these activities as well as support for ad hoc requests, short- and long-term analyses, special requests, and evaluation activities, a total of $3.5 million is requested for this contract, which is provided from the HSPS and SAT Appropriations.

The Substance Abuse and Mental Health Data Archive (SAMHDA) serves as SAMHSA's primary means for dissemination of data through Public-Use Files (PUF). From May 23, 2016 to October 2016, users downloaded over 17,000 PUFs from SAMHDA and generated over 8,000 tables utilizing a web-based analytic tool launched September 15, 2016. Through SAMHDA, CBHSQ provides limited, no-cost, public access to confidential data for researcher analysis. A restricted version of the current web-based analytic tool launched in April 2017, and allows researchers to generate tables based on confidential data.

In FY 2017, web-based analytic tool improvements were implemented; and, projected FY 2017 SAMHDA usage is over 50,000 public-use datasets downloaded by researchers and over 100,000 tables generated using online analytic tools. CBHSQ will continue to incorporate SAMDHA improvements in FY 2018. In FY 2018 Annualized CR, a total of $0.55 million is requested for SAMHDA ($0.18 million from HSPS and $0.37 million from SAT). In FY 2019, funding will remain level from FY 2018 Annualized CR.

Funding History

Fiscal Year	Amount
FY 2015	$47,258,000
FY 2016	$47,258,000
FY 2017	$47,258,000
FY 2018	$46,937,071
FY 2019	$48,842,000

Budget Request

The FY 2019 President's Budget Request is $48.8 million, an increase of $1.9 million from the FY 2018 Annualized CR. This funding will support the continuation of the NSDUH, NREPP, BHSIS, and the Analytic Support Center contracts. The funding will also support $1.0 million to continue collaboration between HRSA and SAMHSA to collect and analyze data to examine the Behavioral Health Workforce. Funding has been prioritized to continue the NSDUH survey at its current sample size. In FY 2019, a total of $19.2 million is requested for BHSIS ($11.5 million in HSPS and $7.7 million from SAT). Additional funds totaling $8.5 million are provided by CMHS and CSAT from the MH and SAT appropriations to support state payment for data collection. In addition, in FY 2019, a total of $57.3 million is request for NSDUH ($13.0 million from HSPS and $44.3 million from SAT) to continue survey activities without reducing sample size, representing a decrease of $1.1 million from the FY 2018 Annualized CR. In FY 2019, SAMHSA will plan to roll out the results of the 2018 survey, field the 2019 survey, plan for the 2020 survey, and will continue to explore options for a future NSDUH redesign.

The $15.0 million will be used to support the 21st Century Cures Act requirement for a Drug Abuse Warning Network (DAWN). This program will provide critical information on ED visits related to substance abuse, which will provide the necessary information for communities on early warning and potential intervention. Given the nature of the current opioid crisis, access to information on overdose deaths and any data available for early warning is critical to fully addressing the crisis.

The Drug Abuse Warning Network (DAWN) survey is a national public health surveillance system that monitors drug-related visits to hospital emergency departments (EDs) and drug-related deaths recorded by medical examiners and coroners (ME/Cs). An important feature of DAWN is that it provides information on the immediate consequence as well as related physical and behavioral health outcomes and case disposition. Required in the 21st Century Cures Act, this system is now more critical than ever in the context of the recent opioid crisis. These data, which can serve as an

imperative tool for clinicians, are not currently available. Data may be used to provide critical information on areas of needed emphasis and can serve as a useful tool for early intervention.

The initial purpose of DAWN was to track emergency department (ED) visits caused by drug abuse in order to identify the drugs being abused, determine patterns in selected metropolitan areas and changing trends across the country, including the detection of new substances of abuse and new combinations. Initially focusing on metropolitan areas only, the system was later expanded to produce estimates for the U.S. and to capture drug abuse-related deaths investigated by medical examiners/coroners in selected metropolitan areas.

DAWN data elements include but are not limited to: patient demographics, visit characteristics, patient diagnosis, substances used, and visit disposition. SAMHSA's last collection of DAWN data was in 2011. National health surveillance is a critical step in adequately addressing the opioid crisis; for that reason, SAMHSA is proposing a re-institution of the DAWN survey in its previous iteration.

Mechanism Table for Health Surveillance

(Dollars in thousands)

Program Activity	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Health Surveillance						
Contracts						
Continuations.....	5	$42,088	5	$46,937	5	$48,842
New/Competing.....	2	5,170	---	---	---	---
Subtotal.....	7	47,258	5	46,937	5	48,842
Total, Health Surveillance	**7**	**47,258**	**5**	**46,937**	**5**	**48,842**

Performance and Quality Information Systems

(Dollars in thousands)

Program Activity	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Performance and Quality Information Systems.....	$10,000	$9,932	$12,893	$2,961
PHS Evaluation Funds (non-add).....	---	---	*12,893*	*12,893*

Authorizing Legislation ..... Sections 501, 509, 516, 520A, and 543A of the Public Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

The Performance and Quality Improvement Systems (PQIS) funding primarily supports the activities of the Center for Behavioral Health Statistics and Quality (CBHSQ). The detailed funding for each activity along with a detailed narrative description of each project follows.

Performance and Quality Information Systems
Resources by Activity/Program

(Dollars in thousands)

Program Activity	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Performance and Quality Information Systems				
Performance Measurement/Systems	$8,116	$7,375	$6,619	-$756
SAMHSA Performance Accountability Reports System (SPARS).....	*8,116*	*7,375*	*6,619*	*-756*
Evidence-Based Programs Resource Center	1,260	1,624	2,814	1,191
Behavioral Health Research and Dissemination	---	---	2,311	2,311
Analytic Support Center (ASC).....	---	---	*2,311*	*2,311*
Support	624	933	1,149	216
Operations.....	*624*	*933*	*1,149*	*216*
Total Performance and Quality Information Systems	**$10,000**	**$9,932**	**$12,893**	**$2,961**

Performance Measurement and Performance Systems

SAMHSA collects data on key output and outcome measures to monitor and manage grantee performance, improve the quality of services provided, and inform program evaluations.

These data previously were collected by legacy systems, including Data Collection, Analyses, and Reporting (DCAR); Prevention Management Reporting and Training System (PMRTS); Services Accountability Improvement System (SAIS); and the Transformation Accountability System (TRAC). These legacy systems were migrated to a single system, the SAMHSA Performance Accountability Reports System (SPARS), in FY 2017 to meet SAMHSA's vision of a more efficient, holistic approach to its performance data collection.

In FY 2017, SPARS was deployed as a real-time data entry and reporting system for all of SAMHSA's discretionary grant programs. Data collected through SPARS are used to monitor the progress of SAMHSA's discretionary grants, serve as a decision-making tool on funding, and improve the quality of services provided through the programs. SAMHSA will continue to implement the 21st Century Cures Act and make any necessary changes to improve the performance metrics used and to evaluate effectiveness of SAMHSA programs.

Program Evaluations

In FY 2012, SAMHSA established a policy for the development and management of evaluation and performance monitoring, with a specific focus on implementing rigorous and consistent program evaluation within SAMHSA. During the fall of 2016, CBHSQ developed an updated Evaluation Policy and Procedure (P&P) document to guide SAMHSA in developing a long-term evaluation plan based on the selection and use of the best methods for answering specific evaluation questions. The objectives of the Evaluation P&P are: to put into place a policy and a consistent business practice to: match the type of evaluation activity to the maturity of the program and to the nature of the research questions, determine the degree of independence of evaluation activities for different types of programs, incorporate these practices and considerations into the contract planning process, collect and disseminate meaningful and critical findings to colleagues and to the behavioral health and scientific fields, and develop a learning agenda to identify priorities for future evaluation activities. The updated Evaluation P&P will be fully implemented for the FY 2018 and FY 2019 planning cycles.

SAMHSA program evaluations are primarily funded by SAMHSA's other three programmatic appropriations: the Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), and Center for Substance Abuse Treatment (CSAT). In FY 2017, the program Centers funded over a dozen evaluations covering a variety of programs (e.g., Strategic Prevention Framework for Prescription Drugs; Screening, Brief Intervention, and Referral to Treatment; Pregnant and Postpartum Women; Children's Mental Health Initiative). CBHSQ has directly funded the Primary and Behavioral Health Care Integration (PBHCI) evaluation since FY 2015. The evaluation of the PBHCI as the program was eliminated in FY 2018.

In FY 2017, CBHSQ conducted small-scale, time-limited assessments and evaluations in collaboration with the program Centers. These include a community assessment for the

Medication-Assisted Treatment for Prescription Drug and Opioid Addiction Program (MAT-PDOA), the CARA-required evaluation of the Pregnant and Post-Partum Women and Pilot (PPWP), and the State Targeted Response to Opioid Crisis (Opioid STR) program authorized by the 21st Cures Act. Activities also include an assessment of barriers and facilitators to implementing the Resiliency in Communities After Stress and Trauma (ReCAST) grants, an analysis of the facilitators to successful implementation of Assisted Outpatient Treatment (AOT) programs, and a study of state's adoption of quality measures for behavioral health clinics.

National Resource Center for Evidence-based Programs and Practices

Section 7002 of the 21st Century Cures Act requires that SAMHSA shall, as appropriate, improve access to reliable and valid information on evidence-based programs and practices, including information on the strength of evidence associated with such programs and practices related to mental illness and drug/alcohol addiction for states, local communities, non-profit entities, and other stakeholders, by posting on SAMHSA's website information on evidence-based programs and practices that have been reviewed.

In FY 2018, SAMHSA ended its existing approach to its National Registry of Evidence-based Programs and Practices (NREPP). That process lacked scientific rigor and resulted in programs with a weak evidence base listed on the registry. SAMHSA is committed to the identification and implementation of EBPs across communities. In FY 2018, funding supported efforts by SAMHSA's newly authorized Policy Lab to develop a scientifically rigorous approach to the implementation of the new Evidence-Based Programs Resource Center.

Behavioral Health Quality Measures

Behavioral health quality activities are housed within CBHSQ. The Center provides oversight of the agency's quality improvement efforts, including the identification of gaps in behavioral health quality measurement and the adoption and implementation of behavioral health quality measures. Oversight of the agency's measure development efforts includes current re-specification work funded by CSAT, re-specification of measures for Healthcare Effectiveness Data and Information Set (HEDIS) adoption, measures-conceptualization development work in suicide prevention in CMHS, and ongoing partnerships with the Center for Medicare & Medicaid Services (CMS) and the Assistant Secretary for Planning and Evaluation (ASPE), among other Federal partners, in quality measure work. CBHSQ serves as the SAMHSA lead to the National Quality Forum (NQF) as well as participates as a Federal advisor for other agencies conducting measure development work, including CMS and ASPE. CBHSQ also represents SAMHSA on the HHS Measurement Policy Council, leading discussions related to behavioral health metrics and contributing to discussions focused on broader healthcare metrics. CBHSQ also participates on the Measures Application Partnership, a group convened to guide CMS on measure adoption.

In response to the National Quality Strategy, SAMHSA developed its own specific quality strategy, the National Behavioral Health Quality Framework, a stand-alone document that recommends core and supplemental measures to be utilized at the payer, provider, and population level to track meaningful service delivery process and outcome measures in behavioral health.

This document is often referenced by NQF as a foundational document used to guide its behavioral health quality measures work.

To date, a significant amount of behavioral health quality measure development has occurred, but gaps remain. A critical issue is field implementation; therefore, SAMHSA is focused on implementation issues since NQF measures have three years to demonstrate use by the field, after which they are retired. Challenges in implementation are frequently encountered due to the lack of infrastructure or personnel for collection and reporting in behavioral health programs. SAMHSA is jointly advancing behavioral health quality measure implementation by co-leading an HHS Behavioral Health Coordinating Council (BHCC) subcommittee on quality measures with ASPE and CMS which will result in recommendations about the uptake of consistent behavioral health quality measures related to alcohol misuse, tobacco cessation, depression measurement and management, and medication reconciliation across HHS programs, including CMS, HRSA, SAMHSA, and others. CBHSQ will continue to engage in these types of activities going forward.

CBHSQ staff provides internal collaborations across SAMHSA, advising on quality measure issues and identifying key next steps. Additionally, CBHSQ staff continues to serve as advisors for NQF projects jointly funded by ASPE and CMS and focused on a broad range of quality activities. CBHSQ staff regularly consults with other Federal agencies, the NQF, and other key stakeholders regarding behavioral health quality indicators, including barriers to and facilitators of data collection, tracking, and reporting. SAMHSA should continue its behavioral health quality measure activities through ongoing identification of behavioral health measurement gaps and the capacity to address such gaps.

Funding History

Fiscal Year	Amount
FY 2015	$12,918,000
FY 2016	$12,918,000
FY 2017	$10,000,000
FY 2018	$ 9,932,090
FY 2019	$12,893,000

Budget Request

The FY 2019 President's Budget Request is $12.9 million, an increase of $3.0 million from the FY 2018 Annualized CR. SAMHSA will use these funds to continue its performance management, quality improvement, and program evaluation activities. This funding will ensure that SAMHSA continues a strong focus on developing and implementing evidence-based practices and programs and continues its emphasis on performance management for quality improvement and program monitoring.

Mechanism Table for Performance and Quality Information Systems

(Dollars in thousands)

Program Activity	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Performance and Quality Information Systems						
Contracts						
Continuations	---	10,000	2	9,932	2	12,893
New/Competing	---	---	---	---	---	---
Subtotal	---	10,000	2	9,932	2	12,893
Total, Performance and Quality Information Systems	**---**	**10,000**	**2**	**9,932**	**2**	**12,893**

The following table provides a detailed description of all funding sources supporting CBHSQ activities.

Center for Behavioral Health Statistics and Quality
Breakout by Activity/Program (all sources)

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Substance Abuse Treatment Appropriation				
Substance Abuse Block Grant Set Aside				
Population Data Collection, Analysis, and Dissemination	$40,356	$44,021	$41,798	-$2,223
PHS Evaluation (non add)	*39,657*	*44,021*	*41,798*	*-2,223*
Treatment Services Data Collection, Analysis, and Dissemination	7,193	5,162	7,675	2,513
PHS Evaluation (non add)	*7,193*	*5,162*	*7,675*	*2,513*
Emergency Department Data Collection, Analysis, and Dissemina	3,875	---	---	---
PHS Evaluation (non add)	*3,875*	---	---	---
Behavioral Health Research and Dissemination	1,802	892	883	-9
PHS Evaluation (non add)	*1,802*	*892*	*883*	*-9*
Support	5,149	5,123	5,220	97
PHS Evaluation (non add)	*5,149*	*5,123*	*5,220*	*97*
Total Substance Abuse Block Grant Set Aside	**58,374**	**55,198**	**55,576**	**379**
Total Substance Abuse Treatment PHS Evaluation	*57,676*	*55,198*	*55,576*	*379*
Health Surveillance and Program Support Appropriation				
Health Surveillance				
Population Data Collection, Analysis, and Dissemination	14,718	11,890	12,992	1,102
PHS Evaluation (non add)	*5,326*	*2,939*	*640*	*-2,300*
Treatment Services Data Collection, Analysis, and Dissemination	11,013	13,696	11,512	-2,184
PHS Evaluation (non add)	*11,013*	*13,696*	*11,512*	*-2,184*
Emergency Department Data Collection, Analysis, and Dissemina	125	4,000	15,000	11,000
PHS Evaluation (non add)	*125*	*4,000*	---	*-4,000*
Community Behavioral Health Surveillance	3,000	3,000	---	-3,000
PHS Evaluation (non add)	*3,000*	*1,000*	---	*-1,000*
Behavioral Health Research and Dissemination	3,903	3,142	929	-2,214
PHS Evaluation (non add)	*517*	*177*	*177*	---
Performance Measurement/Systems	1,756	*441*	---	*-441*
PHS Evaluation (non add)	*100*	---	---	---
Program Evaluations	1,346	1,350	---	-1,350
PHS Evaluation (non add)	*1,346*	*1,350*	---	*-1,350*
Evidence-Based Programs/Practices	2,258	1,191	---	-1,191
PHS Evaluation (non add)	*2,258*	---	---	---
Support	9,140	8,227	8,409	182
PHS Evaluation (non add)	*6,742*	*7,058*	*7,099*	*41*
Total Health Surveillance	**47,258**	**46,937**	**48,842**	**1,905**
Performance and Quality Information Systems				
Performance Measurement/Systems	8,116	7,375	6,619	-756
Program Evaluations	---	---	---	---
Evidence-Based Programs/Practices	1,260	1,624	2,814	1,191
Behavioral Health Research and Dissemination	---	---	2,311	2,311
Support	624	933	1,149	216
Total Performance and Quality Information Systems	**10,000**	**9,932**	**12,893**	**2,961**
Behavioral Health Workforce Data and Development				
Behavioral Health Workforce Data Development	1,000	993	998	5
PHS Evaluation (non add)	*1,000*	*993*	*998*	*5*
Total Behavioral Health Workforce Data and Development	1,000	993	998	5
Total Health Surveillance and Program Support	**58,258**	**57,862**	**62,733**	**4,871**
Total Health Surveillance and Program Support PHS Evaluation	*31,428*	*31,215*	*20,426*	*-10,789*
Total Substance Abuse Block Grant Set Aside and Health Surveillance and Program Support	**$116,632**	**$113,060**	**$118,309**	**$5,249**

Outputs and Outcomes Table

Program: Performance and Quality Information Systems

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 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 2017: 34,315 Target: 1,700,000 (Target Not Met)	34,315	34,315	Maintain
4.4.11 Increase the number of evidence-based programs or practices in review (Output)	FY 2017: 99 Target: 55 (Target Exceeded)	99	99	Maintain

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Program Support

(Dollars in thousands)

Program Activity	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Program Support	$77,000	$76,477	$73,043	-$3,434

Authorizing Legislation ..... Section 501 of the Public Health Service Act
FY 2019 Authorization ..... Permanent
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's programs, as well as business operations and processes, information technology, and overhead expenses, such as rent, utilities, and miscellaneous charges. 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 and the Program Support Center.

SAMHSA supported 590 Full Time Equivalents (FTEs) in FY 2017. In FY 2018, in order to support staffing for areas such as the Office of the Chief Medical Officer and Cures implementation, SAMHSA projects support of 614 FTEs. Staff positions that are not covered through the Health Surveillance and Program Support appropriation are funded with Substance Abuse Prevention and Treatment and Mental Health Block Grant set-asides for activities associated with technical assistance, data collection, and evaluation.

SAMHSA applies an estimated internal administrative charge for overhead expenses to all programs, projects, and activities.

Funding History

Fiscal Year	Amount
FY 2015	$72,002,000
FY 2016	$79,559,000
FY 2017	$77,000,000
FY 2018	$76,477,000
FY 2019	$73,043,000

Budget Request

The FY 2019 President's Budget Request is $73.0 million, a decrease of $3.4 million from the FY 2018 Annualized CR. This level of funding will continue to cover personnel, overhead costs associated with 5600 Fishers Lane, including rent, the Federal Acquisition Service loan repayment program, and security charges. Funding in FY 2016 and FY 2017 reflected an increase due to the agency's relocation; given that these expenses will not be incurred in FY 2018, the funding request has been decreased.

Mechanism Table for Program Support

(Dollars in thousands)

	FY 2017 Final		FY 2018 Annualized CR		FY 2019 President's Budget	
Program Activity	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Program Support						
Contracts						
Continuations……..	---	77,000	---	76,477	---	73,043
New/Competing.....	---	---	---	---	---	---
Subtotal.....	---	77,000	---	76,477	---	73,043
Total, Program Support	**---**	**77,000**	**---**	**76,477**	**---**	**73,043**

Public Awareness and Support

(Dollars in thousands)

Program Activity	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Public Awareness and Support.....	$13,000	$12,912	$11,572	-$1,340

Authorizing Legislation Sections 501, 509, 516, and 520A of the Public Health Service Act
FY 2019 Authorization ..... Permanent
Allocation Method ..... Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

A part of SAMHSA's mission is to raise the public's understanding of mental illness and drug/alcohol addiction, serve as an expert on behavioral health issues, and lead public health efforts to advance the behavioral health of the nation.

Collaborating Across Agencies

In FY 2017, SAMHSA worked with the Office of the Surgeon General and other HHS agencies to release the *Facing Addiction in America: Surgeon General's Report on Alcohol, Drugs, and Health*, the first ever Surgeon General's report on this topic, to bring national attention to substance misuse and addiction. The report called on people throughout the U.S. to take action to end the public health crisis of addiction and discuss the importance of taking a comprehensive approach to the problem of substance abuse. SAMHSA also will promote the Report through conferences, grantee meetings, webinars, and social media.

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 healthcare community through the Public Engagement Platform (PEP), which manages SAMHSA's print and online information resources. The PEP contract is a resource for the public as well as the behavioral health workforce; it provides a warehouse of publications and access to the National Helpline. The PEP provides a customer-oriented order fulfillment system, including an online store, call-in contact center (the National Helpline), warehouse, and e-blasts to thousands of subscribers. The current opioid crisis has increased a demand for treatment services. The National Helpline provides free confidential treatment referral and information services in English and Spanish for individuals and families facing mental illness and/or drug/alcohol addiction. It is operational every day, 24/7. In FY 2016, SAMHSA's Helpline responded to 752,096 inquiries, which was an increase in call volume of more than 25 percent during the course of the fiscal year. Although SAMHSA has instituted new technologies such as text messaging (SMS) and an

interactive voice response system as cost-effective solutions, SAMHSA will continue to explore innovative solutions to avoid any service disruption and to ensure callers get referred to treatment services.

SAMHSA is also responsible for managing the Disaster Distress Helpline 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 for responders and survivors. SAMHSA has adopted a rapid response practice which it will continue. When a disaster occurs, SAMHSA quickly disseminates an e-blast featuring SAMHSA's Disaster Distress Helpline, links too many of SAMHSA's resources, and a link to SAMHSA's behavioral health treatment locator. The Helpline responded to over 16,000 text messages and calls in FY 2016.

Over the last several years, SAMHSA has leveraged mobile technology to increase the reach of its resources by launching multiple mobile apps. Each app has had a greater reach than the ones that preceded it. In FY 2015, SAMHSA launched the "Suicide Safe" app for primary care and behavioral health providers. The Suicide Safe app is designed to help primary care and behavioral health providers address suicide risk and integrate suicide prevention strategies in patient care. Suicide Safe has been downloaded 50,033 times since its March 2015 launch. In FY 2017, SAMHSA launched MATx, an app that provides healthcare practitioners with immediate access to vital information about medication assisted treatment (MAT) for opioid addiction. The MATx app includes information on medications approved by FDA for use in treatment of opioid use disorders and treatment approaches for practitioners, a buprenorphine prescribing guide, clinical support tools, and access to critical helplines and SAMHSA treatment locators. MATx is available free for Apple and Android mobile devices. As of October 2016, MATx has been downloaded 11,303.

Leveraging SAMHSA's Online Presence

Available 24/7, SAMHSA.gov is the public's primary access point for behavioral health information from the federal government. SAMHSA's website and social media presence on channels such as Facebook, Twitter, and YouTube are critical to efforts to engage with citizens about behavioral health. In addition to print and traditional media, social media is now incorporated in communications plans and is employed daily to communicate behavioral health messages and resources. The increasingly effective reach of these online channels is demonstrated by the fact that the number of people following SAMHSA on Twitter was 73,816 (an increase from 7,000 in 2013); the "likes" of SAMHSA's Facebook page was 75,421 (an increase from 20,000 in 2013); and the subscribers on SAMHSA's YouTube were 6,300 (an increase from 800 in 2013).

In the course of prioritizing the internet as a strategic business initiative and communications asset, SAMHSA consolidated and modernized its web presence. In FY 2016, SAMHSA managed a

significant increase in web visits from the previous year: a 16 percent growth in annual web visits (over 33 million visits) and a 50 percent increase in unique visits (almost 9 million new visitors).

Dissemination of Behavioral Health Data and Surveillance

A goal of SAMHSA's Public Awareness and Support effort is to make certain that valuable behavioral health 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 (e.g., MDMS, PEP, the Web, and social media) and other program operations. These include press releases issued by SAMHSA to highlight recent findings from the National Survey on Drug Use and Health and SAMHSA's Behavioral Health Barometer. These surveys provide data on behavioral health trends at the national level, by geographic region, and for each of the 50 states and the District of Columbia.

Funding History

Fiscal Year	Amount
FY 2015	$13,482,000
FY 2016	$15,571,000
FY 2017	$13,000,000
FY 2018	$12,912,000
FY 2019	$11,572,000

Budget Request

The FY 2019 President's Budget Request is $11.6 million, a decrease of $1.3 million from the FY 2018 Annualized CR. Funds for Public Awareness and Support will allow SAMHSA to maintain and update its web presence, manage critical helplines, deliver publications and resources, expand its presence on social media, and provide other resources to support behavioral health and other health. SAMHSA will continue to collaborate with other agencies. These efforts will allow SAMHSA to broaden the reach of its four key messages: behavioral health is essential to health, prevention works, treatment is effective, and people recover.

In FY 2019, through the Materials Development and Marketing Support (MDMS) contract, SAMHSA will continue to promote the Surgeon General's Report through communication products such as fact sheets and infographics. SAMHSA will examine its current suite of opioid related products to identify gaps, to cross-promote, and to maximize promotional opportunities.

Mechanism Table for Public Awareness and Support

(Dollars in thousands)

Program Activity	FY 2017 Final No.	FY 2017 Final Amount	FY 2018 Annualized CR No.	FY 2018 Annualized CR Amount	FY 2019 President's Budget No.	FY 2019 President's Budget Amount
Public Awareness and Support						
Contracts						
Continuations	6	13,000	4	5,342	4	11,572
New/Competing	---	---	1	7,570	---	---
Subtotal	6	13,000	5	12,912	4	11,572
Total, Public Awareness and Support	**6**	**13,000**	**5**	**12,912**	**4**	**11,572**

Outputs and Outcomes Table

Program: Public Awareness and Support

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Final and the FY 2019 targets are based on the FY 2018 Annualized CR.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
4.4.12 Increase the number of individuals referred for behavioral health treatment resources. (Output)	FY 2016: 752,096 Target: 400,000 (Target Exceeded)	600,000	600,000	Maintain
4.4.13 Increase the total number of interactions through phone inquiries, e-blasts, dissemination of SAMHSA publications, and total website hits. (Output)	FY 2016: 41,437,011 Target: 33,000,000 (Target Exceeded)	33,430,000	33,430,000	Maintain

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SAMHSA
Additional Opioids Allocation

(Dollars in thousands)

Programs Activities	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
State Targeted Response to the Opioid Crisis……	--	--	$1,000,000	$1,000,000
Reducing Injection Drug Use, HIV/AIDS, and Hepatitis	--	--	150,000	150,000
Opioid Overdose Reversal Expansion.....	--	--	50,000	50,000
Drug Courts Expansion.....	--	--	20,000	20,000
Treatment for Pregnant and Post-Partum Women…….	--	--	20,000	20,000
Total, Additional Opioids Allocation	**--**	**--**	**$1,240,000**	**$1,240,000**

Program Description

The FY 2019 President's Budget Request includes $10.0 billion in new resources investment across HHS for a variety of new and expanded efforts to fight the opioid crisis and address serious mental illness. As part of this effort, the FY 2019 President's Budget Request would allocate $1.2 billion of that funding for activities in SAMHSA.

This funding includes $1.0 billion to extend the State Targeted Response to the Opioid Crisis program. Funding will addresses the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid addiction. This allocation also includes $150.0 million for opioid-related services to reduce injection drug use and related HIV/AIDS and Hepatitis C infection rates.

In addition, also within SAMHSA, $90.0 million will be used to support efforts to: expand and enhance drug court programs, expand services for pregnant and post-partum women, and promote the use of life-saving overdose reversal drugs by first responders.

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SAMHSA
Drug Control Programs

(Dollars in millions)

Resource Summary	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Drug Resources by Decision Unit and Function			
Programs of Regional and National Significance			
Substance Abuse Prevention	$221.869	$220.362	$120.885
Substance Abuse Treatment	350.427	348.047	255.318
Total Programs of Regional and National Significance	572.296	568.409	376.203
Drug Free Communities[1]	---	---	100,000
State Targeted Response to the Opioid Crisis Grants	500,000	496,605	---
Substance Abuse Prevention and Treatment Block Grant[2]			
Prevention	371.616	369.092	371.616
Treatment	1,486.463	1,476.369	1,486.463
Total, Substance Abuse Prevention and Treatment Block Grant	1,858.079	1,845.461	1,858.079
Health Surveillance and Program Support[3]			
Prevention	20.547	20.413	21.086
Treatment	82.188	81.65	84.345
Total, Health Surveillance and Program Support	102.735	102.063	105.431
Total Funding	**$3,033.110**	**$3,012.538**	**$2,439.713**
Drug Resources Personnel Summary			
Total FTEs[4]	420	474	476
Drug Resources as a Percent of Budget			
Total Agency Budget[5]	$4,258.17	$4,236.462	$4,788.052
Drug Resources Percentage	71.2%	71.1%	51.0%

[1] Drug Free Communities was funded in the Office of National Drug Control Policy at $97.0 million in FY 2017 and at $96.3 million under the FY 2018 Annualized CR.

[2] The Substance Abuse Prevention and Treatment Block Grant is split 20% to the Prevention function and 80% to the Treatment function.

[3] The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health and Substance Abuse as follows: Program Support, Health Surveillance and PQIS are split the same percentage split as between MH/SA appropriations. PAS, and Data Request and Publication User Fees are split 50/50 between MH/SA. The resulting Substance Abuse total is then divided between Prevention (20%) and Treatment (80%).

[4] This figure accounts for the staff needed to ensure the full functioning of the 21st Century Cures Act Mental Health and Substance Use Policy Laboratory. It also represents the staffing needed to administer the $1.2 billion in discretionary funding. It differs from the reported figure in MAX, which does not include these elements.

[5] The FY 2019 President's Budget Request includes $10.0 billion in new resources investment across HHS for a variety of new and expanded efforts to fight the opioid crisis and address mental illness. As part of this effort, the FY 2019 President's Budget Request would allocate $1.2 billion of that funding for activities in SAMHSA. This funding is not reflected in this table. Funding will be reflected in Additional Opioid Allocation funding.

Drug Budget Split between Prevention and Treatment FY 2017-FY 2019

(Dollars in thousands)

Substance Abuse Prevention	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Programs of Regional and National Significance (PRNS)			
Strategic Prevention Framework	$119,484	$118,672	$58,426
Strategic Prevention Framework Rx (non-add)	*10,000*	*9,932*	*10,000*
Budget Authority (non-add)	*109,484*	*108,740*	*48,426*
Federal Drug-Free Workplace	4,894	4,861	4,894
Minority AIDS	40,405	40,925	---
Sober Truth on Preventing Underage Drinking	7,000	6,952	7,000
Center for the Application of Prevention Technologies	7,493	7,442	7,493
Budget Authority (non-add)	*7,493*	*7,442*	*7,493*
Science and Service Program Coordination	4,072	4,044	4,072
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths	12,000	11,919	12,000
Tribal Behavioral Health Grants	14,450	14,898	15,000
First Responder (Comprehensive Addiction and Recovery Act- CARA)	12,000	11,919	12,000
SAP Minority Fellowship Program	71	71	---
Total, Substance Abuse Prevention PRNS	**221,869**	**221,703**	**120,885**
Drug Free Communities[1]	---	---	100,000
Substance Abuse Prevention and Treatment Block Grant[2]	371,616	369,092	371,616
PHS Evaluation Funds (non-add)	*15,840*	*15,732*	*15,840*
Total, Substance Abuse Prevention and Treatment Block Grant	**371,616**	**369,092**	**371,616**
Health Surveillance and Program Support[3]			
Health Surveillance	6,687	6,646	8,005
Budget Authority (non-add)	*2,381*	*2,365*	*5,366*
PHS Evaluation Funds (non-add)	*4,305*	*4,281*	*2,639*
Program Support	10,895	10,822	9,923
Public Awareness and Support	1,300	1,291	1,157
Performance and Quality Information Systems	1,415	1,405	1,751
Data Request/Publication User Fees	150	149	150
Total, Health Surveillance and Program Support	**20,547**	**20,413**	**21,086**
Total, Substance Abuse Prevention	**$614,032**	**$611,208**	**$613,587**

[1] Drug Free Communities was funded in the Office of National Drug Control Policy at $97.0 million in FY 2017 and at $96.3 million under the FY 2018 Annualized CR.

[2] The Substance Abuse Prevention and Treatment Block Grant is split 20% to the Prevention function and 80% to the Treatment function.

[3] The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health and Substance Abuse as follows: Program Support, Health Surveillance and PQIS are split the same percentage split as between MH/SA appropriations. PAS, and Data Request and Publication User Fees are split 50/50 between MH/SA. The resulting Substance Abuse amount is then divided between Prevention (20%) and Treatment (80%).

Drug Budget Split between Prevention and Treatment FY 2017-FY 2019 (Continued)

(Dollars in thousands)

Substance Abuse Treatment	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Programs of Regional and National Significance (PRNS)			
Opioid Treatment Programs/Regulatory Activities	$8,724	$8,665	$8,724
Screening, Brief Intervention and Referral to Treatment	30,000	29,796	---
Budget Authority (non-add)	*28,000*	*27,810*	---
PHS Evaluation Funds (non-add)	*2,000*	*1,986*	---
Targeted Capacity Expansion	67,192	66,736	67,192
Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (non-add)	*56,000*	*55,620*	*56,000*
Pregnant and Postpartum Women	19,931	19,796	19,931
Comprehensive Addiction and Recovery Act (non-add)	4,000	3,973	4,000
Improving Access to Overdose Treatment	1,000	993	1,000
Recovery Community Services Program	2,434	2,417	2,434
Children and Family Programs	29,605	29,404	29,605
Treatment Systems for Homeless	36,386	36,139	36,386
Minority AIDS	65,570	65,125	---
SAP Minority Fellowship Program	3,539	3,515	---
Criminal Justice Activities	74,000	73,497	78,000
Addiction Technology Transfer Centers	9,046	8,985	9,046
Building Communities of Recovery	3,000	2,980	3,000
Total, Substance Abuse Treatment PRNS	**350,427**	**348,047**	**255,318**
State Targeted Response to the Opioid Crisis Grants[1]	500,000	496,605	---
Substance Abuse Prevention and Treatment Block Grant[2]	1,486,463	1,476,369	1,486,463
PHS Evaluation Funds (non-add)	*63,360*	*62,930*	*63,360*
Total, Substance Abuse Prevention and Treatment Block Grant	**1,486,463**	**1,476,369**	**1,486,463**
Health Surveillance and Program Support[3]			
Health Surveillance	26,747	26,583	26,540
Budget Authority (non-add)	*9,526*	*9,462*	*15,983*
PHS Evaluation Funds (non-add)	*17,222*	*17,121*	*10,557*
Program Support	43,581	43,288	45,171
Public Awareness and Support	5,200	5,165	4,629
Performance and Quality Information Systems	5,660	5,622	7,006
Data Request/Publication User Fees	600	596	600
Total, Health Surveillance and Program Support	**82,188**	**81,650**	**84,345**
Total, Substance Abuse Treatment[4]	**$2,419,078**	**$2,402,670**	**$1,826,127**

[1]Additional funding is proposed for this program as part of the Additional Opioids Allocation funding request. That funding request is displayed in its entirety on page 259.

[2]The Substance Abuse Prevention and Treatment Block Grant is split 20% to the Prevention function and 80% to the Treatment function.

[3]The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health and Substance Abuse as follows: Program Support, Health Surveillance and PQIS are split the same percentage split as between MH/SA appropriations. PAS, and Data Request and Publication User Fees are split 50/50 between MH/SA. The resulting Substance Abuse amount is then divided between Prevention (20%) and Treatment (80%).

[4]The FY 2019 President's Budget Request includes $10.0 billion in new resources investment across HHS for a variety of new and expanded efforts to fight the opioid crisis and address mental illness. As part of this effort, the FY 2019 President's Budget Request would allocate $1.2 billion of that funding for activities in SAMHSA. This funding is not reflected in this table. Funding will be reflected in Additional Opioid Allocation funding.

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 2019 will include the Substance Abuse Prevention and Treatment Block Grant, Drug Free Communities, competitive grant programs reflecting Programs of Regional and National Significance (PRNS) and Health Surveillance and Program Support. 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 administer these programs.

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 divided between 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 portion of the HSPS appropriation is divided evenly between Mental Health and Substance Abuse.
    - The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

The prevention function also includes all of the Substance Abuse Prevention appropriation, including the Substance Abuse Prevention Programs of Regional and National Significance, Drug Free Communities, and 20 percent of the Substance Abuse Prevention and Treatment Block Grant funds specifically appropriated for prevention activities from the Substance Abuse Treatment appropriation.

The treatment function also includes 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 2019, SAMHSA requests a total of $2.4 billion for drug control activities, a decrease of $572.8 million from the FY 2018 Annualized CR. 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
FY 2019 Request: $120.9 million
(Reflects a $100.8 million decrease from the FY 2018 Annualized CR)

The Substance Abuse Prevention Programs of Regional and National Significance support states and communities in carrying out an array of activities to improve the quality and availability of services in priority areas. The FY 2019 President's Budget request for SAMHSA's Substance Abuse Prevention Programs of Regional and National Significance includes $120.9 million for seven programmatic activities, and $100.8 million decrease from the FY 2018 Annualized CR. The request includes: $58.4 million for Strategic Prevention Framework, $4.9 million for the Federal Drug-Free Workplace Program, $7.0 million for Sober Truth on Preventing Underage Drinking, $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 Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths, $15.0 million for Tribal Behavioral Health Grants, $12.0 million for First Responder Training (Comprehensive Addiction and Recovery Act).

Strategic Prevention Framework (PRNS non-add)
FY 2019 Request: $58.4 million
(Reflects a $60.2 million decrease from the FY 2018 Annualized CR)

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 Strategic Prevention Framework – Partnerships for Success program addresses underage drinking among youth and young adults age 12 to 20 and allows states to prioritize State-identified top data driven substance abuse target areas.

See page 129 in the CSAP chapter for the start of the full description of this program.

Strategic Prevention Framework for Prescription Drugs (PRNS non-add)

Due to alarming trends related to prescription drug misuse and overdoses involving opioids, SAMHSA is prioritizing efforts to address prescription drug misuse. SAMHSA implemented the Strategic Prevention Framework for Prescription Drugs to raise awareness about the dangers of

sharing medications and to work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program focuses on raising community awareness and bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients. SAMHSA tracks 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. SAMHSA awarded 25 grants in FY 2016. In FY 2017 and under the FY 2018 Annualized CR level, SAMHSA will support 25 grant continuations.

See page 130 in the CSAP chapter for the start of the full description of these efforts.

Budget Request

The FY 2019 President's Budget Request is $58.4 million, a decrease of $60.2 million from the FY 2018 Annualized CR. Funding for the SPF Rx program will be maintained in its entirety ($10.0 million). Funding will support 25 Strategic Prevention Framework for Prescription Drugs continuation grants at a reduced rate, technical assistance, and evaluation to build capacity to address prescription drug misuse and overdose prevention efforts, in conjunction with other state and local partners.

Federal Drug-Free Workplace (PRNS non-add)
FY 2019 Request: $4.9 million
(Reflects a $33,000 increase from the FY 2018 Annualized CR)

SAMHSA's activities related to the Federal Drug-Free Workplace support two principal activities mandated by Executive Order (E.O.) 12564 and Public Law (P.L.) 100-71. This include: 1) oversight of the Federal Drug-Free Workplace, aimed at the elimination of illicit drug use within Executive Branch agencies and the federally-regulated industries; and 2) oversight of the National Laboratory Certification Program (NLCP), which certifies laboratories to conduct forensic drug testing for federal agencies, federally-regulated industries; the private sector also uses the HHS-Certified Laboratories.

See page 134 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $4.9 million, an increase of $33,000 from the FY 2018 Annualized CR. In FY 2019, SAMHSA will continue oversight of the Executive Branch Agencies' Federal Drug-Free Workplace Programs. This includes review of Federal Drug-Free Workplace plans from those federal agencies that perform federal employee testing, random testing of those designed testing positions of national security, public health, and public safety, and testing for illegal drug use and the misuse of prescription drugs. SAMHSA will continue its oversight role for the inspection and certification of the HHS-certified laboratories.

First Responder Training (Comprehensive Addiction and Recovery Act- CARA)
FY 2019 Request: $12.0 million
(Reflects a $81,000 increase from the FY 2018 Annualized CR)

First Responder Training Comprehensive Addiction and Recovery Act (CARA), SAMHSA is authorized to support additional efforts to prevent opioid overdose-related deaths by providing grants to train first responders. In FY 2017, SAMHSA funded 21 grants for the First Responder CARA grant program (FR-CARA). The purpose of this program is to allow first responders and members of other key community sectors to administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose. Grantees will train and provide resources to first responders and members of other key community sectors at the state, tribal, and local governmental levels on carrying and administering a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose. Grantees will also establish processes, protocols, and mechanisms for referral to appropriate treatment and recovery communities. Training, technical assistance, and evaluation activities are also being supported to assist grantees, determine best practices, and assess program outcomes. The FY 2018 Annualized CR level would support continuation grants to 20 grantees to address the opioid crisis in this country.

See page 153 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $12.0 million, an increase of $81,000 from the FY 2018 Annualized CR. This funding will provide continuation grants to 21 grantees and support the continuation of training, technical assistance and evaluation activities to address the opioid crisis in this country.

Sober Truth on Preventing Underage Drinking (PRNS non-add)
FY 2019 Request: $7.0 million
(Reflects a $48,000 increase from the FY 2018 Annualized CR)

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 the age of 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. The STOP Act was reauthorized in the 21st Century Cures Act.

See page 140 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $7.0 million, an increase of $48,000 from the FY 2018 Annualized CR. In FY 2019, SAMHSA will support 95 STOP Act grant continuations. This funding will continue to strengthen SAMHSA's commitment to reduce and prevent underage drinking.

Centers for the Application of Prevention Technologies (PRNS non-add)
FY 2019 Request: $7.5 million
(Reflects a $51,000 increase from the FY 2018 Annualized CR)

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. The program 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 143 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $7.5 million, an increase of $51,000 from the FY 2018 Annualized CR. The program will continue to provide technical assistance and training to over 9,000 individuals in the prevention field.

Science and Service Program Coordination (PRNS non-add)
FY 2019 Request: $4.1 million
(Reflects a $28,000 increase from the FY 2018 Annualized CR)

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 program supports the Tribal Training and Technical Assistance Center and the Underage Drinking Prevention Education Initiatives (UADPEI).

See page 146 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $4.1 million, an increase of $28,000 from the FY 2018 Annualized CR. These funds will support SAMHSA's substance abuse prevention efforts and include a focus on preventing underage drinking and providing technical assistance and training to American Indians/Alaska Native communities.

Tribal Behavioral Health Grants (PRNS non-add)
FY 2019 Request: $15.0 million
(Reflects a $102,000 increase from the FY 2018 Annualized CR)

SAMHSA's Tribal Behavioral Health Grants (TBHG) program addresses the high incidence of substance abuse and suicide among AI/AN populations. Starting in FY 2014, this program supports tribal entities with the highest rates of suicide by providing effective and promising strategies that address substance abuse, trauma, and suicide and by promoting the mental health of AI/AN young people.

See page 148 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $15.0 million, an increase of $102,000 from the FY 2018 Annualized CR. This request, combined with $15.0 million in the Center of Mental Health Services will continue support 76 grants that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families.

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths (PRNS non-add)
FY 2019 Request: $12.0 million
(Reflects a $81,000 increase from the FY 2018 Annualized CR)

Opioid overdose is a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids (including synthetics), such as fentanyl. 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. Grantees can use the funds to purchase naloxone, equip first responders with naloxone and other overdose death prevention strategies, support education on these strategies, provide materials to assemble and disseminate overdose kits.

See page 151 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $12.0 million, an increase of $81,000 from the FY 2018 Annualized CR. This funding will provide continuation grants to 12 states to reduce the number of opioid overdose-related deaths. Funding will help states purchase overdose reversing drugs, equip first responders in high-risk communities, support education on the use of naloxone

and other overdose-related death prevention strategies, provide the necessary materials to assemble overdose kits, and cover expenses incurred from dissemination efforts.

Drug Free Communities
FY 2019 Request: $100.0 million
(Reflects a $100.0 million increase from the FY 2018 Annualized CR)

The goal of the program is to establish and strengthen collaboration among communities, public and private non-profit agencies, as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance abuse among youth. In addition, the program aims to reduce substance abuse among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse. The program also includes the Drug Free Communities Mentoring (DFC-M) Program. The purpose of this program is to provide grant funds to existing DFC recipients so they may serve as mentors to newly-formed and/or developing coalitions that have never received a DFC grant. It is the intent of the DFC-M Program that, at the end of the Mentoring grant, each Mentee coalition will meet all of the statutory eligibility requirements of the DFC Support Program and be fully prepared to compete for a DFC grant on their own.

See page 157 in the CSAP chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $100.0 million. This activity was funded at $96.3 million in the Office of National Drug Control Policy (ONDCP) under the 2018 Annualized CR. SAMHSA has administered this program for several years on behalf of ONDCP. The FY 2019 Budget proposes to directly appropriate these funds to SAMHSA to streamline program management and create administrative efficiencies. Funding will be used to continue both the DFC and DFC-Mentoring programs.

Substance Abuse Treatment

Substance Abuse Treatment Programs of Regional and National Significance
FY 2019 Request: $255.3 million
(Reflects a $96.7 million decrease from the FY 2018 Annualized CR)

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 2019 Budget Request for SAMHSA's Substance Abuse Treatment PRNS includes $255.3 million, a decrease of $96.7 million from the FY 2018 Annualized CR. Specific PRNS activities are described below.

Opioid Treatment Programs/Regulatory Activities (PRNS non-add)
FY 2019 Request: $8.7 million
(Reflects a $59,000 increase from the FY 2018 Annualized CR)

As part of its regulatory responsibility, SAMHSA certifies Opioid Treatment Programs 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 Opioid Treatment Programs Medical Education and Supporting Services project aimed at preparing Opioid Treatment Programs to achieve accreditation and providing technical assistance and clinical training to enhance program clinical activities. Additionally, SAMHSA funds grants and contracts that support the regulatory oversight and monitoring activities of Opioid Treatment Programs.

See page 169 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $8.7 million, an increase of $59,000 from the FY 2018 Annualized CR. SAMHSA intends to continue to support the Secretary's five-prong strategy to address the opioid crisis priorities through regulatory activities, ongoing training, certification, and technical assistance to provider groups and communities impacted by the opioid crisis.

Targeted Capacity Expansion (PRNS non-add)
FY 2019 Request: $67.2 million
(Reflects a $456,000 increase from the FY 2018 Annualized CR)

The Targeted Capacity Expansion (TCE) program provides rapid, strategic, comprehensive, and integrated community-based responses to gaps in and capacity for SUD treatment and recovery support services. Examples of such needs include limited or no access to medication-assisted treatment (MAT) for opioid use disorders; lack of resources needed to adopt and implement health information technologies (HIT) in SUD treatment settings; and short supply of trained and qualified peer recovery coaches to assist individuals in the recovery process.

See page 176 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $67.2 million, an increase of $456,000 from the FY 2018 Annualized CR. SAMHSA intends to fund 32 continuation MAT PDOA grants, 13 new TCE-TAC grants, and 17 TCE-PTP new grants.

Treatment Systems for Homeless (PRNS non-add)
FY 2019 Request: $36.4 million
(Reflects a $247,000 increase from the FY 2018 Annualized CR)

SAMHSA's Treatment Systems for Homeless portfolio supports services for those with substance use disorders and who are experiencing homelessness, including veterans, and those experiencing chronic homelessness.

See page 189 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $36.4 million, an increase of $247,000 from the FY 2018 Annualized CR. SAMHSA intends to fund 65 continuation grants (17 CABHI and 48 GBHI). SAMHSA also plans to award 37 new CABHI grants. Additional funds will support two contracts including the continuation of cross-center contracts for national evaluation and technical assistance.

Pregnant and Postpartum Women Comprehensive Addiction and Recovery Act (PRNS non-add)
FY 2019 Request: $19.9 million
(Reflects a $135,000 increase from the FY 2018 Annualized CR)

The Pregnant and Postpartum Women Pilot, Comprehensive Addiction and Recovery Act (CARA) address the substance use and addiction across the country through the implementation of prevention, treatment, and recovery programs. In FY 2017, SAMHSA funded three new state PPW pilot grants to: 1) support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid disorders; 2) help state substance abuse agencies address the continuum of care, including services provided to women in nonresidential-based settings; and 3) promote a coordinated, effective and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery. An evaluation of this program is underway to determine the effectiveness of the pilot. Under the FY 2018 Annualized CR level, SAMHSA plans to fund three continuation state PPW pilot grants, and one continuation evaluation contract.

See page 181 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $19.9 million, an increase of $135,000 from the FY 2018 Annualized CR. SAMHSA intends to fund two new residential treatment PPW grants and 26 continuation PPW grants. These funds also support the continuation of the three PPW Pilot grants ($4.0 million) to provide an array of services and supports to pregnant women and their children.

Building Communities of Recovery (PRNS non-add)
FY 2019 Request: $3.0 million
(Reflects a $20,000 increase from the FY 2018 Annualized CR)

In FY 2017, SAMHSA funded a new cohort of grant through the Comprehensive Addiction Recovery Act (CARA) Building Communities of Recovery program. The purpose of this program is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery support from drug/alcohol addiction. These grants are intended to support the development, enhancement, expansion, and delivery of recovery support services (RSS) as well as promotion of and education about recovery. Programs are designed to be overseen by people in recovery from SUDs who reflect the community served. Grants support linkages between recovery networks and a variety of other organizations, systems, and communities, including: primary care, other recovery networks, child welfare system, criminal justice system, housing services and employment systems. Grantees will also work to reduce negative attitude, discrimination, and prejudice around addiction and addiction recovery. Under the FY 2018 Annualized CR level, SAMHSA will support five continuation grants.

See page 203 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $3.0 million, an increase of $20,000 from the FY 2018 Annualized CR. These funds will be used to support seven new grants and five continuation grants the Building Communities of Recovery Program to develop, expand, and enhance recovery support services.

Criminal Justice Activities (PRNS non-add)
FY 2019 Request: $78.0 million
(Reflects a $530,000 increase from the FY 2018 Annualized CR)

SAMHSA's Criminal Justice portfolio includes several grant programs that 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. This includes Treatment Drug Courts and the Offender Re-Entry Programs.

See page 195 in the CSAT chapter for the start of the full description of this program.

Drug Court Activities
FY 2019 Request: $60.0 million
(Reflects a $122,000 increase from the FY 2018 Annualized CR)

SAMHSA's Adult Drug Court programs support a variety of services including direct treatment services for diverse populations, wraparound/recovery support services designed to improve access and retention, drug testing for illicit substances, education support, relapse prevention and long-term management, pharmacotherapy), and HIV testing conducted in accordance with state and local requirements. The program seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use, and outcomes among the racial and ethnic minority populations served. Under the FY 2018 Annualized CR level, SAMHSA plans to fund 101 drug court grants continuation, 80 new drug court grants, and three contracts.

See page 195 in the CSAT chapter for the start of the full description of this program.

Ex-Offender Re-Entry Program
FY 2019 Request: $18.0 million
(Reflects a $408,000 increase from the FY 2018 Annualized CR)

In addition to the drug court portfolio, SAMHSA supports Offender Reentry Program (ORP) grants, as well as other criminal justice activities, such as evaluation and behavioral health contracts. In FY 2017, SAMHSA funded 11 new ORP grants and 27 ORP grant continuations. In FY 2018, SAMHSA plans to fund 27 new ORP grants, 11 continuation OFR grants, and contract activities.

See page 197 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $78.0 million ($60.0 million for Drug Courts Activities and $18.0 million for Other Criminal Justice Activities), an increase of $530,000 from the FY 2018 Annualized CR. SAMHSA intends to support 44 new drug court grants, 115 drug court continuation grants, and three contracts. SAMHSA intends to fund 27 ORP continuation grants.

Other PRNS Treatment Programs (PRNS non-add)
FY 2019 Request: $41.1 million
(Reflects a $279,000 increase from the FY 2018 Annualized CR)

The FY 2019 budget includes resources of $41.1 million for several other Treatment Capacity programs including: Recovery Community Services Program; Children and Families; and Addiction Technology Transfer Centers. The FY 2019 Budget includes funds for continuing grants and contracts in these programs. Grant funding will 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 periods.

Substance Abuse Prevention and Treatment Block Grant
FY 2019 Request: $1.9 billion
(Reflects a $12.6 million increase from the FY 2018 Annualized CR)

The Substance Abuse Prevention and Treatment Block Grant (SABG) program 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 (referred to collectively as states) to plan, carry out, and evaluate substance use disorder prevention, treatment, and recovery support services for individuals, families, and communities impacted by substance misuse 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.

See page 219 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget request is $1.9 billion, an increase of $12.6 million from the FY 2018 Annualized CR. SABG funds will continue to serve as a source of safety net funding, including assistance to states in addressing the opioid epidemic, and will continue to support certain services (e.g., recovery support services) not covered by commercial insurance and non-clinical activities and services that address the critical needs of state substance abuse prevention and treatment service systems.

Health Surveillance and Program Support Appropriation

The FY 2019 Budget Request is $105.4 million, an increase of $3.4 million from the FY 2018 Annualized CR, which represents the Substance Abuse portion of the Health Surveillance and Program Support appropriation and supports staffing and activities to administer SAMHSA programs as described below.

Health Surveillance and Program Support (PRNS non-add)
FY 2019 Request: $89.6 million
(Reflects a $2.3 million increase from the FY 2018 Annualized CR)

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 Center for Disease Control and Prevention's National Health Information Survey, and the data archive. This request represents the total funding available for these activities first divided between Mental Health and Substance Abuse using the same percentages splits that exist 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 233 in the HSPS chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $89.6 million, an increase of $2.3 million from the FY 2018 Annualized CR. Health Surveillance funding will support the continuation of the NSDUH, NREPP, BHSIS, C-EMS, and the Analytic Support Center contracts as well as operations and payroll Program Support funding will continue to cover overhead costs associated with 5600 Fishers Lane, including rent, the Federal Acquisition Service loan repayment program, and security charges.

Public Awareness and Support
FY 2019 Request: $5.8 million
(Reflects a $670,000 decrease from the FY 2018 Annualized CR)

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 253 in the HSPS chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $5.8 million, a decrease of $670,000 from the FY 2018 Annualized CR, which supports the President's 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.

Performance and Quality Information Systems
FY 2019 Request: $8.8 million
(Reflects a $1.7 million increase from the FY 2018 Annualized CR)

Performance and Quality Information Systems provides funding to support SAMHSA's Performance Accountability and Reporting System (SPARs) related activities, as well as provide support 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. SPARS will provide a common data and reporting system for all SAMHSA discretionary grantees and allow programmatic technical assistance (TA) on use of the data to enhance grantee performance monitoring and improve quality of service delivery. 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 243 in the HSPS chapter for the start of the full description of this program.

Budget Request

The FY 2019 President's Budget Request is $8.8 million, an increase of $1.7 million from the FY 2018 Annualized CR. SAMHSA will use these funds for system development, training and TA to support operations, National Registry of Evidence-Based Programs (NREPP) and SPARS.

Data Request and Publication User Fees
FY 2019 Request: $750,000
(Reflects a $5,000 increase from the FY 2018 Annualized CR)

The FY 2019 President's Budget Request is $750,000, an increase of $5,000 from the FY 2018 Annualized CR. SAMHSA will collect and retain fees for extraordinary data and publications requests. This represents the total funding estimated for these activities first divided evenly between Mental Health and Substance Abuse. The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

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SAMHSA
Supplementary Tables
Table of Contents

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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]	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$46,242	$49,002	$49,234
Other than full-time permanent (11.3)	2,630	2,800	2,813
Other personnel compensation (11.5)	1,077	1,140	1,146
Military personnel (11.7)	3,304	3,399	3,485
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	**53,253**	**56,340**	**56,678**
Civilian benefits (12.1)	15,535	16,467	16,545
Military benefits (12.2)	1,627	1,663	1,705
Subtotal Pay Costs:	**70,415**	**74,470**	**74,928**
Travel and transportation of persons (21.0)	1,567	1,330	1,356
Transportation of things (22.0)	6	12	11
Rental payments to GSA (23.1)	6,494	6,760	7,356
Rental payments to Others (23.2)	4	---	---
Communication, utilities, and misc. charges (23.3)	374	381	385
Printing and reproduction (24.0)	1,372	1,345	1,373
Other Contractual Services:			
Advisory and assistance services (25.1)	29,262	31,169	31,373
Other services (25.2)	190,965	182,692	198,355
Purchase of Goods & Svcs. from Govt. Accts (25.3)	44,787	46,578	48,441
Operation and maintenance of facilities (25.4)	170	312	317
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	441	420	427
Subtotal Other Contractual Services:	**265,625**	**261,172**	**278,914**
Supplies and materials (26.0)	213	712	712
Equipment (31.0)	131	473	478
Grants, subsidies, and contributions (41.0)	3,776,693	3,755,560	3,060,374
Interest and dividends (43.0)	109	---	---
Subtotal Non-Pay Costs	**4,052,588**	**4,027,745**	**3,350,959**
Total Direct Obligations	**$4,123,003**	**$4,102,214**	**$3,425,887**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

Substance Abuse and Mental Health Services Administration
Mental Health Services
Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2]	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$1,269	$1,225	$1,230
Other than full-time permanent (11.3)	43	41	42
Other personnel compensation (11.5)	18	18	18
Military personnel (11.7)	---	---	---
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	**1,330**	**1,284**	**1,290**
Civilian benefits (12.1)	413	399	401
Military benefits (12.2)	---	---	---
Subtotal Pay Costs:	**1,743**	**1,683**	**1,691**
Travel and transportation of persons (21.0)	263	179	186
Transportation of things (22.0)	1	---	---
Rental payments to GSA (23.1)	64	67	72
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	339	345	349
Printing and reproduction (24.0)	387	303	303
Other Contractual Services:			
Advisory and assistance services (25.1)	13,883	14,438	15,016
Other services (25.2)	70,384	73,199	76,127
Purchase of Goods & Svcs. from Govt. Accts (25.3)	15,221	15,830	16,463
Operation and maintenance of facilities (25.4)	132	137	140
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	23	48	49
Subtotal Other Contractual Services:	**99,643**	**103,653**	**107,794**
Supplies and materials (26.0)	42	25	25
Equipment (31.0)	35	108	110
Grants, subsidies, and contributions (41.0)	1,054,482	1,044,674	933,352
Interest and dividends (43.0)	---	---	---
Subtotal Non-Pay Costs	**1,155,255**	**1,149,354**	**1,042,192**
Total Direct Obligations	**$1,156,998**	**$1,151,036**	**$1,043,883**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

Substance Abuse and Mental Health Services Administration
Substance Abuse Prevention
Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2]	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
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)	---	5	5
Rental payments to GSA (23.1)	---	---	---
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	33	34	34
Printing and reproduction (24.0)	368	457	465
Other Contractual Services:			
Advisory and assistance services (25.1)	5,580	5,804	6,036
Other services (25.2)	30,963	32,202	33,490
Purchase of Goods & Svcs. from Govt. Accts (25.3)	6,976	7,255	7,545
Operation and maintenance of facilities (25.4)	7	69	70
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)		146	148
Subtotal Other Contractual Services:	**43,527**	**45,475**	**47,289**
Supplies and materials (26.0)	---	---	---
Equipment (31.0)		140	143
Grants, subsidies, and contributions (41.0)	177,941	175,592	172,950
Interest and dividends (43.0)	---	---	---
Subtotal Non-Pay Costs	**221,869**	**221,703**	**220,885**
Total Direct Obligations	**221,869**	**221,703**	**220,885**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

Substance Abuse and Mental Health Services Administration
Substance Abuse Treatment
Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2]	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$2,749	$3,251	$3,267
Other than full-time permanent (11.3)	237	280	281
Other personnel compensation (11.5)	47	55	55
Military personnel (11.7)	115	175	180
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	**3,147**	**3,761**	**3,783**
Civilian benefits (12.1)	953	1,127	1,132
Military benefits (12.2)	36	54	55
Subtotal Pay Costs:	**4,135**	**4,942**	**4,970**
Travel and transportation of persons (21.0)	326	331	336
Transportation of things (22.0)		1	---
Rental payments to GSA (23.1)	1,654	1,722	1,873
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	2	2	2
Printing and reproduction (24.0)	533	542	550
Other Contractual Services:			
Advisory and assistance services (25.1)	8,811	9,163	9,530
Other services (25.2)	49,491	42,645	43,327
Purchase of Goods & Svcs. from Govt. Accts (25.3)	17,727	18,436	19,174
Operation and maintenance of facilities (25.4)	31	31	32
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	208	200	203
Subtotal Other Contractual Services:	**76,268**	**70,476**	**72,266**
Supplies and materials (26.0)	38	49	50
Equipment (31.0)	82	80	78
Grants, subsidies, and contributions (41.0)	2,544,270	2,535,294	1,954,072
Interest and dividends (43.0)	---	---	---
Subtotal Non-Pay Costs	**2,623,171**	**2,608,495**	**2,029,227**
Total Direct Obligations	**$2,627,306**	**$2,613,437**	**$2,034,197**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

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]	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$42,225	$44,526	$44,737
Other than full-time permanent (11.3)	2,350	2,478	2,490
Other personnel compensation (11.5)	1,012	1,067	1,072
Military personnel (11.7)	3,189	3,224	3,306
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	**48,776**	**51,295**	**51,605**
Civilian benefits (12.1)	14,169	14,941	15,012
Military benefits (12.2)	1,592	1,609	1,650
Subtotal Pay Costs:	**64,537**	**67,845**	**68,267**
Travel and transportation of persons (21.0)	979	820	833
Transportation of things (22.0)	5	6	6
Rental payments to GSA (23.1)	4,776	4,972	5,410
Rental payments to Others (23.2)	4	---	---
Communication, utilities, and misc. charges (23.3)	1	1	1
Printing and reproduction (24.0)	85	43	55
Other Contractual Services:			
Advisory and assistance services (25.1)	987	1,764	792
Other services (25.2)	40,127	34,646	45,411
Purchase of Goods & Svcs. from Govt. Accts (25.3)	4,863	5,057	5,260
Operation and maintenance of facilities (25.4)	---	75	76
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	210	26	27
Subtotal Other Contractual Services:	**46,187**	**41,568**	**51,565**
Supplies and materials (26.0)	134	638	637
Equipment (31.0)	14	145	147
Grants, subsidies, and contributions (41.0)	---	---	---
Interest and dividends (43.0)	109	---	---
Subtotal Non-Pay Costs	**52,293**	**48,193**	**58,655**
Total Direct Obligations	**$116,830**	**$116,037**	**$126,922**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

Substance Abuse and Mental Health Services Administration
Total PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation Funds	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel Compensation:			
Full Time Permanent (11.1)	$10,762	$9,506	$9,551
Other than Full-Time Permanent (11.3)	681	617	620
Other Personnel Compensation (11.5)	211	193	194
Military Personnel Compensation (11.7)	621	501	513
Special personnel services payments (11.8)	78	---	---
Subtotal Personnel Compensation:	**12,352**	**10,817**	**10,879**
Civilian Personnel Benefits (12.1)	3,519	3,086	3,100
Military Personnel Benefits (12.2)	323	266	273
Subtotal Pay Costs:	**16,194**	**14,169**	**14,252**
Travel (21.0)	263	266	217
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)	---	---	---
Communications, Utilities and Misc. Charges (23.3)	---	---	---
Printing and Reproduction (24.0)	20	30	29
Other Contractual Services:	---	---	---
Advisory and assistance services (25.1)	---	---	---
Other services (25.2)	30,955	34,830	25,607
Purchase of Goods & Svcs. from Govt. Accts (25.3)	191	140	142
Operation and maintenance of equipment (25.7)	---	2	2
Subtotal Other Contractual Services:	**31,146**	**34,972**	**25,751**
Supplies and Materials (26.0)	22	26	25
Equipment (31.0)	---	2	2
Grants, Subsidies, and Contributions (41.0)	86,023	83,296	80,390
Subtotal Non-Pay Costs	**117,473**	**118,591**	**106,413**
Total Reimbursable Obligations	**$133,667**	**$132,759**	**$120,665**

Substance Abuse and Mental Health Services Administration
Mental Health Services
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$1,899	$2,011	$2,021
Other than full-time permanent (11.3)	71	75	76
Other personnel compensation (11.5)	29	31	31
Military personnel (11.7)	100	170	174
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	**2,100**	**2,287**	**2,302**
Civilian benefits (12.1)	643	681	685
Military benefits (12.2)	59	100	103
Subtotal Pay Costs:	**2,802**	**3,068**	**3,089**
Travel and transportation of persons (21.0)	29	38	38
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---
Printing and reproduction (24.0)	15	28	25
Other Contractual Services:			
Advisory and assistance services (25.1)	---	---	---
Other services (25.2)	10,708	11,984	13,203
Purchase of Goods & Svcs. from Govt. Accts (25.3)	53	---	---
Operation and maintenance of equipment (25.7)	---	---	---
Subtotal Other Contractual Services:	**10,761**	**11,984**	**13,203**
Supplies and materials (26.0)	4	8	7
Equipment (31.0)	---	---	---
Grants, subsidies, and contributions (41.0)	7,428	5,771	4,678
Subtotal Non-Pay Costs	**18,237**	**17,827**	**17,951**
Total Reimbursable Obligations	**$21,039**	**$20,896**	**$21,039**

Substance Abuse and Mental Health Services Administration
Substance Abuse Treatment
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$3,381	$3,942	$3,961
Other than full-time permanent (11.3)	120	140	$141
Other personnel compensation (11.5)	58	67	$67
Military personnel (11.7)	190	94	$97
Special personnel services payments (11.8)	78	---	---
Subtotal personnel compensation:	**3,827**	**4,243**	**4,265**
Civilian benefits (12.1)	1,067	1,245	1,250
Military benefits (12.2)	102	51	52
Subtotal Pay Costs:	**4,996**	**5,538**	**5,568**
Travel and transportation of persons (21.0)	206	200	150
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)	---	---	---
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)	370	400	833
Purchase of Goods & Svcs. from Govt. Accts (25.3)	---	---	---
Operation and maintenance of equipment (25.7)	---	2	2
Subtotal Other Contractual Services:	**370**	**402**	**835**
Supplies and materials (26.0)	2	---	---
Equipment (31.0)	---	2	2
Grants, subsidies, and contributions (41.0)	75,625	74,507	72,646
Subtotal Non-Pay Costs	**76,203**	**75,110**	**73,632**
Total Reimbursable Obligations	**$81,200**	**$80,649**	**$79,200**

Substance Abuse and Mental Health Services Administration
Health Surveillance and Program Support
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$5,482	$3,552	$3,569
Other than full-time permanent (11.3)	489	402	$404
Other personnel compensation (11.5)	124	96	$96
Military personnel (11.7)	331	236	$242
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation:	**6,426**	**4,287**	**4,312**
Civilian benefits (12.1)	1,808	1,160	1,165
Military benefits (12.2)	162	115	118
Subtotal Pay Costs:	**8,395**	**5,562**	**5,596**
Travel and transportation of persons (21.0)	28	28	28
Transportation of things (22.0)	---	---	---
Rental payments to GSA (23.1)	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---
Printing and reproduction (24.0)	4	2	4
Other Contractual Services:			
Advisory and assistance services (25.1)	---	---	---
Other services (25.2)	19,877	22,447	11,571
Purchase of Goods & Svcs. from Govt. Accts (25.3)	138	140	142
Operation and maintenance of equipment (25.7)	---	---	---
Subtotal Other Contractual Services:	**20,014**	**22,587**	**11,713**
Supplies and materials (26.0)	16	18	18
Equipment (31.0)	---	---	---
Grants, subsidies, and contributions (41.0)	2,970	3,018	3,066
Subtotal Non-Pay Costs	**23,033**	**25,653**	**14,830**
Total Reimbursable Obligations	**$31,428**	**$31,215**	**$20,426**

Substance Abuse and Mental Health Services Administration
Salaries and Expenses Tables
Direct Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2]	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$46,242	$49,002	$49,234
Other than full-time permanent (11.3)	2,630	2,800	2,813
Other personnel compensation (11.5)	1,077	1,140	1,146
Military personnel (11.7)	3,304	3,399	3,485
Special personnel services payments (11.8)	---	---	---
Subtotal personnel compensation	**53,253**	**56,340**	**56,678**
Civilian benefits (12.1)	15,535	16,467	16,545
Military benefits (12.2)	1,627	1,663	1,705
Subtotal Pay Costs:	**70,415**	**74,470**	**74,928**
Travel (21.0)	1,567	1,330	1,356
Transportation of things (22.0)	6	12	11
Rental payments to Others (23.2)	4	---	---
Communication, utilities, and misc. charges (23.3)	374	381	385
Printing and reproduction (24.0)	1,372	1,345	1,373
Other Contractual Services:			
Advisory and assistance services (25.1)	29,262	31,169	31,373
Other services (25.2)	190,965	182,692	198,355
Purchase of Goods & Svcs. from Govt. Accts (25.3)	44,787	46,578	48,441
Operation and maintenance of facilities (25.4)	170	312	317
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	441	420	427
Subtotal Other Contractual Services:	**265,625**	**261,172**	**278,914**
Supplies and materials (26.0)	213	712	712
Subtotal Non-Pay Costs	**269,162**	**264,952**	**282,752**
Total Salary and Expenses	**339,577**	**339,422**	**357,680**
Rental Payments to GSA (23.1)	6,494	6,760	7,356
Grand Total, Salaries & Expenses and Rent	**$346,071**	**$346,182**	**$365,036**
Direct FTE[3]	482	501	511

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

[3] This figure accounts for the staff needed to ensure the full functioning of the 21st Century Cures Act Mental Health and Substance Use Policy Laboratory. It also represents the staffing needed to administer the $1.2 billion in discretionary funding. It differs from the reported figure in MAX, which does not include these elements.

Substance Abuse and Mental Health Services Administration
Salaries and Expenses Tables
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class[1]	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$10,762	$9,506	$9,551
Other than full-time permanent (11.3)	681	617	620
Other personnel compensation (11.5)	211	193	194
Military personnel (11.7)	621	501	513
Special personnel services payments (11.8)	78	---	---
Subtotal personnel compensation	**12,352**	**10,817**	**10,879**
Civilian benefits (12.1)	3,519	3,086	3,100
Military benefits (12.2)	323	266	273
Subtotal Pay Costs:	**16,194**	**14,169**	**14,252**
Travel (21.0)	263	266	217
Transportation of things (22.0)		---	---
Rental payments to Others (23.2)	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---
Printing and reproduction (24.0)	20	30	29
Other Contractual Services:			
Advisory and assistance services (25.1)	---	---	---
Other services (25.2)	30,955	34,830	25,607
Purch. Goods & Svcs. Govt. Accts (25.3)	191	140	142
Operation and maintenance of facilities (25.4)	---	---	---
Research and Development Contracts (25.5)	---	---	---
Operation and maintenance of equipment (25.7)	---	2	2
Subtotal Other Contractual Services:	**31,146**	**34,972**	**25,751**
Supplies and materials (26.0)	22	26	25
Subtotal Non-Pay Costs	**31,450**	**35,293**	**26,021**
Total Salary and Expenses	**47,644**	**49,462**	**40,273**
Rental Payments to GSA (23.1)	---	---	---
Grand Total, Salaries & Expenses and Rent	**$47,644**	**$49,462**	**$40,273**
Reimbursable FTE[2]	108	113	124

[1] Does not include Other reimbursable FTEs (30) and associated Object Class cost.

[2] This figure accounts for the staff needed to ensure the full functioning of the 21st Century Cures Act Mental Health and Substance Use Policy Laboratory. It also represents the staffing needed to administer the $1.2 billion in discretionary funding. It differs from the reported figure in MAX, which does not include these elements.

Detail of Full Time Equivalent Employee (FTE)

	FY 2017 Final Civilian	FY 2017 Final Military	FY 2017 Final Total	FY 2018 Est. Civilian	FY 2018 Est. Military	FY 2018 Est. Total	FY 2019 Est. Civilian	FY 2019 Est. Military	FY 2019 Est. Total
Health Surveillance and Program Support...									
Direct:.....	413	30	443	428	30	458	436	31	467
Reimbursable:.....	52	4	56	51	5	56	52	5	57
Total:.....	465	34	499	479	35	514	488	36	524
Mental Health Services.....									
Direct:.....	13	0	13	12	0	12	12	0	12
Reimbursable:.....	17	1	19	18	2	20	25	3	28
Total:.....	30	1	31	30	2	32	37	3	40
Substance Abuse Prevention.....									
Direct:.....	0	0	0	0	0	0	0	0	0
Reimbursable:.....	0	0	0	0	0	0	0	0	0
Total:.....	0	0	0	0	0	0	0	0	0
Substance Abuse Treatment.....									
Direct:.....	26	1	26	30	1	31	31	1	32
Reimbursable:.....	31	2	33	36	1	37	38	1	39
Total:.....	57	3	60	66	2	68	69	2	71
SAMHSA FTE Total[1]……	**552**	**38**	**590**	**575**	**39**	**614**	**594**	**41**	**635**

[1] This figure accounts for the staff needed to ensure the full functioning of the 21st Century Cures Act Mental Health and Substance Use Policy Laboratory. It also represents the staffing needed to administer the $1.2 billion in discretionary funding. It differs from the reported figure in MAX, which does not include these elements.

Detail of Positions

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Executive Level IV	1	1	1
Subtotal	1	1	1
Total - Exec Level Salaries	**$155,500**	**$155,500**	**$155,500**
SES	16	18	18
Subtotal	16	18	18
Total, SES salaries	**$3,804,874**	**$4,280,483**	**$4,280,483**
GM/GS-15/EE	64	67	68
GM/GS-14	122	123	124
GM/GS-13	205	208	212
GS-12	54	56	62
GS-11	21	26	31
GS-10	1	1	1
GS-09	20	20	25
GS-08	18	18	18
GS-07	16	23	20
GS-06	11	11	11
GS-05	3	3	3
GS-04	0	0	0
GS-03	0	0	0
GS-02	0	0	0
GS-01	0	0	0
Subtotal	535	556	575
Total, GS salaries	**$77,328,239**	**$78,623,896**	**$79,023,609**
CC-08/09	1	1	1
CC-07	0	0	0
CC-06	15	14	15
CC-05	11	11	11
CC-04	9	11	12
CC-03	2	2	2
CC-02	0	0	0
CC-01	0	0	0
Subtotal	38	39	41
Total, CC salaries	**$5,475,627**	**$5,578,569**	**$5,720,822**
Total Positions[1]	**590**	**614**	**635**
Average ES level	ES	ES	ES
Average ES salary	$155,500	$155,500	$155,500
Average SES level	SES	SES	SES
Average SES salary	$237,805	$237,805	$237,805
Average GS grade	13.5	13.6	13.6
Average GS salary	$144,539	$141,410	$137,432
Average CC level	5	5	5
Average CC salaries	$144,095	$143,040	$139,532

[1] This figure accounts for the staff needed to ensure the full functioning of the 21st Century Cures Act Mental Health and Substance Use Policy Laboratory. It also represents the staffing needed to administer the $1.2 billion in discretionary funding. It differs from the reported figure in MAX, which does not include these elements.

Programs Proposed for Elimination

The following table shows the programs proposed for elimination in the FY 2019 Budget Request. Terminations of these programs total $279.6 million across the three appropriations: Mental Health, Substance Abuse Prevention, and Substance Abuse Treatment.

The following is a brief summary of the program and rational for the elimination proposal.

(Dollars in thousands)

Program	FY 2018 Annualized CR
Project AWARE	$71,475
Primary and Behavioral Health Care Integration	51,516
MH Minority AIDS	9,161
MH Minority Fellowship Program	8,004
SAP Minority AIDS	40,925
SAP Minority Fellowship Program	71
SAT Minority AIDS	65,125
SAT Minority Fellowship Program	3,515
Screening, Brief Intervention and Referral to Treatment	29,796
Total	**$279,588**

Project AWARE

SAMHSA awarded these grants to 20 State Education Authorities (SEAs) to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services. 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 understand, recognize, and respond to signs of mental illness and/or drug/alcohol addiction in children and youth, including how to talk to adolescents and families experiencing these problems so that they are more willing to seek treatment.

SAMHSA is proposing an elimination of Project AWARE ($71.5 million). SAMHSA has developed significant knowledge and evidence for states to begin implementing and bringing to scale these efforts; SAMHSA will continue to ensure this knowledge is disseminated.

Primary and Behavioral Health Care Integration

The Primary and Behavioral Health Care Integration (PBHCI) program began in FY 2009 to address specifically this intersection between primary care and mental disorder treatment. The program supports two activities: grants to community mental health centers and the PBHCI Training and Technical Assistance (TTA) Center, which is co-funded through a competitive cooperative agreement 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 for individuals with SMI and/or people with co-occurring disorders served by the public mental health system. PBHCI seeks to improve health outcomes for people with SMI by encouraging grantees to engage in necessary collaboration,

expand infrastructure, and increase the availability of primary healthcare and wellness services for individuals with mental illness.

The Primary and Behavioral Healthcare Integration ($51.5 million) program is being proposed for elimination, as this program is potentially fundable through other sources of funds including the Substance Abuse Block Grant and Certified Community Behavioral Health Center funding. SAMHSA will continue to disseminate the lessons learned from this program.

Minority AIDS (MAI)

In FY 2014, SAMHSA's Centers for Mental Health Services, Centers for Substance Abuse Prevention, and Centers for Substance Abuse Treatment supported the Minority AIDS Initiative Continuum of Care Pilot (MAI CoC). The MAI CoC supports behavioral health screening, primary prevention, and treatment for racial/ethnic minority populations with or at high risk for mental illness and drug/alcohol addiction and HIV/AIDS. MAI CoC supports substance abuse treatment, primary prevention/treatment service programs, community mental health programs, and HIV/AIDS integrated programs that either can co-locate or have fully integrated HIV/AIDS prevention and medical care services. SAMHSA supports a consolidated evaluation of its HIV/AIDS programs. This comprehensive process and outcome evaluation will assess the degree to which SAMHSA is providing effective and efficient mental and substance abuse treatment services and prevention programs to those with and at risk of HIV/AIDS.

SAMHSA is proposing an elimination of the MAI programs in Mental Health, Substance Abuse Prevention and Substance Abuse Treatment ($115.2 million). States will be able to provide services to reduce injection drug use and related HIV/AIDS and Hepatitis C infection rates through $150 million in new funding proposed as part of the Additional Opioid Allocation described on page 259.

Minority Fellowship Program

SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to funding increases the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance abuse treatment services for minority populations that are underserved. This will result in improved quality of mental and substance abuse prevention and increased treatment delivered to ethnic minorities. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, the program expanded to include marriage and family therapists and later added professional counselors. These individuals often serve in key leadership positions in mental illness and substance abuse treatment services, services supervision, services research, training, and administration. Professional guilds receive competitively awarded grants, and then competitively award the stipends to post-graduate students pursuing a degree in that professional field.

SAMHSA is proposing to eliminate the MFP in Mental Health, Substance Abuse Prevention and Substance Abuse Treatment ($11.6 million) because these programs are duplicative of other federal programs.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

In 2003, SAMHSA started the Screening, Brief Intervention and Referral to Treatment (SBIRT) program, which is intended to help primary care physicians identify individuals who misuse substances and help them intervene early with education, brief treatment, or referral to specialty treatment. The program's goal is to increase the number of individuals who receive treatment and reduce the rate of substance misuse. The SBIRT program seeks to increase the use of SBIRT in medical settings by promoting wide dissemination and adoption of the practice across the spectrum of primary care services. To achieve this, SAMHSA awards state implementation grants to encourage adoption of SBIRT by healthcare providers in each state. SAMHSA has demonstrated the effectiveness of SBIRT and continues to disseminate SBIRT practices.

SAMHSA is proposing to eliminate the SBIRT program ($29.8 million) as significant knowledge has been developed and disseminated for this program and it has been brought to scale in hundreds of communities across the nation. In addition, public and third party insurance can pay for this activity. SAMHSA will continue to disseminate SBIRT program information as necessary.

Physicians' Comparability Allowance (PCA) Worksheet
Substance Abuse and Mental Health Services Administration

(Whole dollars)

		PY 2017 Final	CY 2018 Annualized CR	BY 2019 President's Budget
1) Number of Physicians Receiving PCAs		2	1	1
2) Number of Physicians with One-Year PCA Agreements		---	---	---
3) Number of Physicians with Multi-Year PCA Agreements		2	1	1
4) Average Annual PCA Physician Pay (without PCA payment)		$145,616	$141,894	$141,894
5) Average Annual PCA Payment		$15,000	$16,000	$16,000
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.	2	1	1

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).

We have to offer PCAs because our salaries are not competitive with the private sector.

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

SAMHSA
Significant Items

House Appropriations Committee, Labor/HHS/Education Subcommittee (H. Rept. 115-244)

1. **Funding Opportunity Announcements -** *The Committee directs SAMHSA, where statute allows, when issuing new funding opportunity announcements, to include as eligible applicants, States, political subdivisions of States such as local government or communities, Indian Tribes or tribal organizations, health facilities, or programs operated by or in accordance with a contract or grant with the Indian Health Service, or other public or nonprofit private entities. (Page 74, H. Rept. 115-244)*

   Action taken or to be taken
   SAMHSA follows open eligibility principles as described above unless otherwise indicated by statute or compelling program justification.

2. **Mental Health -** *The Committee requests an update in the fiscal year 2019 Congressional Justification information on the costs to law enforcement, first responders, judicial systems, and health systems that accrue due to recidivist clients, including potential options for more cost-effective solutions to providing care for such clients. (Page 75, H. Rept. 115-244)*

   Action taken or to be taken
   Research indicates that the top 5 percent of all patients account for 50 percent of total U.S. health expenditures and that the annual mean expenditure for them was a staggering $41,000 in 2010, as the federal Agency for Healthcare Research and Quality reported in August. AHRQ reports the costliest of all patients are the top 1 percent, who account for 21 percent of health care expenditures in the United States. The annual mean expenditure for high utilizers is $88,000, 10 times the $8,508 that is the average cost of care for a typical American, according to a recent report from the Commonwealth Fund.[133] Many of these individuals have behavioral health disorders including serious mental illness. In addition to the financial costs, there are significant costs to individuals with these conditions and their families including early mortality, criminal justice involvement, homelessness, and unemployment.

   In response to these high need patients,, in FY 2016, SAMHSA implemented an Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness and awarded 17 grants to eligible entities such as a county, city, mental health system, mental health court, or any other entity with authority under the law of the state in which the grantee is located. This four-year pilot program is intended to implement and evaluate new AOT programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with an SMI. SAMHSA has partnered with the Assistant Secretary for

[133] https://www.managedcaremag.com/archives/2014/1/high-utilizing-patients-where-are-savings

Planning and Evaluation to implement a cross-site evaluation which will assess the effectiveness and impact of the AOT program.

In FY 2018, SAMHSA is awarding a new cohort of Law Enforcement and Behavioral Health Partnerships for Early Diversion grants. The purpose of this program is to design or expand programs that divert adults with a SMI or a co-occurring disorder from the criminal justice system to community-based services prior to arrest and booking. The U.S. Department of Justice, Office of Justice Programs, reported that one in seven state and federal prisoners (14 percent) and one and four jail inmates (26 percent) reported experiences that met the threshold for serious psychological distress. Approximately one quarter of a million individuals with serious mental illnesses are incarcerated at any given moment—about half arrested for non-violent offenses, such as trespassing or disorderly conduct.

The Assertive Community Treatment (ACT) for Adults with Serious Mental Illness (SMI) was authorized under the 21st Century Cures Act of 2016. ACT is an evidence-based practice considered one of the most effective approaches to deliver services to people with SMI. ACT was developed to reduce prehospitalization and improve outcomes soon after discharge. In the FY 2018 President's Budget, SAMHSA has proposed to award grants to states, counties, cities, tribes and tribal organizations, mental health systems, health care facilities and entities to establish, maintain or expand ACT programs. If appropriation for this effort occurs, special consideration will be given to applicants that serve those adults with SMI who are high utilizers of health and social services including homeless and justice involved populations.

SAMHSA continues to work collaboratively with the Centers for Medicare & Medicaid Services and the Assistant Secretary for Planning and Evaluation (ASPE) on Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 (Public Law 113-93, Section 223). In FY 2016, SAMHSA awarded 24 Planning Grants to support states to certify clinics as certified community behavioral health clinics (CCBHCs), to establish prospective payment systems for Medicaid reimbursable services, prepare to collect data and submit an application to participate in a two year demonstration program. In FY 2017 eight states from the 24 planning grant states were selected to participate in the demonstration program. The eight states are Minnesota, Missouri, Nevada, New Jersey, New York, Oregon, Oklahoma, and Pennsylvania. The evaluation by ASPE on the impact of the Demonstration program is in the initial stages.

3. **Mental Health First Aid -** *In continuing competitive funding opportunities, SAMHSA is directed to include as eligible grantees local law enforcement agencies, fire departments, and emergency medical units with a special emphasis on training for crisis de-escalation techniques. SAMHSA is also encouraged to allow training for veterans, armed services personnel and their family members. Any qualified community mental health education program should be considered as eligible for funding under the Mental Health First Aid program. (Page 75, H. Rept. 115-244)*

   Action taken or to be taken

   Funding is not included in the President's Budget for this program; however, should Congress appropriate the funding, the guidance above will be followed in the Funding Opportunity Announcement.

4. **Targeted Capacity Expansion—***SAMHSA should target States with the highest rates of admissions and that have demonstrated a dramatic increase in admissions for the treatment of opioid use disorders. The Center for Substance Abuse Treatment is directed to include as an allowable use medication-assisted treatment and other clinically appropriate services to achieve and maintain abstinence from all opioids and heroin and prioritize treatment regimens that are less susceptible to diversion for illicit purposes. (Page 78, H. Rept. 115-244)*

   Action taken or to be taken

   SAMHSA's previous funding opportunity included eligibility based on data which demonstrated the above criteria. The announcement also included an expectation to prioritize treatment regimens that are less susceptible to diversion for illicit purposes; the announcement also included as an allowable activity the use of medication-assisted treatment and other clinically appropriate services to achieve and maintain abstinence from all opioids and heroin. SAMHSA continues to work with its grantees to monitor these activities.

5. **Drug Courts -** *The Committee directs SAMHSA 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. The Committee further directs SAMHSA to expand training and technical assistance to drug treatment court grant recipients to ensure evidence based practices are fully implemented. (Page 78, H. Rept. 115-244)*

   Action taken or to be taken

   SAMHSA, through the Center for Substance Abuse Treatment, ensures that all funding appropriated for Drug Treatment Courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. In addition, grantees in the program are expected to work with the state substance abuse agency in planning, implementation and evaluation of the grants. SAMHSA also continues to provide training and technical assistance to Drug Treatment Court grantees.

6. **Viral Hepatitis Screening -** *The Committee encourages SAMHSA to continue its work with grantees to incorporate hepatitis screening into programmatic activities and requests a report on the implementation of hepatitis screening activities in the fiscal year 2019 Congressional Justification. (Page 79, H. Rept. 115-244)*

   Action taken or to be taken

   SAMHSA, through the Center for Substance Abuse Treatment, implements the Department of Health and Human Services' Hepatitis Action Plan which notes that people with HIV are disproportionally affected by viral hepatitis and related adverse conditions. Through the Center for Substance Abuse Treatment's Minority AIDS program, grantees are required to implement hepatitis screening as a condition of the award.

7. **Peer Recovery Support Services -** *The Committee requests information in the fiscal year 2019 Congressional Justification on the amount of funds from the Substance Abuse Prevention and Treatment Block Grant used for peer recovery support services. (Page 79, H. Rept. 115-244)*

   Action taken or to be taken

   SAMHSA encourages all grantees, including the SABG recipients, to utilize peer recovery coaches and/or peer recovery specialists in their respective systems of care. Peer recovery support services are a critical part of a comprehensive plan to support the recovery of people with substance use disorders. While states and jurisdictions are not required to report the specific dollar amount expended on PRSS, most states and jurisdictions are implementing elements of PRSS as part of their substance abuse treatment systems of care. In addition, SAMHSA encourages discretionary grantees to use their funds to support PRSS are part of the treatment and recovery continuum of care. In FY 2017, 47 states proposed to do recovery support services. Of those states, 36 states proposed peer support specialist credentialing and 33 states proposed peer coaching in their BG applications/plans.

8. **Pregnant Women -** *The Committee requests information in the fiscal year 2019 Congressional Justification on the amount of funds from the Substance Abuse Prevention and Treatment Block Grant used for pregnant women and women with dependent children, including information on how States are implementing these requirements, funding level by State, and information on availability of treatment, and barriers to treatment. (Page 79, H. Rept. 115-244)*

   Action taken or to be taken

   In FY 2017, $183 million of the Substance Abuse Block Grant funds were used for treatment of pregnant and postpartum women and woman with dependent children. States are implementing this requirement by making available gender specific treatment services, support for transportation and childcare, wrap around services to include public health and children serving agencies, primary pediatric care, including immunization, for children and case management. Common barriers to treatment for pregnant women and women with children are the lack of comprehensive wrap-around services and services for family members, including children. In particular, lack of support services such as parenting skill

development, employment and housing assistance, and child care are common barriers to treatment for this population.

9. **Federal Drug Free Workplace -** *The Committee strongly encourages the Secretary to expeditiously produce the technical guidelines for the use of hair testing as a Federally accepted drug testing method. The Committee requests an update on this effort in the fiscal year 2019 Congressional Justification. (Page 80, H. Rept. 115-244)*

Action taken or to be taken

SAMHSA Mandatory Guidelines for Federal Workplace Drug Testing Programs using Hair has been proposed and has gone through internal review but lacks some acceptable forensic and scientific supportability on key issues. SAMHSA has received over 250 internal comments and recommendations from the Drug Testing Advisory Board, Ex-Offices of DTAB, Office of General Council, federal agencies, and federally regulated entities. The development of the scientifically supported hair drug testing guidelines have required addressing several significant scientific, legal, and policy issues including:

a. Contamination – Hair testing is susceptible to contamination through environmental exposure to a substance (drug) rather than use. External contamination of the hair could cause a false positive drug test, or in other words, a drug test that falsely identifies an individual as a drug user. SAMHSA is considering approaches that might be used to distinguish external contamination from drug use, but such approaches are in need of further scientific research and study.

b. Hair Color Bias – If hair color influences drug incorporation into hair, individuals with darker hair could be more likely to test positive than an individual with lighter colored hair. Additional studies are needed to determine procedures that would effectively rule out, or account for hair color bias.

c. Unique Metabolites/Biomarkers – Additional funding may be needed in order to develop and proceed with the Hair MG resulting from the need to conduct additional scientific studies and performance testing on unique metabolites showing use of a drug

d. Acceptable reasons for using a hair drug test – Hair tests have a much longer window of detection than urine or oral fluid. Therefore, hair is most useful for pre-employment testing. Some stakeholders may have concerns related to detection of drugs that were used as prior to employment or during medical leave.

e. Collection protocols/Donor hair availability/Religious – To address privacy concerns, SAMHSA would propose collecting hair only from the head, and collecting another specimen type (urine or oral fluid) from donors with insufficient head hair. However, this approach may exempt large swaths of the population from hair testing.

f. Impact of hair treatments – The variability of cosmetic and hygienic hair treatments may impact the results of the hair test, thereby impacting the accuracy or reliability. Additional research is needed to resolve this issue.

g. Training for collectors – The final burden estimate for training collectors on hair testing has not yet been determined. Stakeholders may have concerns about their ability to train on the use of and implementation of hair testing procedures.

SAMHSA has been able to answer many of the key concerns, comments and recommendations listed above. The internal review process may take some time. SAMHSA has continued to discuss the concerns and efforts with stakeholder organizations, members of Congress and the Department of Transportation. SAMHSA recognizes the urgency to publish the Federal Workplace Drug Testing Program.

10. **Overdose Fatality Prevention -** 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, including paramedics, to emergency devices used to rapidly reverse the effects of opioid overdoses. Such initiatives should incorporate robust evidence based intervention training, and must facilitate linkage to treatment and recovery services. (Page 80, H. Rept. 115-244)

    Action taken or to be taken

    By statute, the Substance Abuse Block Grant prevention set-aside must be spent on "primary prevention" services or services for individuals who have not been identified as needing treatment. States have the flexibility to use data to decide how to spend funds based on their local needs. Categories include; information dissemination, education, alternatives, problem identification, community-based process, and environmental.

    Additionally, SAMHSA encourage states to use their block grant substance abuse prevention set aside funds for activities that will lead to a reduction in access to alcohol, tobacco, and drugs to include the abuse of opioids; change social attitudes; raise awareness about the consequences of substance abuse to include opioid abuse; and build communities' capacities to effectively deal with opioid misuse disorders. States are encouraged to focus on opioid safety education and training, including initiatives that support the improved access for licensed healthcare professionals, including paramedics, to emergency devices used to rapidly reverse the effects of opioid overdoses, such as education and training on the distribution and use of naloxone.

    Also, states are encouraged within their initiatives to incorporate a robust evidence based intervention training that contributes to the development and success of state collaborations with other agencies and stakeholders including those agencies and stakeholders that facilitate linkage to treatment and recovery services.

11. **Strategic Prevention Framework -***The Committee directs SAMHSA to provide continuation grants for Strategic Prevention Framework activities in fiscal year 2018. (Page 80, H. Rept. 115-244)*

    Action taken or to be taken

    SAMHSA's Strategic Prevention Framework State Incentive Grants (SPF-SIG) and Strategic Prevention Framework Partnerships for Success (SPF-PFS) programs continue to address the nation's top emerging substance abuse priorities including underage drinking and prescription drug misuse. SAMHSA continues 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. SAMHSA provides support for grantees to strengthen substance abuse prevention infrastructure and capacity using the strategic prevention framework.

Senate Appropriations Committee, Labor/HHS/Education Subcommittee, S. Rept. 115-150

12. **Mental Health First Aid -** *The Committee is pleased with the progress of Mental Health First Aid. In issuing new competitive funding opportunities SAMHSA is directed to include as eligible grantees local law enforcement agencies, fire departments, and emergency medical units with a special emphasis on training for crisis de-escalation techniques. SAMHSA is also encouraged to prioritize training for veterans, armed services personnel, and their family members within the Mental Health First Aid program. (Page 117, S. Rept. 115-150)*

    Action taken or to be taken

    Funding is not included in the President's Budget for this program; however, should Congress appropriate the funding, the guidance above will be followed in the Funding Opportunity Announcement.

13. **Community Mental Health Services Block Grant -** *The Committee directs SAMHSA to continue its collaboration with NIMH to ensure that funds from this set-aside are only used for programs showing strong evidence of effectiveness and that target the first episode of psychosis. SAMHSA shall not expand the use of the set-aside to programs outside of the first episode psychosis. The Committee directs SAMHSA to include in the fiscal year 2019 CJ a detailed table showing at a minimum each State's allotment, name of the program being implemented, and a short description of the program. (Page 118, S. Rept. 115-150)*

    Action taken or to be taken

    SAMHSA in collaboration with NIMH continues to provide technical assistance to states for implementation of evidence-based Coordinated Specialty Care (CSC) programs that specifically address treatment, services, and supports to individuals who are diagnosed with first-episode psychosis. Since the set-aside was enacted in FY 2014, the number of states with fully implemented operating CSC treatment programs has steadily increased and SAMHSA continues to monitor and ensure that the set-aside program is solely used to address first-episode psychosis. Beginning in September 2016, SAMHSA, in partnership with NIMH, initiated a three year evaluation study of CSC programs funded through the MHBG set-aside to ensure that funds are only used for programs showing strong evidence of effectiveness and target first episode of psychosis. SAMHSA developed a "snapshot" of all the First Episode Psychosis programs, detailing each State's allotment, name of the program being implemented, and a short description of the program. The requested table is part of SAMHSA's FY 2019 CJ.

14. Children's Mental Health Services - *The Committee includes a 10 percent set-aside for an early intervention demonstration program with persons not more than 25 years of age at clinical high risk of developing a first episode psychosis. SAMHSA is directed to work with NIMH on the implementation of this set-aside. (Page 118, S. Rept. 115-150)*

Action taken or to be taken

SAMHSA is pleased with the opportunity to implement this new set-aside and will work with NIMH as directed.

15. Combating Opioid Abuse - *The Committee continues to direct 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 target States with the highest age adjusted rates of admissions and that have demonstrated a dramatic age adjusted increase in admissions for the treatment of opioid use disorders. (Page 119, S. Rept. 115-150)*

Action taken or to be taken

SAMHSA's previous funding opportunity included eligibility based on data which demonstrated the above criteria. The announcement also included an expectation to prioritize treatment regimens that are less susceptible to diversion for illicit purposes; the announcement also included as an allowable activity the use of medication-assisted treatment and other clinically appropriate services to achieve and maintain abstinence from all opioids and heroin. SAMHSA continues to work with its grantees to monitor these activities.

16. Drug Courts - *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 should expand training and technical assistance to drug treatment court grant recipients to ensure evidence-based practices are fully implemented. (Page 120, S. Rept. 115-150)*

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment, ensures that all funding appropriated for Drug Treatment Courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. In addition, grantees in the program are expected to work with the state substance abuse agency in planning, implementation and evaluation of the grants. SAMHSA also continues to provide training and technical assistance to Drug Treatment Court grantees.

17. **Handheld Analyzers -** *The Committee encourages SAMHSA to support the use of block grant funds and funds authorized under section 1003 of the 21st Century Cures Act for handheld analyzers. SAMHSA shall provide an update on these efforts in the fiscal year 2019 CJ. (Page 120, S. Rept. 115-150)*

Action taken or to be taken

All recipients of SAMHSA discretionary and formula grant funds have the flexibility to use funds for authorized activities to prevent and treat conditions associated with opioid use disorders and other substance use disorders, including mobile technology devices, in support of substance use disorder treatment outcomes such as screening and testing for alcohol and drug use. SAMHSA encourages grantees to provide an array of screening, testing, treatment, and recovery support services for the treatment of substance use disorders, and especially opioid use disorder.

18. **State Targeted Response to the Opioid Abuse Crisis Grants -** *The Committee encourages HHS to ensure that these grants are focused on activities that can continue to provide opioid related treatment and abuse prevention services after Federal funding has ended. The Committee strongly encourages HHS and SAMHSA to refrain from any action that would require States and Territories to resubmit a grant proposal for the second year of State grant funding. By doing so, States could reduce administrative burdens and the Department could focus on promoting and implementing already approved plans. The Committee directs the agency to ensure States provide funds directly to local communities and counties to address the opioid crisis in areas of unmet need, and to report the Committee on such plans 1 year after enactment; SAMHSA is also directed to provide State agencies with technical assistance concerning how to enhance outreach and direct support to rural and underserved communities and providers in addressing this crisis. Further, the Committee is concerned that SAMHSA has restricted State flexibility for addressing the opioid crisis by limiting the amount of funding that can be used for opioid prevention activities. (Page 121, S. Rept. 115-150)*

Action taken or to be taken

SAMHSA continues to work with its Opioid STR grantees to monitor activities to ensure that the most evidence-based prevention, treatment, and recovery support services are being provided to address the nation's opioid crisis. In January 2018, SAMHSA announced the implementation of a new TA Center for the program which capitalizes on the use of local experts to ensure EBPs are being used in the most effective manner possible. Additionally, SAMHSA also announced that grantees would not need to resubmit a competitive application for funding; rather, grantees will submit a noncompetitive continuation for the second year of STR funding.

19. **Treatment Facility Expansion -** *The Committee requests that SAMHSA explore ways that grantees could access Federal funding for the capital costs of new treatment facilities, including planning, construction, repair, preventive maintenance, environmental support, improvement, extension, alteration, purchase of fixed equipment or facilities, as well as the acquisition of land. SAMHSA shall provide an update on these efforts, including any recommendations, in the fiscal year 2019 CJ. (Page 121, S. Rept. 115-150)*

Action taken or to be taken

SAMHSA recognizes the importance of safe and structurally sound treatment facilities in an effort to expand access to vital substance use disorder treatment and works with states to leverage local and state funding opportunities to build and expand treatment facilities within their respective communities. Through state and local collaborations, SAMHSA grantees are encouraged to enter into partnerships with municipal, private sector, and/or not for profit entities and other entities to provide support capital costs for new treatment facilities not otherwise authorized through SAMHSA grant programs. SAMHSA can provide training and technical assistance to grantees to facilitate and develop these partnerships.

20. **Combating Opioid Abuse -** *SAMHSA is directed to ensure applicants outline how proposed activities in the grant would work with treatment and recovery communities in addition to first responders. (Page 123, S. Rept. 115-150)*

Action taken or to be taken

Separate funding was not provided for this program; however, if Congress appropriates such funding, this guidance will be incorporated.

21. **Opioid Prevention Grants -** *SAMHSA shall award opioid prevention grants to communities and community coalitions based on the current state of evidence-based and promising practices. Further, the Committee directs SAMHSA to continue providing technical assistance to communities and coalitions by developing and distributing a list of best practices to prevent opioid abuse. SAMHSA is directed to work with NIDA, other Federal agencies, appropriate stakeholder groups, and States, in implementing these grants and developing best practices. Furthermore, SAMHSA should update this list based on new research findings, including the evaluation of the opioid prevention program grants. (Page 123, S. Rept. 115-150)*

Action taken or to be taken

SAMHSA will implement this program if funding is appropriated.

22. **Methamphetamine Abuse -** *The Committee requests that SAMHSA, in partnership with the National Center for Health Statistics at CDC, investigate the establishment of a comprehensive survey of the rates of methamphetamine abuse and its related indicators. The Committee requests an update on the feasibility of such a survey in the fiscal year 2019 CJ. (Page 124, S. Rept. 115-150)*

Action taken or to be taken

No current funding exists for this effort; however, if funding is appropriated, SAMHSA will implement as directed.

23. **Pediatric Psychiatric Beds -** *The Committee understands there is a shortage of psychiatric beds, particularly pediatric psychiatric beds, which help treat children with mental health and substance abuse issues. The Committee recommends SAMHSA review*

the best practices of pediatric psychiatric programs and provide an update in the fiscal year 2019 Congressional Justification on this topic.

Action taken or to be taken

SAMHSA conducted an analysis of psychiatric bed capacity that covered both adults and children (please see attached). The analysis reviewed:

1. Trends in access to psychiatric inpatient services to identify barriers to access;
2. Options for assisting state, local and tribal governments in ensuring equitable access to inpatient services; and
3. Options for addressing these issues in regions with low numbers of inpatient beds.

SAMHSA also reviewed children's mental health programs to identify urgent needs including prevalence trends, workforce, access, family caregiving, integrated care and special populations. This includes participating in the development of the report of the Interdepartmental Serious Mental Illness Coordinating Committee's report to Congress (https://store.samhsa.gov/shin/content/PEP17-ISMICC-RTC-ES/PEP17-ISMICC-RTC-ES.pdf) that included issues impacting children and youth with serious emotional disturbance (SED). In addressing these needs, in FY '18, SAMHSA, among other efforts, is planning on awarding grants to expand evidence-based systems of care for children with SED in states and communities, transition age youth, college mental health, family networks, and mental health awareness. In addition, SAMHSA is partnering with NIMH to identify effective practices for youth who are at clinically high risk for developing psychosis in order to provide early interventions to prevent long term disability.