DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2014

Substance Abuse and Mental Health Services Administration

Justification of Estimates for Appropriations Committees

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Substance Abuse and Mental Health Services Administration
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Letter from the Administrator

I am pleased to present the Congressional Justification for fiscal year (FY) 2014. A total of $3.572 billion is requested, reflecting a $3.5 million increase over FY 2012 funding levels including $130 million to support the President's plan to protect America's children in the wake of the tragic events of December 14, 2012 in Newtown, Connecticut. This budget maintains balanced funding for substance abuse and mental health at approximately 70 and 30 percent respectively.

This request reflects the Administration's commitment to preventing and reducing the impact of substance abuse and mental illness on America's communities. Many of the services to prevent and treat these conditions have existed outside the mainstream of American health care, with different histories, structures, funding, incentives, providers, and, in some cases, governing laws. Investments made in FY 2012 and FY 2013 will bear fruit in 2014 when up to 11 million people with mental health and substance abuse problems have access to new coverage opportunities. SAMHSA has invested in expanding and modernizing the Substance Abuse Prevention and Treatment Block Grant, the Community Mental Health Services Block Grant, the Strategic Prevention Framework/Partnerships for Success, and Systems of Care programs.

SAMHSA's plans for FY 2014 capitalize on these investments. Approximately $63 million is targeted for states to work with providers to increase enrollment and to maximize third party reimbursements for substance abuse and mental health services. Approximately $21 million is targeted for states to identify and bring to scale evidence-based practices to promote mental health and to prevent and treat mental illness. In addition, funding is requested to implement the National Strategy for Suicide Prevention and to begin a new program focused on trauma and women, Grants for Adult Trauma Screening and Brief Intervention (GATSBI).

Finally, this budget request includes $130 million to ensure young people and the adults who work with them know how to recognize mental illnesses and find a clear pathway to care. This package includes $55 million for Project AWARE (Advancing Wellness and Resilience in Education): $15 million to provide Mental Health First Aid training and $40 million to foster comprehensive state-school-community partnerships to prevent violence, promote mental health, and facilitate referrals to treatment. An additional $25 million request will fund pilot innovative state approaches to serve transition age youth, between 16 and 25 years of age, and their families. A total of $50 million is requested to train more than 5,000 additional professionals to work with students and young adults with mental illnesses and other behavioral health problems.

This FY 2014 budget request prioritizes essential investments in mental health and substance abuse infrastructure and innovation as the nation comes to terms with its long-standing neglect of these public health issues. I believe this request reinforces SAMHSA's efforts to help the nation understand and act on the knowledge that behavioral health is essential to health – that emotional health and freedom from substance abuse are necessary for an individual, a family, a community or a nation to be healthy.

Pamela S. Hyde, J.D.
Administrator

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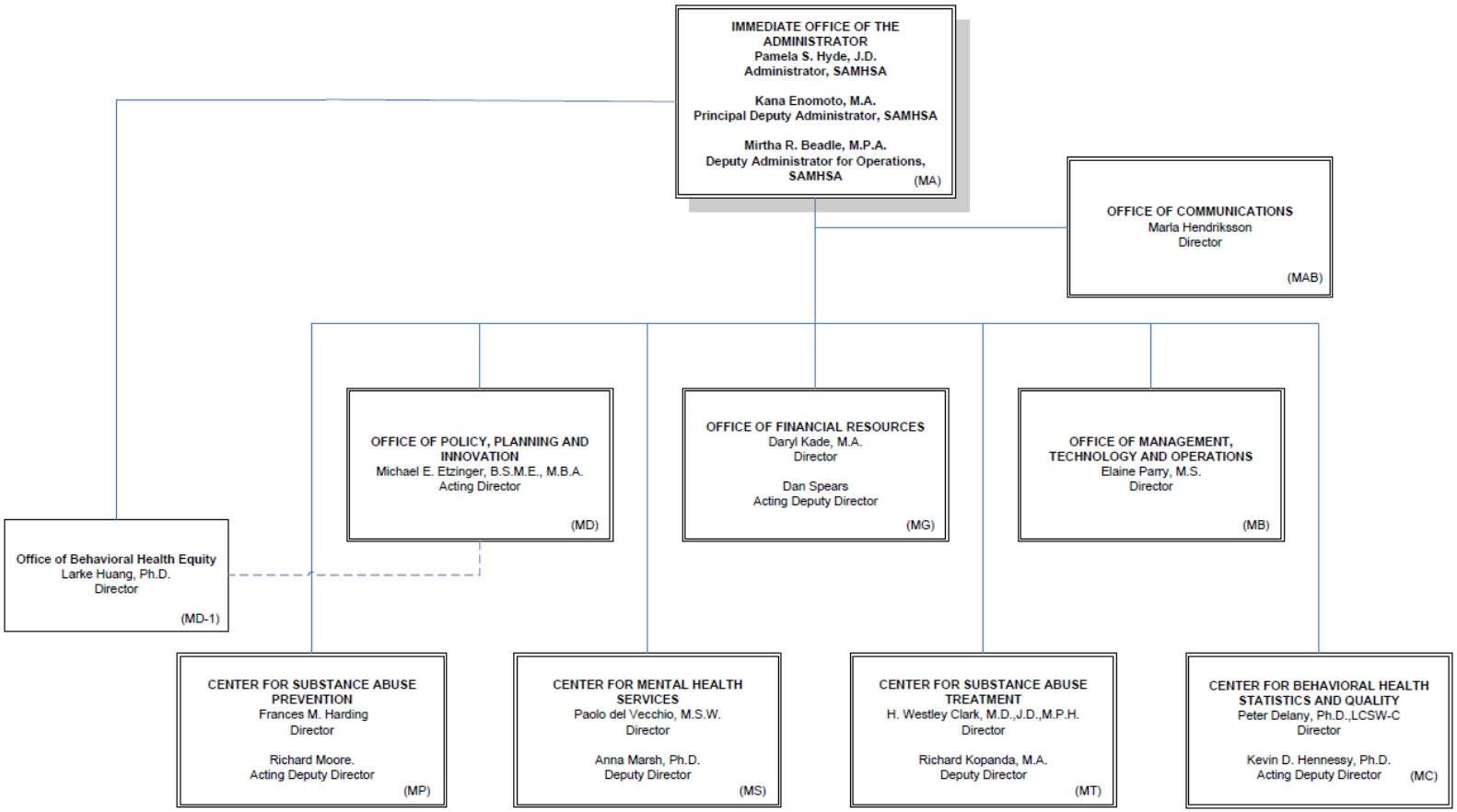
Organizational Structure:
Substance Abuse and Mental Health Services Administration (SAMHSA)



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SAMHSA Overview

Individuals and families cannot be healthy without positive mental health, freedom from addiction and the absence of abuse of substances. Prevention, treatment, and recovery support services for behavioral health are essential components of health service systems and community-wide strategies that work to improve health status and lower costs for individuals, families, businesses, and governments. Substance abuse, addiction, poor emotional health, and mental illnesses take a toll on individuals, families, and communities. They cost money, and they cost lives, as do physical illnesses, particularly when we do not prevent, or manage them effectively. The presence of substance abuse and mental illness exacerbates the cost of treating co-morbid physical diseases and results in some of the highest disability burdens in the world. SAMHSA has a unique responsibility to focus the nation's health and human services agendas on these preventable and treatable problems stemming from disease, trauma, inadequate access to appropriate care, and insufficient community and family supports.

Vision

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

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

Mission

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. By providing leadership, voice, funding, and standards, SAMHSA has the expertise and facilitates the collaboration needed to achieve its vision. SAMHSA accomplishes this mission through partnerships, policies, and programs that build resilience and facilitate recovery for people with or at risk for mental and/or substance use disorders. SAMHSA-funded services help individuals pursue recovery, avoid the abuse of drugs or alcohol, and prevent or reduce the impact of mental illnesses.

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Eight Strategic Initiatives

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

1 Prevention of Substance Abuse and Mental Illness

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

2 Trauma and Justice

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

3 Military Families

Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.

4 Recovery Support

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

5 Health Reform

Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other

medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.

6 Health Information Technology

Ensuring that the behavioral health system, including states, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (Health IT) and interoperable electronic health records (EHRs).

7 Data, Outcomes, and Quality

Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.

8 Public Awareness and Support

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

Overview of the Budget Request

The SAMHSA FY 2014 President's Budget Request for its Total Program Level is $3.572 billion, an increase of $3.5 million from the FY 2012 funding level. This FY 2014 Total Program Level of $3.572 billion includes $3.348 billion in Budget Authority (an increase of $0.9 million from the FY 2012 funding level), $164.8 million in PHS Evaluation funds (an increase of $35.1 million from the FY 2012 funding level), and $58 million in Prevention Fund resources (a decrease of $34.0 million from the FY 2012 funding level). The budget continues to reflect $1.5 million for user fees for extraordinary data and publication requests not currently able to be fulfilled. The FY 2014 Budget Request presents four appropriations consistent with the Consolidated Appropriations Act, 2012, and the FY 2013 President's Budget: Mental Health, Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support.

The SAMHSA FY 2014 Budget Request operates in an efficient manner with demonstrated accountability, as directed by leadership in SAMHSA, HHS, and the Administration. At the same time, SAMHSA's Budget Request reflects an emerging and dynamic healthcare environment marked by the implementation of significant aspects of the Affordable Care Act. The FY 2014 budget request also reflects the Administration's commitment to address the behavioral health needs of youths and their families in the wake of the Newtown, Connecticut tragedy at Sandy Hook Elementary School. The SAMHSA FY 2014 Budget Request mirrors ongoing internal and external changes which have resulted in integrated data and operating structures, uniform guidance, and braided funding strategies. SAMHSA has increased both programmatic and fiscal efficiencies through assessing its internal workforce and through the coordination of funding streams to deliver improved program outcomes.

Programmatic Priorities

SAMHSA's Strategic Initiatives continue to guide its work and Budget Requests. A focused approach to increasing evidence-based substance abuse prevention and mental health promotion practices on a national scale is a paramount goal. In addition, this request includes $45.3 million for initiatives that recognize the complex needs of the people and communities we serve, as well as in the interest of effectiveness and efficiency, by braiding funding from multiple sources into one grant announcement. In order to help the field better accommodate this complexity, several of these activities will be jointly funded across two or more appropriations. In these cases, a single grantee may receive dollars from multiple funding streams, but these distinct funding streams are "braided" rather than "blended"; that is, funds are tracked separately and used for purposes and objectives consistent with legislative direction and intent. In the case of jointly funded grants, programs also will be jointly administered and the grants themselves will reflect a ratio of activity (e.g., percent of clients served, number of people trained, etc.) proportional to and consistent with those funding lines.

For example, the Mental Health and Substance Abuse Treatment appropriations will jointly fund the Statewide Network Development for Recovery and Resiliency program. Drawing funds from Consumer and Family Network Grants in the Center for Mental Health Services (CMHS)

and Recovery Community Services Program in the Center for Substance Abuse Treatment (CSAT), funds will be available for Statewide Consumer Networks, Family Networks, and Addiction Recovery Networks along with a supplement for those grantees who wish to create a broader network that partners between mental health and substance use; as well as links with other health care related groups.

Prevention of Substance Abuse and Mental Illness

SAMHSA is proposing, in FY 2014, a new effort, Project AWARE (Advancing Wellness and Resilience in Education) to improve mental health awareness, increase referrals to services and for those who need help, improve school safety, reduce substance abuse, and improve mental health outcomes for approximately 750,000 students every year. SAMHSA also proposes to support implementation of the newly updated *National Strategy for Suicide Prevention* for a nationally coordinated, locally driven effort to bring down the tenth leading cause of death in the U.S.

In the FY 2014 Budget Request, the 20 percent Substance Abuse Prevention set aside funds are retained in the Substance Abuse Prevention and Treatment Block Grant (SABG). Funding for the Strategic Prevention Framework (SPF) is continued for additional Partnership for Success (PFS) grants to promote state-wide implementation of the SPF--an evidence-based, data-driven approach to substance abuse prevention--with a focus on underage drinking and prescription drug abuse. In the FY 2014 PFS programs, SAMHSA will encourage grantees to take exposure to trauma into consideration as one of the leading risk factors for substance abuse and will expand eligibility to include federally-recognized tribes that have completed a SPF-State Incentive Grant.

Trauma and Justice

Grants for Adult Trauma Screening and Brief Intervention remain a high priority in FY 2014. SAMHSA will award grants to develop or identify safe and effective tools for healthcare providers to meet the recommendation in the 2011 Institute of Medicine report *Clinical Preventive Services for Women*, recommendation for universal screening of women and adolescent girls for intimate partner violence, which includes screening for past experiences of violence and abuse. The Mental Health and Substance Abuse Treatment Appropriations will jointly fund new Behavioral Health Treatment Court Collaboratives (BHTCC) grants. The National Child Traumatic Stress Initiative and Drug Court grant programs are close to level-funded with the FY 2012 funding level and SAMHSA maintains its strong partnership with the Administration for Children and Families and CMS to address HHS's High-Priority Goal on improving trauma services for children and youth in child welfare.

Recovery Support

In FY 2014, SAMHSA is proposing a new competitive grant program, Healthy Transitions, for states to support youth with mental health and substance abuse problems and their families as they move from programs and systems that serve the under 18 population (e.g., education, CHIP,

juvenile justice, child welfare, children's mental health) into service systems and/or benefit programs geared toward adults.

Access to Recovery (ATR) grants will continue to offer vouchers to extend meaningful choice for services and supports by individuals in need of addictions treatment or recovery supports. In FY 2014, ATR funds are reduced and will place greater emphasis on recovery supports and clinical services not covered by other payers, or expected to be supported through the expansion of public and private insurance coverage. Focus areas will include recovery coaching, job training, and employment coaching specifically for individuals on the path to recovery from addiction. ATR will assist providers and clients to participate in the Medicaid insurance marketplace and to bill for services eligible for reimbursement. ATR will continue to foster the collaboration between faith-based providers and other community providers to enhance recovery.

Health Reform

In anticipation of the continuing changes and improvements brought about by the Affordable Care Act, SAMHSA has been, and will continue preparing, and guiding the behavioral health community through health reform implementation. Vulnerable populations, such as individuals who are homeless and those with co-occurring mental and substance use disorders, continue to shape SAMHSA's educational and outreach, eligibility and enrollment efforts. Simultaneously, efforts to increase primary and behavioral health care integration are ongoing, including technical assistance for tribes on integration.

SAMHSA has invested significant time and resources in the review and updating of business practices and processes while leveraging resources to provide technical assistance and innovative collaborations. SAMHSA has also embedded health reform readiness activities regarding enrollment and billing into existing grants and initiatives. The FY 2014/2015 Block Grant Applications have been revised, a new grants management tool has been launched, and SAMHSA project officer training continues.

The Block Grant programs remain key programs in the SAMHSA portfolio for implementation of health reform in FY 2014. The Budget maintains the Community Mental Health Services Block Grant (MHBG) and increases the Substance Abuse Prevention and Treatment Block Grant (SABG) to support states in an effective transition in the first year of the Affordable Care Act, which will include expanded coverage for mental health and substance abuse treatment services. The Budget also proposes funding within the Block Grants to encourage States to build provider capacity to bill public and private insurance and to promote the adoption of evidence-based programs.

Beginning in 2010, SAMHSA undertook a major redesign of the planning section of the application process for the block grants. SAMHSA provided states with guidance on the direction of block grant funds during health reform implementation. Specific priority areas included treatment and support services for individuals not currently covered by other insurers, essential services not covered by other insurers, and primary prevention efforts along with a mandate to collect performance and outcome data to increase accuracy and accountability.

As highlighted by Congress in FY 2012, there is a critical need to expand and strengthen the behavioral health workforce. In an initial attempt to meet the demands of the Medicaid and insurance Marketplace expansion populations, SAMHSA has consulted with the Health Resources and Services Administration (HRSA) to develop this FY 2014 Budget Request in a manner that complements HRSA's ongoing professional workforce programs. SAMHSA proposes to bolster the behavioral health system's prevention, treatment, and recovery support capacity by developing career ladder educational opportunities through community colleges and states who will train, certify, and reimburse for the services of an expanded prevention, peer, and paraprofessional workforce. Training will include key issues relevant to youth 16 to 25 years of age. In addition, new funds support an expansion of the Minority Fellowship Program as part of the support for the President's plan to respond to the Sandy Hook Elementary School tragedy. This new program will strengthen the behavioral health workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on transition age youth. These entry-level providers play a significant role in the delivery of prevention and recovery support services.

The SAMHSA FY 2014 Budget Request prioritizes essential health reform activities to assure individuals with behavioral health needs have full access to the benefits afforded through expanded coverage. Additionally, SAMHSA stands ready to participate fully in and assist the Administration, our federal partners, and state partners with critical undertakings related to the implementation of parity, the expansion of Medicaid, benchmark plans, and essential health benefits within state health insurance marketplaces.

Health Information Technology

Working closely with the Office of the National Coordinator, the Centers for Medicare and Medicaid Services, the National Institutes of Health, and other public and private sector partners, SAMHSA will continue to advance standards around privacy, consent, and interoperability for behavioral health records, as well as advance comprehensive approaches to Continuity of Care Documents that fully and appropriately integrate behavioral health data. The FY 2014 Budget Request outlines a jointly funded effort for standards development and technical assistance using set aside funds from both the SABG and MHBG.

Data, Outcomes, and Quality

In FY 2014, the Health Surveillance and Program Support appropriation will fully phase in both the Common Data Platform, SAMHSA's integrated grant performance management system, as well as an interagency agreement with the Centers for Disease Control and Prevention (CDC) for the Drug Abuse Warning Network (DAWN). The new National Survey on Drug Use and Health (NSDUH) contract will be awarded in FY 2013 and data collection will begin in CY 2014 for the new survey. SAMHSA will continue to advance quality improvement and emphasize improving meaningful outcomes for people, families, and communities by promoting the National Behavioral Health Quality Framework and National Behavioral Health Barometer with its federal partners, states, and other stakeholders.

Public Awareness and Support

The sense of shame and secrecy associated with mental illness and addiction prevents too many people from seeking help. In January 2013, the President directed Secretaries Sebelius and Duncan to launch a national dialogue about mental illness with young people who have experienced mental illness, members of the faith community, foundations, and school and business leaders. SAMHSA will be collaborating with public and private partners to facilitate a National Dialogue on Mental Health in the spring of 2013 to raise awareness and reduce negative attitudes.

Consistent with the President's directive for streamlining federal websites and SAMHSA's critical role in providing high quality, up-to-date information and materials for the public and the behavioral health field, the Public Awareness and Support Initiative will focus on the continued consolidation and modernization of SAMHSA's web presence. Public Awareness and Support funds will be used to support the development of quality content and the use of modern communications platforms to increase efficiencies in SAMHSA's web-based communication with the long-term goals of improving customer satisfaction and achieving cost savings.

The FY 2014 Budget Request prioritizes essential investments which require the programmatic expertise and leadership of SAMHSA's highly trained staff, who are dedicated to improving behavioral health in the nation. As SAMHSA continues its commitment to be an efficient, effective steward of the American people's resources, it will manage resources from the Prevention Fund, the PHS Evaluation Fund, as well as appropriated Budget Authority with utmost care and integrity. Maintaining critical agency investments in FY 2014 will allow SAMHSA to build capacity in states, territories, tribes and communities to protect and promote behavioral health in America. This request reflects the Administration's priorities and the Department of Health and Human Services' key goals that prepare the nation for a new era in health care and reduce the burden of substance abuse and mental illnesses on America's communities.

Program Increases:

<u>Project AWARE (+55 million)</u>
In an effort to support the Administration's response to the tragedy at Sandy Hook Elementary School, $55 million is requested to support Project AWARE, (Advancing Wellness and Resilience in Education) to increase awareness of mental health issues and connect young people with behavioral health issues and their families with needed services. SAMHSA will partner with the Departments of Education and Justice in the development, implementation and management of this initiative to maximize coordination and avoid duplication of efforts.

Project AWARE proposes two components: Project AWARE State Grants ($40.0 million) build on the Safe Schools/Healthy Students State Planning and Community Pilot Program which is intended to create safe and supportive schools and communities. For more than a decade, the Safe Schools/Healthy Students Initiative has successfully decreased violence and increased the number of students receiving mental health services. Project AWARE grants will be braided

with funds from Education and Justice to support 20 grants to State Education Authorities (SEAs) that will promote a comprehensive, coordinated and integrated program with the goal of making schools safer and increasing access to mental health services. The SEAs will be required to partner with the State Mental Health and Law Enforcement agencies to establish Interagency State Management Teams, conduct environmental needs assessments, develop a state plan with an evaluation mechanism, and develop the mechanisms to coordinate funding, service delivery, systems improvement, and data collection. In addition, each SEA will be required to identify three high-need Local Education Authorities (LEAs) as pilot communities that will receive sub-awards to implement comprehensive and coordinated school safety and mental health programs. SAMHSA expects that these 20 State grants will promote data driven models in 60 LEAs (reaching 1000-1500 schools).

The second component, Mental Health First Aid (MHFA) ($15.0 million) proposes widespread dissemination of the Mental Health First Aid curriculum and supports training to reach 750,000 students to identify mental illness early and refer them to treatment. MHFA prepares teachers and other individuals who work with youth to help schools and communities to understand, recognize, and respond to signs of mental illness or substance abuse in children and youth, including how to talk to adolescents and families experiencing these problems so they are more willing to seek treatment. The Budget proposes that $10.0 million of the Project AWARE – MHFA funds will be braided with Education and Justice funds to support competitive grants to LEAs with the goal of making schools safer and providing mental health literacy training. An Interagency Supervisory Team (IST) will work together to provide oversight and guidance to both the state and local initiatives. The additional $5.0 million proposed for MHFA will be braided with the 20 SEA grants to support MHFA training in the 20 SEAs and 60 LEAs sub-grantees implementing Project AWARE.

Healthy Transition (+$25 million)

The FY 2014 Budget includes $25.0 million for a new Healthy Transitions Program, to assist 16 to 25 year-olds with mental illnesses and their families to access and navigate behavioral health treatment systems. Compared with their peers, young adults, aged 18-25 with mental health conditions are more likely to experience homelessness, be arrested, drop out of school and be underemployed. Compared to all other chronic health conditions, mental disorders produce the greatest disability burden within this age group. Furthermore, 18-25 year-olds with mental health conditions are significantly less likely to receive mental health services than other adults. This new demonstration grant program for states proposes innovative approaches to provide support for transition-age youth with mental health and/or co-occurring substance abuse disorders and their families. States will take steps to expand services for these young individuals, develop family and youth networks for information sharing and peer support, and disseminate best practices for services to youth ages 16-25. The $25.0 million would support 5-year grants to 19 states.

Behavioral Health Workforce (+$50 million)

The FY 2014 Budget includes $50.0 million for workforce activities to help train more than 5,000 additional professionals to work with students and young adults with mental illnesses and other behavioral health problems. The proposal includes $35.0 million for a jointly administered activity with HRSA to expand the Mental and Behavioral Health Education and Training

(MBHET) Grant Program, $10.0 million for SAMHSA's Peer Professionals training program; and $5.0 million for the expansion of SAMHSA's Minority Fellowship Program as described below.

Suicide Prevention - National Strategy for Suicide Prevention (NSSP) (+$2 million)
The FY 2014 request for Suicide Prevention includes $2.0 million to assist states in further establishing evidence-based suicide prevention efforts that support the goals and objectives of the NSSP. The requested $2.0 million will support directly the recommendations of the NSSP and allow for the implementation of elements of the Plan that are not currently being addressed in any other national initiative. The funding will be utilized to develop and test nationwide efforts such as suicide awareness, provider credentialing changes, emergency room referral processes, clinical care practice standards, practitioner training regarding depression and suicide screening techniques, and technical assistance for those community human services and health workers most likely to encounter those who may be thinking about suicide.

Disaster Response (+$1.9 million)
The FY 2014 request includes support for a nationally available disaster distress crisis counseling telephone line through a connection to local crisis lines throughout the country. The need for this initiative has been documented through the Assistant Secretary for Preparedness and Response after various emergency conditions throughout the world and also in use after U.S. disasters that did not rise to the level of presidentially declared emergencies (therefore not qualifying for FEMA-coordinated Stafford Act Funding).

Substance Abuse Block Grant (+$19.5 million)
The FY 2014 request for the Substance Abuse Block Grant is $1.820 billion. This includes $1.748 billion in Budget Authority and $71.7 million in PHS Evaluation funds. This represents an increase of $27 million in Budget Authority and a decrease of $7.5 million in PHS Evaluation funds resulting in an overall net increase of $19.5 million for the SABG from the FY 2012 funding level.

Program Decreases:

Consumer and Family Network Grants: (-$1.3 million)
The FY 2014 request for Consumer and Family Network Grants is $5 million. This is a decrease of $1.3 million for the FY 2012 funding level and will support the Consumer and Family Network Grants for the Statewide Network Development for Recovery and Resiliency, including support for braided partnership supplements with funding in the Substance Abuse Treatment appropriation.

Primary and Behavioral Health Care Integration (-$39.7 million)
The FY 2014 request for Primary and Behavioral Health Care Integration (PBHCI) is $28.0 million. This is a decrease of $39.7 million from the FY 2012 funding level that included funding from the Prevention Fund and Affordable Care Act. The FY 2012 funding from the Prevention Fund resources allowed SAMHSA to strategically fully fund multi-year grants in 2012 and they will continue to be monitored in FY 2013.

Suicide Prevention Programs: (-$8.0 million)
The FY 2014 request for Suicide Programs is $50.0 million. This is a decrease of $8.0 million and is attributed primarily to the reduction of funding from the Prevention Fund, which allowed SAMHSA to strategically fully fund multi-year grants in FY 2012. These reductions include -$4.3 million for GLS State/Tribal, -$4.2 million in GLS Campus, -$0.7 million in Suicide Prevention Resource Center and -$0.9 million in Suicide Lifeline. Combined with an increase in the National Strategy for Suicide Prevention (+$2.0 million) and level funding for AI/AN Suicide Prevention Initiative, this results in a net reduction of -$8.0 million in Suicide Programs.

Seclusion and Restraint: (-$1.3 million)
The FY 2014 request for Seclusion and Restraint is $1.2 million. This is a decrease of $1.3 million from the FY 2012 funding level. A new contract in this program area is expected to focus on the reduction of seclusion and restraint through the implementation of core strategies in a trauma-informed context.

Fetal Alcohol Spectrum Disorder (-$8.8 million)
The FY 2014 request for Fetal Alcohol Spectrum Disorder is $1 million. This is a decrease of $8.8 million from the FY 2012 funding level. In 2012, SAMHSA awarded a new FASD Center for Excellence contract to work toward the prevention of FASD in communities throughout the nation. The request will continue to support technical assistance efforts to support new methods for screening and providing preventative services to women of child bearing age.

Screening, Brief Intervention and Referral to Treatment (-$23.2 million)
The FY 2014 request for Screening, Brief Intervention and Referral to Treatment is $30 million, all funded from the Prevention Fund. This reflects a decrease of $23.2 million from the FY 2012 funding level. While overall funding for this program is reduced in FY 2014, it will allow for the continuation of all grant programs and the funding of 16 new grants and support of one contract. This funding level will further support the integration and use of the SBIRT model with state and tribal primary and other health care related settings.

Targeted Capacity Expansion – General: (-$14.7 million)
The FY 2014 request for Targeted Capacity Expansion – General is $13.3 million. This is a decrease of $14.7 million from the FY 2012 funding level. While overall funding for this program is reduced in FY 2014, this funding level will allow the continuations for all grant programs and related support contracts.

Access to Recovery: (-$33.3 million)
The FY 2014 request for Access to Recovery is $65.0 million. This is a decrease of $33.3 million from the FY 2012 funding level. While the overall funding is reduced in FY 2014 the program will continue to build on the expansion and adoption of voucher based payment mechanisms. SAMHSA plans to award 19 three-year grants of $3.2 million annually.

Program Support: (-4.2 million)
A total of $72.7 million is requested for Program Support, reflecting a decrease of $4.2 million. Savings will be generated through administrative efficiencies.

Overview of Performance Section

SAMHSA reduces the impact of substance abuse and mental illness in America's communities by demonstrating that prevention works, treatment is effective, and people recover. SAMHSA uses performance management as an operational tool, consistent with the Government Performance and Results Act of 1993 (GPRA), to advance productivity, efficiency, and effectiveness, including rapid response in times of national emergency. Consistent with the GPRA Modernization Act of 2010 and related regulations, SAMHSA is expanding the integration of performance results with evaluation data, and other sources of evidence. Performance goals and measurement are powerful tools that advance effective, efficient and productive government.

In a time of limited resources and fiscal restraint, SAMHSA continues to meet the challenges of a changing health care environment, offering leadership to states and other community stakeholders as they embark on health reform. During FY 2012, SAMHSA demonstrated progress in each of its eight Strategic Initiatives (SIs), which guide the Agency's vision (http://www.samhsa.gov/About/strategy.aspx). Each SI has action steps that link SAMHSA's programs to the FY 2010 – FY 2015 HHS Strategic Plan, the inaugural FY 2013 HHS Performance Plan, the HHS High Priority Performance Goal (HPG) to reduce cigarette smoking, an HHS effort to increase the percentage of children receiving trauma informed services, and response to emergency situations, such as hurricane relief. Within the initial FY 2013 HHS Performance Report, SAMHSA is responsible for eleven measures related to the services provided to diverse populations and groups, including children receiving mental health services and those who access a suicide hotline.

Performance Management

SAMHSA uses a data-driven performance management approach to achieve measurable impact. SAMHSA emphasizes action to assist low performing programs through Center performance review boards and similar initiatives based on the grantee continuation process. Performance management activities are aided by implementation of tools, such as the National Behavioral Health Quality Framework (NBHQF), designed to integrate performance, evaluation, and other sources of evidence. The NBHQF facilitates communication within SAMHSA and with federal partners, states, networks, and non-governmental groups. As implementation continues, SAMHSA's NBHQF will track the population-based indicators needed to monitor trends and promote use of the latest available evidence.

In addition to centralized GPRA reporting at the Agency level, each of SAMHSA's program Centers currently operates their own performance management system. SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) is leading the development of a common data platform designed to streamline performance reporting and management, validate data quality, and assure evidence-based decision-making.

SAMHSA plays a key role in federal drug control efforts and contributes to the National Drug Control Budget. This budget provides a reliable, accurate, and transparent accounting of federal funding directed to the President's drug control efforts. This is reflected in the *National Drug*

Control Strategy: *FY 2013 Budget and Performance Summary* (*http://www.whitehouse.gov/sites/default/files/ondcp/fy2013_drug_control_budget_and_performance_summary.pdf*). A wide array of SAMHSA's funding supports drug control efforts, including programs awarded directly to providers. These programs collectively advance specific treatment methods, modalities, and services to targeted groups and include SAMHSA's Substance Abuse Treatment Block Grant (SABG). This formula-based funding to states expands substance abuse treatment services, while providing maximum flexibility. For example, grants support the delivery of treatment while also allowing states to access funding for prevention services.

Highlights of SAMHSA Accomplishments:

SAMHSA quickly responds when disasters strike and communities are in need and serves as the voice of behavioral health when federal response efforts engage, such as hurricane relief. SAMHSA provides resources that quickly aid states and communities in providing and coordinating behavioral health treatment, crisis counseling, disaster distress help-lines, resiliency training for educators and many other services. For example, soon after Hurricane Sandy, SAMHSA responded with additional support to the Disaster Distress Helpline, as well as other response teams from other agencies. A list can be found here: (http://www.samhsa.gov/dtac/dbhis/dbhis_hurricane_links.asp#specific). The impact of these resources is measured and evaluated in similar ways to all other SAMHSA programs.

SAMHSA's Health Information Technology (Health IT) activities address integration of behavioral health into broader federal efforts designed to implement the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the American Recovery and Reinvestment Act of 2009 (ARRA) and the Affordable Care Act, including advancement of standards and the use of Electronic Health Records. Through these efforts, SAMHSA promotes the adoption of Health IT with the goal of improving health care, advancing health outcomes, and reducing costs.

SAMHSA links the goals of the National HIV/AIDS Strategy (to reduce HIV incidence, increase access to care and optimize health outcomes for people living with HIV, and reduce HIV-related health disparities) to behavioral health. SAMHSA resources are directed to high-risk populations through state and local health departments to facilitate the development and expansion of culturally competent and effective integrated behavioral health and primary care networks in an effort to reduce the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas.

SAMHSA also participates actively in the Secretary's Program Integrity Initiative by conducting risk assessments on SAMHSA's major programs. In FY 2012, risk assessments were conducted on the Community Mental Health Services Block Grant (MHBG) program, the Access to Recovery (ATR) program, and the Sober Truth On Preventing Underage Drinking (STOP Act) program. Risk assessments were conducted in FY 2013 for the Projects for Assistance in Transition from Homelessness (PATH) and Substance Abuse Block Grant (SABG) formula programs.

On September 10, 2012, the National Action Alliance for Suicide Prevention (Action Alliance) released an ambitious national strategy to reduce the number of deaths by suicide. The strategy was called for by Health and Human Services (HHS) Secretary Kathleen Sebelius and former Department of Defense Secretary Robert Gates when they launched the Action Alliance on Sept. 10, 2010. The 2012 National Strategy for Suicide Prevention, a report from the U.S. Surgeon General and the Action Alliance, details 13 goals and 60 objectives for reducing suicides over the next 10 years. The Action Alliance, co-chaired by Gordon Smith, chief executive of the National Association of Broadcasters, and Army Secretary John McHugh, highlights four immediate priority is to reduce the number of suicides: integrating suicide prevention into health care policies; encouraging the transformation of health care systems to prevent suicide; changing the way the public talks about suicide and suicide prevention; and improving the quality of data on suicidal behaviors to develop increasingly effective prevention efforts.

Administrative Efficiencies

1) Grants and Contracts Restructuring to Effect Priority Programmatic Changes – SAMHSA created a uniform block grant application; inventoried and reviewed all grants and contracts to align RFAs/RFPs with the SIs; braided funding across SAMHSA or with other OpDivs/federal agencies where appropriate; and consolidated multiple contracts into similar priority areas or brought those functions in-house to increase efficiency and improve capacity. Examples are:

a. *Primary Behavioral Health Care Integration (PBHCI) TA Center* – Launched the SAMHSA/HRSA jointly funded Center for Integrated Health Solutions (CIHS) to focus on models, technical assistance and workforce issues in bi-directional integration of primary care and behavioral health (BH); developed ideas with CMS and HRSA for enhancement of these efforts.
b. *Housing/Homelessness and Recovery Supports TA Centers* – Braided funding across SAMHSA to create two consolidated and consistent technical assistance (TA) Centers addressing recovery support issues.
c. *HIV/AIDS Grants* – Braided multiple funding streams to create a focus on the CDC 12-cities approach, consistent with HHS' HIV/AIDS Implementation Strategy.

2) Budget Management – SAMHSA managed the budget to provide strong fiscal oversight and focus on SIs such as prevention (including for tribes), trauma and justice, military families, Health IT for BH providers, and other high-priority areas and to implement a theory of change that would use limited funding for innovative grants to test approaches for improvement of the nation's behavioral health system; planned for real and anticipated reductions in available resources at the state/territory/tribe and federal levels.

a. *Trauma* – SAMHSA incorporated concepts of trauma-informed and trauma-specific care in multiple grant programs; brought together multiple TA centers to discuss a common approach and models; developed a conceptual approach for Grants for Adult Trauma Screening and Brief Intervention (GATSBI) proposed for FY 2013.
b. *Prevention* – SAMHSA created a focus on prevention of behavioral health conditions through development of a draft paper on prevention concepts, inclusion of prevention in multiple grants, contracts and publications, and

development of a Strategic Prevention Framework Expansion (SPF-E) grant program for interested states/territories and tribes to take this evidence-based prevention approach to scale.

c. *Health Information Technology (Health IT) Grants* – SAMHSA provided supplemental grant funding for Primary and Behavioral Health Care Integration (PBHCI) grantees to purchase or expand interoperable electronic health record (EHR) systems; provided additional grant funding for other Health IT approaches through the Targeted Capacity Expansion (TCE) grant program; partnered with ONC on privacy standards and prescription drug monitoring.

3) *Office of Indian Alcohol and Substance Abuse (OIASA)* – As required by TLOA, SAMHSA established this new Office to lead interagency coordination efforts.
4) *Office of Behavioral Health Equity (OBHE)* – SAMHSA established this new Office using a team approach with staff throughout SAMHSA, to provide input and guidance to SI Leads and Executive Leadership about BH disparities for ethnic minorities, Tribal members, LGBTQ individuals, and women and girls.

Behavioral Health Prevention, Treatment and Recovery System Improvement

SAMHSA uses performance data to assure that resources directly address behavioral health disparities. Minority AIDS grants are awarded to community-based organizations through three different programs. The collective output from these programs enhances and expands provision of effective, culturally competent HIV-AIDS services related to behavioral health and associated risk factors. In the Minority AIDS Initiative (MAI), led by SAMHSA's Center for Substance Abuse Prevention (CSAP), implementation of evidence-based substance abuse and HIV prevention interventions are supported, including HIV testing that specifically targets high risk populations. All grantees use SAMHSA's Strategic Prevention Framework for assessing community needs. During FY 2011, targets were met or exceeded for all measures, including the number of people served who were exposed to substance abuse prevention education services and the percent of those served who reported no use of alcohol or illicit drugs at pre-test and then remained non-users at post-test. Additional data demonstrates that SAMHSA grant programs serve hard-to-reach populations. For example, results from the cross-site evaluation of the CSAP Minority AIDS Initiative grants showed that grantees served larger proportions of Hispanics and African Americans (28.6 percent and 66.4 percent, respectively) than are represented in the general population (14.6 percent and 12.6 percent, respectively). In addition, grantees also served other minority populations such as lesbian, gay, bisexual, and transgender (LGBT) youth and adults; homeless adults; and individuals who lacked health coverage at program entry.

- SAMHSA uses a focused approach to increase use of evidence-based substance abuse prevention and mental health promotion practices. Performance efforts document improvement resulting from services for military families, young children, and those exposed to trauma. For FY 2011, performance targets for the Mental Health Block Grants (MHBG) were met or exceeded for the number of evidence-based practices implemented and the percentage of the service population receiving any evidence-based practice.
- SAMHSA addresses homelessness through a number of programs, including the Cooperative Agreement to Benefit Homeless Individuals (CABHI)

program. Through such services, SAMHSA supports behavioral health by promoting transition into permanent supportive housing. Performance results are encouraging, overall, but leave room for improvement. Targets were exceeded for the number served, number employed, number housed, and the number receiving mental health services. Challenges continue in terms of social connectedness and improved functioning as well as enrollment of those with serious mental illness.

Cross-Agency Collaborations

1) Active Participation in Health Reform Implementation – SAMHSA articulated health reform as a central organizing context for all SAMHSA activities and helped to position BH as a central construct within HHS' health reform implementation efforts; redesigned SAMHSA's two block grant applications into a single uniform application offering states/territories more flexibility while encouraging and supporting them to plan for and implement a recovery-oriented good and modern service delivery system as health reform continues to evolve. Efforts included:
    a. *Behavioral Health Services Definitions* – Based on the Good and Modern Services Paper developed in FY 2010, SAMHSA began to develop service definitions for use within SAMHSA programs, CMS and other payers, and to develop a baseline of spending of block grant funds by states/territories.
    b. *Technical Assistance/Training* – SAMHSA provided multiple webinars, workshops, speeches and stakeholder meetings regarding aspects of health reform and its impact on BH systems, providers and service recipients.
    c. *Affordable Care Act Implementation* – SAMHSA participated in all aspects of implementation focusing especially on preparing states/territories and other BH actors for 2014, responding to all health reform related regulations and guidance documents, representing SAMHSA and BH in essential benefits planning, and developing a working group on enrollment strategies to begin preparing stakeholders for the next phase of health reform implementation.

2) Building Strategic Partnerships and Increasing Awareness of BH – SAMHSA created or built upon relationships and collaborative work with other HHS OPDIVS, STAFFDIVS, and other federal agencies, with 25 new and creative projects to advance the nation's behavioral in systems served or functions performed by these other entities, making SAMHSA a valuable partner and increasing the visibility of BH as an essential part of health. Examples include:
    a. *Behavioral Health Coordinating Council (BHCC)* – With OASH, SAMHSA co-chaired and helped manage this Secretary's council and subcommittees to address cross-HHS BH policy issues such as common definitions of terms, response to ONDCP prescription drug abuse plan, PBHCI implementation issues with CMS, BH measures for Phase 2 and 3 of meaningful use, BH budget cross-cut, drinking on college campuses, BH workforce and quality.
    b. *Tribal Law and Order Act (TLOA) Implementation* – SAMHSA worked with DOJ, DOI/BIA and IHS to engage in Tribal consultations and planning for development and implementation of the Memorandum of Agreement (MOA) signed by the three Secretaries on July 29, 2011; drafted guidelines for Tribal

Action Plans (TAPs); and testified with other Departments before the Senate Indian Affairs Committee regarding status of TLOA implementation.

c. *Interagency Coordinating Council on Prevention of Underage Drinking (ICCPUD)* – SAMHSA re-engaged multiple departments' principals to direct staff work across departments/agencies to begin work on a National Strategy for the Prevention of Underage Drinking.
d. *National Action Alliance for Suicide Prevention* – SAMHSA worked with public and private partners to help determine policy goals, strategies for the updated Surgeon General's National Strategy for Suicide Prevention (NSSP), and elements of a presentation to CMS about how to address suicide in Medicaid, Medicare and health reform.
e. *Olmstead* – SAMHSA worked with OCR, Office of Disability, ASPE, CMS and behavioral health stakeholders to design an approach to assist states to address community-based service needs of people in institutional settings.

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

Program Activities	FY 2012 Actual	FY 2013 Annualized CR [1/]	FY 2014 President's Budget	FY 2014 +/- FY 2012
Now is the Time Presidential Initiatives				
Mental Health:				
Project AWARE	**$---**	**$---**	**$55,000**	**+$55,000**
Project AWARE State Grants (non-add)	---	---	40,000	+40,000
Mental Health First Aid (non-add)	---	---	15,000	+15,000
Healthy Transitions	---	---	**25,000**	**+25,000**
Health Surveillance and Program Support:				
Workforce	---	---	**50,000**	**+50,000**
Minority Fellowship Program Expansion (non-add)	---	---	5,000	+5,000
Mental Health Workforce Expansion (non-add)	---	---	35,000	+35,000
Peer Professionals (non-add)	---	---	10,000	+10,000
TOTAL 2/	---	---	**$130,000**	**+130,000**
Mental Health:				
Programs of Regional and National Significance	315,666	272,323	361,277	+45,611
Prevention and Public Health Fund (non-add)	*45,000*	*N/A*	*28,000*	*-17,000*
Children's Mental Health Services	117,315	118,300	117,315	---
Projects for Assistance in Transition from Homelessness	64,794	65,191	64,794	---
Protection and Advocacy for Individuals with Mental Illness	36,238	36,460	36,238	---
Community Mental Health Services Block Grant	459,756	462,570	459,756	---
PHS Evaluation Funds (non-add)	*21,039*	*21,168*	*21,039*	---
Total, Mental Health	**993,770**	**954,844**	**1,039,380**	**+45,610**
Substance Abuse Prevention:				
Programs of Regional and National Significance	185,885	187,076	175,560	-10,325
Total, Substance Abuse Prevention	**185,885**	**187,076**	**175,560**	***-10,325***
Substance Abuse Treatment:				
Programs of Regional and National Significance	428,697	402,751	334,794	-93,903
Prevention and Public Health Fund (non-add)	*29,000*	*N/A*	*30,000*	*+1,000*
PHS Evaluation Funds (non-add)	*2,000*	*2,012*	---	*-2,000*
Substance Abuse Prevention and Treatment Block Grant	1,800,332	1,811,350	1,819,856	+19,524
PHS Evaluation Funds (non-add)	*79,200*	*79,685*	*71,724*	*-7,476*
Total, Substance Abuse Treatment	**2,229,029**	**2,214,101**	**2,154,650**	**-74,379**
Health Surveillance and Program Support:				
Health Surveillance and Program Support:	124,318	106,968	120,157	-4,161
Prevention and Public Health Fund (non-add)	*18,000*	*N/A*	---	*-18,000*
PHS Evaluation Funds (non-add)	*27,428*	*27,596*	*45,428*	*+18,000*
Public Awareness and Support	13,545	13,628	13,571	+26
PHS Evaluation Funds (non-add)	---	---	*13,571*	*+13,571*
Performance and Quality Information Systems	12,940	13,051	12,996	+56
PHS Evaluation Funds (non-add)	---	---	*12,996*	*+12,996*
Agency-Wide Initiatives	9,200	9,256	54,395	+45,195
Data Request/Publications User Fees	---	---	1,500	+1,500
Total, Health Surveillance/Program Support	**160,003**	**142,903**	**202,619**	**+42,616**
TOTAL, SAMHSA Discretionary PL	**3,568,687**	**3,498,924**	**3,572,209**	**+3,523**
Less PHS Evaluation Funds	*129,667*	*130,461*	*164,758*	*+35,091*
Less Prevention and Public Health Funds	*92,000*	*N/A*	*58,000*	*-34,000*
Less Data Request and Publications User Fees	---	---	*1,500*	*+1,500*
TOTAL, SAMHSA Budget Authority	**$3,347,020**	**$3,368,463**	**$3,347,951**	**+932**
FTEs	**590**	**631**	**655**	**+65**

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

2/ A total of $130 million is requested to address the behavioral health needs of transition age youth and their families in the wake of the Newtown, Connecticut tragedy at Sandy Hook Elementary School.

Summary of the Request
SAMHSA

The SAMHSA FY 2014 President's Budget Request for its total program level is $3.572 billion, an increase of $3.5 million from the FY 2012 funding level. This FY 2014 Total Program Level of $3.572 billion includes $3.348 billion in Budget Authority (an increase of $0.9 million from the FY 2012 funding level), $164.8 million in PHS Evaluation funds (an increase of $35.1 million from the FY 2012 funding level), and $58 million in Prevention Fund resources (a decrease of $34.0 million from the FY 2012 funding level). The budget continues to reflect $1.5 million for user fees (new in the FY 2013 President's Budget) for extraordinary data and publication requests not currently able to be fulfilled. The FY 2014 President's Budget Request is divided among four appropriations consistent with the FY 2012 Consolidated Appropriations Act and the FY 2013 President's Budget: (1) Mental Health, (2) Substance Abuse Prevention, (3) Substance Abuse Treatment, and (4) Health Surveillance and Program Support. The Budget Request includes $1.039 billion for Mental Health appropriation (an increase of $45.6 million from the FY 2012 funding level), $175.6 million for Substance Abuse Prevention (a decrease of $10.3 million) from the FY 2012 funding level, $2.155 billion for Substance Abuse Treatment (a decrease of $74.4 million from the FY 2012 funding level), $202.6 million for Health Surveillance and Program Support (an increase of $42.6 million from the FY 2012 funding level).

The FY 2014 President's Budget Request includes $130 million in SAMHSA to support the Administration's response to the Sandy Hook tragedy. This includes:

- $55 million for Project AWARE to improve mental health awareness, increase referrals to behavioral health services and support systems, including $40 million for Project AWARE State Grants and $15 million for Mental Health First Aid.
- $25 million for Healthy Transitions to support youth ages 16 to 25 with mental health and substance abuse problems and their families.
- $50 million for Behavioral Health Workforce activities, which includes $35 million for a jointly administered activity with HRSA to expand the Mental and Behavioral Health Education and Training (MBHET) Grant Program, $10 million for SAMSHA's Peer Professionals Workforce Development training program; and $5 million for the expansion of SAMHSA's Minority Fellowship Program - Youth.

FY 2014 Braided Programs

(Dollars in Thousands)

Braided Programs	FY 2014 President's Budget
Statewide Network Development for Recovery and Resiliency	$1,800
Mental Health: Consumer and Family Network Grants (non-add)	*400*
Substance Abuse Treatment: Recovery Community Services Program (non-add)	*1,400*
Transforming Lives through Supported Employment Grant Program	5,000
Mental Health: MH System Transformation and Health Reform (non-add)	*1,987*
Mental Health: Practice Improvement and Training (non-add)	*3,013*
Housing and Homelessness	28,617
Mental Health: Homelessness Prevention Program (non-add)	*18,759*
Substance Abuse Treatment: Treatment Systems for Homeless (non-add)	*9,858*
Behavioral Health Treatment Court Collaboratives	4,434
Mental Health: Criminal and Juvenile Justice Program (non-add)	*2,250*
Substance Abuse Treatment: Criminal Justice Activities (non-add)	*2,184*
Health Information Technologies	5,477
Mental Health Block Grant Set Aside (non-add)	*2,200*
Substance Abuse Prevention and Treatment Block Grant Set Aside (non-add)	*3,277*
Total, Braided Programs	**$45,328**

The FY 2014 President's Budget Request includes $45.3 million for five braided programs within and between the Mental Health and Substance Abuse Treatment appropriations. Any amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent. Braided programs include:

- $1.8 million including $0.4 million from the Mental Health appropriation (Consumer and Family Network Grants) and $1.4 million from the Substance Abuse Treatment appropriation (Recovery Community Services Program) for the Statewide Network Development for Recovery and Resiliency program supplements.
- $5.0 million from the Mental Health appropriation (Mental Health System Transformation and Health Reform and Practice Improvement and Training) for the Transforming Lives through Supported Employment Grant Program.
- $28.6 million including $18.8 million from the Mental Health appropriation (Homelessness Prevention Program) and $9.9 million from the Substance Abuse Treatment appropriation (Treatment Systems for Homeless) for a joint initiative with SAMHSA, the Department of Housing and Urban Development and the Centers for Medicare and Medicaid Services on homelessness.
- $4.4 million including $2.3 million from the Mental Health appropriation (Criminal and Juvenile Justice Programs) and $2.2 million from the Substance Abuse Treatment appropriation (Criminal Justice Activities) for the Behavioral Health Treatment Court Collaboratives (BHTCC).
- $5.5 million, including $2.2 million from the Mental Health Block Grant Set Aside and $3.3 million from the Substance Abuse Prevention and Treatment Block Grant Set Aside

for supporting states to adopt health information technology, including the use of intra and interoperable electronic health records.

Mental Health Appropriation

The FY 2014 Budget requests $1.039 billion Mental Health priorities, an increase of $45.6 million from the FY 2012 funding level, which include $990.3 million in Budget Authority (an increase of $62.6 million from the FY 2012 funding level), $21.0 million in PHS Evaluation funds (the same as the FY 2012 funding level), and $28.0 million in Prevention Fund resources (a decrease of $17 million from the FY 2012 funding level). The following mental health priorities are requested:

$361.3 million for Programs of Regional and National Significance (PRNS) which represents a $45.6 million increase from the FY 2012 funding level and will provide support for the following key PRNS programs:

$55 million for Project AWARE (Advancing Wellness and Resilience in Education) which includes $40 million for Project AWARE State Grants and $15 million for Mental Health First Aid. This program will support the Administration's response to the tragedy at Sandy Hook Elementary by providing support for increased access to vital mental health services and related supports.

$25 million for Healthy Transitions to support the Administration's efforts to address the tragedy at Sandy Hook Elementary by providing support to 16 to 25-year-olds with mental illnesses and their families. This new competitive grant program for states proposes innovative approaches to providing support for transition-age youth with mental health conditions and/or substance abuse disorders and their families.

$45.7 million for the National Child Traumatic Stress Network, which is a minor increase from the FY 2012 funding level, to continue support for a national network of grantees which develop and promote effective community practices for children and families exposed to a wide array of traumatic events.

$34.6 million for Project LAUNCH, the same as the FY 2012 funding level, to support the implementation of evidence-based practices that promote wellness and resilience of young children.

$28 million for PBHCI, which represents a reduction of $39.7 million from the FY 2012 funding level, to continue coordination and integration of primary care services into publicly funded community behavioral health settings.

$50 million for Suicide Prevention projects, which is a $8.0 million reduction from the FY 2012 funding level and includes $2 million to support the National Strategy for Suicide Prevention to expand technical assistance efforts for the adoption of available of evidence-based suicide prevention strategies.

$2.9 million for Disaster Response, which is a $1.9 million increase from the FY 2012 funding level and includes support for a disaster distress helpline.

$2.9 million for Grants for Adult Trauma Screening and Brief Intervention which represents a $2.9 million increase from FY 2012 funding level, to support grants focused on advancing the knowledge base to address trauma screening and brief interventions for women in primary health care settings.

$117.3 million in all other PRNS programs including Seclusion and Restraint ($1.1 million), Youth Violence ($23.2 million), Children and Family Programs ($6.5 million), Consumer and Family Network Grants ($5 million), Mental Health Transformation ($10.6 million), Homelessness Prevention Program ($30.8 million), Minority AIDS ($22.8 million), Criminal and Juvenile Justice ($4.3 million), Practice Improvement and Training ($7.9 million), Consumer and Consumer Supporter TA Centers ($1.9 million), Homelessness ($2.3 million) and HIV/AID Education ($0.773 million).

$117.3 million for Children's Mental Health Services, which is the same as the FY 2012 funding level, to continue to support the development of comprehensive, community-based systems of care.

$64.8 million for PATH Homeless Formula Grants, which is the same as the FY 2012 funding level to continue to address the critical behavioral health needs of individuals with serious mental illness and/or a co-occurring substance use disorder who are experiencing homelessness or are at risk for homelessness.

$36.2 million for the Protection and Advocacy of Individuals with Mental Illness (PAIMI), which is the same as the FY 2012 funding level.

$459.8 million for the MHBG, which is the same as the FY 2012 funding level. This includes $438.7 million in Budget Authority and $21.0 million in PHS Funds. In FY 2014, states will be expected to expend at least 3 percent of the state allocations to encourage providers in building capacity for third party billing and/or assist individuals to enroll in insurance for which they are eligible and expend at least 5 percent of the state allocations to implement evidence-based mental health promotion and mental illness prevention and treatment.

The Minority Fellowship Program (MFP) has been consolidated within the Health Surveillance and Program Support (HSPS) appropriation as an agency-wide activity within the Behavioral Health Workforce program. This streamlines the management of the program, which was previously funded through three separate appropriations.

Substance Abuse Prevention Appropriation

The FY 2014 Budget requests $175.6 million from Budget Authority for Substance Abuse Prevention priorities, a $10.3 million decrease from the FY 2012 funding level, and includes the following key prevention priorities:

$109.8 million the Strategic Prevention Framework, which is the same level of funding from FY 2012 funding level, to support national efforts of reducing substance-abuse related problems, preventing the onset and reducing the progression of substance abuse, strengthening the capacity and infrastructure at the state and community level in support of prevention and leveraging, redirecting and realigning state-wide funding streams for prevention.

$4.9 million for Mandatory Drug Testing, a minor decrease ($0.290 million) from FY 2012 funding level, to support a critical nationwide prevention program supporting Executive Order 12564 and Public Law 100-71 which provide oversight of the Federal Drug-Free Workplace program and the National Laboratory Certification program.

$41.3 million for Minority AIDS, which is the same as the FY 2012 funding level to continue to support substance abuse prevention efforts for people at risk for HIV/AIDS.

$7.0 million for the Sober Truth on Prevention Underage Drinking Act (STOP Act, which is an increase ($0.013 million) from FY 2012 funding level, to continue to support the nation's first comprehensive legislation addressing the prevention of underage drinking which enables organizations to strengthen collaboration and coordination to achieve a reduction in underage drinking at a community level.

$1.0 million for Fetal Alcohol Spectrum Disorder, which is a $8.8 million decrease from FY 2012 funding level, to support technical assistance efforts to support new methods for screening and providing preventative services to women of child bearing age.

$11.6 million in all other PRNS programs including Center for the Application of Prevention Technologies ($7.5 million) and Science and Service Program Coordination ($4.1 million).

The Minority Fellowship Programs (MFP) has been consolidated into the Health Surveillance and Program Support (HSPS) appropriation as an agency-wide activity within the Behavioral Health Workforce program. This streamlines the management of the program, which was previously funded through three separate appropriations.

Substance Abuse Treatment Appropriation

The FY 2014 Budget requests $2.155 billion for Substance Abuse Treatment activities, a decrease of $74.4 million from the FY 2012 funding level. The request includes $2.053 billion in Budget Authority, (a decrease of $65.9 million) $71.7 million in PHS Evaluation funds (a decrease of $9.5 million from the FY 2012 funding level), and $30.0 million in Prevention Fund (PPHF) resources (an increase of $1.0 million from the FY 2012 funding level).

This request includes $334.8 million for Programs of Regional and National Significance (PRNS) which represents a $93.9 million decrease from the FY 2012 funding level and will provide support for the following key PRNS programs:

$8.8 million for Opioid Treatment Programs/Regulatory Activities, which is a slight ($0.140 million) decrease from the FY 2012 funding level, to continue support for SAMHSA's regulatory and monitoring activities for opioid treatment programs.

$30.0 million in Prevention Fund resources for Screening and Brief Intervention and Referral to Treatment (a decrease of $23.2 million for FY 2012 funding level) to continue to support the expansion and enhancement of integrated screening, brief intervention, referral and treatment services within general medicine and primary care settings.

$16 million for Pregnant and Postpartum Women, which is the same as the FY 2012 funding level, to continue to support gender and culturally specific treatment service grants for pregnant, postpartum, and other parenting women.

$2.6 million for Recovery Community Services Program, of which $1.8 million will provide support for the Statewide Network Development for Recovery and Resiliency Initiative, of which $0.4 million will be braided for partnership supplements with funding in the Mental Health appropriation. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent.

$65.0 million for Access to Recovery (a decrease of $33.3 million from FY 2012 funding level) to continue to support voucher programs that expand substance abuse treatment capacity and promote choice among clinical treatment and recovery support providers.

$41.6 million for Treatment Systems for Homeless of which $9.9 million is directed for a braided program with funding from the Mental Health appropriation for a joint initiative with SAMHSA, the Department of Housing and Urban Development, and the Centers for Medicare and Medicaid Services on homelessness. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent.

$52.4 million for Minority AIDS, a $13.5 million reduction from the FY 2012 funding level. Although a reduction in the Substance Abuse appropriation, the total SAMHSA support for Minority AIDS is funded at the FY 2012 funding level.

$65.1 million in Criminal Justice Activities of which $2.2 million is directed for a braided program with funding from the Mental Health appropriation for the Behavioral Health Treatment Court Collaboratives. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent.

$54.0 million in all other PRNS programs including TCE-General ($13.3 million), Strengthen Treatment Access and Retention ($1.0 million), Children and Families ($29.7 million), Addiction Technology Transfer Centers ($8.1 million), and Special Initiatives/Outreach ($1.4 million).

$1.820 billion for the Substance Abuse Block Grant (SABG) in FY 2014. This represents a $27 million increase in Budget Authority from the FY 2012 funding level and a $7.5 million decrease in PHS Evaluation funds from the FY 2012 funding level resulting in a net increase for the SABG of $19.5 million from the FY 2012 funding level. In FY 2014, states will be expected to expend at least 3 percent of the state allocations to encourage providers in building capacity for third party billing and/or assist individuals to enroll in insurance for which they are eligible.

The Minority Fellowship Program (MFP) has been consolidated and is now funded within the Health Surveillance and Program Support (HSPS) appropriation as an agency-wide activity within the Behavioral Health Workforce program. This streamlines the management of the program, which was previously funded through three separate appropriations.

Health Surveillance and Program Support

The FY 2014 Budget requests a total of $202.6 million for Health Surveillance and Program Support, a $42.6 million increase from the FY 2012 funding level, and includes the following key priorities:

$47.4 million for Health Surveillance activities, reflecting level funding from FY 2012. The source of part of the funding for CBHSQ within HSPS has shifted from the Prevention Fund (PPHF) to the Public Health Service Evaluation Fund (PHS). Funding from HSPS reflects the phasing out of Legacy data collection and analysis programs and the full implementation of the Common Data Platform and the expansion of the new BHSIS contract.

$72.7 million for Program Support, a decrease of $4.2 million from the FY 2012 funding level. Savings will be generated through administrative efficiencies. Sufficient funds are available to staff up to 655 FTE, an increase of 3.8 percent over the FY 2013 projections, reflecting full annualization of SAMHSA's in sourcing initiative.

$13.6 million for Public Awareness and Support (PAS), a $0.026 million increase from the FY 2012 funding level. The increase of $13.6 million in PHS evaluation is offset by the decrease of $13.6 million of Budget Authority from the FY 2012 funding level. These funds will be used to continue work on the Public Engagement Platform, Project Evolve, the Federal Digital Strategy, the Knowledge Management System, and the Public Awareness and Support Initiative. In addition, funds will support a National Dialogue on Mental Health aimed at educating Americans about the impact of mental illness on children and youth adults.

$13.0 million is requested for Performance and Quality Information Systems (PQIS), an increase of $0.056 million from the FY 2012 funding level. An increase of $13.0 million in PHS evaluation is offset by the decrease of $13.0 million of Budget Authority to reflect the transfer to a different source of funding. These funds will be used to fully fund the new Common Data Platform which will be awarded in FY 2013 and fully implemented in 2014.

$54.4 million is requested for Agency Wide Initiatives, a net increase of $45.2 million from the FY 2012 funding level (a reduction of $3.5 million for activities under Military Families). The FY 2014 Budget request includes: an increase of $35 million for a jointly administered activity with HRSA to expand the Mental and Behavioral Health Education and Training (MBHET) Grant Program, an increase of $10 million for Peer Professionals, and an increase of $5 million for Minority Fellowship Program Expansion. In addition, the Budget request also includes the core Minority Fellowship Program activity, an increase of $4.4 million, which was realigned from all three centers to the HSPS appropriation.

This request includes an estimated $1.5 million in Data Request and Publication User Fees. Fees will be collected for extraordinary data and publications user requests not otherwise able to be fulfilled within existing resources.

NOW IS THE TIME

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

(Dollars in thousands)

Program Activities	FY 2012 Actual	FY 2013 Annualized CR 1/	FY 2014 President's Budget	FY 2014 +/- FY 2012
Now is the Time Presidential Initiatives				
Mental Health:				
Project AWARE	**$ ---**	**$ ---**	**$55,000**	**+$55,000**
Project AWARE State Grants (non-add)	---	---	*40,000*	*+40,000*
Mental Health First Aid (non-add)	---	---	*15,000*	*+15,000*
Healthy Transitions	---	---	**25,000**	**+25,000**
Health Surveillance and Program Support:				
Workforce	---	---	**50,000**	**+50,000**
Minority Fellowship Program Expansion (non-add)	---	---	*5,000*	*+5,000*
Mental Health Workforce Expansion (non-add)	---	---	*35,000*	*+35,000*
Peer Professionals (non-add)	---	---	*10,000*	*+10,000*
TOTAL	**$ ---**	**$ ---**	**$130,000**	**+$130,000**

The FY 2014 Budget request reflects the Administration's commitment to the President's Plan, *Now is the Time*[1] to increase access to mental health services. The FY 2014 Budget includes funding to expand mental health services to help teachers recognize signs of mental illness in students early, improve referrals and access to mental health services for young people ages 16-25, and help train 5,000 more mental health professionals with a focus on serving students and young adults. This package includes:

Project AWARE

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

Project AWARE proposes two components: Project AWARE State Grants ($40.0 million) build on the Safe Schools/Healthy Students State Planning and Community Pilot Program which is

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

intended to create safe and supportive schools and communities. For more than a decade, the Safe Schools/Healthy Students Initiative has successfully decreased violence and increased the number of students receiving mental health services. Project AWARE grants will be braided with funds from Education and Justice to support 20 grants to State Education Authorities (SEAs) that will promote a comprehensive, coordinated and integrated program with the goal of making schools safer and increasing access to mental health services. The SEAs will be required to partner with the State Mental Health and Law Enforcement agencies to establish Interagency State Management Teams, conduct environmental needs assessments, develop a state plan with an evaluation mechanism, and develop the mechanisms to coordinate funding, service delivery, systems improvement, and data collection. In addition, each SEA will be required to identify three high-need Local Education Authorities (LEAs) as pilot communities that will receive sub-awards to implement comprehensive and coordinated school safety and mental health programs. SAMHSA expects that these 20 State grants will promote data driven models in 60 LEAs (reaching 1000-1500 schools).

The second component, Mental Health First Aid (MHFA) ($15.0 million) proposes widespread dissemination of the Mental Health First Aid curriculum and supports training to reach 750,000 students to identify mental illness early and refer them to treatment. MHFA prepares teachers and other individuals who work with youth to help schools and communities to understand, recognize, and respond to signs of mental illness or substance abuse in children and youth, including how to talk to adolescents and families experiencing these problems so they are more willing to seek treatment. The Budget proposes that $10.0 million of the Project AWARE – MHFA funds will be braided with Education and Justice funds to support competitive grants to LEAs with the goal of making schools safer and providing mental health literacy training. An Interagency Supervisory Team (IST) will work together to provide oversight and guidance to both the state and local initiatives. The additional $5.0 million proposed for MHFA will be braided with the 20 SEA grants to support MHFA training in the 20 SEAs and 60 LEAs sub-grantees implementing Project AWARE.

Healthy Transitions

The FY 2014 Budget includes $25.0 million for a new Healthy Transitions Program, to assist 16 to 25 year-olds with mental illnesses and their families to access and navigate behavioral health treatment systems. Compared with their peers, young adults, aged 18-25 with mental health conditions are more likely to experience homelessness, be arrested, drop out of school and be underemployed. Compared to all other chronic health conditions, mental disorders produce the greatest disability burden within this age group. Furthermore, 18-25 year-olds with mental health conditions are significantly less likely to receive mental health services than other adults. This new demonstration grant program for states proposes innovative approaches to provide support for transition-age youth with mental health and/or co-occurring substance abuse disorders and their families. States will take steps to expand services for these young individuals, develop family and youth networks for information sharing and peer support, and disseminate best practices for services to youth ages 16-25. The $25.0 million would support 5-year grants to 19 states.

Behavioral Health Workforce

The FY 2014 Budget includes $50.0 million for workforce activities to help train more than 5,000 additional professionals to work with students and young adults with mental illnesses and other behavioral health problems. The proposal includes $35.0 million for a jointly administered activity with HRSA to expand the Mental and Behavioral Health Education and Training (MBHET) Grant Program, $10.0 million for SAMHSA's Peer Professionals training program; and $5.0 million for the expansion of SAMHSA's Minority Fellowship Program as described below.

SAMHSA-HRSA Mental and Behavioral Health Education and Training (MBHET) Grant Program

In FY 2014, SAMHSA will collaborate with HRSA in expanding the Mental and Behavioral Education and Training (MBHET) Grant Program. This expansion will increase the clinical service capacity of the behavioral health workforce by supporting training for Master's level social workers, psychologists and marriage and family therapists as well as behavioral health paraprofessionals. This effort is critical to ensure that the behavioral health workforce is able to meet the needs of high need and high demand populations, including rural, vulnerable, and underserved populations. In FY 2014, the program will include an emphasis on training to address the needs of children, adolescents, and transition-age youth (ages 16-25) and their families. SAMHSA requests $35.0 million in FY 2014 for the SAMHSA-HRSA expansion of the MBHET grant program and will help increase the behavioral health workforce by 3,950.

Peer Professionals Workforce Development

For FY 2014, SAMHSA requests $10.0 million to strengthen the behavioral health workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16-25. Because of their lived experience with behavioral health conditions, and being able to build trust and foster connections with individuals accessing care, these entry entry-level providers play a significant role in the delivery of prevention and recovery support services. SAMHSA plans to award up to 19 grant awards to community colleges or community college networks, states and national organizations. These funds will provide tuition support and further establish the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education.

Minority Fellowship Program – Youth (MFP-Y)

For FY 2014, SAMHSA requests $5.0 million for the Minority Fellowship Program (MFP-Y) to provide stipends to graduate students to increase the number of culturally competent behavioral health professionals who provide direct mental health and/or co-occurring substance abuse services to underserved minority populations. MFP-Y would utilize the existing infrastructure of the MFP to expand the focus of the program to support master's level trained behavioral health providers in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing. This support would increase the number of providers who are available to

provide clinical services to underserved, at-risk children, adolescents, and populations transitioning to adulthood (ages 16 – 25) in an effort to increase access to, and quality of, behavioral health services for this age group.

Appropriations Language

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

MENTAL HEALTH

For carrying out titles III and V of the PHS Act with respect to mental health, subpart I of part B of title XIX of such Act, and the Protection and Advocacy for Individuals with Mental Illness Act, $990,341,000, of which $438,717,000 shall be for carrying out section 1911 of the PHS Act: 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 carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1920(b) activities shall not exceed 5 percent of the amounts appropriated for subpart I of part B of title XIX: Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated under this Act for fiscal year 2014: Provided further, That notwithstanding section 565(b)(1) of the PHS Act, technical assistance may be provided to communities that wish to establish programs for comprehensive mental health services for children with serious emotional disturbances, irrespective of whether the communities have a grant under section 561(a) of such Act: Provided further, That States shall expend at least three percent of the amount each receives for carrying out section 1911 of the PHS Act to assist providers in building capacity to bill third party insurance or assist individuals in enrolling in insurance for which they are eligible: Provided further, That States shall expend at least five percent of the amount each receives for carrying out section 1911 of the PHS Act to support effective evidence-based mental health prevention

and treatment practices: Provided further, That any State receiving two percent or more of the total amount distributed for carrying out section 1911 of the PHS Act shall expend the amounts described in the two immediately preceding provisos through competitive subawards. Note.-- A full year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

SUBSTANCE ABUSE TREATMENT

For carrying out titles III and V of the PHS Act with respect to substance abuse treatment and subpart II of part B of title XIX of such Act, $2,052,926,000, of which $1,748,132,000 shall be for carrying out section 1921 of the PHS Act: Provided, That in addition to amounts provided herein, $71,724,000 shall be available under section 241 of the PHS Act 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 States shall expend at least 3 percent of the amount each receives for carrying out section 1921 of the PHS Act to assist providers in building capacity to bill third party insurance or assist individuals in enrolling in insurance for which they are eligible: Provided further, That any State receiving 1 percent or more of the total amount distributed for carrying out section 1921 of the PHS Act shall expend the amounts described in the immediately preceding proviso through competitive subawards. Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

SUBSTANCE ABUSE PREVENTION

For carrying out titles III and V of the PHS Act with respect to substance abuse prevention, $175,560,000. Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

HEALTH SURVEILLANCE AND PROGRAM SUPPORT

For program support and cross-cutting activities that supplement activities funded under the headings ``Mental Health'', ``Substance Abuse Treatment'', and ``Substance Abuse Prevention'' in carrying out titles III, V, and XIX of the PHS Act and the Protection and Advocacy for Individuals with Mental Illness Act in the Substance Abuse and Mental Health Services Administration, $129,124,000: Provided, That in addition to amounts provided herein, $71,995,000 shall be available under section 241 of the PHS Act to supplement funds available to carry out national surveys on drug abuse and mental health, to collect and analyze program data, and to conduct public 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 funds made available under this heading may be used to supplement program support funding provided under the headings ``Mental Health'', ``Substance Abuse Treatment'', and ``Substance Abuse Prevention'': Provided further, That the Administrator may transfer funds between any of the accounts of SAMHSA with

notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer. Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

Language Analysis

Language Provision	Explanation
For carrying out titles III and V of the PHS Act with respect to mental health, subpart I of part B of title XIX of such Act $990,341,000, …of which $438,717,000 shall be for carrying out section 1911 of the PHS Act	This change conforms this language to new Substance Abuse Treatment Account language, which now provides a clearer direction to carry out the entirety of the Community Mental Health Block Grant with Mental Health Account funds and the entirety of the SABG with Substance Abuse Treatment funds. This change also specifies the amount for the block grant, which is necessary given the new language.
Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated under this Act for fiscal year 2014.	Because nearly all states have received a grant under the Garrett Lee Smith Youth Suicide Prevention state-sponsored statewide program and the original purpose of this language has been served, this language would allow states to receive more than one grant.
Provided further, That notwithstanding section 565(b)(1) of the PHS Act, technical assistance may be provided to communities that wish to establish such programs irrespective of whether the communities have a grant under section 561(a).	SAMHSA's goal is the promotion of the use of system of care model, and it is hoped that non-grantee communities will pick up and implement the evidence based model, then SAMHSA should provide TA to communities whether they have a current grant or not; therefore., this grant would permit technical assistance to communities that wish to establish Systems of Care programs even though the community may not have a grant.

For carrying out titles III and V the PHS Act with respect to substance abuse treatment, and subpart II of part B of tile XIX of such Act, , $2,052,926,000, of which $1,748,132,000 shall be for carrying out section 1921 of the PHS Act:	This change makes clear that the legislative intent, despite "title…XIX with respect to substance abuse treatment", is that the Substance Abuse Prevention and Treatment Block Grant should be used for both prevention and treatment.
Provided further, That states shall expend at least three percent of the amount for carrying out section 1911 of the PHS Act to award competitive grants that assist providers in building capacity to bill third party insurance and/or assist individuals to enroll in insurance for which they are eligible:	This would ensure that States use at least three percent of their Community Mental Health Services Block Grant award to assist providers with enrolling eligible individuals in insurance and billing third party insurance.
Provided further, That states shall expend at least five percent of the amount for carrying out section 1911 of the PHS Act to support the most effective evidence-based mental health promotion and mental illness prevention approaches	States must use at least five percent of their Community Mental Health Services Block Grant award to support effective evidence-based mental health promotion and mental illness prevention approaches.
Provided further, That any State receiving two percent or more of the total amount distributed for carrying out section 1911 of the PHS Act shall expend the amounts described in the two immediately preceding provisos through competitive subawards.	This would ensure that funds are awarded competitively.
Provided further, That states shall expend at least three percent of the amount for carrying out section 1921 of the PHS Act to award	This would ensure that States use at least three percent of their Substance Abuse Block grant award to assist providers with enrolling

competitive grants that assist providers in building capacity to bill third party insurance and/or assist individuals to enroll in insurance for which they are eligible.	eligible individuals in insurance and billing third party insurance.
Provided further, That any State receiving one percent or more of the total amount distributed for carrying out section 1921 of the PHS Act shall expend the amounts described in the two immediately preceding proviso through competitive subawards.	This would ensure that funds are awarded competitively, while providing flexibility to States for which a three percent or five percent portion of their block grant allocation would be inefficient or ineffective in such a form. The trigger is one percent in the case of the Substance Abuse Block Grant to acknowledge the larger size compared to the Mental Health Block Grant.
Provided further, That, in addition, fees may be collected for the costs of publications, data, data tabulations, and data analysis completed under title V of the PHS Act and provided to a public or private entity upon request, which shall be credited to this appropriation and shall remain available until expended for such purposes	This section allows for fees to be collected for data and publications which would otherwise not be fulfilled because they incur especially onerous costs upon SAMHSA, and for those fees to be available for the same appropriation until expended.
Provided further, That funds made available under this heading may be used to supplement program support funding provided under the headings "Mental Health", "Substance Abuse Treatment", and "Substance Abuse Prevention": Provided further, That the Administrator may transfer funds between any	Establishes more clearly that the Program Support account can be used to supplement or transfer between accounts.

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 three percent by any such transfer.	

Substance Abuse and Mental Health Services Administration

Amounts Available for Obligation

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Appropriation:			
Labor/HHS/Ed-Annual Appropriation	3,354,313,000	3,498,924,000	3,572,209,000
Across the Board Reduction (P.L. 112-74 Sec. 527)	(6,340,000)	---	---
Subtotal, adjusted appropriation	3,347,973,000	3,498,924,000	3,572,209,000
Real Transfer to: Office of the Secretary	(954,000)	---	---
Offsetting Collections from:			
Federal Sources	129,667,000	130,460,562	164,758,000
Data Request and Publications User Fees	---	---	1,500,000
Unobligated balance start of year	3,579,000	175,000	---
Unobligated balance end of year	801,000	699,785	714,442
Unobligated balance expiring	---	---	---
Total obligations	$3,481,066,000	$3,630,259,347	$3,739,181,442

Summary of Changes

(Dollars in Thousands)

2012

Total estimated budget authority	$ 3,347,019,540
(Obligations)	3,347,019,540

2014

Total estimated budget authority	3,347,951,097
(Obligations)	3,347,951,097
Net Change	**+$931,557**

	FY 2014 President's Budget FTE	FY 2014 President's Budget BA	FY 2014 +/- FY 2012 FTE	FY 2014 +/- FY 2012 BA
Increases:				
A. Built-in:				
1. Annualization of Personnel Costs	---	74,729	---	+684
2. Annualized Civilian Pay Increase	---	74,729	---	+668
3. Annualized Commission Corp Pay Increase	---	74,729	---	+85
4. One additional compensable day	---	74,729	---	+293
Subtotal, Built-in Increases	**---**	**74,729**	**---**	**+1,730**
A. Program:				
1. Mental Health PRNS	---	333,277	---	+62,611
2. Children's Mental Health Services	---	117,315	---	---
3. Substance Abuse Block Grant	---	1,748,132	---	+27,000
4. Agency-wide Initiatives	---	54,395	---	+45,195
Subtotal, Program Increases	---	2,253,119	---	+134,807
Total Increases	**---**	**2,327,848**	**---**	**+136,537**
Decreases:				
A. Built-in:				
1.	---	---	---	---
2.	---	---	---	---
Subtotal, Built-in Decreases	---	---	---	---
A. Program:				
1. Substance Abuse Prevention PRNS	---	175,560	---	-10,325
2. Substance Abuse Treatment PRNS	---	304,794	---	-92,903
3. Health Surveillance and Program Support	---	74,729	---	-4,161
4. Program Support	---	---	---	-1,730
5. Public Awareness and Support	---	---	---	-13,545
6. Performance and Quality Information Systems	---	---	---	-12,940
Subtotal, Program Decreases	**---**	**555,083**	**---**	**-135,604**
Total Decreases	**---**	**---**	**---**	**-135,604**
Net Change	**---**	**$2,327,848**	**---**	**$932**

Budget Authority by Activity

(Dollars in Thousands)

Program Activities	FY 2012 Actual	FY 2013 Annualized CR [1/]	FY 2014 President's Budget	FY 2014 +/- FY 2012
1. Mental Health:				
Programs of Regional and National Significance	$315,666	$272,323	$361,277	+$45,611
Project AWARE (non-add) 2/	---	---	*55,000*	*+55,000*
Healthy Transitions (non-add) 2/	---	---	*25,000*	*+25,000*
Prevention and Public Health Fund (non-add)	*45,000*	*N/A*	*28,000*	*-17,000*
Children's Mental Health Services	117,315	118,300	117,315	---
Projects for Assistance in Transition from Homelessness	64,794	65,191	64,794	---
Protection and Advocacy for Individuals with Mental Illness	36,238	36,460	36,238	---
Community Mental Health Services Block Grant	459,756	462,570	459,756	---
PHS Evaluation Funds (non-add)	*21,039*	*21,168*	*21,039*	---
Total, Mental Health	**993,770**	**954,844**	**1,039,380**	**+45,610**
2. Substance Abuse Prevention:				
Programs of Regional and National Significance	185,885	187,076	175,560	-10,325
Total, Substance Abuse Prevention	**185,885**	**187,076**	**175,560**	***-10,325***
3. Substance Abuse Treatment:				
Programs of Regional and National Significance	428,697	402,751	334,794	-93,903
Prevention and Public Health Fund (non-add)	*29,000*	*N/A*	*30,000*	*+1,000*
PHS Evaluation Funds (non-add)	*2,000*	*2,012*	---	*-2,000*
Substance Abuse Prevention and Treatment Block Grant	1,800,332	1,811,350	1,819,856	+19,524
PHS Evaluation Funds (non-add)	*79,200*	*79,685*	*71,724*	*-7,476*
Total, Substance Abuse Treatment	**2,229,029**	**2,214,101**	**2,154,650**	**-74,379**
4. Health Surveillance and Program Support:				
Health Surveillance	124,318	106,968	120,157	-4,161
Prevention and Public Health Fund (non-add)	*18,000*	*N/A*	---	*-18,000*
PHS Evaluation Funds (non-add)	*27,428*	*27,596*	*45,428*	*+18,000*
Public Awareness and Support	13,545	13,628	13,571	+26
PHS Evaluation Funds (non-add)	---	---	*13,571*	*+13,571*
Performance and Quality Information Systems	12,940	13,051	12,996	+55,587
PHS Evaluation Funds (non-add)	---	---	*12,996*	*+12,996*
Agency-Wide Initiatives	9,200	9,256	54,395	+45,195
Workforce (non-add) 2/	---	---	*50,000*	*+50,000*
Data Request/Publications User Fees	---	---	1,500	+1,500
Total, Health Surveillance/Program Support	**160,003**	**142,903**	**202,619**	**+42,616**
TOTAL, SAMHSA Discretionary PL	**3,568,687**	**3,498,924**	**3,572,209**	**+3,523**
Less PHS Evaluation Funds	*129,667*	*130,461*	*164,758*	*+35,091*
Less Prevention and Public Health Funds	*92,000*	*N/A*	*58,000*	*-34,000*
Less Data Request and Publications User Fees	---	---	*1,500*	*+1,500*
TOTAL, SAMHSA Budget Authority	**$3,347,020**	**$3,368,463**	**$3,347,951**	**+$932**
FTEs	**590**	**631**	**655**	**+65**

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

2/ A total of $130 million is requested to address the behavioral health needs of transition age youth and their families in the wake of the Newtown, Connecticut tragedy at Sandy Hook Elementary School.

Authorizing Legislation

	FY 2012 Amount Authorized	FY 2012 Actual	FY 2014 Amount Authorized	FY 2014 President's Budget
NASPER				
Sec. 399O	Expired	$0	Expired	$0
Grants for the Benefit of Homeless Individuals				
Sec. 506	Expired	$41,571,281	Expired	$41,571,000
Residential Treatment Programs for Pregnant and Postpartum Women				
Sec. 508	Expired	$15,969,760	Expired	$15,970,000
Priority Substance Abuse Treatment Needs of Regional and National Significance				
Sec. 509*	Expired	$309,535,762	Expired	$217,575,000
Substance Abuse Treatment Services for Children and Adolescents				
Sec. 514*	Expired	$30,620,019	Expired	$29,678,000
Priority Substance Abuse Prevention Needs of Regional and National Significance				
Sec. 516*	Expired	$169,095,712	Expired	$168,560,080
Programs to Reduce Underage Drinking				
Sec. 519B*	Expired	$ 6,986,770	Expired	$ 7,000,000
Centers of Excellence on Services for Individuals with FAS and Alcohol-related Birth Defects and Treatment for Individuals with Such Conditions and Their Families				
Sec. 519D*	Expired	$9,802,438	Expired	0
Prevention of Methamphetamine and Inhalant Abuse and Addiction				
Sec. 519E*	Expired	0	Expired	0
Priority Mental Health Needs of Regional and National Significance				
Sec. 520A*	Expired	$155,530,492	Expired	$220,531,318
National Centers of Excellence for Depression				
Sec. 520B	Expired	0	0	0
Youth Interagency Research, Training, and Technical Assistance Centers				
Sec. 520C*	Expired	$4,947,631	Expired	$4,947,631
Suicide Prevention for Children and Youth				
Sec. 520E1*	Expired	$29,681,795	Expired	$29,681,795
Sec. 520E2*	Expired	$4,965,597	Expired	$4,965,597
Grants for Jail Diversion Programs				
Sec. 520G*	Expired	$6,671,367	Expired	$4,281,000
SSAN = Such Sums as Necessary				

Authorizing Legislation

	FY 2012 Amount Authorized	FY 2012 Actual	FY 2014 Amount Authorized	FY 2014 President's Budget
Awards for Co-locating Primary and Specialty Care in Community-based Mental Health Settings				
Sec. 520K……	SSAN	0	SSAN	0
PATH Grants to States				
Sec. 535(a)……	Expired	$64,794,307	Expired	$64,794,000
Community Mental Health Services for Children with Serious Emotional Disturbances				
Sec. 565 (f)……	Expired	$117,314,524	Expired	$117,314,524
Children and Violence Program				
Sec. 581*……	Expired	$23,156,152	Expired	$23,156,152
Grants for Persons who Experience Violence Related Stress				
Sec. 582 **……	Expired	$45,713,438	Expired	$45,714,000
Community Mental Health Services Block Grants				
Sec. 1920(a)……	Expired	$438,717,254	Expired	$438,717,000
Substance Abuse Prevention and Treatment Block Grants				
Sec. 1935(a)……	Expired	$1,721,131,901	Expired	$1,748,132,000
Other Legislation/Program Description				
Protection and Advocacy for Individuals with Mental Illness Act				
P.L. 99-319, Sec. 117……	Expired	$36,238,380	Expired	$36,238,000
Health Surveillance and Program Support				
Program Management, Sec. 501……	Indefinite	$77,787,971	Indefinite	$71,569,000
SEH Workers' Compensation Fund				
P.L. 98-621……	Indefinite	$1,160,000	Indefinite	$1,160,000
Total, Program Management……	0	$76,889,616	0	$72,729,000
Heath Surveillance…….	Indefinite	$2,000,000	Indefinite	$2,000,000
Public Awareness and Suppport (FY12)……	Indefinite	$13,545,351	Indefinite	0
PQIS(FY12)…….	Indefinite	$12,940,413	Indefinite	0
Agency-Wide Initiatives…….	0	$9,199,580	0	$54,395,000
Indian Health Care Improvement Reauthorization and Extension Act of 2009				
Substance Abuse and Mental Health Services Administration Grants				
Sec. 724 ……..	SSAN	0	SSAN	0
Indian Youth Life Skills Development Demonstration Program				
Sec. 726……..	$1,000,000	0	$1,000,000	0
TOTAL, SAMHSA Budget Authority……	$1,000,000	$3,347,019,540	0	$3,347,951,097

SSAN = Such Sums as Necessary

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

Appropriation History

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2005				
General Fund Appropriation:				
Base	$3,428,939,000	$3,270,360,000	$3,361,426,000	$3,295,361,000
P.L. 108-447 & P.L. 108-309 as amended				
Rescission	0	0	0	-$26,895,592
Subtotal	$3,428,939,000	$3,270,360,000	$3,361,426,000	$3,268,465,408
FY 2006				
General Fund Appropriation:				
Base	$3,336,023,000	$3,352,047,000	$3,398,086,000	$3,237,813,000
P.L. 109-149				
Rescission (P.L. 109-359)	0	0	0	-$1,681,000
Transfers (Section 202)	0	0	0	-$2,201,000
Subtotal	$3,336,023,000	$3,352,047,000	$3,398,086,000	$3,233,931,000
FY 2007				
General Fund Appropriation:				
Base	$3,260,001,000	$3,326,341,772	$3,326,341,772	$1,211,654,381
P.L. 109-383				
Continuing Resolution	0	0	0	$3,326,341,772
Subtotal	$3,260,001,000	$3,326,341,772	$3,326,341,772	$4,537,996,153
FY 2008				
General Fund Appropriation:				
Base	$3,167,589,000	$3,393,841,000	$3,404,798,000	$3,291,543,000
P.L. 110-161				
Rescission (P.L. 110-161)	0	0	0	-$57,503,000
Subtotal	$3,167,589,000	$3,393,841,000	$3,404,798,000	$3,234,040,000
FY 2009				
General Fund Appropriation:				
Base	$3,024,967,000	$3,303,265,000	$3,257,647,000	$3,334,906,000
P.L. 111-8				
Subtotal	$3,024,967,000	$3,303,265,000	$3,257,647,000	$3,334,906,000

Appropriation History

	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	7/
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	8/
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	$ 3,368,463,000	9/
S.R. 112-176					
Subtotal	$ 3,151,508,000	$ -	$ 3,472,213,000	$ 3,368,463,000	
FY 2014					
General Fund Appropriation:					
Base	$ 3,347,951,097				
Subtotal	$ 3,347,951,097				

Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2014
Grants for the Benefit of Homeless Individuals Sec. 506	2003	$ 50,000,000	$ 16,700,000	$ 41,571,000
Residential Treatment Programs for Pregnant and Postpartum Women Sec. 508	2003	SSAN	$0	$ 15,970,000
Priority Substance Abuse Treatment Needs of Regional and National Significance Sec. 509*	2003	$ 300,000,000	$ 322,994,000	$ 217,575,000
Substance Abuse Treatment Services for Children and Adolescents Sec. 514*	2003	$ 40,000,000	$ 20,000,000	$ 29,678,000
Priority Substance Abuse Prevention Needs of Regional and National Significance Sec. 516*	2003	$ 300,000,000	$ 138,399,000	$ 167,560,080
Centers of Excellence on Services for Individuals with FAS and Alcohol-related Birth Defects and Treatment for Individuals with Such Conditions and Their Families Sec. 519D*	2003	$ 5,000,000	$ 2,416,000	$ 1,000,000
Priority Mental Health Needs of Regional and National Significance Sec. 520A*	2003	$ 300,000,000	$ 94,289,000	$ 220,531,318
Youth Interagency Research, Training, and Technical Assistance Centers Sec. 520C*	2007	$ 5,000,000	$ 3,960,000	$ 4,947,631
Suicide Prevention for Children and Youth Sec. 520E (GLS - State Grants)	2007	$ 30,000,000	$ 17,829,000	$ 29,681,795
Sec. 520E2 (GLS-Campus Grants)	2007	$ 5,000,000	$ 4,950,000	$ 4,965,597
Grants for Jail Diversion Programs Sec. 520G*	2003	$ 10,000,000	$ 6,043,000	$ 4,281,000
PATH Grants to States Sec. 535(a)	2003	$ 75,000,000	$ 46,855,000	$ 64,794,000
Community Mental Health Services for Children with Serious Emotional Disturbances Sec. 565 (f)	2003	$ 100,000,000	$ 96,694,000	$ 117,314,524
Children and Violence Program Sec. 581*	2003	$ 100,000,000	$ 83,035,000	$ 23,156,152
Grants for Persons who Experience Violence Related Stress Sec. 582 *	2003	$ 50,000,000	$ 20,000,000	$ 45,714,000
Community Mental Health Services Block Grants Sec. 1920(a)	2003	$ 450,000,000	$ 433,000,000	$ 438,717,000
Substance Abuse Prevention and Treatment Block Grants Sec. 1935(a)	2003	$ 2,000,000,000	$ 1,785,000,000	$ 1,748,132,000
Other Legislation/Program Description				
Protection and Advocacy for Individuals with Mental Illness Act P.L. 99-319, Sec. 117	2003	$ 19,500,000	$ 32,500,000	$ 36,238,000
TOTAL, SAMHSA Budget Authority		$ 4,222,500,000	$ 3,142,664,000	$ 3,211,827,097

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

**Congress authorized two provisions as section 514.

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SAMHSA/Programs of Regional and National Significance

Mental Health Services

(Dollars in thousands)

Programs of Regional & National Significance	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
CAPACITY				
Seclusion and Restraint	$2,444	$2,459	$1,149	-$1,295
Youth Violence Prevention	23,156	23,298	23,156	---
Project AWARE	---	---	*55,000*	*+55,000*
Project AWARE State Grants (non-add)	---	---	*40,000*	*+40,000*
Mental Health First Aid (non-add)	---	---	*15,000*	*+15,000*
Healthy Transitions	---	---	*25,000*	*+25,000*
National Child Traumatic Stress Initiative	*45,713*	*45,993*	*45,714*	*+1*
Children and Family Programs	6,474	6,513	6,474	---
Consumer and Family Network Grants	6,224	6,262	4,966	-1,258
Project LAUNCH	34,640	34,852	34,640	---
MH System Transformation and Health Reform	10,603	10,668	10,603	---
Primary and Behavioral Health Care Integration	65,749	30,937	26,004	-39,744
Prevention & Public Health Fund (non-add)	*35,000*	*N/A*	*26,004*	-8,996
Suicide Prevention	58,045	48,339	50,045	-8,000
National Strategy for Suicide Prevention (non-add)	---	---	*2,000*	*+2,000*
Suicide Lifeline (non-add)	*6,373*	*5,545*	*5,512*	*-862*
Prevention & Public Health Fund (non-add)	*862*	*N/A*	---	*-862*
GLS- Youth Suicide Prevention - States (non-add)	*34,002*	*29,863*	*29,682*	*-4,320*
Prevention & Public Health Fund (non-add)	*4,320*	*N/A*	---	*-4,320*
GLS- Youth Suicide Prevention - Campus (non-add)	*9,134*	*4,996*	*4,966*	*-4,168*
Prevention & Public Health Fund (non-add)	*4,168*	*N/A*	---	*-4,168*
GLS - Suicide Prevention Resource Center (non-add)	*5,598*	*4,978*	*4,948*	*-650*
Prevention & Public Health Fund (non-add)	*650*	*N/A*	---	*-650*
AI/AN Suicide Prevention Initiative (non-add)	*2,938*	*2,956*	*2,938*	---
Homelessness Prevention Programs	30,772	30,960	30,772	---
Minority AIDS	9,265	9,322	22,770	+13,505
Grants for Adult Trauma Screening & Brief Intervention	---	---	2,896	+2,896
Criminal and Juvenile Justice Programs	6,671	6,712	4,281	-2,390
Subtotal, Capacity	**299,758**	**256,317**	**343,470**	**+43,712**

Programs of Regional & National Significance	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
SCIENCE AND SERVICE				
Practice Improvement Training.....	7,863	7,911	7,863	---
Consumer and Consumer Supporter Technical Assistance Centers.....	1,923	1,935	1,923	---
Primary and Behavioral Health Care Integration TTA.....	1,996	2,008	1,996	---
Prevention & Public Health Fund (non-add).....	---	*N/A*	*1,996*	+1,996
Disaster Response.....	1,052	1,058	2,950	+1,898
Homelessness.....	2,302	2,316	2,302	---
HIV/AIDS Education.....	773	777	773	---
Subtotal, Science and Service	**15,909**	**16,006**	**17,807**	**+1,898**
TOTAL, PRNS[1/ 2/]	**$315,666**	**$272,323**	**$361,277**	**+$45,611**

1/ The PRNS FY 2012 total includes $35.0 million for the PBHCI program and $10 million for the Garrett Lee Smith (GLS) Suicide Prevention and the Suicide Lifeline programs funded by the Prevention and Public Health Fund. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary. The FY 2014 total includes $28.0 million for PBHCI funded by the Prevention and Public Health Fund.

2/ The Minority Fellowship Program budget is now reflected in the Health Surveillance and Program Support

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

FY 2014 Authorization:

520K of the Public Health Service Act ..... Such Sums as Necessary

All others ..... Expired

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

Program Description and Accomplishments

Seclusion & Restraint

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

This program area supports states/tribes and communities in their efforts to implement best practices to reduce and ultimately eliminate the use of restraints and seclusion in institutional-

and community-based settings that provide services for individuals with mental and co-occurring substance use disorders. While this initiative includes a focus on the mental health delivery system, it also includes other service sectors such as criminal justice, schools, and child welfare that are likely to use coercive practices with people with mental and co-occurring substance use disorders. SAMHSA's vision for this initiative is to facilitate the implementation of evidence-based strategies for preventing and reducing the use of seclusion and restraint and implementing trauma-informed care, an approach that mitigates the use and harmful effects of coercive practices.

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

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

Recent evidence of the effectiveness of this training includes reduced use of seclusion and restraint in facilities where the training has taken place as well as reduced incidents of violence where these trauma-informed strategies have been employed. In FY 2012, SAMHSA awarded the final year of this contract.

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

Youth Violence Prevention

Youth violence remains a public health problem in the United States. In a 2009 nationwide survey, approximately 32 percent of high school students reported being in a physical fight in the 12 months before the survey. Close to six percent of high school students in 2009 reported taking a gun, knife, or club to school in the 30 days before the survey. An estimated 20 percent of high school students reported being bullied on school property in 2009.

The Safe Schools/Healthy Students (SS/HS) Initiative is a discretionary grant program that seeks to create healthy learning environments which help students thrive, succeed in school, and build healthy relationships. Since 1999, this program has been jointly administered by SAMHSA, the Department of Education (ED), and the Department of Justice (DOJ). The SS/HS initiative implements an enhanced, coordinated, and comprehensive plan of activities, programs, and services that promote healthy childhood development, prevent violence, and prevent alcohol and drug abuse. Grantees are required to develop local strategic plans that address five required elements across the three sectors: (1) safe school environments and violence prevention activities; (2) alcohol, tobacco, and other drug prevention activities; (3) student behavioral, social, and emotional supports; (4) mental health services; and, (5) early childhood social and emotional learning programs. Grantees have developed organizational, informational, and programmatic systems that bring together many diverse sectors of the community, creating the capacity for comprehensive system reform so all agencies concerned with the welfare of children and families could collaborate on an ongoing basis. As a result of the SS/HS initiative implemented in local educational authorities (LEAs), more than 90 percent of school staff saw reduced violence on school grounds and almost 80 percent reported that SS/HS had reduced violence in their communities. Children and adolescents participating in the SS/HS grant program experienced a 47.1 percent increase in access to school-based mental health service, 29.7 percent increase in access to community-based mental health services, and a 29.8 percent increase in receipt of community-based mental health services. Nearly 90 percent of school staff stated that they were better able to detect mental health problems in their students and more than 80 percent of school staff reported that they saw reductions in alcohol and other drug use among their students.

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

In FY 2013, SAMHSA will award eight new 4-year grants, which build on the investments in the SS/HS Initiative through state and community level partnerships among educational, behavioral health, and criminal justice systems that promote systems integration and policy change and sustainable policies, infrastructure, services, and supports. The SS/HS State Planning and Community Pilot Program is intended to create safe and supportive schools and communities.

National Child Traumatic Stress Initiative

Established in 2000, the purpose of the National Child Traumatic Stress Initiative (NCTSI) is to improve behavioral health treatment, services, and interventions for children and adolescents exposed to traumatic events. The NCTSI has provided funding for a national network of grantees known as the National Child Traumatic Stress Network (NCTSN) to develop and promote effective community practices for children and adolescents exposed to a wide array of

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

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

The NCTSN is composed of three types of centers:

- The National Center for Child Traumatic Stress (Category I) develops and maintains the collaborative network structure, supports resource development and dissemination, and coordinates the Network's national child trauma education and training efforts. It promotes further product development, learning collaborations, and system change efforts in systems across the country.

- The Treatment and Service Adaptation (TSA) Centers - (Category II) provide national expertise and assume responsibility in the Network for specific areas of trauma, such as specific types of traumatic events, population groups, and service systems; and support the development and adaptation of effective trauma treatments and services for children, adolescents and their families that can be implemented throughout the nation. The TSAs are comprised of nationally-recognized experts in child and adolescent trauma who have developed evidence-based interventions to treat children who have experienced a range of traumas including neglect, physical abuse, sexual abuse, medical trauma, school violence, war, refugee status, and disasters

- The Community Treatment and Services (CTS) Centers - (Category III) are primarily community service providers across multiple child-serving systems service programs that implement and evaluate effective treatment and services in community settings and youth serving service systems and collaborate with other NCTSN centers on clinical issues, service approaches, policy, financing, and training issues.

The program has provided over 25,000 trainings and/or education in assessment and treatment of traumatic stress to over 1.1 million people including mental health professionals, primary care providers, and other professionals in child-serving systems, consumers, and members of the public. The Network has developed resources for child/adolescent trauma on the NCTSN website, which receives more than 2,000 visits a day and houses over 150 Network-developed resources downloaded more than 50,000 times a year. More than 121,310 people were trained in 2012 in annual training/education events. In FY 2012, 76.1 percent of children receiving trauma-informed services reported positive functioning at six-month follow-up. The unduplicated count of the number of children and adolescents receiving trauma-informed services at 2,367 was improved in FY 2012.

In FY 2012, SAMHSA awarded a new cohort of NCTSI 78 grants, (1 Category I, 21 Category II and 56 Category III) with an increased focus on effective implementation and dissemination strategies for maximizing the uptake of trauma interventions, enhanced learning networks, and strong linking of child trauma in the child welfare and juvenile justice systems. In FY 2013, the NCTSI will build on the robust work of the NCTSN and improve and enhance the capacity of the NCTSI to deliver effective interventions and core practices developed by the NCTSN to children and youth in need.

Children and Family Programs

The Children and Family Programs provide support for the State/Community Partnerships to Integrate Services and Supports for Youth and Young Adults 16-25 with Serious Mental Health Conditions and their Families and Circles of Care grant programs. These two programs provide services and support to children and youth with and at risk for mental health conditions and their families. The State/Community Partnerships to Integrate Services and Supports for Youth and Young Adults 16-25 with Serious Mental Health Conditions And Their Families program was funded in 2009 as a five-year pilot program that promotes a system of care approach which facilitates seamless transitions to independence and the successful adaptation of adult roles and responsibilities for youth and young adults with serious mental health conditions and their families. Young people with serious mental health conditions (often with co-occurring substance use disorders) face a difficult transition to adulthood compared to their peers. Moreover, youth who age out of child-serving systems may have difficulty obtaining developmentally appropriate, culturally-competent, and appealing support services as they move into adulthood. By creating supportive state-level policies and making available evidence-based, age-appropriate services and supports, these at-risk youth are better able to navigate the transition to adulthood.

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

In FY 2012, SAMHSA provided continuation support for seven Circles of Care grants and seven State/Community Partnerships to Integrate Services and Supports for Youth and Young Adults 16-25 with Serious Mental Health Conditions and their Families grants.

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

Consumer & Family Network Programs

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

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

In FY 2012, SAMHSA awarded 11 new Statewide Consumer Network grants and the final year of 19 grants. In addition, SAMHSA awarded the 4th year of a 5-year technical assistance contract.

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

The Statewide Family Network Program is a three year program that provides education and training to increase family organizations' capacity for policy and service development by 1) strengthening organizational relationships and business management skills, 2) fostering leadership skills among families of children and adolescents with serious emotional disturbances, and 3) identifying and addressing the technical assistance needs of children and adolescents with serious emotional disturbances and their families. The Statewide Family Network Program focuses on families: parents; the primary caregivers of children; youth; and young adults. In this case, 'young adults' refers to individuals generally up to age 18, up to age 21 if they have an Individual Education Plan, or up to age 26 if they are transitioning to the adult mental health system.

In FY 2012, SAMHSA awarded six new Statewide Family Network grants and continuation funding of 37 grants. In addition, SAMHSA continued funding of a technical assistance contract.

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

Project LAUNCH

In FY 2008, Congress provided initial funding to implement the Project LAUNCH Wellness Initiative. Project LAUNCH implements evidence-based practices that promote and enhance the wellness of young children by increasing grantees' capacities to develop infrastructure and implement prevention/promotion strategies necessary to promote wellness for young children. Project LAUNCH focuses on children from birth through age eight. The goal of Project LAUNCH is to create a shared vision for the wellness of young children that drives the development of federal, state, territorial, tribal and local networks for the coordination of key child-serving systems and the integration of behavioral and physical health services.

In FY 2011, the most recent data available, 78,944 children and parents have been screened and assessed in diverse settings and over 14,021 families have been served in Project LAUNCH-supported home visiting and family strengthening programs. Over 24,500 community providers have been trained on social-emotional and behavioral health for young children. Mental health consultation has been provided to 3,876 child care and education staff, as well as 2,337 primary care providers. Project LAUNCH data also indicates that nearly 5,778 organizations are collaborating, coordinating, and sharing resources to implement prevention/promotion strategies for young children.

In FY 2012, SAMHSA continued to support continuation grants and contracts and awarded grants to a new cohort of Project LAUNCH grantees. In FY 2013, SAMHSA plans to support Project LAUNCH continuations and contracts.

Mental Health System Transformation and Health Reform

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

quality mental health services. In FY 2011, SAMHSA awarded 11 BHTCC grants for three years.

The purpose of the BHTCC program is to help state and local courts offer treatment and recovery support instead of incarceration for individuals who are in a court system due to mental or substance use disorders and to provide more flexibility within the criminal justice system to work with other authorities and service providers to better address behavioral health needs of detainees, inmates and parolees. SAMHSA's vision of a BHTCC in the justice system is one that encourages treatment and recovery support for individuals involved in the criminal justice system with mental and substance abuse disorders and also improves public health and public safety by facilitating the transformation of the behavioral health/criminal justice system at the community level. The court system can direct an individual into the appropriate forum, whether it is - Drug Court, Veterans Court, Mental Health Court, Family Court, or another combined specialty court approach. This will be done as is appropriate for the individual and the services with which the court(s) coordinate to provide treatment and services for individuals engaged in the criminal justice system.

In FY 2012 SAMHSA funded continuations for the MHT and the BHTCC grants and an evaluation contract.

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

Primary & Behavioral Health Care Integration (PBHCI)

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

The PBHCI program is comprised of competitive cooperative agreements and the PBHCI Training and Technical Assistance (TTA) Center which is co-funded with HRSA. The program supports the coordination and integration of primary care services into publicly-funded community behavioral health settings. This program is also a part of SAMHSA’s Health Reform Strategic Initiative. The expected outcome of improved health status for people with SMI will be achieved by encouraging grantees to engage in necessary partnerships, expand infrastructure, and

increase the availability of primary health care and wellness services to individuals with mental illness. Partnerships between primary care and behavioral health organizations, as well as information technology entities, are deemed crucial to the success of this program**.** The population of focus for this grant program is individuals with SMI and/or people with co-occurring disorders served by the public mental health system. Recipients are non-profit mental health provider agencies that will use these grant funds to develop and offer primary care as well as behavioral health services in an integrated manner.

In FY 2011, $35.0 million was allocated from the Prevention Fund (PPHF) for PBHCI to promote more integrated services between primary care services and mental health services. These funds were used to facilitate screening and referral for necessary primary care prevention and treatment needs. SAMHSA funded eight new multi-year funded PBHCI grants and 34 continuation grants with PPHF and 22 grant and 1 contract continuations with Budget Authority.

In FY 2012, SAMHSA supported 56 existing grants and multi-year funded 20 new grants and 10 annually funded grants awarded from both SAMHSA Budget Authority and Prevention Fund ($30.5M - BA and $35M - PPHF) as well as $1.9 million for the PBHCI Training and Technical Assistance (TTA) Center. SAMHSA plans to continue the program in FY 2013. SAMHSA has awarded 94 PBHCI grants to date.

Because the program is new, evaluation results are not yet complete. Over 23,000 consumers were served in FY 2012, an increase of 94.4 percent over FY 2011. Improvements in all four National Outcome Measures were consistently positive as a result of this intervention, with individual measure ratings improving an average of 13 percent. Of particular importance were the increases in measures of functioning and education/employment, demonstrating that the program supports health and productivity.

Suicide Prevention Programs

National Suicide Prevention Lifeline

The National Suicide Prevention Lifeline, 1-800-273-TALK, launched in FY 2005, coordinates a network of 160 crisis centers across the United States by providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night. The Lifeline routes calls from anywhere in the country to a network of certified local crisis centers that can then link callers to local emergency, mental health, and social services resources, averaging nearly 73,000 answered calls per month during FY 2012. National Suicide Prevention Lifeline crisis centers across the nation are responding to people in suicidal crises. At the same time, these centers are threatened with significant cutbacks in funding from state and local governments and other sources of support.

Since FY 2007, SAMHSA has partnered with the Department of Veterans Affairs (VA) to provide and ensure 24/7 access to the Veterans' suicide prevention hotline. In FY 2012, more than 17,500 callers per month have accessed the Veterans crisis line. The National Suicide

Prevention Lifeline is also responding to calls from active duty military and their families. SAMHSA is in the process of developing a suicide hotline outcome measure to determine the number of people who contacted the Lifeline who believe the call prevented them from taking their lives. This new data collection will help inform SAMHSA and HHS on the vital impact the Lifeline is having across the nation.

In addition, in FY 2012, SAMHSA awarded a new Suicide Lifeline grant and provided continuation support for 12 National Suicide Prevention Lifeline Crisis Center grants to provide follow up to suicidal callers. Evaluation and research findings indicated that in the immediate aftermath of suicidal crises, there is a period of heightened risk for suicide, but in this time there is a great potential for suicide prevention. Preliminary data from this program indicated that when asked by an independent evaluator, "To what extent did the counselor's calling you stop you from killing yourself?" more than 50 percent of those receiving follow-up phone contact indicated the call played a significant role in keeping them alive.

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

In FY 2013, SAMHSA will support the continuation of the Suicide Lifeline grant and grants to crisis centers. In addition, six new crisis center grants will be awarded, which will include a focus on providing follow up to suicidal people discharged from emergency rooms and inpatient units. This focus is based on current evaluation and research findings.

The National Suicide Prevention Lifeline uses evaluation results to document and improve program effectiveness. Evaluation results have been used to develop standards for suicide risk assessment, guidelines for callers at imminent risk for suicide, and follow up protocols for suicidal callers. In turn, these quality and performance improvement efforts have been evaluated and found to have positive impacts. Some of these outcomes have included decreases in suicidal ideation and hopelessness among callers, increased frequency of performing suicide risk assessments by crisis counselors, increased follow up of suicidal callers by crisis centers, and suicidal callers reporting such calls played a significant role in keeping them alive. To see one aspect of this outreach effort in action, visit https://www.facebook.com/800273TALK.

GLS Youth Suicide Prevention

The Garrett Lee Smith (GLS) Memorial Act authorizes SAMHSA to manage two significant youth suicide prevention programs and one resource center. The GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program currently supports a total of 61 grantees which includes four multi-year funded grants in FY 2011, three multi-year funded grants in FY 2012, and 54 annually funded grants, 26 states, 28 tribes or tribal organizations, and the District of Columbia in developing and implementing youth suicide prevention and early

intervention strategies involving public-private collaborations among youth serving institutions. The GLS Campus Suicide Prevention program currently provides funding to 60 institutions of higher education, inclusive of tribal colleges and universities, which includes 5 multi-year funded grants in FY 2011, 15 multi-year funded grants and 40 annually funded grants in FY 2012, to prevent suicide and suicide attempts.

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

In FY 2012, SAMHSA also received $10.0 million in Prevention Funds, which supported the GLS grants, the National Suicide Prevention Lifeline, and the Suicide Prevention Resource Center. Three grants were multi-year funded for the GLS state/tribal grantees and 15 grants were multi-year funded for the campus grantees.

According to the evaluation of the GLS suicide prevention programs, more than 500,000 individuals have been trained in suicide prevention since FY 2005, with most of this training focused on recognizing the warning signs of suicide and actions to take in response. In addition 367,950 trained in the state/Tribal program and 194,904 trained in the Campus Suicide Prevention program. Significant numbers of those trained used what they had learned to intervene with people at risk.

In FY 2013, SAMHSA anticipates funding the continuation of existing state/tribal and campus grantees.

Suicide Prevention Resource Center

In addition to programs that build suicide prevention capacity, SAMHSA also supports the Suicide Prevention Resource Center (SPRC). This program promotes the implementation of the National Strategy for Suicide Prevention and enhances the nation's mental health infrastructure by providing states, tribes, government agencies, private organizations, colleges and universities, and suicide survivor and mental health consumer groups with access to the science and experience that can support their efforts to develop programs, implement interventions, and promote policies to prevent suicide. The SPRC also advances youth suicide prevention efforts in states, territories, tribes, and campuses as authorized through the Garrett Lee Smith (GLS) Memorial Act.

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

In FY 2011, SAMHSA received $10.0 million in Prevention Funds, from which SAMHSA funded one supplement to the SPRC of $0.7 million to expand and enhance the level of support provided to the NAASP. This supplement expanded future organizational development,

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

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

In FY 2013, SAMHSA anticipates funding the continuation of the SPRC grant with a reduced level of support for the NAASP as it transitions to alternate sources of funding.

AI/AN Suicide Prevention

SAMHSA supports an innovative training and technical assistance project that helps tribal communities mobilize existing social and educational resources by facilitating the development and implementation of comprehensive and collaborative community based prevention plans to reduce violence, bullying, and suicide among American Indian/Alaska Native (AI/AN) youth. To date, 65 tribal communities have been provided specialized technical assistance and support in suicide prevention and related topic areas. In addition, over 9,200 community members were trained in prevention and mental health promotion in these communities.

In FY 2012, SAMHSA continued to support the existing AI/AN Suicide Prevention training and technical assistance efforts including evaluation efforts.

In FY 2013, SAMHSA's CMHS AI/AN Suicide Prevention and CSAP's NACE programs will collaborate through braided funding to provide comprehensive, broad, focused, and/or intensive training and technical assistance to federally-recognized tribes and other American Indian/Alaska Native communities, seeking to address and prevent mental and substance use disorders, suicide, and promote mental health. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent.

Homelessness Prevention and Housing Program

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

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

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

The first program, SSH, was implemented in 2007 and is in its sixth year of funding grants to help end chronic homelessness. The SSH program provides comprehensive services that focus on outreach, engagement, intensive case management, mental health services, substance abuse treatment, benefits support, and linkage to permanent housing. The population of focus is individuals with serious mental illness and/or a co-occurring mental and substance use disorder and their families who have been continuously homeless for at least one year or have had at least four episodes of homelessness in the past three years. At the start of FY 2013, the SSH program's outreach efforts resulted in 9,611 total contacts made. In FY 2012, SAMHSA provided support for 51 SSH grants. In FY 2013, SAMHSA plans to provide support for 48 grants.

The second program, GBHI, awarded the Cooperative Agreements to Benefit Homeless Individuals (CABHI) in FY 2011 by CSAT in collaboration with CMHS. The major goal of the program is to ensure that the most vulnerable individuals who experience chronic homelessness receive access to sustainable permanent housing, treatment, and recovery supports through grant funds and mainstream funding sources. This program builds on the success of the previous SAMHSA SSH and CSAT's Treatment for Homeless programs. As of FY 2012, there are 31 funded grants that have served 1,630 people with notable evidence of reduced experiences of depression and anxiety (60.7 percent and 64.3 percent respectively).

In FY 2013, CMHS will continue to jointly fund 31 CABHI grants with CSAT. In addition, SAMHSA plans to fund another cohort of the CABHI program, which will provide grants to states with the highest prevalence of individuals who are chronically homeless. The program will help states and communities enhance their infrastructure for providing treatment and services for individuals with mental and substance use disorders who need supportive services to sustain housing and support recovery.

Minority AIDS

The purpose of the Minority AIDS program is to enhance and expand the provision of effective, culturally-competent HIV/AIDS-related mental health services in minority communities for people living with HIV/AIDS and who have a need for mental health services. The Centers for Disease Control and Prevention (CDC) reports significantly higher rates of HIV/AIDS among people of color. African Americans accounted for 44 percent and Hispanics accounted for 20 percent of all HIV/AIDS cases diagnosed in 2009, per the most recent data available (CDC, 2011). The 2009 data also shows a significant increase of 48 percent in HIV incidence among African American Men who have Sex with Men (MSM) aged 13-29, even as overall rates remained stable. Reasons for this increase are not fully known, although the high HIV prevalence rate in African American MSM and factors such as prejudice and discrimination; in addition, CMHS uses social inclusion (in the promotion of) and social exclusion (in trying to end) of HIV and homosexuality, limited healthcare access, and poverty may create an enabling environment for HIV (CDC 2011). Psychiatric and psychosocial complications are frequently

not diagnosed or addressed either at the time of diagnosis or through the course of the HIV/AIDS disease process. When untreated, these complications are associated with increased morbidity and mortality, impaired quality of life, and numerous medical and/or behavioral challenges, such as non-adherence with the treatment regimen. Over 2,200 individuals received services in FY 2011 and almost 1,000 received services in FY 2012. The Mental Health Care Provider Education in HIV/AID Education program disseminates knowledge and training on the treatment of the neuropsychiatric and psychological sequelae of HIV/AIDS. The program provides training to front line providers, including psychiatrists, psychologists, social workers, primary care practitioners and medical students.

In FY 2012, SAMHSA collaborated with CDC to provide support for 11 continuation grants for the Minority AIDS Initiative Targeted Capacity Expansion: Integrated Behavioral Health/Primary Care Network Cooperative Agreements with funding provided by CMHS, CSAT, and CSAP. This grant program facilitates the development and expansion of culturally competent and effective integrated behavioral health and primary care networks, which include HIV services, medical treatment, and the expansion of behavioral health services within racial and ethnic minority communities in 11 Metropolitan Statistical Areas and Metropolitan Divisions most impacted by HIV/AIDS. Recipients are state and city health departments from the 12 cities most impacted by HIV/AIDS. The grant fosters development of a network of care for those with behavioral health conditions who are at risk for or who have HIV/AIDS.

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

Criminal and Juvenile Justice Programs

Studies of people involved in the criminal justice system have found higher rates of co-occurring psychiatric and substance use disorders than the general population.[1] The number of individuals involved in the criminal justice system with mental or substance use disorders whose treatment needs are not being met by community treatment and supportive services is significant. As a result, they are at greater risk for parole or probation failure leading to re-incarceration at substantial additional governmental and societal cost. There is an ongoing need for broader implementation of effective treatment and reentry services for this high-risk, mostly nonviolent population.

Over the past 30 years, the criminal justice system has become a repository for a large number of individuals with SMI who are arrested for a wide range of crimes.[2] Since 2002, SAMHSA has administered the Jail Diversion Program for adults involved in the criminal justice system and has awarded grants to 48 states and communities. The purpose of this initiative is to divert individuals with mental illness from the criminal justice system to more appropriate, community-based treatment and recovery support services including primary health care, housing, and job counseling/placement.

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

In FY 2012, SAMHSA provided continuation support for three cohorts of 13 grants and related contracts.

In FY 2013 SAMHSA will fund the continuation of seven grants and the evaluation and technical assistance contracts. In FY 2013, SAMHSA will fund another cohort of the Jail Diversion Program. This three-year grant program will emphasize on early diversion of individuals with behavioral health conditions at risk of being arrested. Early diversion will focus on the role of law enforcement working collaboratively with community behavioral health providers to prevent arrest and adjudication. Police will divert these individuals to behavioral health providers in the community who will assess their needs and coordinate a comprehensive plan of treatment and supports.

Performance data demonstrate that the program has had a positive impact on the welfare of participants with significant increases in housing stability and employment and with major reductions in arrests and incarcerations.

Practice Improvement/Training

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

The purpose of the HBCU-Center of Excellence is to network the 103 HBCUs in the United States and promote workforce development through expanding knowledge of best practices, developing leadership, and encouraging community partnerships that enhance the participation of African Americans in the substance abuse treatment and mental health professions. The comprehensive focus of the HBCU–Center for Excellence will simultaneously expand service capacity on campuses and in other treatment venues.

There is one grant awarded for the HBCU-Center for Excellence. In FY 2012 SAMHSA provided continuation support to the grantee for the coordination and monitoring of 34 substance abuse treatment workforce development and mental health sub-award projects. Funding will be continued in FY 2013.

The Rehabilitation Research and Training Centers (RRTCs) are funded in partnership with the U.S. Department of Education's National Institute of Disability, Rehabilitation and Research. The RTCs develop, test, and disseminate a broad range of care models and practices that promote and support recovery for adults with mental illnesses and support resilience and recovery among youth and young adults with serious mental health challenges. This program was first established in 1979. Currently there are four RRTCs funded for up to five years.

Program outcomes include the development of new treatments and interventions, trainings, workforce development, and new products.

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

Education for Social Inclusion is a five-year contract, funded in FY 2009, which promotes social inclusion, opportunities for full community participation and integration, broad public acceptance, and recovery and wellness through evidence-based tools for education, awareness, technical assistance, engagement, and support. In FY 2013, CMHS will fund the continuation of this contract.

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

Consumer and Consumer-Supporter TA Centers

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

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

Performance data indicate that the program has been effective. In the past fiscal year, over 50,000 persons were trained and more than 11,500 consumers and family members have become involved in mental health-related planning and advocacy.

In FY 2010, SAMHSA awarded grants to five organizations for a five-year period. In FY 2011 and FY 2012 SAMHSA provided support to the five continuation grants and plans to continue this support in FY 2013.

Disaster Response

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

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

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

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

The SAMHSA's Disaster Distress Helpline (DDH) is the first national hotline dedicated to providing year-round disaster crisis counseling. This toll-free, multilingual crisis support service is available 24/7 via telephone (1-800-985-5990) and SMS (text 'TalkWithUs' to 66746) to residents in the United States and its territories who are experiencing emotional distress related to natural or man-made disasters. In FY 2012, DDH received 1,483 calls and 1,528 text messages. Four Core Region Centers implemented trainings for 200 paid staff, interns and volunteers. The helpline established relationships with over 300 local, state and national disaster relief stakeholders. A website was created (disasterdistress.samhsa.gov) with social media pages that continue to grow, offering information and resources on healthy coping. The website has

received 2000+ visits post-Hurricane Isaac (August 2012) while the Helpline itself received over 2,600 calls.

SAMHSA and the nation are aware that when disasters strike, the role of behavioral health in recovery is immense. In 2013, SAMHSA received 10 million in supplemental funds to assist the survivors of Hurricane Sandy recover. Efforts focused on providing for behavioral health treatment that could be funded no other way, restoring the capability of medication assisted substance abuse treatment services in the impacted areas, ensuring the operation of the DDH, conducting resiliency training with educators, and ensuring crisis counseling services wherever Sandy survivors relocated. No additional funding is requested for 2014.

Funding History[1\]

Fiscal Year	Amount
FY 2010	$356,038,000
FY 2011	$83,998,000
FY 2012	$315,666,472
FY 2013	$272,322,951
FY 2014	$361,277,493

[1\]The funding history is presented on a comparable basis to previous funding levels to represent the revised budget structure and includes the PHS Evaluation Funds and Prevention Funds other than in FY 2013. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Budget Request

The FY 2014 Budget Request is comprised of $361.3 million at the program level with $333.3 million from Budget Authority (BA) and $28.0 million provided by Prevention Fund. This is an increase of $45.6 million from the FY 2012 funding level. This level of funding enables the continuation of most programmatic activities. The request will support 279 grant and 18 contract continuations, as well as 206 new grants and 27 new contracts.

Project AWARE

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

Project AWARE proposes two components: Project AWARE State Grants ($40.0 million) build on the Safe Schools/Healthy Students State Planning and Community Pilot Program which is

intended to create safe and supportive schools and communities. For more than a decade, the Safe Schools/Healthy Students Initiative has successfully decreased violence and increased the number of students receiving mental health services. Project AWARE grants will be braided with funds from Education and Justice to support 20 grants to State Education Authorities (SEAs) that will promote a comprehensive, coordinated and integrated program with the goal of making schools safer and increasing access to mental health services. The SEAs will be required to partner with the State Mental Health and Law Enforcement agencies to establish Interagency State Management Teams, conduct environmental needs assessments, develop a state plan with an evaluation mechanism, and develop the mechanisms to coordinate funding, service delivery, systems improvement, and data collection. In addition, each SEA will be required to identify three high-need Local Education Authorities (LEAs) as pilot communities that will receive sub-awards to implement comprehensive and coordinated school safety and mental health programs. SAMHSA expects that these 20 State grants will promote data driven models in 60 LEAs (reaching 1000-1500 schools).

The second component, Mental Health First Aid (MHFA) ($15.0 million) proposes widespread dissemination of the Mental Health First Aid curriculum and supports training to reach 750,000 students to identify mental illness early and refer them to treatment. MHFA prepares teachers and other individuals who work with youth to help schools and communities to understand, recognize, and respond to signs of mental illness or substance abuse in children and youth, including how to talk to adolescents and families experiencing these problems so they are more willing to seek treatment. The Budget proposes that $10.0 million of the Project AWARE – MHFA funds will be braided with Education and Justice funds to support competitive grants to LEAs with the goal of making schools safer and providing mental health literacy training. An Interagency Supervisory Team (IST) will work together to provide oversight and guidance to both the state and local initiatives. The additional $5.0 million proposed for MHFA will be braided with the 20 SEA grants to support MHFA training in the 20 SEAs and 60 LEAs sub-grantees implementing Project AWARE.

Healthy Transitions

The FY 2014 Budget includes $25.0 million for a new Healthy Transitions Program, to assist 16 to 25 year-olds with mental illnesses and their families to access and navigate behavioral health treatment systems. Compared with their peers, young adults, aged 18-25 with mental health conditions are more likely to experience homelessness, be arrested, drop out of school and be underemployed. Compared to all other chronic health conditions, mental disorders produce the greatest disability burden within this age group. Furthermore, 18-25 year-olds with mental health conditions are significantly less likely to receive mental health services than other adults. This new demonstration grant program for states proposes innovative approaches to provide support for transition-age youth with mental health and/or co-occurring substance abuse disorders and their families. States will take steps to expand services for these young individuals, develop family and youth networks for information sharing and peer support, and disseminate best practices for services to youth ages 16-25. The $25.0 million would support 5-year grants to 19 states.

Statewide Network Development Program for Recovery and Resiliency

In FY 2014, SAMHSA requests a total of approximately $1.8 million in Budget Authority ($0.4 million in CMHS and $1.4 million in CSAT) in support of SAMHSA's Recovery Support Strategic Initiative. These funds will be used to build capacity for statewide consumer-run, family member-run, or addiction recovery community organizations to promote cross-service system and infrastructure development that is recovery-focused and resiliency oriented. $1.0 million in budget authority will be used to award new addiction recovery community statewide networks. The remaining $0.8 million will be braided to allow for supplemental awards for collaborative partnerships across the mental and substance use disorder fields. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent. Eligible applicants for supplements will be those organizations who have an existing mental health or addiction statewide network award. Up to 10 grant awards at $100,000 will be made for addiction recovery statewide networks. Eight supplemental awards will be given at $100,000 each.

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

Behavioral Health Treatment Court Collaboratives

In support of SAMHSA's Recovery Support Strategic Initiative, SAMHSA proposes to use a total of $4.5 million in Budget Authority ($2.3 million in CMHS and $2.2 million in CSAT) to fund an additional cohort of Behavioral Health Treatment Court Collaboratives Grants. The purpose of this grant program is to allow local courts more flexibility to collaborate with multiple criminal justice system components and local community treatment and recovery providers to address the behavioral health needs of adults who are involved with the criminal justice system. The court collaborative will focus on diversion of adults with behavioral health problems from the criminal justice system, including alternatives to incarceration. The collaborative will allow eligible individuals to receive treatment and recovery support services as part of a court collaborative. This program will focus on connecting with individuals early in their involvement with the criminal justice system and prioritize the participation of municipal and misdemeanor courts in the collaborative. The program will support community behavioral health services for individuals with mental and/or substance disorders and will include a focus on veterans involved with the criminal justice system.

Transforming Lives through Supported Employment Grant Program

In support of SAMHSA's Recovery Support Strategic Initiative, SAMHSA proposes to use a total of approximately $5.0 million in Budget Authority to establish the Transforming Lives through Supported Employment Grant Program. Based on learning from previous Mental Health Transformation grant cohorts, SAMHSA will use a total of $5 million of Mental Health Systems Transformation and Health Reform funds and Practice Improvement and Training funds to focus the program on an existing activity: enhancing state and community capacity to provide evidence-based supported employment programs for adults and youth with serious mental illnesses/emotional disturbances. This strengthening of an existing program activity is consistent with SAMHSA's four pillars of Recovery (Health, Home, Purpose, and Community). In addition, Supported Employment was one of five allowable activities in earlier Transformation grants and has demonstrated excellent outcomes in helping individuals achieve and sustain recovery.

By having gainful employment as the target outcome and helping mental health consumers, their treatment providers, and their employers develop mutual understanding and successful relationships, Transforming Lives through Supported Employment Grants will help people with mental illnesses discover paths of self-sufficiency and recovery rather than disability and dependence. A total of up to 13 grant awards of approximately $375,000 dollars each will be awarded for five years.

Housing and Homelessness

SAMHSA works in partnership with the U.S. Interagency Council on Homelessness (USICH) to support and implement *Opening Doors: The Federal Plan to Prevent and End Homelessness.* Through both the Recovery Support and Criminal Justice and Trauma Strategic Initiatives, SAMHSA promotes collaborative leadership with other federal agencies with collaborative calls, trainings, workgroups, and expert panels to address various goals and objectives outlined in the Plan. SAMHSA accomplishes the goals and objectives outlined in the Plan by providing technical assistance to grantees and other stakeholders regarding behavioral health, homelessness, and successful interventions to prevent and end homelessness. SAMHSA takes a leadership role in convening expert panels and developing a Policy Academy to address homelessness. SAMHSA encourages grantees to provide consumers with meaningful and sustainable employment opportunities and permanent housing that supports recovery to prevent and end homelessness. The SAMHSA Cooperative Agreements to Benefit Homeless Individuals (CABHI) grant program aligns with the USICH goal to improve access to mainstream programs and services to reduce people's financial vulnerability to homelessness and to provide integrated primary and behavioral health care services. SAMHSA along with HUD, other HHS agencies, and VA, will explore the possibility of developing criteria to incentivize demonstrated collaboration between primary and behavioral healthcare providers and homeless assistance providers.

In support of the Federal Strategic Plan to Prevent and End Homelessness and SAMHSA's Recovery Support Strategic Initiative, SAMHSA proposes to use approximately $28.6 million in Budget Authority in working with state and local Public Housing Authorities and state Medicaid agencies to develop systematic, cost-effective, and integrated approaches to housing that includes treatment and services for mental and substance use disorders. This program will build upon lessons learned from the CABHI and the Department of Housing and Urban Development's (HUD) new Section 811 demonstration program, and will be developed by SAMHSA in collaboration with its federal partners, including HUD, Health Resources and Services Administration, Centers for Medicare and Medicaid Services, and the Interagency Council on Homelessness. The program will specifically focus on providing support services and housing to individuals who are chronically homeless.

The program will support innovative strategies to transform and increase the availability of affordable housing and to provide needed services and supports that will help integrate individuals who are homeless with substance abuse and mental health disorders into the community, assist providers in strengthening their infrastructure for delivering and sustaining housing to support recovery with integrated behavioral health, and other critical services. The program also will assist providers in preparing for implementation of the Affordable Care Act by encouraging third-party billing and requiring that clients are enrolled in eligible benefit programs. Efforts will include the design and implementation of strategies that require the use of SAMHSA funds for providing supportive services to individuals who are not Medicaid-eligible (or who in the process of being enrolled), Medicaid funds for covered services, and HUD vouchers or other funding sources for housing. SAMHSA's FY 2014 request for housing and homelessness includes a total of $28.6 million ($18.8 million in CMHS and $9.9 million in CSAT). A total of up to 38 grant awards of approximately $750,000 dollars each will be awarded for five years.

National Strategy for Suicide Prevention

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

In 2008, suicide became the tenth leading cause of death in the U.S. and remained so in 2009, the most recent year for which there is available mortality data. Previously, suicide had been the eleventh leading cause of death. In 2010, SAMHSA's National Survey on Drug Use and Health reported that over 1.1 million Americans over the age of 18 attempt suicide annually and over 8 million seriously consider it. Research, however, has shown that implementing comprehensive

public health approaches that make suicide prevention a priority within health and community systems can reduce the rates of death by suicide as well as suicide attempts. These comprehensive approaches also need to focus on reducing suicide since in 2009 more than 70 percent of the suicides in the U.S. took place among adults between ages 25-64.

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

Consequently, and consistent with SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, $2.0 million is requested to assist states in further establishing evidence based suicide prevention efforts that support the goals and objectives of the NSSP. The requested $2.0 million will directly support the recommendations of the NSSP and allow for the implementation of elements of the NSSP that are not currently being addressed in any other national initiative. This year is critical in continuing the momentum achieved during the release of the National Strategy. Some states will require assistance in developing these plans required under the block grants as well as in collaborating with Medicaid, dual eligible, and health home efforts. The $2.0 million will be utilized to develop and test nationwide efforts such as suicide awareness, provider credentialing changes, emergency room referral processes, clinical care practice standards, practitioner training regarding depression and suicide screening techniques, and technical assistance for those community human services and health workers most likely to encounter those who may be thinking about suicide.

Grants for Adult Trauma Screening and Brief Intervention

Consistent with the Trauma and Justice Strategic Initiative, $2.9 million is requested for a new program line, Grants for Adult Trauma Screening and Brief Intervention. Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of individuals receiving treatment for mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of trauma place a heavy burden on individuals, families, and communities and create challenges for public institutions and service systems. Although many individuals who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationship among traumatic events, impaired neurodevelopment and immune

system responses, and subsequent health risk behaviors resulting in chronic physical and behavioral disorders. In fact, the chronic stress that often accompanies repeated or unresolved trauma has even been linked to physically observable negative changes in brain development, including a reduction in the size of the hippocampus, the portion of the brain associated with long-term memory and spatial reasoning. With appropriate supports and intervention, individuals can overcome traumatic experiences. However, most individuals go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders, chronic physical diseases, and early death.

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

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

The Grants for Adult Trauma Screening and Brief Intervention (GATSBI) program will advance the knowledge base to address trauma in common health care settings, such as emergency departments, primary care, and OB/GYN. The concept and design for these grants will be developed by SAMSHA in consultation with its federal partners: CDC, NIAAA, NIDA, NIMH, and VA. An estimated four grants will be awarded with up to $0.6 million per year for five years.

The FY 2014 Budget Request includes increases for the following (+$95.4 million):

- Project AWARE: $55 million, a new request for the FY 2014 Budget. This funding will support Project AWARE State Grants and Mental Health First Aid. The funding will support 15 grants and five contracts.
- Healthy Transitions: $25 million, a new request for the FY 2014 Budget. The funding will support 19 new grants, and 2 new contracts.
- Minority AIDS: $22.8 million, which is an increase of $13.5 million from the FY 2012 funding level in the Mental Health appropriation, but when combined with the additional resources from Substance Abuse Prevention and Substance Abuse Treatment appropriations reflects level funding SAMHSA-wide from the FY 2012 SAMHSA-wide funding level. The Mental Health funding will support 1 contract continuation, 20 new grants, and 1 new contract.

- Disaster Response: $3.0 million, which is an increase of $1.9 million above the FY 2012 funding level to support a nationally available disaster distress crisis counseling telephone line through a connection to local crisis lines throughout the country. The need for this initiative has been documented through the Assistant Secretary for Preparedness and Response after various emergency conditions throughout the world and after U.S. disasters that did not rise to the level of presidentially declared emergencies and therefore did not qualify for Stafford Act Funding.

The FY 2014 Budget Request includes level funding, the same as FY 2012, for the following:

- Children and Family Programs: $6.5 million
- Youth Violence Prevention: $23.2 million
- NCTSI: $45.7 million
- MH State Transformation and Health Reform: $10.6 million
- Project LAUNCH: $34.6 million
- PBHCI Technical Assistance: $1.9 million is level funded from the FY 2012 level but is now requested in Prevention Funds.
- AI/AN Suicide Prevention Initiative: $2.9 million
- Homelessness Prevention Programs: $30.8 million
- Practice Improvement and Training: $7.8 million
- Consumer and Consumer Supporter TA Centers: $1.9 million
- Homelessness: $2.3 million
- HIV/AIDS Education: $0.8 million

The FY 2014 Budget Request includes decreases for the following (-$54.8 million):

- Seclusion and Restraint: $1.2 million, which is $1.3 million below the FY 2012 funding level. SAMHSA intends to integrate much of the Seclusion and Restraint strategies into current programs.
- Consumer and Family Network Grants: $5.0 million, which is $1.3 million below the FY 2012 funding level. Funding will support 55 grant continuations and 5 new supplements.
- Primary and Behavioral Health Care Integration: $26.0 million, which is $39.7 million below the FY 2012 funding level and is now requested in Prevention Funds. This level of funding will support 10 grant continuations and 13 new grants.
- Suicide Lifeline: $5.5 million, which is $0.9 million below the FY 2012 funding level. Reduction was a result of one-time activities supported the Prevention Fund in FY 2012.
- GLS-Youth Suicide Prevention-States: $29.7 million, which is $4.3 million below the FY 2012 funding level. Reduction was a result of multi-year funding grants in FY 2012 by the Prevention Fund. The funding will support 20 grant continuations and 34 new grants and 1 new contract.
- GLS-Youth Suicide Prevention-Campus: $4.9 million, which is $4.2 million below the FY 2012 funding level. Reduction was a result of fully funding grants in FY 2012 with the Prevention Fund. Funding will support 23 grants and 18 new grants.

- GLS-Suicide Prevention Resource Center: $4.9 million, which is $0.7 million below the FY 2012 funding level. Reduction was a result of not renewing supplemental funds that were received as part of the Prevention Fund in FY 2012.
- Criminal and Juvenile Justice Programs: $4.3 million, which is $2.4 million below the FY 2012 funding level. This funding will support 1 grant and 1 contract continuation and 5 new grants.

A detailed table for all grant and contract continuations and new activities can be found in supplementary tables.

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

	FY 2012 Actual		FY 2013 Annualized CR		FY 2014 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Programs of Regional & National Significance						
Grants/Cooperative Agreements						
Continuations	375	$140,941	428	$179,649	279	$117,690
New/Competing	207	116,863	84	32,472	172	107,818
Subtotal	582	257,803	512	212,122	451	225,508
Contracts						
Continuations	32	49,964	30	41,156	18	40,552
New/Competing	10	7,899	9	19,046	20	15,217
Subtotal	42	57,863	39	60,201	38	55,769
Children's Mental Health Services						
Grants/Cooperative Agreements						
Continuations	47	76,720	62	75,954	56	57,695
New/Competing	22	19,292	26	23,583	42	42,004
Subtotal	69	96,012	88	99,537	98	99,700
Contracts						
Continuations	2	9,264	1	8,296	2	10,539
New/Competing	---	---	1	1,500	---	---
Subtotal	2	9,264	2	9,796	2	10,539
Technical Assistance	4	11,619	4	8,966	3	7,076
Report to Congress	---	420	---	---	---	---
Projects for Assistance in Transition from Homelessness	**56**	**64,794**	**56**	**65,191**	**56**	**64,794**
Protection and Advocacy for Individuals with Mental Illness	**57**	**36,238**	**57**	**36,460**	**57**	**36,238**
Mental Health Block Grant	**59**	**459,756**	**59**	**462,570**	**59**	**459,756**
Total, Mental Health [1/]	**871**	**$993,770**	**817**	**$954,844**	**764**	**$959,380**

1/ The Prevention and Public Health Funds amount to $45.0 million in FY 2012 and $73.1 million in FY 2014. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Outcomes and Outputs

Program: Youth Violence Prevention

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
3.2.04 Number of children served through the Youth Violence Prevention program (Outcome)	FY 2012: 973,694 Target: 2,328,500 (Target Not Met)	2,328,500	979,724	-1,348,776
3.2.10 Percentage of students who receive mental health services (Outcome)	FY 2012: 66.8% Target: 66.0% (Target Exceeded)	66.0%	66.0%	Maintain
3.2.29 Percentage of middle and high school students who have been in a physical fight on school property (Outcome)	FY 2012: 15.9% Target: 27.0% (Target Exceeded)	27.0%	27.0%	Maintain
3.2.30 Decrease the percentage of middle and high school students who report current substance abuse (Outcome)	FY 2012: 19.1% Target: 20.0% (Target Exceeded)	20.0%	20.0%	Maintain
3.2.31 Number of children (ages 0-5) screened for mental health or related interventions (Outcome)	N/A	N/A	TBD	N/A
3.2.32 Number of organizations collaborating and sharing resources with other organizations as a result of the grant (Outcome)	N/A	N/A	TBD	N/A

Program: National Child Traumatic Stress Initiative (NCTSI)

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
3.2.02a Increase the percentage of children receiving trauma informed services who report positive functioning at 6 month follow-up (Outcome)	FY 2012: 76.1% (Historical Actual)	76.1%	76.1%	Maintain
3.2.23 Unduplicated count of the number of children and adolescents receiving trauma-informed services (Outcome)	FY 2012: 2,367 Target: 1,922 (Target Exceeded)	3,052	2,658	-394
3.2.24 Number of child-serving professionals trained in providing trauma-informed services (Outcome)	FY 2012: 121,310 Target: 95,186 (Target Exceeded)	73,992	136,204	+62,212
3.2.33 Percentage of children receiving trauma informed services who demonstrated significant improvement in functioning (Outcome)	N/A	Set Baseline	TBD	N/A

Program: Project LAUNCH

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.94 Number of people served (Output)	N/A	Set Baseline	TBD	N/A
2.3.95 Number of people trained in mental illness prevention or mental health promotion (Outcome)	N/A	Set Baseline	TBD	N/A
2.3.99 Percentage of youth age 12-25 who experiences a Major Depressive Episode in the past 12 months (Outcome)	N/A	Set Baseline	TBD	N/A

Program: Mental Health System Transformation Grants[3]

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.11 Number of people in the mental health and related workforce trained in specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2012: 34,127 Target: 4,095 (Target Exceeded)	1,488[4]	13,647	+12,159

[3] This program is still under development and performance measures will be added once the program is finalized. In the interim, targets for FY 2013, FY 2014, and FY 2015 have been included and are subject to change.

[4] Target has been reduced to reflect the reduced program funding.

Program: Suicide Prevention

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.59 Total number of individuals trained in youth suicide prevention (Outcome)	FY 2012: 103,529 Target: 35,371 (Target Exceeded)	35,371	90,270	+54,899
2.3.60 Total number of youth screened (Output)	FY 2012: 33,904 Target: 3,360 (Target Exceeded)	3,360	29,562	+26,202
2.3.61 Increase the number of calls answered by the suicide hotline (Output)	FY 2012: 884,536 Target: 555,132 (Target Exceeded)	555,132	765,638	+210,506

Program: Mental Health Homelessness Prevention Programs

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
3.4.01 Number of clients served (Output)	FY 2012: 5,423 Target: 2,223 (Target Exceeded)	5,034	5,413	+379
3.4.02 Increase the percentage of adults receiving homeless support services who report positive functioning at 6 month follow-up (Outcome)	FY 2012: 66.7% Target: 68.4% (Target Not Met)	63.1%	63.1%	Maintain
3.4.03 Percentage of adults receiving services who were currently employed at 6 month follow-up (Outcome)	FY 2012: 23.0% Target: 15.6% (Target Exceeded)	15.6%	15.6%	Maintain
3.4.05 Percentage of adults receiving services who had a permanent place to live in the community at 6 month follow-up (Outcome)	FY 2012: 84.3% Target: 60.6% (Target Exceeded)	74.2%	60.6%	-13.6%
3.4.06 Percentage of adults receiving services who had positive social support at 6 month follow-up (Outcome)	FY 2012: 74.0% Target: 78.0% (Target Not Met but Improved)	71.0%	71.0%	Maintain

Program: Mental Health - Other Capacity Activities[5]

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.05 Percentage of clients receiving services who report positive functioning at 6 month follow-up (Outcome)	FY 2012: 53.4% Target: 54.0% (Target Not Met but Improved)	54.0%	54.0%	Maintain
1.2.82 Percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up (Outcome)	FY 2012: 67.5% Target: 67.7% (Target Not Met)	67.7%	67.7%	Maintain
1.2.83 Percentage of clients receiving services who are currently employed at 6 month follow-up (Outcome)	FY 2012: 24.3% Target: 14.0% (Target Exceeded)	14.0%	14.0%	Maintain
1.2.88 Number of individuals screened for mental health or related interventions (Outcome)	FY 2012: 58,782 Target: 32,763 (Target Exceeded)	32,763	61,574	+28,811

[5] Includes the following programs: Jail Diversion, Older Adults, HIV/AIDS, Primary and Behavioral Health Care Integration, and Healthy Transitions.

Program: Mental Health - Science and Service Activities[6]

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.4.06 Number of people trained by CMHS Science and Service Programs (Output)	FY 2012: 70,227 Target: 4,237 (Target Exceeded)	3,390	30,481[7]	+27,091
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2012: 108,494 Target: 37,896 (Target Exceeded)	110,000[8]	110,000[9]	Maintain

Size of Awards

(Whole Dollars)	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	582	512	451
Average Awards	$442,961	$414,300	$500,019
Range of Awards	$15,000 - $6,000,000	$15,000 - $6,000,000	$15,000 - $6,000,000

[6] Includes the following programs: Consumer and Consumer Supported TA Center, HBCU, HIV Training, , Suicide Prevention Resource Center, TTA-Primary Behavioral Health Care Integration.

[7] Target increase due to the addition of several programs to the calculation of this outcome.

[8] Target has been increased from previously reported.

[9] Target has been increased from previously reported.

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Children's Mental Health Services Program

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority.....	$117,315	$118,300	$117,315	---

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

FY 2014 Authorization..... Expired

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

Program Description and Accomplishments

Authorized in 1992, the Children's Mental Health Initiative (CMHI) supports the development of comprehensive, community-based systems of care for the estimated nine to13 percent of children and youth with serious emotional disorders (SED) and their families. A system of care (SOC) is a strategic approach to the delivery of services and supports that incorporate family-driven, youth-guided, strength-based, and culturally and linguistically competent care in order to meet the physical, intellectual, emotional, cultural, and social needs of children and youth. The SOC helps prepare children and youth for successful transition to adulthood and successful assumption of adult roles and responsibilities. These guiding principles also call for a broad array of effective services, individualized care, and coordination across child and youth-serving systems (e.g. Juvenile Justice, Child Welfare, Education, Primary Care, and Substance Abuse) and have become standards for care throughout much of the nation. A hallmark of this program is that youth and families partner with state and local providers and policy makers in service delivery, system reform planning, and decision-making. In addition to the substantial role children, youth, and families play in the care they receive, services are delivered in the least restrictive environment with evidence-supported treatments and interventions. Individualized care management ensures that planned services and supports are delivered both appropriately and effectively.

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

for children and youth with serious mental health conditions and their families. In addition, SAMHSA also supported 47 CMHI continuation grants as well as five contract continuations.

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

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

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

In FY 2013, SAMHSA intends to award a new cohort of one-year System of Care Expansion Planning and support the continuation of 46 CMHI and 16 System of Care Expansion Implementation grants and contracts.

Funding History

Fiscal Year	Amount
FY 2010	$121,316,000
FY 2011	$117,803,000
FY 2012	$117,314,524
FY 2013	$118,299,944
FY 2014	$117,314,524

Budget Request

The FY 2014 Budget Request is comprised of $117.3 million, the same as the FY 2012 funding level. At this funding level, SAMHSA expects to maintain current programmatic activities and support a robust technical assistance effort, a vitally important component of CMHI. In addition, SAMHSA is considering opportunities within the CMHI program for in-sourcing technical expertise in the evolving children's mental health services arena. In FY 2014, an estimated 6,331 children with a serious emotional disorder will be served by this program and approximately 10,430 mental health professionals will be trained in children's mental health practices. The request will support 56 service grants, one technical assistance cooperative agreement, and two technical assistance and two evaluation contract continuations, as well as the implementation of 42 new grants.

SAMHSA/Mental Health

Mechanism Table

(Dollars in thousands)

	FY 2012 Actual		FY 2013 Annualized CR		FY 2014 President's Budget	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Children's Mental Health Services						
Grants/Cooperative Agreements						
Continuations	47	$76,720	62	$75,954	56	$57,695
New/Competing	22	19,292	26	23,583	42	42,004
Subtotal	69	96,012	88	99,537	98	99,700
Contracts						
Continuations	2	9,264	1	8,296	2	10,539
New/Competing	---	---	1	1,500	---	---
Subtotal	2	9,264	2	9,796	2	10,539
Technical Assistance	4	11,619	4	8,966	3	7,076
Report to Congress	---	420	---	---	---	---
Total, Children's Mental Health Services	**75**	**$117,315**	**94**	**$118,300**	**103**	**$117,315**

Outcomes and Outputs

Program: Children's Mental Health Services

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
3.2.16 Number of children receiving services (Output)	FY 2012: 6,357 Target: 4,930 (Target Exceeded)	6,457	6,331	-126
3.2.25 Percentage of children receiving services who report positive social support at 6 month follow-up (Outcome)	FY 2012: 88.3% Target: 87.6% (Target Exceeded)	87.6%	87.6%	Maintain
3.2.26 Increase the percentage of children receiving Systems of Care mental health services who report positive functioning at 6 month follow-up (Outcome)	FY 2012: 64.2% Target: 63.1%[11] (Target Exceeded)	64.2%[12]	64.2%	Maintain

[11] Target has been revised from previously reported.

[12] Target has been revised from previously reported.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
3.2.27 Number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the program (Output)	FY 2012: 10,473 Target: 4,571 (Target Exceeded)	4,571	3,385	-1,186
3.2.28 Number of organizations that entered into formal written inter/intra-organizational agreements (e.g. MOUs/MOAs) to improve mental health-related practices/activities as a result of the grant (Output)	FY 2012: 668 Target: 928 (Target Not Met)	928	691	-237

Size of Awards

(Whole Dollars)	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	69	88	98
Average Awards	$1,391,472	$1,131,104	$1,017,343
Range of Awards	$330,000 - $2,000,000	$330,000 - $2,000,000	$330,000 - $2,000,000

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Projects for Assistance in Transition from Homelessness

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority.....	$64,794	$65,191	$64,794	---

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

FY 2014 Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments

In 1990, the Stewart B. McKinney Homeless Assistance Amendments Act authorized the Projects for Assistance in Transition from Homelessness (PATH) program. The PATH budget supports 56 grants to all 50 states, the District of Columbia, Puerto Rico, Guam, American Samoa, the United States Virgin Islands, and the Northern Mariana Islands as well as centralized activities such as technical assistance and evaluation. PATH funds community-based outreach, mental health, substance abuse, case management, other supportive services, and a limited set of housing services in more than 500 communities. All recipients of PATH allocations (except the territories) are required by the authorizing legislation to provide a matching contribution of $1 for every $3 of federal money received. The PATH formula calculates state allotments based on the population living in urbanized areas. This population data is updated after each census.

PATH is unique in that is specifically authorized to address the needs of individuals with serious mental illness (SMI) and/or SMI with a co-occurring substance use disorder who are experiencing homelessness or are at risk of homelessness. On a single night in January 2012, it is estimated that 633,782 people were homeless in the United States. Behavioral health issues are common among this population, as are chronic physical illnesses and other disabling conditions. Almost half of people experiencing homelessness have mental health problems and/or substance use disorders. In addition many individuals who have SMI are at risk of becoming homelessness due to their disabling conditions. The PATH program has been highly successful in targeting assistance to individuals with SMI who are homeless or are at-risk for homelessness or experiencing a co-occurring mental and substance use disorder. PATH connects members of this largely under-served population with critical services and resources to assist them on their recovery.

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

measures show the number of homeless individuals contacted by the PATH program has increased from 135,007 individuals contacted in 2008 to 192,290 individuals contacted in 2012. Of these 103,259 individuals were enrolled in the PATH program, and 68,652 of the enrolled received community mental health services.

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

The need for standardized definitions are addressed through the PATH's Administrative Workgroup and is in the process of defining PATH data elements. Issues relating to retention, staff shortages, and funding are managed at the local level. PATH has implemented several activities to improve data collection and reporting. The PATH program continues its efforts towards program-wide use of Homeless Management Information System (HMIS) for PATH data collection and GPRA reporting and the goal is 100 percent PATH provider participation of HMIS by 2016. This will enable SAMHSA to report reliable and consistent client-and-aggregate-level data on the performance of the PATH program.

Performance for the number of PATH providers trained on Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), Outreach, Access, and Recovery (SOAR) was not met in FY 2011. It is important to note, however, that nearly 24,000 PATH funded providers have been trained since the initiative began. This output is important in that once trained, PATH providers are better able to assist PATH clients in applying for and getting the income benefits for which they are eligible.[13]

The PATH program is improving program performance through alignment with HMIS, which will ensure that more reliable and standardized data is collected and reported by all PATH providers. Training and technical assistance (TA) are ongoing and long-term TA engagements (i.e., virtual classrooms, follow-up consultation) are being implemented to ensure that PATH providers are able to use the information obtained in the training to make changes in their programs.

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

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

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

Funding History

Fiscal Year	Amount
FY 2010	$65,047,000
FY 2011	$64,917,000
FY 2012	$64,794,307
FY 2013	$65,190,848
FY 2014	$64,794,000

Budget Request

The FY 2014 Budget Request is comprised of $64.8 million, the same as the FY 2012 funding level. These funds will support outreach to an estimated 192,000 individuals with a serious mental illness and/or co-occurring mental and substance use disorder who are experiencing homelessness or at risk of homelessness and training for 4,591 providers. Although not all people enroll in services when first contacted, on average the program provides mental health and co-occurring substance use disorders services to over half of those contacted. The request will support 56 grants to states and territories, as well as centralized activities such as technical assistance and evaluation. In FY 2014, the PATH grant allotment calculations will use the newly available 2010 Decennial Census's total population of urbanized areas count.

Outcomes and Outputs

Program: Projects to Assist in the Transition from Homelessness

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
3.4.15 Percentage of enrolled homeless people who receive community mental health services (Outcome)	FY 2012: 66.0% Target: 47.0% (Target Exceeded)	50.0%	47.0%	-3.0%
3.4.16 Number of homeless persons contacted (Outcome)	FY 2012: 192,290 Target: 182,000 (Target Exceeded)	182,000	191,926	+9,926
3.4.17 Percentage of contacted homeless people with serious mental illness who become enrolled in services (Outcome)	FY 2012: 58.0% Target: 55.0% (Target Exceeded)	55.0%	55.0%	Maintain
3.4.20 Increase the number of PATH providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits. (Output)	FY 2012: 4,781 Target: 5,420 (Target Not Met but Improved)	5,420	4,591	-829

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2014 Discretionary State/Formula Grants
CFDA # 93.150

STATE/TERRITORY	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	$586,000	$588,000	$611,000	+$25,000
Alaska	300,000	300,000	300,000	---
Arizona	1,179,000	1,184,000	1,346,000	+167,000
Arkansas	300,000	300,000	303,000	+3,000
California	9,034,000	9,077,000	8,789,000	-245,000
Colorado	969,000	974,000	1,016,000	+47,000
Connecticut	859,000	863,000	797,000	-62,000
Delaware	300,000	300,000	300,000	---
District Of Columbia	300,000	300,000	300,000	---
Florida	4,063,000	4,082,000	4,323,000	+260,000
Georgia	1,511,000	1,518,000	1,665,000	+154,000
Hawaii	300,000	300,000	300,000	---
Idaho	300,000	300,000	300,000	---
Illinois	2,937,000	2,951,000	2,698,000	-239,000
Indiana	1,029,000	1,034,000	1,009,000	-20,000
Iowa	336,000	338,000	334,000	---
Kansas	364,000	366,000	376,000	-2,000
Kentucky	473,000	475,000	468,000	+12,000
Louisiana	765,000	768,000	731,000	-5,000
Maine	300,000	300,000	300,000	-34,000
Maryland	1,281,000	1,287,000	1,268,000	---
Massachusetts	1,700,000	1,708,000	1,555,000	-13,000
Michigan	1,984,000	1,994,000	1,725,000	-145,000
Minnesota	818,000	822,000	809,000	-259,000
Mississippi	300,000	300,000	300,000	-9,000
Missouri	932,000	937,000	891,000	---
Montana	300,000	300,000	300,000	-41,000
Nebraska	300,000	300,000	300,000	---
Nevada	506,000	508,000	614,000	---
New Hampshire	300,000	300,000	300,000	+108,000

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2014 Discretionary State/Formula Grants
CFDA # 93.150

STATE/TERRITORY	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	2,339,000	2,350,000	2,132,000	-207,000
New Mexico	300,000	300,000	300,000	---
New York	4,677,000	4,699,000	4,212,000	-465,000
North Carolina	1,134,000	1,140,000	1,376,000	+242,000
North Dakota	300,000	300,000	300,000	---
Ohio	$2,205,000	$2,216,000	$1,981,000	-$224,000
Oklahoma	448,000	450,000	452,000	+4,000
Oregon	596,000	599,000	629,000	+33,000
Pennsylvania	2,477,000	2,488,000	2,360,000	-117,000
Rhode Island	300,000	300,000	300,000	---
South Carolina	565,000	568,000	678,000	+113,000
South Dakota	300,000	300,000	300,000	---
Tennessee	894,000	898,000	907,000	+13,000
Texas	4,463,000	4,484,000	4,982,000	+519,000
Utah	527,000	530,000	590,000	+63,000
Vermont	300,000	300,000	300,000	---
Virginia	1,422,000	1,428,000	1,468,000	+46,000
Washington	1,298,000	1,304,000	1,326,000	+28,000
West Virginia	300,000	300,000	300,000	---
Wisconsin	857,000	861,000	834,000	-23,000
Wyoming	300,000	300,000	300,000	---
American Samoa	50,000	50,000	50,000	---
Guam	50,000	50,000	50,000	---
Northern Marianas	50,000	50,000	50,000	---
Puerto Rico	1,049,000	1,054,000	889,000	-160,000
Virgin Islands	50,000	50,000	50,000	---

Protection and Advocacy for Individuals with Mental Illness

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority.....	$36,238	$36,460	$36,238	---

Authorizing Legislation..... Section 102 of the PAIMI Act

FY 2014 Authorization..... Expired

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

Program Description and Accomplishments

The Protection and Advocacy for Individuals with Mental Illness Program (PAIMI) began in 1986 and is authorized by Section 102 of the PAIMI Act. The PAIMI Program provides formula grant awards to support protection and advocacy systems designated by the Governor of each state and the territories, and the Mayor of the District of Columbia. State protection and advocacy systems monitor compliance with respect to the rights of individuals through activities that ensure the enforcement of the constitution and federal and state laws. State protection and advocacy systems monitor public and private residential care and treatment facilities and non-medical community-based facilities for children and youth. An independent evaluation of the program was completed in FY 2009 which confirmed that PAIMI programs provide those with psychiatric disability a voice in the exercise of their rights and are highly successful in achieving client and system goals and objectives.

In 2011, the PAIMI program:

- Provided casework to 3,900 children and adolescents and 12,592 adults and elderly individuals with mental illness;
- Closed 13,133 cases, of which 3,389 were related to abuse, 2,658 to neglect, and 7,086 to a violation of individual rights; and
- Resolved 91 percent of alleged abuse cases, 91 percent of alleged neglect cases, and 93 percent of alleged rights violations cases that resulted in positive change for the client in her/his environment, community, or facility.

The FY 2011 funding resolved over an estimated 11,000 complaints, based on a marginal cost analysis conducted for this program (which estimated an average cost per complaint resolved successfully in FY 2009 of $3,164). Complaints of alleged abuse that were resolved resulting in positive change for the client in her or his environment, community, or facility as a result of PAIMI involvement was at a rate of 83 percent in FY 2007, improving to 91 percent in FY 2011.

PAIMI programs within each state Protection and Advocacy agency are monitored via on-site reviews on a regular schedule. These on-site monitoring reviews are conducted by trained federal staff to provide SAMHSA an assessment of key areas: governance, legal, fiscal, and consumer/constituent services/activities of the state's PAIMI Program. Following these site

visits, a report is completed that summarizes program findings and when appropriate, may include recommendations for technical assistance and/or corrective action.

The first external evaluation in the 24-year history of the PAIMI Program was completed in 2010. The evaluation found that individual PAIMI programs provide those with psychiatric disabilities a voice in the exercise of their rights and are highly successful in achieving client and system goals and objectives. The PAIMI Program contributes to the transformation of this nation's mental health system into a more open, adaptive system that promotes recovery.

In FY 2012 SAMHSA continued to fund 57 grants to states and territories as well as centralized activities such as technical assistance. This will remain the same in FY 2013.

Funding History

Fiscal Year	Amount
FY 2010	$36,380,000
FY 2011	$36,307,000
FY 2012	$36,238,380
FY 2013	$36,460,159
FY 2014	$36,238,000

Budget Request

The FY 2014 Budget Request is $36.2 million, the same as the FY 2012 funding level. These funds support state and territorial protection and advocacy systems for individuals with serious mental illness in public and private residential care and treatment facilities and community-based services. In FY 2014, an estimated 16,428 people will be served by the program and over 74,092 people will receive public education and trainings on consumer rights and services. In FY 2014 SAMHSA continued to fund 57 grants to states and territories as well as centralized activities such as technical assistance.

Outcomes and Outputs

Program: Protection & Advocacy

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
3.4.12 Number of people served by the PAIMI program (Outcome)	FY 2011: 16,492 Target: 22,325 (Target Not Met)	16,499[14]	16,428	-71
3.4.19 Number attending public education/constituency training and public awareness activities (Output)	FY 2011: 74,382 Target: 120,000 (Target Not Met)	92,953	74,092	-18,861
3.4.21 Increase percentage of complaints of alleged **abuse, neglect, and rights violations** substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making,elimination of other barriers to personal decision-making,as a result of PAIMI involvement (Outcome)	FY 2011: 92.0% Target: 87.0% (Target Exceeded)	87.0%	87.0%	Maintain

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

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2014 Discretionary State/Formula Grants
CFDA # 93.138

STATE/TERRITORY	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	$451,372	$458,563	$453,879	+$2,507
Alaska	429,100	431,700	429,100	---
Arizona	633,443	604,746	610,923	-22,520
Arkansas	429,100	431,700	429,100	---
California	3,134,571	3,171,629	3,179,373	+44,802
Colorado	429,546	431,700	429,705	+159
Connecticut	429,100	431,700	429,100	---
Delaware	429,100	431,700	429,100	---
District Of Columbia	429,100	431,700	429,100	---
Florida	1,642,108	1,686,787	1,685,433	+43,325
Georgia	933,039	912,364	912,424	-20,615
Hawaii	429,100	431,700	429,100	---
Idaho	429,100	431,700	429,100	---
Illinois	1,102,843	1,097,035	1,084,662	-18,181
Indiana	610,362	616,840	608,409	-1,953
Iowa	429,100	431,700	429,100	---
Kansas	429,100	431,700	429,100	---
Kentucky	429,100	431,700	429,100	---
Louisiana	429,100	431,700	429,100	---
Maine	429,100	431,700	429,100	---
Maryland	456,215	460,446	459,052	+2,837
Massachusetts	521,358	511,836	506,782	-14,576
Michigan	941,212	929,395	914,289	-26,923
Minnesota	450,085	449,619	446,424	-3,661
Mississippi	429,100	431,700	429,100	---
Missouri	551,979	545,926	543,318	-8,661
Montana	429,100	431,700	429,100	---
Nebraska	429,100	431,700	429,100	---
Nevada	429,100	431,700	429,100	---
New Hampshire	429,100	431,700	429,100	---

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2014 Discretionary State/Formula Grants
CFDA # 93.138

STATE/TERRITORY	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	686,332	687,801	684,390	-1,942
New Mexico	429,100	431,700	429,100	---
New York	1,591,215	1,551,920	1,526,904	-64,311
North Carolina	880,448	895,788	897,017	+16,569
North Dakota	429,100	431,700	429,100	---
Ohio	$1,069,448	$1,061,943	$1,045,456	-23,992
Oklahoma	429,100	431,700	429,100	---
Oregon	429,100	431,700	429,100	---
Pennsylvania	1,099,025	1,104,273	1,091,386	-7,639
Rhode Island	429,100	431,700	429,100	---
South Carolina	444,614	452,018	452,775	+8,161
South Dakota	429,100	431,700	429,100	---
Tennessee	595,224	595,752	590,212	-5,012
Texas	2,204,946	2,276,461	2,256,111	+51,165
Utah	429,100	431,700	429,100	---
Vermont	429,100	431,700	429,100	---
Virginia	657,158	669,228	665,512	+8,354
Washington	562,766	572,780	574,672	+11,906
West Virginia	429,100	431,700	429,100	---
Wisconsin	510,809	509,744	505,535	-5,274
Wyoming	429,100	431,700	429,100	---
American Samoa	229,900	231,300	229,900	---
Guam	229,900	231,300	229,900	---
Northern Marianas	229,900	231,300	229,900	---
Puerto Rico	618,294	579,460	568,084	-50,210
Virgin Islands	229,900	231,300	229,900	---
American Indian Consortium	229,900	231,300	229,900	---

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Community Mental Health Services Block Grant

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Community Mental Health Services Block Grant.....	$459,756	$462,570	$459,756	---
PHS Evaluation Funds (non-add).....	*$21,039*	*$21,168*	*$21,039*	---

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

FY 2014 Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments

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

Ninety-five percent of the funds allocated to the MHBG program are distributed to states through a formula prescribed by the authorizing legislation. Factors used to calculate the allotments include total personal income, state population data by age groups (total population data for territories), total taxable resources, and a cost of services index factor. States and territories may expend Block Grant funds only to carry out the annual plan, to evaluate programs and services carried out under the plan, and for planning, administration, and educational activities related to providing services under the plan.

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

The MHBG statute provides a five percent set-aside to allow SAMHSA to assist the states and territories in the development of their mental health systems through the support of technical assistance, data collection and evaluation activities.

In FY 2011, SAMHSA redesigned the FY 2012/2013 MHBG and SABG applications to better align with the current federal/state environments and related policy initiatives, including the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Tribal Law and Order Act (TLOA). The new design offered states the opportunity to complete a combined application for mental health and substance abuse services, submit a bi-annual versus an annual plan,[15,16] and provide information regarding their efforts to respond to various federal and state initiatives. Almost one-half of the states took advantage of this streamlined application and submitted combined plans for mental health and substance abuse services. Over 95 percent of the states provided specific information requested by SAMHSA regarding strategies to respond to a variety of areas including primary care and behavioral health integration, recovery support services, prevention of substance use, and promotion of emotional health. States continued to provide information regarding the spending of their Block Grant funds to support services identified in SAMHSA's *Good and Modern Service System* brief.

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

Most states are currently reporting on National Outcome Measures (NOMS) for public mental health services within their state. The first compilation of state NOMS data was submitted to Congress in the spring of 2005. State level outcome data for mental health are currently reported by State Mental Health Authorities through the Uniform Reporting System. The following outcomes for all people served by the publicly funded mental health system[17] during 2011 show that:

- For the 54 states and territories that reported data in the Employment Domain, 18 percent of the mental health consumers were in competitive employment;
- For the 55 states and territories that reported data in the Housing Domain, 82 percent of the mental health consumers were living in private residences;
- For the 56 states and territories that reported data in the Access/Capacity Domain, state mental health agencies provided mental health services for 21.93 people per 1,000 population;
- For the 50 states and territories that reported data in the Retention Domain, only 9 percent of the patients returned to a state psychiatric hospital within 30 days of state hospital discharge; and

[15] 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))
[16] State Plan (Sec. 1932(b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x-32(b))
[17] May reflect multiple sources of funding including, MHBG, State General Fund, Medicaid, Private Insurance, etc.

- For the 51 states and territories that reported data in the Perception of Care Domain, 70 percent of adult mental health consumers improved functioning as a direct result of the mental health services they received.

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

Funding History[1/]

Fiscal Year	Amount
FY 2010	$420,774,000
FY 2011	$419,933,000
FY 2012	$459,756,254
FY 2013	$462,569,962
FY 2014	$459,756,000

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

Budget Request

The FY 2014 Budget Request is $459.8 million, the same as the FY 2012 funding level. These funds will support the public mental health system which provides services for over 7.4 million individuals. The request will support 59 grants to states and territories.

Enrollment and Provider Business Practices (3 Percent Block Grant Set Aisde)

Through the Affordable Care Act, up to 62 million people will benefit from Federal parity protections under the ACA. This includes 32 million who will gain coverage for behavioral health conditions, including 27 million who are currently uninsured, and 30.4 million who have some behavioral health benefits and will benefit from federal parity protections[18]. Persons with mental and substance use disorders are uninsured at higher rates than the general population. Of the 27 million who are uninsured, up to 11 million of these individuals are estimated to have substance abuse and/or mental health conditions. The Qualified Health Plans (QHPs) to be offered by the new insurance marketplaces are required to have sufficient mental health and

[18] US Department of Health and Human Services. Office of the Assistance Secretary of Performance and Evaluation, Office of Health Policy. "Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans." By Sherry Glied, Laura Skopec, Rosa Po, and Kirsten Beronio. 20 Feb. 2013. <http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf>.

substance abuse providers to assure timely access to mental health and substance services. However, many providers supported by MHBG funds are not sufficiently prepared to be part of the network of providers under contract with QHPs, Medicaid and Medicare plans, and commercial insurance plans. It is critical for specialty behavioral health providers to be able to participate in integrated care models, utilize interoperable electronic health records (EHRs), and bill for and collect insurance resources for which persons they serve are eligible in order to maximize limited MHBG and SABG funds for those services and those persons not covered by public and commercial insurance plans.

After the full implementation of the Affordable Care Act, SAMHSA strongly recommends that MHBG and SABG funds be directed toward four purposes: (1) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; (2) to fund priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery; (3) to fund primary prevention (universal, selective, and indicated) prevention activities and services for individuals not identified as needing treatment; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis. State authorities should make every effort to ensure that the right recipient is receiving the right payment for the right reason at the right time.

In FY 2014, the President's Budget includes a requirement that states set aside at least three percent of their MHBG allocation to support providers of mental health services in improving their enrollment, billing, and business practices and to support enrollment into health insurance for eligible individuals served in the public mental health system. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub-award process for their funds. Major needs identified by both mental health and substance abuse providers are education and technical support to improve business management, integrate with primary care and develop the capability needed to effectively deploy electronic health records to meaningful use standards, billing and scheduling systems that are aligned with those in the commercial insurance and primary care environment. Particular concern was raised related to the lack of provider experience, especially peer, recovery, and opioid treatment organizations, in negotiating contracts with and billing third party payers, ensuring compliance, revenue management, and accountability reporting.

Business operations practices needed include:

- Outreach and enrollment support for individuals in need of behavioral health services who may be eligible for Medicare, Medicaid, private insurance offered through the State and Federally Facilitated Marketplaces;
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA, (e.g., development of a strategic plan that is responsive to the changing marketplace, identification of new markets, revision of data management systems, integration of recovery support and treatment service payment systems, negotiating agreements/partnerships with primary care organizations, [e.g., Federally Qualified Health Centers (FQHCs)] and other provider networks to develop business operations

systems that ensure appropriate care management across the continuum of services, (e.g. preventive clinical services, treatment, referral and recovery support services);
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billings, collections, risk management and compliance;
- Third-party contract negotiation; e.g., negotiating contracts for participation in a qualified health plan, or Medicaid managed care plan;
- Coordination of benefits among multiple funding sources, including insurance and MHBG funding; and
- Adoption of health information technology that meets meaningful use standards.

The Affordable Care Act has already enhanced opportunities for individuals with behavioral health conditions to have continuous access to insurance and a benefit package that includes mental health and substance abuse services, as well as preventive, medical, and other health services. A series of immediate private insurance market reforms help to give individuals the stability and flexibility they need to make informed choices about their health care. Under these market reforms, individuals have a right to appeal health insurance plan decisions, including appeals to health plans when payment for a service or treatment is denied; helps children with pre-existing conditions gain and keep coverage, and will extend this protection to adults starting in 2014; allows individuals to continue to choose their primary care provider; keeps certain young adults covered up to age 26 on their parents' health plans; ends lifetime limits on coverage; provides for review of unreasonable increases in insurance premiums; and requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, helping to ensure that premium dollars be primarily spent on health care (including behavioral health care).

Use of MHBG dollars for these purposes will help states assist their specialty provider infrastructure to be prepared for the shifting funding environment and maximize limited MHBG dollars for those individuals, services and activities not otherwise funded through other sources.

Evidence-Based Prevention and Treatment Approaches (5 Percent Block Grant Set Aside)

While the federal statute requires states to spend a portion of the SABG on primary substance abuse prevention services, no such set aside requirement currently exists in the MHBG statute. Likewise, the MHBG statute currently directs funding only to those children and adults with the most severe disorders without recognizing the growing science about preventing mental disorders or preventing the disability caused by early onset of such disorders through earlier intervention.

The scientific understanding of mental health promotion and mental illness prevention was not well-known or developed when the MHBG was first authorized in the 1980s. Since that time, the knowledge base of effective mental health promotion and mental illness prevention and mitigation approaches has rapidly expanded via research findings, the identification of best practices in community coordination, and proven planning processes such as the Strategic Prevention Framework. SAMHSA efforts such as Project LAUNCH, Safe Schools/Healthy Students, Implementing Evidence-Based Prevention Practices in Schools, along with suicide

prevention activities have demonstrated that such approaches can achieve successful outcomes. The landmark 2009 Institute of Medicine report, *Preventing, Mental, Emotional, and Behavioral Disorders Among Young People*, and the *Clinical Manual of Prevention in Mental Health* (Michael Compton, MD, ed.) clearly defined and delineated the efficacy of such models. These models can ultimately assist states and the nation as a whole reduce the future prevalence along with the human and financial costs of mental and behavioral disorders.

The knowledge base on evidence-based treatment and recovery support services has also grown dramatically. SAMHSA has developed a series of evidence-based practice toolkits (http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs) to assist states and communities to adopt such approaches. SAMHSA's National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov/) has collected more than 280 interventions that support mental health promotion, treatment, and recovery.

Thus, in FY 2014, states should take such scientific developments of the last 25 years into account and prioritize proven mental illness prevention, emotional health promotion, and treatment/recovery support approaches as they develop comprehensive and coordinated plans to address mental disorders.

Additionally, states have worked to utilize their MHBG funds for evidence-based treatment strategies for populations served with MHBG and other public dollars. Evidence is growing about treatment approaches and system designs that can help to prevent and/or mitigate the disabilities caused by serious and persistent mental illness and severe emotional disturbances. Taking into consideration the findings of the National Institute of Mental Health's (NIMH) emerging work on early intervention with first break psychosis and the findings from SAMHSA's mental health discretionary portfolio serving children and youth with the most serious mental disorders, SAMHSA will work with states to utilize at least five percent of their MHBG funds to award grants to implement the most effective evidence-based prevention and treatment approaches, focusing on promotion, prevention and early intervention. This new set-aside and focus will be used by states to demonstrate how both MHBG and other funding streams can be utilized in the changing funding and service delivery environment to have the most positive impact on the health and well-being of the persons and communities served through these set-aside awards. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process for their funds.

Health Reform

As a result of the analysis and examination of the various components of the Affordable Care Act beginning in 2010, SAMHSA has undertaken a major redesign of the planning section of the application process for both the MHBG and SABG. SAMHSA is aligning the block grants to be critical components of the 2014 Affordable Care Act implementation in which state and federal responsibility is supporting behavioral health services and supports for those otherwise unable to receive services through Medicaid, Medicare, and/or private insurance plans offered through employers or through the new insurance marketplaces. Together, SAMHSA's block grants support the provision of services and related supports to approximately eight million individuals with mental and substance use conditions. With an estimated 11.4 million adults having a severe

mental illness[19], 44.7 million adults having any mental illness[20], and another 22.1 million adults with substance use disorder[21], demand clearly outpaces the public behavioral health system's established capacity. Many of these individuals and some of the services they need will continue to be without coverage through public or private insurance mechanisms. Aligning and coordinating the SAMHSA block grants with the 2014 Affordable Care Act implementation process begins assembling a cohesive national service system that is responsive to potential gaps in service delivery and effectively provides needed behavioral health serves across sectors and across payment sources.

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

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

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

Outcomes and Outputs

Program: Mental Health Block Grant

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.14 Number of people served by the public mental health system (Output)	FY 2011: 6,879,637 Target: 6,300,000 (Target Exceeded)	6,340,320	7,418,653	+1,078,333
2.3.11 Number of evidence based practices (EBPs) implemented (Output)	FY 2011: 4.3 per State Target: 4.2 per State (Target Exceeded)	4.2 per State	4.2 per State	Maintain
2.3.15 Rate of consumers (adults) reporting positively about outcomes (Outcome)	FY 2011: 70.5% Target: 72.0% (Target Not Met)	72.0%	72.0%	Maintain
2.3.16 Rate of family members (children/adolescents) reporting positively about outcomes (Outcome)	FY 2011: 64.6% Target: 73.0% (Target Not Met but Improved)	67.0%	67.0%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.81 Percentage of service population receiving any evidence based practice (Outcome)	FY 2011: 6.4% Target: 7.2% (Target Not Met)	7.2%	7.2%	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2014 Discretionary State/Formula Grants
Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	$6,551,928	$6,419,986	$6,206,418	-$345,510
Alaska	765,128	745,652	716,710	-48,418
Arizona	10,381,931	9,837,513	9,766,415	-615,516
Arkansas	3,996,615	4,089,681	3,949,834	-46,781
California	57,438,409	58,317,193	57,487,129	+48,720
Colorado	7,176,225	6,377,861	6,313,606	-862,619
Connecticut	4,464,764	4,464,350	4,448,783	-15,981
Delaware	812,652	1,009,327	972,793	+160,141
District Of Columbia	813,506	848,427	826,377	+12,871
Florida	28,619,330	28,948,326	28,760,329	+140,999
Georgia	14,426,622	13,436,228	13,187,135	-1,239,487
Hawaii	2,112,561	2,220,618	2,174,299	+61,738
Idaho	1,968,874	2,413,318	2,361,788	+392,914
Illinois	16,726,381	16,505,505	16,013,432	-712,949
Indiana	8,545,466	8,107,978	7,901,301	-644,165
Iowa	3,588,593	3,573,876	3,453,075	-135,518
Kansas	3,343,934	3,338,959	3,228,673	-115,261
Kentucky	5,847,060	6,172,172	5,980,327	+133,267
Louisiana	5,980,444	5,455,568	5,169,957	-810,487
Maine	1,758,811	1,757,226	1,692,699	-66,112
Maryland	7,936,269	8,674,816	8,390,403	+454,134
Massachusetts	8,810,187	9,555,824	9,242,248	+432,061
Michigan	13,557,223	13,779,285	13,532,906	-24,317
Minnesota	7,380,034	6,823,431	6,588,812	-791,222
Mississippi	4,265,884	4,023,164	3,896,910	-368,974
Missouri	7,592,862	7,536,595	7,259,445	-333,417
Montana	1,279,671	1,292,445	1,260,990	-18,681
Nebraska	2,079,360	2,080,565	1,989,680	-89,680
Nevada	4,007,238	4,256,500	4,203,668	+196,430
New Hampshire	1,613,013	1,791,212	1,722,505	+109,492

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2014 Discretionary State/Formula Grants
Community Mental Health Services Block Grant Program
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State/Territory	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	12,251,010	12,371,221	11,983,048	-267,962
New Mexico	2,565,434	2,658,520	2,597,688	+32,254
New York	25,017,742	26,980,283	26,406,631	+1,388,889
North Carolina	12,312,708	12,319,025	11,897,432	-415,276
North Dakota	794,932	810,657	764,117	-30,815
Ohio	14,858,394	14,518,749	14,120,367	-738,027
Oklahoma	4,715,738	4,749,501	4,598,474	-117,264
Oregon	5,380,731	5,757,744	5,536,269	+155,538
Pennsylvania	15,696,685	15,747,128	15,216,936	-479,749
Rhode Island	1,478,709	1,701,196	1,635,470	+156,761
South Carolina	6,363,877	6,307,585	6,167,611	-196,266
South Dakota	936,853	903,449	881,742	-55,111
Tennessee	8,415,280	8,457,731	8,166,062	-249,218
Texas	35,096,299	34,582,003	33,831,667	-1,264,632
Utah	3,380,306	3,313,813	3,215,736	-164,570
Vermont	788,942	800,470	776,168	-12,774
Virginia	10,863,652	10,867,463	10,544,719	-318,933
Washington	9,258,112	9,776,840	9,641,077	+382,965
West Virginia	2,562,028	2,619,228	2,510,561	-51,467
Wisconsin	8,015,911	7,034,083	6,822,203	-1,193,708
Wyoming	490,976	473,792	472,878	-18,098
American Samoa	93,638	83,740	81,658	-11,980
Guam	254,936	240,363	236,107	-18,829
Northern Marianas	68,105	81,273	77,174	+9,069
Puerto Rico	5,608,135	5,619,682	5,483,550	-124,585
Palau	50,000	50,000	50,000	---
Marshall Islands	92,831	99,336	99,387	+6,556
Micronesia	151,038	161,622	158,050	+7,012
Virgin Islands	154,697	160,493	156,493	+1,796

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

Programs of Regional & National Significance	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
CAPACITY				
Strategic Prevention Framework.....	$109,754	$110,479	$109,754	$---
Mandatory Drug Testing.....	5,196	5,228	4,906	-290
Minority AIDS Initiative.....	41,307	41,560	41,307	---
Sober Truth on Preventing Underage Drinking (STOP Act).....	6,987	7,030	7,000	+13
Subtotal, Capacity	**163,244**	**164,296**	**162,967**	**-277**
SCIENCE AND SERVICE				
Fetal Alcohol Spectrum Disorder.....	9,802	9,862	1,000	-8,802
Center for the Application of Prevention Technologies (CAPT).....	8,059	8,108	7,511	-548
Science and Service Program Coordination.....	4,780	4,809	4,082	-698
Subtotal, Science and Service	**22,641**	**22,780**	**12,593**	**-10,048**
TOTAL, PRNS [1/]	**$185,885**	**$187,076**	**$175,560**	**-$10,325**

1/In the FY 2014 Request, the CSAP Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

Authorizing Legislation.....Sections 516, 519B, 519D of the PHS Act

FY 2014 Authorization..... Expired

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

Program Description and Accomplishments

Strategic Prevention Framework

Partnerships for Success

The Partnerships for Success (PFS) program was initiated in FY 2009 with the goals of reducing substance abuse-related problems; preventing the onset and reducing the progression of substance abuse; strengthening prevention capacity and infrastructure at the state- and community-levels in support of prevention; and leveraging, redirecting and realigning state-wide funding streams for substance abuse prevention. Eligible applicants are states and Territories that have completed a SPF State Incentive Grant (SPF-SIG). In FY 2009, four grants were awarded, and in FY 2010, one

additional award was made. The first two cohorts incorporated an incentive award to grantees that have reached or exceeded their prevention performance targets (subject to availability of funds). In FY 2012, SAMHSA supported these efforts by awarding five continuation grants. The FY 2011 data from the first cohort reporting show that 50 communities increased the number of activities supported through collaboration and leveraging. Grantees reported implementing almost two thousand evidence based programs during FY 2011. Thirty-two communities reported improvements on targeted National Outcome Measures indicators. The vast majority of communities (88 percent) targeted alcohol use.

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

In FY 2013, SAMHSA will support continuation awards for the initial cohort established in FY 2009 and FY 2010. SAMHSA will make a new SPF SIG award to Iowa, the last SPF SIG state remaining to receive one and will award up to 17 new PFS grants. In addition, SAMHSA will make funds available for grantees in the first cohort who meet their performance targets and are eligible to apply for the incentive supplement.

Mandatory Drug Testing

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

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

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

The program is further supported by the CSAP Workplace Helpline, a toll-free telephone service for business and industry that answers questions about drug abuse in the workplace.

SAMHSA will continue these activities in FY 2013. In addition, the Drug Testing program is examining the scientific basis for oral fluid testing as an alternative specimen to urine, and also to include additional Schedule II prescription medications (e.g., oxycodone, oxymorphone, hydrocodone and hydromorphone) in the drug testing protocol. Any changes will be based on scientific supportability. SAMHSA continues to partner with NIH/NIDA, FDA, and other federal agencies to ascertain the scientific evidence needed to set standards for the Mandatory Guidelines.

Minority AIDS Initiative (MAI)

Implemented in FY 1999, SAMHSA/CSAP's Minority AIDS Initiative (MAI) supports efforts to increase access to substance abuse and HIV prevention services for the highest risk and hardest-to-serve racial and ethnic minority populations. Grantees must implement integrated, evidence-based substance abuse and HIV prevention interventions, including HIV testing, that target one or more high-risk populations such as African-American women, adolescents, individuals who have been released from prisons and jails within the past two years, or men having sex with men (MSM). In addition, the MAI supports partnerships between public and private nonprofit organizations to prevent and reduce the onset of substance abuse and transmission of HIV among high-risk populations.

Since its inception, CSAP has funded a total of ten cohorts. In FY 2011, SAMHSA/CSAP funded the Ready-To-Respond Initiative and the Capacity Building Initiative programs, and a total of 62 grants in these cohorts will continue to be funded in FY 2013. The Ready-To-Respond Initiative, targeted toward experienced MAI grantees, provides substance abuse and HIV prevention services to at-risk minority populations in communities disproportionately affected by HIV/AIDS. The Capacity Building Initiative focuses on using evidence-based prevention strategies and media technology to reach college students, who comprise one-third of the 18-24 year old population in the United States and are particularly at risk for substance use and HIV infection. Performance data for FY 2011, the most recent available showed that over 4,000 people received substance abuse prevention education services. Over 355,000 were reached through environmental approaches. Additionally, 95.5 percent of participants rated the risk of harm from substance abuse as great. Of those participants who were non-users, 92.5 percent remained non-users of drugs and 88.1 percent remained alcohol free. During FY 2011, over 11,000 participants were tested for HIV, of whom almost 4,000 were tested for the first time. SAMHSA has supported these grants in FY 2012 and will continue to do so in FY 2013.

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

incidence, and HIV-related health disparities in these areas. SAMHSA continued to support these grants in FY 2012 and is continuing to do so in FY 2013.

In FY 2013, SAMHSA is awarding a new cohort of grants for the *MAI and HIV Prevention in High Risk Minority Serving Institutions (MSI) and Communities (MAI/MSI) program*. The purpose of the MAI/MSI program is to equip and empower high risk MSIs located in communities with the highest risk of substance abuse and HIV infections with evidence-based methodologies to increase access to comprehensive, integrated substance abuse and HIV prevention services on their campuses/institutions and in the surrounding community. High risk population are communities with higher prevalence rate of substance abuse, HIV/AIDS, underage drinking and/or prescription drug misuse and has limited resources or has had fewer opportunities or less success in identifying and bringing to bear resources to address the identified priorities. The MAI/MSI recipients also will be required to partner with local community organizations serving at-risk racial/ethnic minority young adults, MSMs, as well as (if applicable), other demonstrated high risk groups in communities disproportionately affected by SA and HIV/AIDS, i.e. Black/African American men and women, Latino(a), Hispanic and sexual minorities. The goal is to reduce the rate of new substance abuse and HIV infections on minority serving college/institution campuses and the surrounding at risk communities. SAMHSA will award up to 60 grants for three years.

SAMHSA supports the National HIV/AIDS Strategy through its grant programs, including the cross-Center Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements, the CSAT Targeted Capacity Expansion/HIV program, and the CSAP Ready-to-Respond and Capacity Building Initiative programs, all described in their respective sections of this document. SAMHSA also provides technical assistance to its grantees to assure they are focusing on the goals of the Strategy and collaborates with other HHS Operating Divisions involved with the Strategy to assure a coordinated, Departmental approach.

Sober Truth on Preventing Underage Drinking Act (STOP Act)

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 is the nation's first comprehensive legislation on underage drinking. One of the primary components of the Act is the STOP Act grant program, which provides additional funds to current or former grantees under the Drug Free Communities Act of 1997 to prevent and reduce alcohol use among youth age 12-20. The STOP Act grant program enables organizations to strengthen collaboration and coordination among stakeholders in order to achieve a reduction in underage drinking in their communities. Grants are limited by statute to $50,000 per year for four years. In FY 2012, 81 new grants were awarded. In FY 2011, performance data show that the STOP Act grant program has exceeded targets in all GPRA performance measures. Eighty-four percent of coalitions reported a reduction in the past 30 day use of alcohol, 75 percent of coalitions reported an increase in perceived risk, and 75 percent of coalitions reported an increase in perception of parental disapproval of alcohol use (69.6 percent). In FY 2013, SAMHSA will award up to 16 new grants.

Another component of the STOP Act is the National Adult-Oriented Media Public Service Campaign, which educates parents regarding how to speak with their 11- through 15-year-old children about underage drinking in order to delay the onset of, and ultimately reduce, underage

drinking. Nationwide, 38.9 percent of the estimated 10 million underage drinkers were provided free alcohol by adults 21 or older (2010 NSDUH). Further research continues to show that parents of teens generally underestimate the extent of alcohol used by youth and its negative consequences, with the vast majority viewing underage drinking as "inevitable."

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

Fetal Alcohol Spectrum Disorders (FASD)

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

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

In FY 2011, the most recent year for which data is available, SAMHSA's FASD CFE screened 10,829 at-risk individuals and provided direct services to a total of 1,651 individuals. Over 90 percent of participants who used alcohol reported decreased current and binge drinking after

program participation. In addition, SAMHSA's FASD provided 26 trainings to over 1,483 providers nationwide.

In FY 2012, SAMHSA continued to support the FASD CFE to work toward the prevention of FASD in communities throughout the nation. In FY 2013, SAMHSA will continue to support FASD CFE to focus on identifying new methods for screening and providing preventive services and resources to women of childbearing age, as well as increasing collaboration and coordination of prevention efforts with other federal and national partners.

Center for the Application of Prevention Technologies (CAPT)

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

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

During FY 2011, SAMHSA's CAPT delivered over 415 training events nationwide and trained over 10,060 substance abuse prevention professionals. During FY 2012, there was a slight decline to 9,041 in numbers. In addition, SAMHSA's CAPT provided technical assistance services to 7,655 people. Over 96 percent of service recipients reported that their organization's capacity was increased as a result of the service. Almost half of the recipients reported fully implementing the training recommendations. Additional performance data for the CAPT is captured using common measures with other technical assistance activities in the Science and Service Program Coordination category.

Science and Service Program Coordination

The Science and Service Program Coordination category primarily encompasses contracts that provide technical assistance and training to states, tribes, communities, and grantees around

substance abuse prevention. Included in the performance measurement section for this category are the Native American Center for Excellence (NACE) and the Underage Drinking Prevention Education Initiative (UADPEI).

The purpose of SAMHSA's NACE is to promote effective substance abuse prevention programs in tribal and urban American Indian and Alaska Native (AI/AN) communities throughout the United States. The NACE mission is to promote best practices in substance abuse prevention by disseminating information on cultural- and evidence-based programs, practices, and policies and providing training and technical assistance (TTA) to prevention programs and organizations serving urban and tribal Native American communities. The target audiences include the Native American SPF-SIG grantees, tribal nations and organizations, health and social service providers, federal and state level organizations, and community and faith-based providers serving Native Americans. It has provided TTA to 482 recipients and training to 213 people during FY 2011. Additionally 88 percent of recipients report that the NACE services increased their individual capacity to provide prevention services.

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

In FY 2013, SAMHSA's CSAP's NACE and CMHS's AI/AN Suicide Prevention programs will collaborate through braided funding to provide comprehensive, broad, focused, and/or intensive training and technical assistance to federally-recognized tribes and other American Indian/Alaska Native communities, seeking to address and prevent mental and substance use disorders, suicide, and promote mental health. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent.

The UADPEI engages parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences. Through this initiative, families, their children, and other youth-serving organizations have been reached through Town Hall Meetings (held in even-numbered years), technical assistance, trainings, and a variety of tools and materials. In FY 2011, more than 2,800 people were trained.

Performance data show that, collectively, the CAPT and Science and Service Program Coordination programs have exceeded their targets for customer satisfaction, and for the proportion of participants who report implementing recommendations. Efficiencies have been achieved from the growing focus on train-the-trainer models rather than training of individuals. In addition, since the Town Hall Meetings under the UADPEI contract occur biannually, numbers served expand in the years the meetings occur and contract in alternate years.

Funding History[1\]

Fiscal Year	Amount
FY 2010	$192,439,000
FY 2011	$186,302,000
FY 2012	$185,884,920
FY 2013	$187,076,000
FY 2014	$175,560,080

[1\]The funding history is presented on a comparable basis to previous funding levels to represent the revised budget structure and includes the PHS Evaluation Funds and Prevention Funds other than in FY 2013. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Budget Request

The FY 2014 Budget Request is comprised of $175.6 million, $10.3 million less than FY 2012. This level of funding enables the continuation of programmatic activities. The request will support 260 grant and 26 contract continuations, as well as 56 new grants and two new contracts.

Partnerships for Success

In FY 2014, SAMHSA requests $36.7 million to implement a new cohort of Partnerships for Success (PFS) grants, which will be consistent with the Prevention of Substance Abuse and Mental Illness Strategic Initiative. Similar to the previous cohorts, this PFS program will focus on implementing the Strategic Prevention Framework to strengthen prevention capacity and infrastructure at the state, territorial, and community levels; preventing the onset and reducing the progression of substance abuse; and leveraging, redirecting, and aligning statewide funding streams and resources to focus on promoting evidence-based substance abuse prevention. The new PFS grantees will also have the option of focusing on addressing trauma as one of the risk factors for substance abuse. Up to 32 grants will be awarded to eligible states, territories and tribes who have completed SPF-SIG grants. Grant award amounts will be divided into tiers with a maximum grant of approximately $2.0 million per year for the top tier.

SAMHSA will also consider how best to help tribes committed to substance abuse prevention to strengthen their existing service delivery systems and/or to begin building the necessary capacity and/or infrastructure to successfully prevent substance abuse in their communities.

The FY 2014 Budget Request includes increases for the following (+$0.013 million):

- The STOP Act program request is $7.0 million. This reflects a $0.013 million increase from the FY 2012 funding level. This level of funding will support 97 continuation grants and two continuation contracts.

The FY 2014 Budget Request includes same level of funding for the following:

- Minority AIDS Initiative request is $41.3 million, which is the same as the FY 2012 funding level which will support 133 continuation grants, 22 new grants, and one continuation contract
- Strategic Prevention Framework request is $109.8 million, which is the same as FY 2012 funding. These funds will support 30 grant and nine contract continuations and 34 new grants.

The FY 2014 Budget Request includes decreases for the following (-$10.3 million):

- Mandatory Drug Testing request is $4.9 million, reduced by $0.3 million. These funds will support three continuation contracts and one new contract.
- The FASD Center of Excellence program request is $1.0 million, reduced by $8.8 million, for technical support activities. These funds will continue to support prevention strategies, in partnership with other activities, to prevent alcohol use among women of childbearing age. In order to maximize dissemination of knowledge developed previously under this contract through direct services, the new phase of this contract will focus on technical assistance and training and will no longer provide funds to support direct services to communities. These activities can be supported by states through the Substance Abuse Prevention and Treatment Block Grant at their discretion.
- The CAPT program request is $7.5 million, reduced by $0.6 million. These funds will enable provisional continuation of technical assistance to the field in support of delivery of effective prevention programs and practices.
- Science and Services Program Coordination request is $4.1 million, reduced by $0.7 million. These funds will support six continuation contracts and one new contract.

A detailed table for all grant and contract continuations and new activities can be found in supplementary tables.

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Substance Abuse Prevention Programs of Regional and National Significance
Mechanism Table by APT
(Dollars in thousands)

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Annualized CR No.	FY 2013 Annualized CR Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
Grants						
Continuations	195	$95,867	199	$84,997	260	$82,389
New/Competing	96	45,762	99	48,800	56	49,149
Subtotal	291	141,629	298	133,797	316	131,538
Contracts						
Continuations	22	33,445	15	38,916	21	41,943
New	6	10,811	10	14,364	2	2,079
Subtotal	28	44,256	25	53,279	23	44,022
Total, CSAP PRNS [1/]	**319**	**$185,885**	**323**	**$187,076**	**339**	**$175,560**

1/In the FY 2014 Request, the CSAP Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

Key Outputs and Outcomes Table
(SAMHSA)

Program: Minority AIDS Initiative[22]

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.56 Number of program participants exposed to substance abuse prevention education services (Output)	FY 2011: 4,283 Target: 1,535[23] (Target Exceeded)	5,734[24]	3,000[25]	-2,734
2.3.82 Percent of program participants that rate the risk of harm from substance abuse as great (all ages) (Outcome)	FY 2011: 95.5% Target: 88.0% (Target Exceeded)	88.0%	88.0%	Maintain
2.3.83 Percent of program participants who report no use of alcohol at pre-test who remain non-users at post-test (all ages) (Outcome)	FY 2011: 88.1% Target: 91.2% (Target Not Met)	91.2%	91.2%	Maintain
2.3.84 Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (all ages) (Outcome)	FY 2011: 92.5% Target: 92.6% (Target Not Met)	92.6%	92.6%	Maintain
2.3.85a Number of individuals tested for HIV through the Minority AIDS Initiative prevention activities (Output)	FY 2011: 11,066 (Historical Actual)	Set Baseline	TBD	N/A

[22] The Minority AIDS Initiative in CSAP is a cohort-based program. As a result, there are observable decreases in targets in various years. For example, FY 2011 reflects the close-out of Cohort VI and start-up of Cohorts VII and VIII. Targets increase during FY 2012 and FY 2013 to reflect the newly funded Cohorts IX and X. However, in FY 2014, targets begin to decrease to reflect the close-out of Cohort VII.

[23] Target reflects close-out of Cohort VI and start-up of Cohort VII and Cohort VIII.

[24] Target has been revised from previously reported. Target has been changed to include Cohorts VII, VIII, IX, and X.

[25] Decrease in target is due to cohort effects and includes Cohorts IX and X.

Program: Sober Truth on Preventing Underage Drinking (STOP Act)[26]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
3.3.01 Increase the percentage of coalitions that report at least 5.0% improvement in the past 30-day use of alcohol in at least two grades (Outcome)	FY 2011: 84.4% Target: 41.0% (Target Exceeded)	40.0%[27]	40.0%	Maintain
3.3.02 Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades (Outcome)	FY 2011: 75.0% Target: 63.4% (Target Exceeded)	60.9%[28]	60.9%	Maintain
3.3.03 Percentage of coalitions that report improvement in youth perception of parental disapproval on the use of alcohol in at least two grades (Outcome)	FY 2011: 75.0% Target: 56.7% (Target Exceeded)	54.5%[29]	54.5%	Maintain

[26] The STOP Act program provides additional funds to current or prior Drug Free Community Program (DFC) grantees to support activities targeting underage alcohol. As is the case with the DFC grantees, STOP Act grantees collect performance data using a variety of school and community surveys and report them online through the COMET (Coalition Online Management and Evaluation Tool) system every two years – thereby affecting the ability to make accurate comparisons of performance from year to year. Lastly, Cohort I of STOP Act will close-out at the end of FY 2012 and Cohort II will close-out at the end of FY 2013. As a result, targets for performance measures have been decreased to reflect the decrease in the number of grantees.

[27] Target has been changed from previously reported. The target has been decreased due to cohort effects. Now, the target reflects close-out of Cohort I and start of Cohort III.

[28] Target has been changed from previously reported. The target has been decreased due to cohort effects. This target now reflects close-out of Cohort I and start of Cohort III.

[29] Target has been changed from previously reported. The target has been decreased due to cohort effects. Now, the target reflects close-out of Cohort I and start of Cohort III.

Program: Prevention - Science and Service Activities[30]

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.71 Number of people provided technical assistance (TA) services (Output)	FY 2011: 7,868 Target: 21,420 (Target Not Met)	13,143	N/A	N/A
2.3.74 Percentage of TA recipients who reported that the TA recommendations have been fully implemented (Outcome)	FY 2011: 53.1% Target: 54.0% (Target Not Met)	60.2%	N/A	N/A
2.3.75 Number of individuals receiving prevention information directly (Output)	FY 2011: 1,254 Target: 550[31] (Target Exceeded)	368[32]	N/A	N/A
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2012: 108,494 Target: 37,896 (Target Exceeded)	110,000[33]	110,000[34]	Maintain

[30] Measures in the Science and Service category include the Center for Application of Prevention Technology (CAPT), Native American Center of Excellence (NACE), Prevention Fellowships, and Town Hall Meetings.

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

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

[33] Target has been increased from previously reported.

[34] Target has been increased from previously reported.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.4.10 For CSAP, the number of individuals trained by SAMHSA's Science and Services Programs	FY 2012: 9,211 Target: 37,896 (Target Not Met)	37,049	30,000	-7,049
2.3.36 Percent of participants that agree or strongly agree that the training or TA provided increased their capacity to do substance abuse prevention work (Outcome)	FY 2011: 83.8% (Historical Actual)	Set Baseline	TBD	N/A
2.3.37 Percent of participants that agree or strongly agree that the training or TA provided increased their organization's capacity to do substance abuse prevention work (Outcome)	N/A	Set Baseline	TBD	N/A

Program: Partnerships for Success

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.78 Number of communities who report an increase in prevention activities that are supported by collaboration and leveraging of funding streams (Output)	FY 2011: 50 Target: 24 (Target Exceeded)	50	50	Maintain
2.3.79 Number of EBPs implemented by sub-recipient communities (Output)	FY 2011: 1,976 Target: 96 (Target Exceeded)	950	950	Maintain
2.3.80 Number of sub-recipient communities that improved on one or more targeted NOMs indicators (Outcome)	FY 2011: 32 Target: 24 (Target Exceeded)	50	50	Maintain

Program: Strategic Prevention Framework State Incentive Grants[35]

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.21 Decrease underage drinking as measured by an increase in the percent of SPF SIG states that show a decrease in 30-day use of alcohol for individuals 12 - 20 years old (Outcome)	FY 2011: 85.0% Target: 50.4%[36] (Target Exceeded)	50.0%	50.0%	Maintain
2.3.23 Percent of SPF SIG states showing a decrease in state level estimates of survey respondents (age 12-17) who report 30-day use of other illicit drugs (Outcome)	FY 2011: 50.0% Target: 59.0%[37] (Target Not Met but Improved)	52.0%	52.0%	Maintain
2.3.25 Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who rate the risk of substance abuse as moderate or great (Outcome)	FY 2011: 27.0% Target: 47.1%[38] (Target Not Met but Improved)	50.0%	50.0%	Maintain
2.3.28 Number of evidence-based policies, practices, and strategies implemented (Output)	FY 2011: 834 Target: 397[39] (Target Exceeded)	250[40]	250	Maintain

[35] The SPF SIG program is cohort-based and, as a result, there are observable decreases in targets to reflect the close-out of Cohort III in FY 2011, Cohort IV in FY 2012, and Cohort V in FY 2013. Data reported for output measures are collected through the PMRTS. However, outcome data are based on calculations from NSDUH state-level, pooled sample estimates that are available at the time of the budget submission. For example, FY 2011 results were calculated using pooled NSDUH samples from 2009/2010 and 2010/2011.

[36] Includes Cohorts III and IV. Cohort IV began the SPF process July 2009.

[37] Includes Cohorts III and IV. Cohort IV began the SPF process July 2009.

[38] Includes Cohorts III and IV. Cohort IV began the SPF process July 2009.

[39] Includes Cohorts III and IV. Cohort IV began the SPF process July 2009.

[40] Target decreased due to close-out of Cohort III and IV.

Grant Award Table

(Whole Dollars)	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	291	298	316
Average Awards	$486,698	$448,982	$416,260
Range of Awards	$50,000 - $2,300,000	$50,000 - $2,300,000	$50,000 - $2,300,000

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

Programs of Regional & National Significance	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
CAPACITY:				
Opioid Treatment Programs/Regulatory Activities.....	$12,886	$8,941	$8,746	-$4,140
*Prevention and Public Health Fund.....	*4,000*	*N/A*	---	*-4,000*
Screening, Brief Intervention and Referral to Treatment..	53,187	28,360	30,000	-23,187
*PHS Evaluation Funds (non-add).....	*2,000*	*2,012*	---	*-2,000*
*Prevention and Public Health Fund.....	*25,000*	*N/A*	*30,000*	*+5,000*
TCE-General.....	27,980	28,151	13,256	-14,724
Pregnant & Postpartum Women.....	15,970	16,067	15,970	---
Strengthening Treatment Access and Retention.....	1,672	1,682	1,000	-672
Recovery Community Services Program.....	2,445	2,460	2,562	+116.63
Access to Recovery.....	98,268	98,869	65,000	-33,268
Children and Families.....	30,620	30,807	29,678	-942
Treatment Systems for Homeless.....	41,571	41,826	41,571	---
Minority AIDS.....	65,863	66,266	52,359	-13,504
Criminal Justice Activities.....	66,903	67,920	65,135	-1,768
Subtotal, Capacity	**417,366**	**391,351**	**325,277**	**-92,089**
SCIENCE AND SERVICE:				
Addiction Technology Transfer Centers.....	9,064	9,119	8,081	-983
Special Initiatives/Outreach.....	2,267	2,281	1,436	-831
Subtotal, Science and Service	**11,331**	**11,400**	**9,517**	**-1,814**
TOTAL, PRNS	**$428,697**	**$402,751**	**$334,794**	**-$93,903**

1/The FY 2012 total includes Prevention and Public Health Fund (PPHF) dollars in the amount of $25.0 million for SBIRT and $3.8 million for Opioid. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary, the FY 2014 total includes PPHF dollars in the amount of $30.0 million for SBIRT. In FY 2012- FY 2014, the CSAT Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

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

FY 2014 Authorization..... Expired

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

Program Description and Accomplishments

Opioid Drug Treatment/Regulatory Activities

SAMHSA/CSAT funds a number of contracts that support its regulatory efforts and monitoring activities of opioid treatment programs. In FY 2012, SAMHSA funded the continuation of two grants, supported eight contracts, as well as nine new multi-year grants.

SAMHSA will continue to support the Physician Clinical Support System-Opioids (PCSS-O), a national mentoring network offering support (clinical updates, evidence-based outcomes, and training) to physicians and other medical professionals in the appropriate use of methadone and other opioids for the treatment of chronic pain and opioid addiction. This program also addresses the nation's rise in opioid-associated morbidity and mortality that has been spurred by misuse/abuse, and fatal drug interactions involving methadone and other prescription medications, over the counter medications, and illicit drugs. The PCSS-O program works to develop a variety of evidence-based, authoritative, and educational programs that will be offered in multiple media formats and are cost effective, easy to use, and sensitive to the varied needs of different healthcare providers. This will increase the likelihood that these materials will be used by prescribers to develop an extensive system of dissemination activities through the efforts of consortium members aimed at increasing the knowledge base and training of prescribers (or those in training who will become prescribers) from diverse multi-disciplinary healthcare backgrounds, and also to develop a novel system of peer support and mentoring for providers from diverse clinical backgrounds or those who practice in diverse geographic and demographic areas, both urban and rural, in order to provide the necessary support to increase confidence in the ability to safely and effectively utilize opioids in patients with chronic pain or opioid use disorders.

In FY 2012, SAMHSA continued funding for the last year of the Physician Clinical Support System-Buprenorphine (PCSS-B), a program designed to assist practicing physicians that want to incorporate into their practices the treatment of prescription opioid-and-heroin dependent patients using the medication buprenorphine. The goal of this program is to expand access to office-based buprenorphine treatment by first providing expert education and training to physicians on the appropriate use of buprenorphine, and to certify their eligibility to treat opioid dependent patients. The PCSS-B works collaboratively with medical organizations to educate physicians about opioid use disorders and the use of buprenorphine in treating opioid addiction. Mentoring is also made available to physicians-in-training and those engaged in clinical practice. Educational presentations on advanced topics in the treatment of opioid use disorders are offered monthly by telemedicine modalities, including telephone conferencing and webinars.

In FY 2012, SAMHSA supported a new program, the Prescription Drug Monitoring Program (PDMP) Electronic Health Record (EHR) Integration and Interoperability Expansion, with $4 million in funding from the Prevention Fund. Working collaboratively with the Harold Rogers Prescription Drug Monitoring National Training and Technical Assistance Program at the Department of Justice, this program is intended to complement existing federal efforts by improving real-time access to PDMP data by integrating PDMPs into existing technologies, like EHRs, in order to improve the ability of state PDMPs to reduce the nature, scope, and extent of

misuse, use and also to strengthen state PDMPs that are currently operational by providing resources to make the changes necessary to increase interoperability of state PDMPs.

Nine states received funding to integrate their PDMPs into EHR and other health information technology systems to expand utilization of PDMP data by increasing the production and distribution of unsolicited reports and alerts to prescribers and dispensers of prescription data. Grant funds will also be used by states to allow for modification of their systems to expand interoperability; enhancement of current EHR and pharmacy systems; adoption of specification for exchanging PDMP reports; and modification of EHR and pharmacy systems to permit new linkages.

This grant program is complemented by an evaluation program conducted by the Centers for Disease Control and Prevention (CDC).

SAMHSA also collaborated with the Office of the National Coordinator (ONC), the CDC, and the Office of the National Drug Control Policy (ONDCP) on a jointly funded Enhancing Access to PDMPs Project. This project stems from joint efforts of public sector and private industry experts that participated in the White House Roundtable on Health IT and Prescription Drug Abuse in June 2011. In turn, the HHS Prescription Drug Abuse and Health IT Work Group of the Behavioral Health Coordinating Committee created the Action Plan for Improving Access to Prescription Drug Monitoring Programs through Health Information Technology.

The project's purpose is to use Health IT to increase timely access to PMDP data in an effort to reduce prescription drug misuse and overdose. The project's focus is to enhance access for three types of medical professionals within a variety of care settings:

- Ambulatory clinic healthcare providers (e.g., physicians, nurses, nurse practitioners)
- Emergency department (ED) physicians
- Dispensing pharmacists

The project sets out to investigate and develop the standards necessary to utilize existing technologies, the health information exchanges, and the PDMPs to improve the tracking of opioid use by convening work groups and implementing pilot studies. The first part of the project involving the work groups was completed and a report summarizing the findings, recommendations, and artifacts of the work groups was finalized and published in June 2012. To date, six pilot projects have been launched and an additional pilot candidate is actively being engaged to cover seven different pilot types.

SAMHSA also certifies opioid treatment programs (OTPs) that use methadone, buprenorphine, or buprenorphine/naloxone to treat patients with opioid dependence. SAMHSA carries out this responsibility by enforcing regulations that established an accreditation-based system, and it is accomplished in coordination with the Drug Enforcement Administration (DEA), states, territories, and the District of Columbia. An OTP must comply with applicable state licensing requirements to operate as an OTP and must meet regulatory requirements set forth in Title 42 Code of Federal Regulations Part 8 (42 CFR Part 8). The regulations also require each OTP to achieve and sustain accreditation by a SAMHSA/CSAT approved accreditation organization as a

condition for SAMHSA certification. SAMHSA funds the Medical Education and Supporting Services for Opioid Treatment Program to educate and prepare OTPs to achieve accreditation by SAMHSA's approved accreditation organizations. Accreditation has been shown to improve treatment and access to treatment for patients and provides the opportunity for OTPs to incorporate best practices in their treatment programs. Other goals include improving OTP administration and management, increasing staff retention, providing more OTP staff training, increasing availability of comprehensive services and emergency services, and improving patient outcomes. Even though most OTPs have been able to achieve initial accreditation (approximately 97 percent of over 1,260 active OTPs are accredited), continuing technical assistance is considered necessary to assist OTPs in maintaining accreditation, as they are subject to re-survey, occurring at least triennially.

In FY 2013 SAMHSA anticipates funding one grant continuation, 46 new grants and supporting seven contracts. New grants include: 20 Enhancing Opioid Treatment Program Patient Continuity of Care through Data Interoperability (OTP-CoC) one-year grants. The purpose of this program is to provide resources to opioid treatment programs (OTPs) that will enable them to develop electronic health record systems that fulfill regulatory requirements, achieve certified status, and become interoperable with other patient health record systems. By enhancing OTP EHR systems in this manner and achieving levels of integration, it is expected that OTPs will improve behavioral health outcomes. Additionally, SAMHSA also anticipates funding 25 one-year grants to support the Rapid Hepatitis C Virus Screening and Referral grants. The purpose of this program is to address the high prevalence of viral hepatitis C infection among IV drug users in selected opioid treatment programs (OTPs). In addition to providing rapid hepatitis C virus (HCV) testing, applicants must develop a plan for providing referrals for care and treatment that include, but are not limited to primary health care, public health, mental health, and medical services for those who are HCV positive or are at high-risk of HCV infection. Also planned is a one, three-year Cooperative Agreement for the Physician Clinical Support System – Medication Assisted Treatment grant. The purpose of this program is to build upon the current SAMHSA-funded PCSS-B, a national mentoring network offering support (clinical updates, evidence-based outcomes and training) by expanding the focus on buprenorphine to include the other two FDA approved medications for the treatment of opioid addiction, methadone and extended release naltrexone and increasing the amount of training for office based physicians and opioid treatment program medical professionals. The program will provide up to date and evidence-based information to support training of health professionals and to address complex issues of addiction.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) was initiated by SAMHSA/CSAT in FY 2003, using cooperative agreements to expand and enhance a state or tribal organization's continuum of care. The purpose of the program is to integrate screening, brief intervention, referral, and treatment services within general medical and primary care settings.

The SBIRT program requires grant recipients to effect practice change throughout the spectrum of medical practice. This is achieved through implementation in all levels of primary care, including hospitals, trauma centers, health clinics, nursing homes, employee assistance

programs, and school systems. Practice change also alters the educational structure of medical schools by developing and implementing SBIRT curricula as standard and permanent practice. Research and clinical experience supports the use of the SBIRT approach to provide effective early identification and interventions in primary care and general medical settings. Early identification can decrease total healthcare costs by arresting progression toward addiction. SBIRT also can identify people, individuals with more serious problems and encourage them to obtain appropriate specialty treatment services. Funds may be used for the following services: pre/screening for substance use and co-occurring disorders; brief Interventions designed with client centered, non-judgmental, motivational interviewing techniques; brief treatment including the monitoring of individuals who misuse alcohol and other drugs but are not yet dependent; referral to treatment (when indicated) for those who have a substance use disorder; and when appropriate, referral to and expansion of specialty treatment services. Since the beginning of this program, more than 1.7 million individuals have been screened. Of those, 19 percent required a brief intervention, brief treatment, or referral to specialty treatment programs.

In 2011, over 213,000 clients were served by the SBIRT Program. The percentage of clients reporting abstinence at follow-up tripled compared to the percentage reporting abstinence at baseline.

SBIRT has great future potential for promoting changes to the entire primary care medical service delivery system. Efforts are underway to identify other funding streams to help take this practice to scale. For example, new diagnostic codes have been adopted by 16 states, making it easier for doctors to get reimbursed for screening Medicaid patients. Likewise, alcohol screening is now available to Medicare beneficiaries as a preventive service without cost. In FY 2012, SAMHSA funded the continuation of 27 SBIRT grants, supported five contracts as well as three new multi-year grants funded out of the Prevention Fund, and continued to monitor the progress of the three FY 2011 multi-year Prevention Fund grants. In FY 2013 SAMHSA anticipates funding up to 19 new grants as well as 12 grant continuations and supporting five contracts.

Targeted Capacity Expansion-General (TCE-General)

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

In FY 2011, SAMHSA funded Grants to Expand Care Coordination Through the Use of Health Information Technology (HIT) in Targeted Areas of Need. The purpose of this program is to leverage technology to enhance and/or expand the capacity of substance abuse treatment and service providers to serve people, individuals in treatment who have been underserved because

of lack of access to treatment in their immediate community due to transportation concerns, an inadequate number of substance abuse treatment and service providers in their community, and/or financial constraints. The use of HIT, including web-based services, smart phones, behavioral health electronic applications (e-apps), and telehealth will expand and enhance the ability of providers to effectively communicate with people, individuals in treatment and to track and manage their health to ensure treatment and services are available where and when needed. Grantees will use technology that will support recovery and resiliency efforts and promote wellness.

In FY 2012, SAMHSA funded 46 grant continuations and supported 12 contracts as well as six new multi-year funded HIT grants. In FY 2013, SAMHSA anticipates funding 14 TCE-Technology Assisted Care (TAC) grants, 20 TCE-Peer to Peer (TCE-PTP) services, 30 grant continuations, and supporting 10 contracts. The purpose of TCE-TAC is to expand and/or enhance the capacity of substance abuse treatment and service providers to serve people, individuals in treatment who have been underserved because of lack of access to treatment in rural areas, or in their immediate community due to transportation concerns, an inadequate number of substance abuse treatment and service providers in their community, and/or financial constraints. The use of technology, including web-based services, smart phones, and behavioral health electronic applications (e-apps), will expand and/or enhance the ability of providers to effectively communicate with individuals in treatment and to track and manage their health to ensure treatment and services are available where and when needed.

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

Pregnant & Postpartum Women (PPW)

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

As part of SAMHSA's Strategic Initiative on Trauma and Justice, SAMHSA/CSAT's Pregnant and Postpartum Women (PPW) program has supported gender-and culturally-specific treatment service grants for pregnant, postpartum, and other parenting women. Using a family-centered

trauma-informed treatment approach in residential and community settings, with women and their minor children at the center, the program has focused on the strengths and resources of the entire family. It supports sustained recovery for individual family members, coordinates with services in the community, and improves overall family functioning. The PPW program is designed to support comprehensive substance abuse prevention, treatment, and recovery support services for women, their minor children, age 17 and under children, and family members.

Services for women include: outreach, engagement, pre-treatment, screening, and assessment; detoxification; substance abuse education, treatment, and relapse prevention; health care services; specialized assessment, monitoring, and referrals for education, peer support, therapeutic interventions and physical safety; mental health care including a trauma-informed system of assessments and interventions; parenting education and interventions; home management and life skills training; education, testing, counseling, and treatment of hepatitis, HIV/AIDS, other STDs, and related issues; and wraparound services including employment readiness, and job training and placement, education and tutoring assistance, peer-to-peer recovery support activities; and transportation.

Services for children include: screenings and developmental diagnostic assessments; prevention assessments and interventions related to mental, emotional, and behavioral wellness; trauma-informed system of assessments, interventions, and social-emotional skill building services; developmental services and therapeutic interventions; health care services; social services; and education and recreational services.

Services for families include: family-focused programs to support family strengthening including fathers where appropriate; reunification; alcohol and drug education and referral services; mental health promotion and assessment, prevention and treatment services, in a trauma-informed context; and social services.

Case management services include: coordination and integration of services; assessment and monitoring of services; assistance with community reintegration; and assistance in accessing resources from federal, state, and local programs that provide a range of services.

In FY 2011, the PPW program funded a new cohort of grantees. FY 2011 data show that the percentage of women reporting abstinence at six month follow-up doubled compared to those reporting abstinence at intake. Employment also showed large increases with the percentage tripling from intake to follow-up. In FY 2012, SAMHSA funded the continuation of 20 grants, seven new grants, and support for five contracts. In FY 2013, SAMHSA anticipates funding 27 grant continuations and supporting five contracts

Strengthening Treatment Access & Retention (STAR)

During the initial phase of the STAR program, CSAT joined with the Robert Wood Johnson Foundation (RWJF) in an initiative to substantially increase client access and retention using process improvement methods. Under a program titled Network for the Improvement of

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

Based on the NIATx program success, CSAT funded a follow-up effort in 2006, the STAR-State Implementation (STAR-SI) program, an infrastructure initiative that promotes state-level implementation of process improvement methods to improve access to and retention in outpatient treatment.

In FY 2010 and FY 2011, the STAR initiative provided technical assistance and support to six SAMHSA/CSAT discretionary grant programs and over 50 treatment organizations to improve client access, retention and handoffs to other levels of care. The program also conducted a learning collaborative with over 300 treatment and service providers on how to improve third-party billing practices in anticipation of the expansion in addiction treatment services coverage and health insurance affordability program eligibility under the Affordable Care Act. In FY 2012, SAMHSA supported four contracts to continue to provide technical assistance in promoting service efficiency. In FY 2013 SAMHSA is supporting four contracts.

Recovery Community Services Program (RCSP)

SAMHSA's Strategic Initiative on Recovery Support focuses on health, home, purpose, and community. As part of the community component of this initiative, the Recovery Community Services Program (RCSP) responds to the need for community-based recovery support services that help prevent relapse and promote long-term recovery. Such services can reduce the strain relapse places upon the already overburdened treatment system and minimize the negative effects of relapse when it does occur, as well as contribute to a better quality of life for people in recovery and their families and communities. The purpose of the RCSP is to advance peer-to-peer recovery support services that help to prevent relapse and promote sustained recovery from alcohol and drug use disorders.

The RCSP program has targeted a variety of underserved groups including women, African-Americans, Latinos, rural populations, people, individuals recently released from incarceration, the homeless, adolescents, and gay, lesbian, and transgender populations. In addition, the RCSP program serves family members and allies of individuals in recovery. The primary targets for the RCSP initiative are people with a history of alcohol and/or drug problems who are in or seeking recovery. RCSP grants provide a wide range of services such as peer coaching; peer support groups; life skills workshops; peer-led resource connector programs for housing,

employment, educational assistance, vocational rehabilitation and training; leadership development; alcohol and drug free events; and recovery drop-in centers. In FY 2011, the RCSP program provided supplemental funding to the existing 13 grantees. FY 2011 data demonstrates positive outcomes, with 80 percent of clients served reporting being abstinent at follow-up; 35 percent reported being employed; 57 percent reported being housed; and 99 percent reported not being involved in the criminal justice system.

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

Access to Recovery

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

Since 2004, ATR has funded a total of 69 grants in a total of three cohorts: 15 three-year grants were awarded in FY 2004, 24 three-year grants were awarded in FY 2007, and 30 four-year grants were awarded in FY 2010. ATR is designed to: (1) allow recovery to be pursued through personal choice and many pathways; (2) require grantees to manage performance based on outcomes that demonstrate client successes; and (3) expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services. The target is 225,000 clients for the third cohort, which began in FY 2010, with approximately 33,500 to be served in the first year; 70,750 clients to be served in each of the two subsequent years; and 50,000 to be served in the final year. In its first year of operation this cohort of ATR has exceeded its target of 33,500, having served over 47,000 clients. SAMHSA funded the continuation of 30 grants and supported six contracts in FY 2012. SAMHSA will fund 30 grant continuations in the final year of the third cohort in FY 2013 as well as one contract.

Children & Family Programs

As part of SAMHSA's Trauma and Justice Strategic Initiative, SAMHSA/CSAT's Adolescent Treatment grants are designed to address the gaps in substance abuse services by providing services to adolescents and their families/primary caregivers using previously proven effective

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

Each site has received training and certification to conduct a standardized bio-psychosocial clinical assessment that identifies substance use disorders, co-occurring mental health problems, mental illness, and family support and functioning. Utilizing this intensive process ensures that a standardized implementation of the intervention is completed. Important lessons to be learned from these grantee sites include how to effectively implement and sustain best and proven practices in community-based agencies.

The Assertive Adolescent and Family Treatment (AAFT) grants provide adolescents 12 through 17 and their families/care givers with: a full bio-psycho-social clinical assessment, the Global Appraisal of Individual Needs, which identifies substance use disorders, co-occurring mental health problems, mental illness, and family support and functioning; six months of substance abuse treatment and follow-up monitoring using the ACRA and ACC; urine testing; case management; and referrals to other needed community service providers.

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

In addition to the adolescent treatment grant programs, SAMHSA/CSAT has been collaborating with the Administration for Children and Families (ACF) through an inter-agency agreement to fund a National Center on Substance Abuse and Child Welfare (National Center). The vast majority of children, particularly infants, who are placed in protective custody have a parent with a substance use disorder. Thus, it is imperative that child welfare, substance abuse treatment and service providers, and the courts work efficiently together. Activities of this National Center include in-depth technical assistance to states, forging more extensive partnerships with family drug courts, and planning greater emphasis on work with tribes. ACF grantees will be able to draw upon SAMHSA technical assistance provided to the child welfare and substance abuse treatment fields, including grants awarded under an ACF grant program entitled "Targeted Grants to Increase the Well Being of and to Improve the Permanency Outcomes for Children Affected by Methamphetamine and Other Substance Abuse," referred to as Regional Partnership grants.

In FY 2012, the adolescent portfolio supported 32 grant continuations, six contracts and 13 new state grants. In FY 2013, SAMHSA anticipates funding 13 grant continuations and supporting five contracts. Additionally, SAMHSA anticipates funding 11 new grants.

Treatment Systems for Homelessness

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

The Treatment for Homeless-General grants, funded solely by CSAT, enable communities to expand and strengthen their substance abuse treatment services for individuals who are at risk for homelessness or have experienced homelessness (including chronic homelessness) who have substance use disorders or with co-occurring substance use and mental disorders, and move them to permanent supportive housing. In addition, CSAT provides funds for expanding and strengthening substance abuse treatment services for homeless, alcohol-dependent people, individuals who have histories of public inebriation, frequent emergency room visits, arrests, mental illness, or co-occurring substance use and mental disorders.

In FY 2008, CSAT also funded grants that address services in supportive housing (SSH). The Treatment for Homeless-SSH grants seek to expand and strengthen treatment services for people, individuals who experience chronic homelessness by providing linkages to appropriate treatment for substance use or other support services. This approach combines long-term, community-based housing assistance and intensive individualized treatment and recovery support services to those experiencing chronic homelessness who have substance use disorders or co-occurring substance use and mental disorders. This is a cost-effective combination of affordable housing with substance abuse treatment services which helps people live more stable, productive lives and leads to reductions in substance use.

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

All programs funded under the GBHI authority (Treatment for Homeless (general and SSH) and CABHI) may purchase a number of services: outreach and direct treatment (including screening, assessment, and active treatment) for both mental and substance use disorders. Treatment must be provided in outpatient (including outreach-based services), day treatment or intensive outpatient, or short-term residential programs (90 days or less in duration and at a cost not to exceed 6.5 percent of total grant funds). Case management or other strategies to link with and retain clients in housing and other necessary services, including but not limited to primary care

services, and to coordinate these services with other services provided to the client; engage and enroll individuals in Medicaid and other mainstream benefit programs (e.g., SSI/SSDI, TANF, SNAP, etc.); recovery support services designed to improve access to and retention in services and to continue treatment gains, which may include (as appropriate for each client) vocational, child care, educational and transportation services; independent living skills (e.g., budgeting and financial education); employment readiness, training, and placement; crisis care; medications management; self-help programs; discharge planning; psychosocial rehabilitation; and peer recovery support(s).

Grantees may also provide the following allowable services: education, screening, and counseling for hepatitis and other sexually transmitted infections; active steps to reduce HIV/AIDS risk behaviors by their clients. Active steps include client screening and assessment, and either direct provision of appropriate services or referral to and close coordination with other providers of appropriate services; trauma-informed services, including assessment and interventions for emotional, sexual, and physical abuse; and use of an integrated primary/substance abuse/mental health care approach in developing the service delivery plan. This approach involves screening for health issues and delivery of client-centered substance abuse and mental health services in collaboration and consultation with medical care providers. In FY 2012, SAMHSA funded the continuation of 95 grants and supported four contracts.

In FY 2013, SAMHSA anticipates funding 71 grant continuations and support five contracts. In addition, CSAT in collaboration with CMHS, also anticipates funding 12 new Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States). CABHI-States builds on the current CABHI program by adding a state infrastructure improvement approach addressing chronic homelessness to the community-based behavioral health service component for newly housed individuals who experience chronic homelessness with substance use disorders or co-occurring substance use and mental disorders.

Minority AIDS

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

In addition to providing substance abuse treatment services, pre-treatment services are provided, including the provision of literature and other materials to support behavior change, facilitation of access to drug treatment, HIV/AIDS testing and counseling services, and other medical and social services in the local community.

In FY 2011, SAMHSA/CSAT's TCE/HIV program served approximately 6,200 individuals. Of these individuals, approximately 70 percent were between the ages of 25 and 54 years old.

Approximately 31 percent identified themselves as Hispanic/Latino in ethnicity; 46 percent as African-American; 22 percent White; one percent Asian, Native Hawaiian, or Pacific Islander; and 4 percent as American Indian/Alaska Native.

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

In FY 2012, SAMHSA funded the continuation of 75 grants and supported five contracts as well as a new cohort of 52 grants to target areas of highest need based on the most recently available HIV epidemiological data.

In FY 2013, SAMHSA anticipates funding 79 grant continuations and supporting four contracts and 38 new grants. The 38 grants will support Targeted Capacity Expansion: Substance Abuse Treatment for Racial/Ethnic Minority Women at High Risk for HIV/AIDS (TCE-HIV: Minority Women). The purpose of this program is to expand substance abuse treatment and HIV services for African American, Hispanic/Latina, and other racial/ethnic minority women (ages 18 years and older), including heterosexual, lesbian, bisexual, previously incarcerated women, and these women's significant others, who have substance use or co-occurring substance use and mental disorders, and are living with or at risk for HIV/AIDS.

Criminal Justice Activities

Criminal Justice (CJ) activities include grant programs which focus on diversion, alternatives to incarceration, and re-entry from incarceration for adolescents and adults with substance use disorders, and/or co-occurring substance use and mental disorders. These activities comport directly with SAMHSA's Trauma and Justice Strategic Initiative efforts. Data shows positive improvements in outcomes of clients served by the CJ portfolio. For example, in 2011, abstinence increased by over 62 percent from intake to follow-up, CJ involvement decreased by 11.7 percent, and employment and housing increased by 37 percent and 30 percent, respectively.

The proposed number of clients to be served with 2014 funding is 3,552. Outcomes including abstinence from substance use will also be tracked. By 2015, 80 percent of clients are expected to report being abstinent from substance use and 94.9 percent of clients are expected to report having no involvement with the criminal justice system.

Drug Courts

Drug courts are designed to combine the sanctioning power of courts with effective treatment services for a range of populations and problems such as alcohol and/or drug use, child

abuse/neglect or criminal behavior, mental illness, and veterans' issues. In 2010, the criminal justice system was the largest single source of referrals to substance abuse treatment. As treatment drug courts and other problem solving courts addressing drug and other behavioral health-related issues are being established at a high rate, communities are challenged to find sufficient substance abuse treatment and recovery support resources for people referred by the courts.

In FY 2010, SAMHSA/CSAT funded 10 new adult treatment drug court grants for three years at a cost of up to $325,000 per year. Also in FY 2010, SAMHSA and the Department of Justice (DOJ)/Office of Justice Programs (OJP)/Bureau of Justice Affairs (BJA) developed a joint program to enhance court services, coordination, and the substance abuse treatment capacity of adult drug courts. The purpose of this joint initiative is for applicants to submit one application that outlines a comprehensive strategy for enhancing drug court capacity. SAMHSA and BJA jointly funded 20 new adult treatment drug court grants. Each grantee was awarded one separate grant from each agency, representing an innovative braided funding opportunity. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent. This collaboration was modeled after the successful SAMHSA and DOJ/Office of Juvenile Justice and Delinquency Prevention (OJJDP) collaborative juvenile treatment drug court grant program.

Funding for both the SAMHSA/CSAT and the SAMHSA/OJP/BJA adult treatment drug court programs must be used primarily for the following: direct treatment or prevention services for diverse populations at risk; "wrap-around"/recovery support services designed to improve access and retention; to provide drug testing for illicit substances required for supervision, treatment compliance, and therapeutic intervention; education support; relapse prevention and long-term management; Medication-Assisted Treatment (MAT); and HIV testing conducted in accordance with state and local requirements.

In 2010 SAMHSA started the Children Affected by Methamphetamine/Family Treatment Drug Court program. These grants provide a child care coordinator to link available community-based social services resources that will focus on the trauma to the youngest victims caused by substance abuse/methamphetamine use in the family and concurrent criminal justice system involvement. In FY 2010, SAMHSA/CSAT funded 12 grants at up to $370,000 per year for up to four years.

The Children Affected by Methamphetamine (CAM) program delivers services to the children of parents participating in Family Drug Treatment Court (FDTC). This grant program has been instrumental in developing a FDTC model that includes services for children, as well as, parenting/family programs for the family. Examples of services and supports for children, parents and families include: identification of substance exposed newborns so that interventions can be initiated/enhanced with these infants at birth; coordination with child welfare agencies around services provided to the family and child; home visiting services or referrals and linkages for medical and/or developmental follow-up with pediatric specialists knowledgeable about exposure to methamphetamine; primary care coordination; developmental assessments and services, and intervention with children identified as needing services; mental health services to children; and case management services. Services and linkages for parents include: evidence-

based strategies to promote parenting abilities and address trauma; ancillary services for families to provide assistance in securing needed services such as safe and drug-free housing, transportation, vocational training and education, government benefits, legal services and child care; family planning services to avoid future in-utero exposure to methamphetamine and other drugs; domestic violence prevention/intervention services; and training for foster parents, relatives, and other substitute caregivers about the special needs of children and youth who have suffered from abuse or neglect and whose parents have a substance use disorder. Services for families include: evidence-based family and parenting interventions designed for children of parents with substance use disorders and their parents; and family counseling to strengthen family functioning and assist with reunification of families when children have been in out-of-home placements.

In FY 2012, SAMHSA funded the continuation of 81 Drug Court grants and supported eight contracts, as well as 54 new grants. In FY 2013, SAMHSA will fund the continuation of 76 grants, support for five contracts, and 51 new grants.

Offender Re-entry Program

The Offender Reentry Program (ORP) grants provide screening, assessment and comprehensive treatment and recovery support services to offenders reentering the community, as well as offenders who are currently on or being released from probation or parole. SAMHSA and the DOJ/BJA share a mutual interest in supporting and shaping offender re-entry-treatment services, as both agencies fund "offender reentry" programs. Formal agreements have been developed to further encourage and engage in mutual interests and activities related to criminal justice-treatment issues. ORP grantees are expected to seek out and coordinate with local federally-funded offender reentry initiatives, including the DOJ/BJA's Prisoner Reentry Initiative or "Second Chance Act" offender re-entry programs, as appropriate.

Funding for the ORP may be used for the following services/activities: screening, comprehensive individual assessment for substance use and/or co-occurring mental disorders, case management, program management and referrals related to substance abuse treatment for clients; alcohol and drug treatment; wraparound services supporting the access to and retention in substance abuse treatment or to address the treatment-specific needs of clients during or following a substance abuse treatment episode; individualized services planning; drug testing as required for supervision, treatment compliance, and therapeutic intervention; support in obtaining a GED and/or other necessary education; and relapse prevention and long-term management support.

Other Criminal Justice Activity

In FY 2011, SAMHSA awarded grants to Develop and Expand Behavioral Health Treatment Court Collaboratives (BHTCC) in collaboration with CMHS. SAMHSA's vision of a BHTCC in the criminal justice system is one that supports treatment and recovery for people with behavioral health conditions and that improves public health and public safety by transforming the behavioral health system at the community level. The purpose of the BHTCC grant program is to provide state and local criminal and dependency courts serving adults with more flexibility to collaborate with the other judicial components and local community treatment and recovery

providers to better address the behavioral health needs of adults who are involved with the criminal justice system. Funds may be used for the following services/activities: purchase and/or administration of brief diagnostic and screening tools and instruments for identification of behavioral health needs for the identified individuals in need; treatment services in outpatient, day treatment, intensive out patient, and residential treatment; services to improve family functioning; employment support services; addressing criminogenic factors leading to recidivism; case management models such as wraparound services, team approaches that include adult criminal court supervising authorities, and existing treatment alternatives organizations; drug testing for illicit substances required for supervision, treatment compliance, and therapeutic intervention; education support; relapse prevention and long-term management; forensic peer support; medication-assisted treatment (MAT); and HIV testing conducted in accordance with state and local requirements.

In FY 2012, SAMHSA funded the continuation of 27 grants and supported five contracts and funded 28 new grants. This includes funding for the Teen Courts program (TCP), of which the primary focus is on preventing crimes by diverting youth with substance abuse treatment needs from deeper penetration into the traditional juvenile justice system. Funds will be used to provide screening, assessment, substance abuse treatment, and recovery support services for youth involved in a TCP.

Funding for the TCP may be used for the following services/activities: screening, comprehensive individual assessment for substance use and/or co-occurring mental disorders, case management, program management and referrals related to substance abuse treatment for youth; alcohol and drug treatment; wrap-around services supporting the access to and retention in substance abuse treatment or to address the treatment-specific needs of clients during or following a substance abuse treatment episode; individualized services planning; drug testing as required for treatment compliance and therapeutic intervention; support in obtaining a GED and/or other necessary education; and relapse prevention and long-term management support.

In FY 2013, SAMHSA/CSAT's Other Criminal Justice Program anticipates funding 39 grant continuations, supporting four contracts and also anticipates funding 15 new grants.

Addiction Technology Transfer Centers (ATTCs)

The Addiction Technology Transfer Center (ATTC) Network supports national activities and implements programs and initiatives in response to regional needs, decreasing the gap in time between the release of new scientific findings and evidence-based practices and the implementation of these interventions by front-line clinicians. ATTCs disseminate evidence-based, promising practices to addiction treatment/recovery professionals, public health/mental health personnel, institutional and community corrections professionals, and other related disciplines. The ATTC program dissemination models include technical assistance, training events, a growing catalog of educational and training materials, and an extensive array of Web-based resources created to translate the latest science for adoption into practice by the substance use disorders treatment workforce. The ATTCs are highly responsive to emerging challenges in the field. Data show that over 25,000 people were trained in 2011, exceeding the target of 20,516. In FY 2012, SAMHSA funded a new cohort of 15 grants. Ten of the new grants are

geographically consistent with HHS's 10 regional offices in order to coordinate SAMHSA services, technical assistance and workforce training and development with other HHS Operating Divisions such as HRSA, CMS, ACF, and the SAMHSA Regional Administrators. The remaining five awards support one national and four focus area ATTCs. In FY 2013, SAMHSA will fund the continuation of all 15 grants and support two contracts.

Special Initiatives/Outreach

Special Initiatives/Outreach activities include a grant program for Historically Black Colleges and Universities (HBCU)-Center for Excellence, which is an innovative national resource center dedicated to continuing the effort to network the 105 HBCUs throughout the United States. The HBCU-Center for Excellence promotes workforce development through expanding knowledge of best practices and leadership development that enhance the participation of African-Americans in the substance abuse and mental health professions. The Center also supports a policy academy which focuses on workforce development, leadership development, cross-systems collaboration, cultural competency, and eliminating disparities. The Center collaborates with other HHS agencies including the HHS/Office of Minority Health (OMH) to achieve the objectives of various Executive Orders on educational excellence for minority populations.

Through this program, approximately 31 Substance Abuse Treatment Workforce Development pilots were funded to provide opportunities for more students to obtain practical experience in the addictions field. This program has increased the number of students interning in behavioral health and has established or increased HBCU partnerships with local, regional and state behavioral health partners, primarily substance abuse, committed to increasing diversity in the addictions field.

In FY 2010 SAMHSA/CSAT entered into an inter-agency agreement with the Agency for Healthcare Research and Quality (AHRQ) to examine and graphically display selected trends in hospital-based stays for mental health and substance abuse treatment. This work was used to write a chapter in the annual AHRQ publication, *Healthcare Cost and Utilization Project (HCUP) Facts and Figures: Statistics on Hospital Based Care in the US 2008*. This report drew attention to the extensive hospital resources devoted to people with mental and substance use disorders, some of which may be more effectively and efficiently served in community-based settings with a recovery-based system of care approach. In FY 2012, SAMHSA funded the continuation of one grant and supported one contract. In FY 2013, SAMHSA will fund the continuation of one grant and support two contracts.

Funding History[1\]

Fiscal Year	Amount
FY 2010	$451,912,000
FY 2011	$430,842,000
FY 2012	$428,696,822
FY 2013	$402,750,627
FY 2014	$334,794,000

[1\]The funding history is presented on a comparable basis to previous funding levels to represent the revised budget structure and includes the PHS Evaluation Funds and Prevention Funds other than in FY 2013. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Budget Request

The FY 2014 Budget Request is comprised of $334.8 million at the program level with $304.8 million from Budget Authority and $30.0 million provided by Prevention Funds. This reflects a decrease of $92.9 million in Budget Authority. This level of funding enables the continuation of most programmatic activities. The request will support 367 grant and 20 contracts, as well as 183 new grants and two new contracts. The Request includes:

Screening, Brief Intervention and Referral to Treatment

In FY 2014, SAMHSA requests $30.0 million from the Prevention Fund for the SBIRT program (an increase of $5 million from the Prevention Fund, but an overall decrease of $23.2 million from FY 2012). This level of funding will further support the integration and use of the SBIRT model into states and tribal primary care settings. In FY 2014, an estimated 141,435 individuals will be served by the program. The request will support 41 grants (25 continuations and 16 new) and one contract. Grant funds will further integrate SBIRT within medical treatment settings to provide early identification and intervention to at-risk individuals within the context of their primary care provider.

Based on the CSAT funded cross-site evaluation of SBIRT's cohort one grantees (conducted between 2004 and 2009)), alcohol was the most widely used substance (74.4 percent) among those who screened positive. Among those who reported using illicit drugs, 70.2 percent also reported consuming alcohol. Marijuana use was second in prevalence (27.3 percent), and cocaine was third (14.5 percent). Rates of use reported for other drugs, although generally low (less than 5 percent for most specific substances), were consistently higher among patients assigned to Brief Treatment (BT) and Referral to Treatment (RT) than those for whom Brief Intervention (BI) was recommended. Overall, patients receiving Brief Intervention, Brief Treatment or Referral to Treatment BI, BT, or RT reduced their alcohol and substance use at follow-up as compared to baseline. Reductions as measured by the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) included significant decreases in:

- Total Substance Involvement Score (TSIS) among higher-risk BI, BT, and RT patients. For patients in the high-risk BI, BT, and RT groups, reductions in total substance use risk, as measured by the TSIS, were observed and were statistically significant at the 0.05 level.
- Specific Substance Score for Alcohol (SSA) among BT and RT patients (44 percent and 49 percent decreases, respectively).
- Total Illicit Substance Involvement Score (TISIS) among RT patients (45 percent decrease).
- Percentages of higher-risk BI, BT, and RT patients using alcohol.
- Percentages of BT and RT patients using marijuana and also cocaine.

The SBIRT program generated net social cost savings that far exceeded the costs of the program. Correcting for covariates such as gender, race, age, income, education, and marital status, the evaluation team found a reduction in social cost from baseline to follow-up when considering the cost areas of healthcare utilization, criminal justice (e.g., arrests), automobile incidents (e.g., DUIs), and work absences. When all costs were considered, estimated cost savings were $1,206 per patient over a 6-month period. When healthcare costs alone were considered, estimated cost savings were $644 per patient. Compared to the average total cost of $70 per patient, the magnitude of social cost reduction suggests that SBIRT provides significant value for a limited investment.

Access to Recovery

The FY 2014 budget request includes $65.0 million for the ATR program. Although reduced in scale from past years, it will serve 21,000 individuals. In FY 2014, the program will preserve the core concepts embodied in the three previous ATR cohorts, while also striving to better support provisions of the Affordable Care Act.

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

SAMHSA plans to award 19 three-year grants of $3.2 million annually. The majority of services provided are expected to be recovery support not otherwise fundable through insurance mechanisms. These include services such as transportation, housing, and jobs support.

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

covered under Medicaid and other sources; and increasing availability and access to training and certification programs for non-traditional providers, such as faith-based and peer providers.

The ATR program will be better integrated into the fabric of health reform as it is implemented during 2014. At the same time, service gaps will be filled, especially in the area of recovery support, to help achieve comprehensive coverage for those with substance abuse disorders.

The proposed number of clients to be served with 2014 funding is 21,242. Outcomes including abstinence from substance use will also be tracked. By 2015, 80 percent of clients are expected to report being abstinent from substance use, 93 percent of clients are expected to report having no involvement with the criminal justice system, and 88 percent of clients are expected to report having improved social support.

Statewide Network Development Program for Recovery and Resiliency

In FY 2014, SAMHSA requests a total of approximately $1.8 million in Budget Authority ($1.4 million in CSAT and $0.4 million in CMHS) in support of SAMHSA's Recovery Support Strategic Initiative. These funds will be used to build capacity for statewide consumer-run, family member-run, or addiction recovery community organizations to promote cross-service system and infrastructure development that is recovery-focused and resiliency oriented. $1.0 million in budget authority will be used to award new addiction recovery community statewide networks. The remaining $0.8M will be braided to allow for supplemental awards for collaborative partnerships across the mental and substance use disorder fields. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent. Eligible applicants for supplements will be those organizations who have an existing mental health or addiction statewide network award. Up to 10 grant awards at $100,000 will be made for addiction recovery statewide networks. Eight supplemental awards will be given at $100,000 each.

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

Housing and Homelessness

SAMHSA works in partnership with the U.S. Interagency Council on Homelessness (USICH) to support and implement *Opening Doors: The Federal Plan to Prevent and End Homelessness.*

Through both the Recovery Support and Criminal Justice and Trauma Strategic Initiatives, SAMHSA promotes collaborative leadership with other federal agencies with collaborative calls, trainings, workgroups, and expert panels to address various goals and objectives outlined in the Plan. SAMHSA accomplishes the goals and objectives outlined in the Plan by providing technical assistance to grantees and other stakeholders regarding behavioral health, homelessness, and successful interventions to prevent and end homelessness. SAMHSA takes a leadership role in convening expert panels and developing a Policy Academy to address homelessness. SAMHSA encourages grantees to provide consumers with meaningful and sustainable employment opportunities and permanent housing that supports recovery to prevent and end homelessness. The SAMHSA Cooperative Agreements to Benefit Homeless Individuals (CABHI) grant program aligns with the USICH goal to improve access to mainstream programs and services to reduce people's financial vulnerability to homelessness and to provide integrated primary and behavioral health care services. SAMHSA along with HUD, other HHS agencies, and VA, will explore the possibility of developing criteria to incentivize demonstrated collaboration between primary and behavioral healthcare providers and homeless assistance providers.

In support of the Federal Strategic Plan to Prevent and End Homelessness and SAMHSA's Recovery Support Strategic Initiative, SAMHSA proposes to use approximately $28.6 million in Budget Authority in working with state and local Public Housing Authorities and state Medicaid agencies to develop systematic, cost-effective, and integrated approaches to housing that includes treatment and services for mental and substance use disorders. This program will build upon lessons learned from the CABHI and the Department of Housing and Urban Development's (HUD) new Section 811 demonstration program, and will be developed by SAMHSA in collaboration with its federal partners, including HUD, Health Resources and Services Administration, Centers for Medicare and Medicaid Services, and the Interagency Council on Homelessness. The program will specifically focus on providing support services and housing to individuals who are chronically homeless.

The program will support innovative strategies to transform and increase the availability of affordable housing and to provide needed services and supports that will help integrate individuals who are homeless with substance abuse and mental health disorders into the community, assist providers in strengthening their infrastructure for delivering and sustaining housing to support recovery with integrated behavioral health, and other critical services. The program also will assist providers in preparing for implementation of the Affordable Care Act by encouraging third-party billing and requiring that clients are enrolled in eligible benefit programs. Efforts will include the design and implementation of strategies that require the use of SAMHSA funds for providing supportive services to individuals who are not Medicaid-eligible (or who in the process of being enrolled), Medicaid funds for covered services, and HUD vouchers or other funding sources for housing. SAMHSA's FY 2014 request for housing and homelessness includes a total of $28.6 million ($9.9 million in CSAT and $18.8 million in CMHS). A total of up to 38 grant awards of approximately $750,000 dollars each will be awarded for five years.

Criminal Justice

Behavioral Health Treatment Court Collaboratives

In support of SAMHSA's Recovery Support Strategic Initiative, SAMHSA proposes to use a total of $4.5 million in Budget Authority ($2.2 million in CSAT and $2.3 million in CMHS) to fund an additional cohort of Behavioral Health Treatment Court Collaboratives Grants. The purpose of this grant program is to allow local courts more flexibility to collaborate with multiple criminal justice system components and local community treatment and recovery providers to address the behavioral health needs of adults who are involved with the criminal justice system. The court collaborative will focus on diversion of adults with behavioral health problems from the criminal justice system, including alternatives to incarceration. The collaborative will allow eligible individuals to receive treatment and recovery support services as part of a court collaborative. This program will focus on connecting with individuals early in their involvement with the criminal justice system and prioritize the participation of municipal and misdemeanor courts in the collaborative. The program will support community behavioral health services for individuals with mental and/or substance disorders and will include a focus on veterans involved with the criminal justice system.

The FY 2014 Budget Request includes increases in the following ($0.1 million):

- The Recovery Community Services Program request is $2.6 million, an increase of $0.1 million from FY 2012. This level of funding will support 18 new grants, one contract continuation, and one new contract.

The FY 2014 Budget Request includes level funding in the following:

- The Pregnant and Postpartum Women request is $16.0 million, the same as FY 2012. This level of funding will support the continuation of seven grants and two contracts as well as 14 new grants. The proposed number of clients to be served with 2014 funds is 700. Outcomes including abstinence from substance use will also be tracked. By 2015, 82 percent of clients are expected to report being abstinent from substance use, 26 percent of clients are expected to report being employed or engaged in productive activities, 22 percent of clients are expected to report a permanent place to live in the community.
- The Treatment Systems for Homeless program request is $41.6 million. This level of funding will support the continuation of 35 grants and four contracts as well as 49 new grants. The proposed number of clients to be served with 2014 funding is 5,800. Outcomes including abstinence from substance use will also be tracked. By 2015, 66.4 percent of clients are expected to report being abstinent from substance use, 31.7 percent of clients are expected to report being employed or engaged in productive activities, and 24.6 percent of clients are expected to report a permanent place to live in the community.

The FY 2014 Budget Request includes decreases in the following ($89.9 million):

- The Opioid Treatment Programs request is $8.8 million. This reflects a decrease of $0.1 million below FY 2012. This level of funding will support the continuation of two grants and eight contracts as well as 40 new grants.
- The SBIRT program request is $30.0 million from the Prevention Fund. This reflects a program level decrease of $23.2 million below FY 2012. This level of funding will support the continuation of 25 grants, support two contract continuations as well as 16 new grants.
- The Targeted Capacity Expansion program request is $13.3 million. This reflects a decrease of $14.7 million below FY 2012. This level of funding will support the continuation of 30 grants and support four contracts, and will continue to monitor the progress of the four FY 2012 multi-year funded HIT Grants. The proposed number of clients to be served with 2014 funds is 3,300. Outcomes including abstinence from substance use will also be tracked. By 2015, 69 percent of clients are expected to report being abstinent from substance use, 44 percent of clients are expected to report being employed or engaged in productive activities, 57 percent of clients are expected to report a permanent place to live in the community, and 96 percent of clients are expected to report having no involvement with the criminal justice system.
- The Strengthening Treatment Access and Retention program request is $1.0 million. This reflects a decrease of $0.7 million below FY 2012.
- The Access to Recovery program request is $65.0 million. This reflects a decrease of $33.3 million below FY 2012. This level of funding will support 19 new grants and one contract continuation and two new contracts.
- The Children and Families program request is $29.7 million. This reflects a decrease of $0.9 million below FY 2012. This level of funding will support the continuation of 24 grants and support three contracts. SAMHSA expects to serve approximately 2,500 clients with FY 2014 funds. All outcomes, including abstinence from substance use, will also be tracked. By 2015, 56 percent of clients are expected to report being abstinent from substance use, 80 percent of clients are expected to report being employed or engaged in productive activities. This reduction is to technical assistance and contracts and will not impact the number of individuals served.
- The Criminal Justice Activities program request is $65.1 million. This reflects a decrease of $1.8 million below FY 2012. This level of funding will support 142 grant continuations and eight contract continuations and 26 new grants.
- The Minority HIV/AIDS program request is $52.4 million. This reflects a decrease of $13.5 million below FY 2012 in the Substance Abuse Treatment appropriation, but when combined with the additional resources from Substance Abuse Prevention and Mental Health appropriation reflects level funding SAMHSA-wide from the FY 2012 SAMHSA-wide funding level. The Substance Abuse Treatment funding will support the continuation of 87 grants and support five contracts, and will continue to monitor the progress of the 3 FY 2012 multi-year funded grants. The proposed number of clients to be served with 2014 funds is 13,558. Outcomes including abstinence from substance use will also be tracked. By 2015, 62 percent of clients are expected to report being abstinent from substance use, 38 percent of clients are expected to report being employed or engaged in productive activities, 48 percent of clients are expected to report a permanent

place to live in the community, and 96 percent of clients are expected to report having no involvement with the criminal justice system.

- The Addiction Technology Transfer Centers program request is $8.1 million. This reflects a decrease of $1 million below FY 2012. This level of funding will support the continuation of 15 grants. The proposed number of individuals to be trained with 2014 funding is 20,516. Outcomes including participants who report implementing improvements will also be tracked. By 2015, 90 percent of participants are expected to report implementing improvements in treatment methods on the basis of information and training provided by the program.
- The Special Initiatives/Outreach program request is $1.4 million. This reflects a decrease of $0.8 million below FY 2012. This level of funding will support one contract as well as one new grant.

A detailed table for all grant and contract continuations and new activities can be found in supplementary tables.

SAMHSA/Substance Abuse Treatment

PRNS Mechanism Table by APT

(Dollars in thousands)

PRNS-Treatment	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Annualized CR No.	FY 2013 Annualized CR Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
Grants/Cooperative Agreements:						
Continuations	441	$246,494	399	$243,981	367	$172,138
New/Competing	187	106,096	226	90,634	173	97,548
Subtotal	**628**	**352,590**	**625**	**334,615**	**540**	**269,686**
Contracts:						
Continuations	28	73,406	18	61,568	20	60,378
New/Competing	2	2,700	5	6,568	2	4,731
Subtotal	**30**	**76,106**	**23**	**68,136**	**22**	**65,108**
Subtotal, PRNS-Treatment 1/	**658**	**$428,697**	**648**	**$402,751**	**562**	**$334,794**

1/ This total includes PRNS items funded with both Budget Authority, Prevention and Public Health Funds and PHS Evaluation Funds in FY 2012 and FY 2014. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary. The CSAT Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

Outcomes and Outputs

Program: Screening, Brief Intervention and Referral to Treatment

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.40 Number of clients served (Output)	FY 2012: 142,016 Target: 139,650 (Target Exceeded)	139,650	75,015	-64,635
1.2.41 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2012: 42.1% Target: 36% (Target Exceeded)	36%	36%	Maintain

Program: Access to Recovery

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.32 Number of clients gaining access to treatment (Output)	FY 2012: 76,592 Target: 70,750 (Target Exceeded)	70,750	22,142	-48,608
1.2.33 Increase the percentage of adults receiving services who had no past month substance use (Outcome)	FY 2012: 84.1% Target: 83.0% (Target Exceeded)	83.0%	80.0%	-3.0%
1.2.35 Percentage of adults receiving services who had no/reduced involvement with the criminal justice system (Outcome)	FY 2012: 96.6% Target: 96.0% (Target Exceeded)	96.0%	93.0%	-3.0%
1.2.36 Percentage of adults receiving services who had improved social support (Outcome)	FY 2012: 91.9% Target: 91.0% (Target Exceeded)	91.0%	88.0%	-3.0%

Program: Treatment System for Homelessness (GBHI)

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
3.4.22 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2012: 67.1% Target: 67.4% (Target Not Met but Improved)	67.4%	66.4%	-1.0%
3.4.23 Number of clients served (Output)	FY 2012: 5,882 Target: 5,800 (Target Exceeded)	5,800	5,800	Maintain
3.4.24 Percentage of clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2012: 32.7% Target: 32.7% (Target Met)	32.7%	31.7%	-1.0%
3.4.25 Increase the percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2012: 35.7% Target: 25.6% (Target Exceeded)	25.6%	24.6%	-1.0%

Program: Criminal Justice - Drug Courts

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.63 Percentage of juvenile clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2012: 88% Target: 88% (Target Met)	88%	Discontinued	N/A
1.2.64 Percentage of juvenile clients receiving services who had a permanent place to live in the community (Outcome)	FY 2012: 79.3% Target: 82% (Target Not Met but Improved)	82%	Discontinued	N/A
1.2.65 Percentage of juvenile clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2012: 94% Target: 95% (Target Not Met but Improved)	95%	Discontinued	N/A
1.2.67 Percentage of juvenile clients receiving services who had no past month substance use (Outcome)	FY 2012: 61.6% Target: 73% (Target Not Met)	73%	Discontinued	N/A
1.2.70 Number of juvenile clients served (Output)	FY 2012: 475 Target: 1,463 (Target Not Met)	1,463	Discontinued	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.72 Percentage of adult clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2012: 60.8% Target: 57.0% (Target Exceeded)	57.0%	55.0%	-2.0%
1.2.73 Percentage of adult clients receiving services who had a permanent place to live in the community (Outcome)	FY 2012: 44.2% Target: 43.0% (Target Exceeded)	43.0%	41.0%	-2.0%
1.2.74 Percentage of adult clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2012: 93.1% Target: 93.0% (Target Exceeded)	93.0%	91.0%	-2.0%
1.2.76 Percentage of adult clients receiving services who had no past month substance use (Outcome)	FY 2012: 86.1% Target: 73.0% (Target Exceeded)	73.0%	71.0%	-2.0%
1.2.79 Number of adult clients served (Output)	FY 2012: 5,845 Target: 5,265 (Target Exceeded)	5,265	4,413	-852

Program: Criminal Justice – Teen Courts

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.89 Number of teen court clients served (Output)	N/A	Set Baseline	TBD	N/A
1.2.90 Percentage of teen court clients receiving services who had no involvement with the criminal justice system (Outcome)	N/A	Set Baseline	TBD	N/A
1.2.91 Percentage of teen court clients receiving services who had no past month substance use (Outcome)	N/A	Set Baseline	TBD	N/A

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

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.80 Number of clients served (Outcome)	FY 2012: 3,532 Target: 2,912 (Target Exceeded)	2,912	3,552	+640
1.2.81 Percentage of clients who had no past month substance use (Outcome)	FY 2012: 77.4% Target: 80.0% (Target Not Met)	80.0%	80.0%	Maintain
1.2.84 Percentage of clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2012: 96.1% Target: 95.0% (Target Exceeded)	96.0%	94.9%	-1.1%

Program: Treatment - Other Capacity[41]

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.25 Percentage of adults receiving services who had no past month substance use (Outcome)	FY 2012: 70.0% Target: 62.0% (Target Exceeded)	66.0%	60.0%	-6.0%
1.2.26 Number of clients served (Output)	FY 2012: 40,026 Target: 34,784 (Target Exceeded)	34,784	30,849	-3,935
1.2.27 Percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2012: 43.3% Target: 47.0% (Target Not Met)	47.0%	45.0%	-2.0%
1.2.28 Percentage of adults receiving services who had a permanent place to live in the community (Outcome)	FY 2012: 51.4% Target: 49.0% (Target Exceeded)	49.0%	47.0%	-2.0%

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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.29 Percentage of adults receiving services who had no involvement with the criminal justice system (Outcome)	FY 2012: 95.9% Target: 95.0% (Target Exceeded)	96.0%	93.0%	-3.0%

Program: Treatment - Science and Service Activities[42]

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.4.01 Percentage of participants who report implementing improvements in treatment methods on the basis of information and training provided by the program (Outcome)	FY 2012: 90.0% Target: 90.0% (Target Met)	90.0%	90.0%	Maintain
1.4.02 Number of individuals trained per year (Output)	FY 2012: 29,056 Target: 20,516 (Target Exceeded)	20,516	20,516	Maintain

[42] Includes Addiction Technology Transfer Centers.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2012: 108,494 Target: 37,896 (Target Exceeded)	110,000[43]	110,000[44]	Maintain

Size of Awards

(Whole Dollars)	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	628	624	550
Average Award	$561,450	$536,242	$490,338
Range of Awards	$300,000-$7,575,000	$300,000-$600,000	$300,000-$600,000

[43] Target has been increased from previously reported.
[44] Target has been increased from previously reported.

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Substance Abuse Prevention and Treatment Block Grant

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Substance Abuse Prevention and Treatment Block Grant.....	$1,800,332	$1,811,350	$1,819,856	+$19,524
PHS Evaluation Funds (non-add).....	*$79,200*	*$79,685*	*$71,724*	*-$7,476*

Authorizing Legislation..... Sections 1921 of the Public Health Service Act

FY 2014 Authorization..... Expired

Allocation Method ..... Formula Grants

Program Description and Accomplishments

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

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

The program's overall goal is to support and expand substance abuse prevention and treatment services while providing maximum flexibility. States and territories may expend Block Grant funds only for the purpose of planning, carrying out, and evaluating activities related to these services. Targeted technical assistance is available for the states and territories through CSAT's State Systems Technical Assistance Project. The SABG requires states to maintain expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the state for the two year period preceding the year for which the state is applying for a grant. Given the current economic situation, a number of states experienced challenges meeting the maintenance of effort requirement in the federal FY 2012 grant cycle, and SAMHSA continues to monitor the situation closely.

Of the amounts appropriated for the SABG program, 95 percent are distributed to states and other eligible applicants through a formula prescribed by the authorizing legislation. Factors

used to calculate the allotments include total personal income, state population data by age groups (total population data for territories), total taxable resources, and a cost of services index factor.

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

In FY 2011, SAMHSA redesigned the FY 2012/2013 MHBG and SABG applications to better align with the current federal/state environments and related policy initiatives, including the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Tribal Law and Order Act (TLOA). The new design offered states the opportunity to complete a combined application for mental health and substance abuse services, submit a bi-annual versus an annual plan, and provide information regarding their efforts to respond to various federal and state initiatives. Almost one-half of the states took advantage of this streamlined application and submitted combined plans for mental health and substance abuse services. Over 95 percent of the states provided specific information requested by SAMHSA regarding strategies to respond to a variety of areas including primary care and behavioral health integration, recovery support services, prevention of substance use, and promotion of emotional health. States continued to provide information regarding the spending of their Block Grant funds to support services identified in SAMHSA's Good and Modern Service System brief.[45]

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

The independent evaluation of the SABG program[46] demonstrated how states have leveraged the statutory requirements of this Block Grant to expand existing or establish new treatment capacity

[5] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf
[46] http://tie.samhsa.gov/SAPT2010.html#Evaluation

in underserved areas of states and territories and to improve coordination of services with other state systems.

As noted below, the SABG Program has been successful in expanding treatment capacity in the latest year for which actual data are available in FY 2011[47] by supporting approximately two million[48] admissions to treatment programs receiving public funding. Outcome data for the Block Grant program show positive results. In FY 2011, at discharge, clients have demonstrated high abstinence rates from both illegal drug (73.5 percent) and alcohol (81.7 percent) use.

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

- For the 50 states[49] and D.C that reported data in the Abstinence from Drug/Alcohol Use Domain for alcohol use, 51 of 51 identified improvements in client abstinence.
- Similarly, for the 50 states and D.C. that reported data in the Abstinence from Drug/Alcohol Use Domain for drug use, 50 of 51 identified improvements in client abstinence.
- For the 50 states and D.C. that reported data in the Employment Domain, 47 of 51 identified improvements in client employment.
- For the 50 states and D.C. that reported in the Criminal Justice Domain, 46 of 51 reported an increase in clients with no arrests based on data reported to TEDS.
- For the 49 states and D.C. that reported data in the Housing Domain, 42 of 49 identified improvements in stable housing for clients based on data reported to TEDS.

20 Percent Prevention Set-Aside

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

In an effort to streamline the application and reporting procedures for both the SABG and the Mental Health Block Grant programs, SAMHSA has developed a uniform application and reporting process to promote consistent planning, application, assurance, and reporting dates across both block grants. States are encouraged to make prevention a top priority, taking advantage of recent science, best practices in community coordination, proven planning processes, and the science articulated by the IOM report on *Preventing Mental, Emotional, and*

[47] Source: 2013 SABG Report – Tables 16-21. While this is referenced as FY 2011, the actual time period varies by State, e.g; CY 2011 (imported TEDS data); SFY 2011 (manually entered by States); SFY 2012 (manually entered by States.

[48] Source: 2013 SABG Report – Table II

[49] Source: West Virginia numbers have been included in the text, but that appear lower than expected.

Behavioral Disorders Among Young People[50]. SAMHSA will work with states to increase their accountability systems for prevention and to develop necessary reporting capacities.

Synar

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

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

By regulation, states must achieve a retailer noncompliance rate of 20 percent or less. Since FY 2006, all 50 states, Puerto Rico, and the District of Columbia have been in compliance with the Synar requirements. In FY 2011, the most recent year available, the national weighted average retailer violation rate was 8.5 percent.

Funding History

Fiscal Year	Amount[1/]
FY 2004	$1,779,146,000
FY 2005	$1,755,555,000
FY 2006	$1,757,425,000
FY 2007	$1,758,591,000
FY 2008	$1,758,728,000
FY 2009	$1,778,591,000
FY 2010	$1,798,472,000
FY 2011	$1,782,528,000
FY 2012	$1,800,331,901
FY 2013	$1,811,349,932
FY 2014	$1,819,856,000

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

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

Budget Request

The Substance Abuse Block Grant (SABG) request is $1.820 billion. This reflects a $27 million increase in Budget Authority from FY 2012 funding level and a $7.5 million decrease in PHS Evaluation funds from FY 2012 funding level for a net increase of $19.5 million

Enrollment and Provider Business Practices (3 Percent Block Grant Set-Aside)

Through the Affordable Care Act, up to 62 million people will benefit from Federal parity protections under the ACA. Up to 11 million of these individuals are estimated to have substance abuse and/or mental health conditions. Persons with mental and substance use disorders are uninsured at higher rates than the general population. The Qualified Health Plans (QHPs) to be offered by the new insurance marketplaces are required to have sufficient mental health and substance providers to assure timely access to mental health and substance services. However, many providers supported by SABG funds are not sufficiently prepared to be part of the network of providers under contract with QHPs, Medicaid and Medicare plans, and commercial insurance plans. It is critical for specialty behavioral health providers to be able to participate in integrated care models, utilize interoperable electronic health records (EHRs), and bill for and collect insurance resources for which persons they serve are eligible in order to maximize limited MHBG and SABG funds for those services and those persons not covered by public and commercial insurance plans.

After the full implementation of the Affordable Care Act, SAMHSA strongly recommends that MHBG and SABG funds be directed toward four purposes: (1) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods for time; (2) to fund priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery; (3) to fund primary prevention: universal, selective, and indicated prevention activities and services for people, individuals not identified as needing treatment; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis. State authorities should make every effort to ensure that the right recipient is receiving the right payment for the right reason at the right time.

Therefore, in FY 2014, the President's Budget includes a requirement that states set aside at least three percent of their SABG allocation to support providers of mental health services in improving their enrollment, billing, and business practices, and to support enrollment into health insurance for eligible individuals served in the public mental health system. States that receive one percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process for their funds. Major needs identified by both mental health and substance abuse providers are education and technical support to improve business management, integrate with primary care and develop the capability needed to effectively deploy electronic health records to meaningful use standards, billing and scheduling systems that are aligned with

those in the commercial insurance and primary care environment. Particular concern was raised related to the lack of provider experience, especially peer, recovery, and opioid treatment organizations, in negotiating contracts with and billing third party payers, ensuring compliance, revenue management, and accountability reporting.

Business operations practices needed include:

- Outreach and enrollment support for individuals in need of behavioral health services who may be eligible for Medicare, Medicaid, private insurance offered through the State and Federally Facilitated Marketplaces;
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA, (e.g., development of a strategic plan that is responsive to the changing marketplace, identification of new markets, revision of data management systems, integration of recovery support and treatment service payment systems, negotiating agreements/partnerships with primary care organizations, [e.g., Federally Qualified Health Centers (FQHCs)] and other provider networks to develop business operations systems that ensure appropriate care management across the continuum of services, (e.g. preventive clinical services, treatment, referral and recovery support services);
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billings, collections, risk management and compliance;
- Third-party contract negotiation; e.g., negotiating contracts for participation in a qualified health plan, or Medicaid managed care plan;
- Coordination of benefits among multiple funding sources, including insurance and SABG funding; and
- Adoption of health information technology that meets meaningful use standards.

The Affordable Care Act has already enhanced opportunities for individuals with behavioral health conditions to have continuous access to insurance and a benefit package that includes mental health and substance abuse services, as well as preventive, medical, and other health services. A series of immediate private insurance market reforms help to give individuals the stability and flexibility they need to make informed choices about their health care. Under these market reforms, individuals have a right to appeal health insurance plan decisions, including appeals to health plans when payment for a service or treatment is denied; helps children with pre-existing conditions gain and keep coverage, and will extend this protection to adults starting in 2014; allows individuals to continue to choose their primary care provider; keeps certain young adults covered up to age 26 on their parents' health plans; ends lifetime limits on coverage; provides for review of unreasonable increases in insurance premiums; and requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, helping to ensure that premium dollars be primarily spent on health care (including behavioral health care).

Use of SABG dollars for these purposes will help states assist their specialty provider infrastructure to be prepared for the shifting funding environment and maximize limited SABG dollars for those individuals, services and activities not otherwise funded through other sources.

Health Reform

As a result of the analysis and examination of the various components of the Affordable Care Act beginning in 2010, SAMHSA has undertaken a major redesign of the planning section of the application process for both the MHBG and SABG. SAMHSA is aligning the block grants to be critical components of the 2014 Affordable Care Act implementation in which state and federal responsibility is supporting behavioral health services and supports for those otherwise unable to receive services through Medicaid, Medicare, and/or private insurance plans offered through employers or through the new insurance marketplaces. Together, SAMHSA's block grants support the provision of services and related supports to approximately eight million individuals with mental and substance use conditions. With an estimated 11.4 million adults having a severe mental illness[51], 44.7 million adults having any mental illness[52], and another 22.1 million adults with substance abuse disorder[53], demand clearly outpaces the public behavioral health system's established capacity. Many of these individuals and some of the services they need will continue to be without coverage through public or private insurance mechanisms. Aligning and coordinating the SAMHSA block grants with the 2014 Affordable Care Act implementation process begins assembling a cohesive national service system that is responsive to potential gaps in service delivery and effectively provides needed behavioral health serves across sectors and across payment sources.

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

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

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

Key Outputs and Outcomes Table

Program: Treatment Activities

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.43 Number of admissions to substance abuse treatment programs receiving public funding (Output)	FY 2010: 2,073,708 Target: 1,881,515 (Target Exceeded)	1,937,960	1,937,960	Maintain
1.2.48 Percentage of clients reporting no drug use in the past month at discharge (Outcome)	FY 2011: 76.2% Target: 70.3% (Target Exceeded)	74.0%	74.0%	Maintain
1.2.49 Percentage of clients reporting no alcohol use in the past month at discharge (Outcome)	FY 2011: 84.2% Target: 74.7% (Target Exceeded)	78.0%	78.0%	Maintain
1.2.50 Percentage of clients reporting being employed/in school at discharge (Outcome)	FY 2011: 36.5% Target: 43.9% (Target Not Met)	43.0%	43.0%	Maintain
1.2.51 Percentage of clients reporting no involvement with the Criminal Justice System (Outcome)	FY 2011: 94.6% Target: 88.9% (Target Exceeded)	92.0%	92.0%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.85 Percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2011: 93.6% Target: 92.0% (Target Exceeded)	92.0%	92.0%	Maintain

Program: Synar Amendment

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.49 Number of States (including Puerto Rico) whose retail sales violations is at or below 20% (Outcome)	FY 2011: 52 Target: 52 (Target Met)	52	52	Maintain
2.3.62 Number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% (Outcome)	FY 2011: 34 Target: 26 (Target Exceeded)	34	34	Maintain

Program: Prevention Set-Aside

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target`
2.3.65: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 12-20) (Outcome)	FY 2011: 78.0% Target: 52.9% (Target Exceeded)	52.9%	60.0%	+7.1%
2.3.67: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 12-17) (Outcome)	FY 2011: 49.0% Target: 64.7% (Target Not Met)	64.7%	61.0%	-3.7%
2.3.68: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 18+) (Outcome)	FY 2011: 49.0% Target: 37.3% (Target Exceeded)	37.3%	37.3%	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2014 Discretionary State/Formula Grants
Substance Abuse Prevention and Treatment Block Grant Program
CFDA #93.959

State/Territory	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	$23,669,104	$23,691,410	$23,379,947	-$289,157
Alaska	4,903,771	4,993,804	4,928,152	+24,381
Arizona	37,009,944	37,044,822	36,557,806	-452,138
Arkansas	13,234,062	13,246,534	13,072,386	-161,676
California	248,892,428	249,126,983	245,851,797	-3,040,631
Colorado	26,103,262	26,127,862	25,784,368	-318,894
Connecticut	16,883,413	16,899,324	16,677,154	-206,259
Delaware	6,670,567	6,792,562	6,703,262	+32,695
District Of Columbia	6,670,567	6,792,562	6,703,262	+32,695
Florida	99,581,639	99,675,484	98,365,084	-1,216,555
Georgia	50,140,789	50,188,041	49,528,236	-612,553
Hawaii	7,576,229	7,583,369	7,483,673	-92,556
Idaho	6,855,073	7,451,403	7,353,442	+498,369
Illinois	69,343,892	69,409,241	68,496,741	-847,151
Indiana	33,055,561	33,086,712	32,651,732	-403,829
Iowa	13,422,031	13,434,680	13,258,059	-163,972
Kansas	12,198,382	12,209,878	12,049,359	-149,023
Kentucky	20,508,321	20,527,648	20,257,778	-250,543
Louisiana	25,654,671	25,678,848	25,341,257	-313,414
Maine	6,670,567	6,792,562	6,703,262	+32,695
Maryland	31,737,430	31,767,339	31,349,704	-387,726
Massachusetts	34,073,216	35,206,135	34,743,292	+670,076
Michigan	57,459,952	57,514,102	56,757,983	-701,969
Minnesota	24,707,075	24,730,359	24,405,237	-301,838
Red Lake Indians	608,939	609,513	601,500	-7,439
Mississippi	14,150,075	14,163,410	13,977,208	-172,867
Missouri	25,960,043	25,984,508	25,642,898	-317,145
Montana	6,670,567	6,792,562	6,703,262	+32,695
Nebraska	7,833,059	7,840,441	7,737,365	-95,694
Nevada	13,745,028	14,452,647	14,262,643	+517,615
New Hampshire	$6,670,567	6,792,562	6,703,262	+32,695
New Jersey	46,585,408	46,629,310	46,016,290	-569,118
New Mexico	8,909,981	8,918,378	8,801,131	-108,850
New York	114,637,337	114,745,371	113,236,852	-1,400,485
North Carolina	39,601,511	39,638,831	39,117,713	-483,798

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2014 Discretionary State/Formula Grants
Substance Abuse Prevention and Treatment Block Grant Program
CFDA #93.959

State/Territory	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
North Dakota	5,440,418	5,540,304	5,467,467	+27,049
Ohio	66,155,781	66,218,126	65,347,578	-808,203
Oklahoma	17,579,842	17,596,409	17,365,075	-214,767
Oregon	17,801,059	17,865,150	17,630,283	-170,776
Pennsylvania	58,639,671	58,694,933	57,923,290	-716,381
Rhode Island	6,670,567	6,792,562	6,703,262	+32,695
South Carolina	20,457,841	20,477,120	20,207,914	-249,927
South Dakota	5,030,871	5,123,238	5,055,884	+25,013
Tennessee	29,522,772	29,550,594	29,162,102	-360,670
Texas	134,956,016	135,083,198	133,307,304	-1,648,712
Utah	17,005,006	17,021,031	16,797,261	-207,745
Vermont	5,379,071	5,477,831	5,405,816	+26,745
Virginia	42,761,980	42,802,279	42,239,572	-522,408
Washington	34,712,990	34,745,703	34,288,913	-424,077
West Virginia	8,644,366	8,652,512	8,538,760	-105,606
Wisconsin	27,880,736	27,907,011	27,540,127	-340,609
Wyoming	3,495,265	3,559,438	3,512,643	+17,378
American Samoa	367,834	328,680	324,025	-43,809
Guam	1,001,449	943,422	936,890	-64,559
Northern Marianas	267,531	318,995	306,233	+38,702
Puerto Rico	22,030,073	22,057,192	21,759,154	-270,919
Palau	115,607	123,607	123,017	+7,410
Marshall Islands	364,661	389,895	394,374	+29,713
Micronesia	593,312	634,367	627,153	+33,841
Virgin Islands	607,686	629,933	620,977	+13,291

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SAMHSA Health Surveillance and Program Support
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Health Surveillance and Program Support

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR [1/]	FY 2014 President's Budget	FY 2014 +/- FY 2012
Health Surveillance and Program Support.....				
Health Surveillance and Program Support.....	**$124,318**	**$106,968**	**$120,157**	**-$4,161**
Health Surveillance (non-add).....	*47,428*	*29,608*	*47,428*	---
Budget Authority (non-add).....	*2,000*	*2,012*	*2,000*	---
Prevention and Public Health Fund (non-add)....	*18,000*	*N/A*	---	*-18,000*
PHS Evaluation Funds (non-add).....	*27,428*	*27,596*	*45,428*	*+18,000*
Program Support (non-add).....	*76,890*	*77,360*	*72,729*	*-4,161*
Total, Health Surveillance and Program Support.....	**$124,318**	**$106,968**	**$120,157**	**-$4,161**
Data Request and Publication User Fees.....	---	---	1,500	+1,500

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Authorizing Legislation.....Section 501 of the Public Health Service Act
FY 2014 Authorization..... Expired
Allocation Method .....Direct Federal/Intramural, Contracts, Other

Program Description and Accomplishments

Health Surveillance and Program Support

Health Surveillance

The Health Surveillance budget supports many of the critical behavioral health data systems, national surveys, and surveillance activities for DHHS undertaken by SAMHSA/CBHSQ to support SAMHSA grantees, the field, and the public. The National Survey on Drug Use and Health (NSDUH) serves as the nation's primary source for information on the incidence and prevalence of substance use and mental disorders and related health conditions. A new NSDUH contract will be awarded in FY 2013 to finance surveys for 2014, 2015, 2016 and 2017 pending the availability of funds.

The Drug Abuse Warning Network (DAWN) is a national public health surveillance system that monitors emergency room visits for drug and mental illness-related problems. This activity represents a partnership with the National Center for Health Statistics (NCHS)/CDC which is expected both to increase response rates and improve the quality of behavioral health data available to help inform public policy and prevention and treatment initiatives. NCHS and CBHSQ are working under an Interagency Agreement (IAA) on the development and integration of DAWN into the emergency department component of the National Hospital Care Survey (NHCS). These changes are consistent with proposals presented in previous budgets. The IAA will allow SAMHSA to incorporate DAWN within the NCHS ED data collection system which will include data elements now collected by NCHS for the nation. SAMHSA has phased in support for the IAA with CDC in FY 2012 and will continue to do so FY 2013 and FY 2014.

In FY 2013, SAMHSA is working to modify the current Drug Abuse Services Information System (DASIS) contract to become the new Behavioral Health Services Information System (BHSIS). DASIS was the primary source of data on substance abuse treatment facilities and treatment admissions. One aspect of this program is the treatment locator, which is accessed more than two million times a year by individuals, families, community groups, and organizations to identify appropriate treatment services. The DASIS/BHSIS project is currently piloting a new program with the intention of integrating a mental health treatment admissions data set with its counterpart in substance abuse. This was a contract modification in 2013 and the 2014 contract will be funded by both CBHSQ and CMHS. SAMHSA will be working closely with stakeholders including the National Association of State Alcohol and Drug Abuse Directors (NASADAD), the National Association of State Mental Health Program Directors (NASMHPD), and our state partners in the development and implementation of this integration effort which includes identifying metrics for reporting. In addition, SAMHSA will field integrated substance abuse and mental health facility surveys in FY 2013. FY 2013 and FY 2014 provides for $16.1 million, and $23.1 million respectively for DASIS/BHSIS. In addition, CMHS will provide $7.5 million in FY 2013 and FY 2014 for DASIS/BHSIS.

With the implementation of health reform, new models for integrating behavioral health and primary health care are being developed. It is expected that these changes will have a profound impact on the currently separate systems of substance abuse and mental health treatment. SAMHSA will explore additional strategies to capture changes in the behavioral health systems resulting from reform efforts during 2013 with the expectation of expanding its current facilities efforts during 2014. This expanded effort will provide decision makers and researchers enhanced information about how systems of care are organized and financed as well as the outcomes of care on treatment engagement and recovery. This expansion of systems level data will provide information in the following areas:

- the structure and management of care across multiple modalities of care within selected markets;
- the availability, quality, and accessibility to behavioral health services delivered by providers who treat individuals who have substance use and/or mental disorders and related conditions;
- the costs, financing, and effectiveness of service delivery in terms of treatment access, entry, retention, and outcomes (i.e., reductions in substance use and/or symptoms of mental illness, criminal behavior, and other high risk behaviors, as well as improvements in social functioning);
- the nature and function of collaborative relationships among behavioral health, primary care, and other service as they relate to meeting patient care needs; and
- the way individuals progress over time through the recovery process.

Any new effort would work in concert with the National Survey of Drug Use and Health, the Community Early Warning and Monitoring System, the Financing Center of Excellence, and ongoing analytic projects within the Center for Behavioral Health Statistics and Quality to respond to critical questions related to parity, program effectiveness, financing, and access.

Additional information can be found in the CBHSQ chapter on page 209.

Program Support

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

In FY 2012, SAMHSA continued to insource positions for activities that are central to SAMHSA's mission, represent critical skills for the agency, and result in overall savings. The additional positions are fiscally neutral. The amount of FTEs for FY 2012 was 590.

In FY 2013, SAMHSA projects a total of 631 FTEs, which reflects, the impact of insource-related hiring not finalized in FY 2012. SAMHSA's historical attrition factors have been applied to determine the overall anticipated FY FTE forecast.

SAMHSA applies an estimated internal administrative charge for overhead expenses to all programs, projects and activities including its Programs of Regional and National Significance, both Block Grants, CMHI, PATH, PAIMI and the Health Surveillance and Program Support appropriation. These estimates will be adjusted to reflect final operating plans during the year of execution.

Funding History[1\]

Fiscal Year	Amount
FY 2010	$101,947,000
FY 2011	$119,789,000
FY 2012	$124,317,616
FY 2013	$106,968,280
FY 2014	$120,157,000

[1\]The funding history is presented on a comparable basis to previous funding levels to represent the revised budget structure and includes the PHS Evaluation Funds and Prevention Funds other than in FY 2013. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Budget Request

A total of $120.2 million is requested for Health Surveillance and Program Support, reflecting a decrease of $4.2 million. This includes a decrease of $4.2 million in BA and a shift of funding source in the amount of $18.0 million from Health Surveillance Prevention Fund to the Public Health Service (PHS) evaluation fund. SAMHSA will use $1.7 million for DAWN, $1.2 million for CDP (DCAR), $0.707 million for NSDUH, $4.3 million for DAISIS, $1.9 million for National Analytic Center, $0.500 million for C-EMS, $1.8 million for CDP SAIS and TRAC, $5.0 million for Grantee Data Development TA, and $0.888 million for Operations.

A total of $47.4 million is requested for Health Surveillance activities, reflecting level funding. The source of part of the funding for CBHSQ within HSPS has shifted from the Prevention Fund to the Public Health Service Evaluation Fund (PHS). Funding from HSPS reflects the phasing out of Legacy data collection and analysis programs and the full implementation of the Common Data Platform and the expansion of the new BHSIS contract. Addition detail on the CBHSQ budget can be found starting on page 209.

A total of $72.7 million is requested for Program Support, reflecting a decrease of $4.2 million. Savings will be generated through administrative efficiencies. Sufficient funds are available to staff up to 655 FTE, an increase of 3.8 percent over the FY 2013 forecast, reflecting full annualization of SAMHSA's in sourcing initiative.

Public Awareness and Support

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Program Level	**$13,545**	**$13,628**	**$13,571**	**$26**
PHS Evaluation Funds (non-add)	---	---	*13,571*	*+13,571*

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

FY 2014 Authorization..... Expired

Allocation Method .....Contracts

Program Description and Accomplishments

The rapidly changing healthcare environment, the critical role behavioral health plays in achieving national health status objectives, and advances in communications technology provide new opportunities to change the way behavioral health is viewed and services are delivered in the U.S.

The unmet need for prevention, treatment, and recovery support services provides a vast untapped market for SAMHSA products and services. Today in the U.S., opportunities to prevent or intervene early to reduce disability and death associated with mental and substance use disorders are often missed. The tragedy at Sandy Hook Elementary School in December, 2012 affords us an unprecedented opportunity to educate the American people about the importance of mental health and substance abuse. The Departments of Health and Human Services and Education are working to facilitate a national dialogue on the mental and emotional health of young people. About 60 percent of adults experiencing a mental disorder did not receive treatment and nearly 90 percent of people who needed substance abuse treatment did not receive care (2010 National Survey on Drug Use and Health). For children and adolescents, only about 1 in 5 receives the treatment they need for diagnosable mental health and substance use disorders.

By learning to recognize the signs and symptoms of mental illness and substance abuse, friends and family members can help their loved ones take action and seek care. Trained health professionals can also work with patients and families to identify problems early.

By confronting fear and misunderstanding with facts, raising awareness about the effectiveness of prevention and treatment, and improving knowledge about when and where to seek help, SAMHSA can bring mental illness, and addictions out of the shadows and help the nation achieve the full potential of prevention and treatment for mental illnesses and substance abuse.

The SAMHSA Office of Communications, through the Communications Governance Council (CGC), is charged with setting the strategic direction and policy for SAMHSA's public communication activities. The CGC is working to assure research based approaches are used to

influence behavior change for the sake of improving health, preventing injuries, protecting the environment, and/or contributing to the community. Individual behavior change involves five basic steps: knowledge, approval, intention, practice, and advocacy.

To employ the best communication practices and technologies that focus on creating and sustaining behavior change, SAMHSA is putting into place a new science-based life cycle approach for public education communication efforts. The lifecycle provides a five step process for planning, creating, disseminating, promoting, and evaluating educational information produced and distributed by SAMHSA.

SAMHSA's Public Engagement Platform (PEP) and Project Evolve, SAMHSA's web consolidation and modernization project, are funded through the Public Awareness and Support budget line. These two initiatives provide the SAMHSA the wide infrastructure required to advance SAMHSA's Strategic Initiatives by engaging audiences in a meaningful way.

The internet is the primary way people engage with the government. SAMHSA has prioritized the internet as a strategic business and communications asset and launched Project Evolve to consolidate and modernize SAMHSA's web presence. Elimination of redundant web development efforts is a key objective for this project and the installation of a Web Content Management System will result in lower overall costs, greater efficiency, increased effectiveness, and improved service for visitors to SAMHSA's website. Related project activities include audience analysis, usability testing, and planning for the prioritized migration of information from other sites to a consolidated SAMHSA.gov site.

Consistent with the draft Federal Digital Strategy, the project is working to support the development of quality content and effective communications governance, and the use of modern communications platforms all to increase efficiencies in SAMHSA's web based communication efforts with the long term goals of improving customer satisfaction and achieving cost savings to the agency.

SAMHSA's PEP provides the agency's programs a customer-oriented fulfillment system. SAMHSA's online store (http://store.samhsa.gov) is its most highly visible customer interface and works in concert with a call-in contact center, warehouse, email updates, exhibit program, and strategic partnerships to fulfill the publication needs of public and health services providers. The various channels of communication managed by the Office of Communications generated more than 24 million customer interactions last year and enabled SAMHSA to gather data that illuminate the "voice" of SAMHSA customers and how well they are being served by the agency.

Through its Knowledge Management System, SAMHSA integrates content, operations, and data collection and analytics on all PEP customer interactions. These touch points annually include about 500,000 inquiries to the contact center; 143,400 publication orders; 21,290,000 publication copies shipped; 1,734,000 SAMHSA Store visitors; 530,000 PDF documents downloaded; 11,941,000 email updates delivered; and 12,000 exhibit booth visitors. SAMHSA's email update service has grown to nearly 193,000 subscribers. PEP also distributes a bi-weekly electronic resource entitled *SAMHSA Headlines* that provides the behavioral health

field with the latest news, upcoming events, resources, and a quarterly newsletter, *SAMHSA News,* that provides in-depth information on key SAMHSA developments and findings.

Just as Americans are aware of the connection between hypertension, stroke, and heart disease and accordingly take action to monitor their blood pressure they can become aware of the connection between mental and substance use disorders and physical health and take action to prevent and treat these conditions. SAMHSA's PEP and new Web Program provides prevention, treatment, and recovery support programs the communication channels needed to reach public and professional audiences with critical behavioral health information.

The Public Awareness and Support Initiative (http://www.samhsa.gov/publicAwareness/) continues to be driven by research with SAMHSA stakeholders-- including web-based public engagement strategies/platforms-- and applies the communications and marketing principles of customer research and audience segmentation, message development and evaluation. Because it is based on customer needs and input, the Public Awareness and Support Initiative is dynamic and continues to evolve based on the shifting landscape of communications technologies and government involvement with the public.

The Public Awareness and Support Initiative specifically supports the agency's role in "Supporting the field with Information/Communications by conducting and sharing information from national surveys and surveillance (e.g., NSDUH, DAWN, DASIS); vetting and sharing information about evidence-based practices (e.g., National Registry of Evidence-based Programs and Practices [NREPP]); using the Web, print, social media, public appearances, and the press to reach the public, providers (e.g., primary, specialty, guilds, peers), and other stakeholders; and listening to and reflecting the voices of people in recovery and their families." (See "*SAMHSA's Roles*" in the agency's strategic planning document "*Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014*", p. 6)

Budget Request

$13.6 million is requested for PAS, reflecting level funding. The increase of $13.6 million in PHS evaluation offsets the decrease of $13.6 million of BA to reflect the transfer to a different source of funding.

These funds will be used to continue to support the Public Engagement Platform (PEP) and Project Evolve, the Federal Digital Strategy, the Knowledge Management System, and the Public Awareness and Support Initiative. Collectively, these programs will help to consolidate and streamline digital engagement efforts, and implement SAMHSA's five-step life cycle approach to public education communication. Part of this lifecycle seeks to provide customers with increased access to SAMHSA's services, website, publications, and data, ensuring more effective communication and meaningful customer service. These funds will also aid SAMHSA's efforts to research the best methods of collaboration with its stakeholders, which will improve its messaging and marketing; and, as a result, more accurately reflect the voices of people and families in recovery.

This request also includes $1.5 million in Data Request and Publication User Fees (please see the HSPS table on page 191). Fees will be collected for extraordinary data and publications user requests are not otherwise able to be fulfilled within existing resources.

Outcomes and Outputs

Program: Public Awareness Activities

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
2.3.76 Number of persons receiving prevention information indirectly from advertising, broadcast, or website (Output)	FY 2011: 9,408,930 Target: 906,707 (Target Exceeded)	1,250,000	250,000	-1,000,000
4.4.06 Percentage of persons reporting knowledge of how to find treatment services for mental and substance use disorders (Outcome)	N/A	Discontinued	N/A	N/A
4.4.07 Percentage of persons indicating they were screened by a health care provider for mental and substance use disorder (Outcome)	N/A	Discontinued	N/A	N/A
4.4.12 Number of individuals referred for behavioral health treatment resources (Output)	FY 2012: 319,290 Target: 310,000 (Target Exceeded)	310,000	310,000	Maintain
4.4.09 Percentage of children reporting their parents have talked to them about alcohol and drugs (Outcome)	FY 2011: 57.7% Target: 58.2% (Target Not Met)	58.2%	Discontinued	N/A

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Performance and Quality Information Systems

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Program Level	**$12,940**	**$13,051**	**$12,996**	**$56**
PHS Evaluation Funds (non-add)	---	---	*12,996*	*+12,996*

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

FY 2014 Authorization..... Expired

Allocation Method ..... Contract

Program Description and Accomplishments

Funding is requested for performance and quality information systems includes funding to phase in the implementation of SAMHSA's Common Data Platform (CDP) which will provide a uniform collection and reporting system providing SAMHSA management and staff with the ability to analyze programs at various levels (state, program, community, etc.), provide each Center with tailored information in real-time about the progress and activities of their grantees, and provide data to grantees to support them in the efficient and effective implementation of projects. Funding from PQIS along with funding from HSPS activities will support the continuation of all three Center legacy programs (SAIS, TRAC, and DCAR) during FY 2013 while the CDP is being phased in.

During 2013 and 2014, SAMHSA will be working closely with the National Association of State Alcohol and Drug Abuse Directors (NASADAD), the National Association of State Mental Health Directors (NASMHD), and state partners to identify, refine, and test measures that, where possible, build upon current efforts within states. Moving forward, SAMHSA is committed to harmonizing measures across data collection programs in a way that reduces burden, increases the quality of data collected, and provides necessary information to measure performance and manage grants.

Funding is also requested for the continuation of the National Registry of Evidence-based Programs and Practices (NREPP), a searchable online system that supports states, communities, and tribes in identifying and implementing evidence-based mental health promotion, substance abuse prevention, and substance abuse and mental health treatment interventions.

Other SAMHSA activities related to the Strategic Initiative on Data, Quality and Outcomes include the development of the National Behavioral Health Quality Framework, stemming from the National Quality Strategy recently released by AHRQ in cooperation with CMS and ONC; and coordination with Health Information Technology efforts and Meaningful Use Measures for application in electronic health records, lead by ONC and CMS.

Budget Request

$13.0 million is requested for PQIS, reflecting level funding. An increase of $13.0 in PHS evaluation is offset by a decrease of $13.0 million of BA to reflect the transfer to a different source of funding. These funds will be used to fully fund the new Common Data Platform which will be awarded in FY 2013 and fully implemented in FY 2014.

Outcomes and Outputs

Program: Performance and Quality Improvement Systems[54]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 Target +/- FY 2012 Target
4.4.10 Combined count of webpage hits, hits to the locator, and hits to SAMHDA for SAMHSA-supported data sets (Output)	FY 2012: 1,707,165 Target: 6,000,300 (Target Not Met)	6,000,300	1,882,149	-4,118,151[55]
4.4.11 Number of evidence-based programs or practices in review (Output)	FY 2012: 46 Target: 44 (Target Exceeded)	44	48	+4

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

[55] Decrease in target due to change in data collection methodology.

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Agency-Wide Initiatives

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Agency-Wide Initiatives	**$9,200**	**$9,256**	**$54,395**	***+$45,195***
Military Families(non-add)	*3,493*	*3,515*	---	*-3,493*
Behavioral Health Workforce (non-add)	5,706	*5,741*	*54,395*	*+48,689*
Minority Fellowship Program (non-add) 1/	*5,706*	*5,741*	*9,395*	*+3,689*
Minority Fellowship Program - Youth (non-add)	---	---	*5,000*	*+5,000*
Peer Professional Workforce Development (non-add)	---	---	*10,000*	*+10,000*
SAMHSA-HRSA MBHET Grant Program (non-add)	*$---*	*$---*	*$35,000*	*+$35,000*

1/ The Minority Fellowship Program budgets from the MH, SAP, and SAT appropriations are reflected under the Workforce initiative.

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

FY 2014 Authorization..... Expired

Allocation Method ..... Discretionary Grants

Program Descriptions and Accomplishments

Military Families

In FY 2013, SAMHSA will conduct at least two Service Members, Veterans, and their Families (SMVF) Policy Academies for the remaining 17 states that have not yet participated, as well as for the Virgin Islands and Guam. SAMHSA's Policy Academies help states and territories strengthen their behavioral health care systems and services for SMVF through the development of interagency strategic plans and the provision of technical assistance to facilitate implementation of those plans. The strategic plans developed by the Policy Academies will be available immediately; thereby assuring the maximum impact will be felt in a short time. SAMHSA will also provide intensive technical assistance to those states and territories to ensure implementation of evidence-based behavioral health prevention, treatment, and recovery support services that advance and sustain the interagency approach to their strategic plan, and that meet the behavioral health needs of service members (especially National Guard and Reserves), veterans, and their families. The intensive technical assistance provided will greatly assist in the building of linkages between evidence-based services and recovery support services.

Minority Fellowship Program

Through a partnership among SAMHSA's CMHS, CSAP and CSAT centers, this program increases behavioral health practitioners' knowledge of issues related to ethnic minority mental health and substance use disorders. Additionally, it aims to improve the quality of mental health and substance abuse prevention and treatment delivered to ethnic minorities by providing stipends to post-graduate students. This will increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental health/substance abuse services to underserved minority populations. Since its start in 1973, the Minority Fellowship Program (MFP) has helped to enhance services to minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology, and since 2006, marriage and family therapists. These individuals often serve in key leadership positions in mental health and substance abuse direct services, services supervision, services research, training, and administration. In FY 2011, 125 individuals were trained across the five disciplines represented. In FY 2012, SAMHSA received additional funding to increase the pool of culturally competent mental health professions eligible to receive funds through this program to include professional counselors. In FY 2013, SAMHSA anticipates funding all MFP continuation grants.

Budget Request

The FY 2014 Budget request for Agency Wide initiatives is $54.4 million, a net increase of $45.2 million from the FY 2012 funding level. The request includes plans to phase out Military Families in 2014. The Minority Fellowship Program (MFP) has been comparably adjusted as MFP was realigned from the three centers to the Health Surveillance and Program Support (HSPS) appropriation. SAMHSA plans on braiding these funds, tracking them as distinct funding streams and for use consistent with legislative direction and intent, to continue to support the same core activities supported in the centers. The FY 2014 budget request for MFP core activities is $9.4 million, which is a $4.4 million increase from FY 2012. In addition, FY 2014 includes new funding for MFP-Youth (expansion) at $5.0 million, $35 million for a jointly administered activity with HRSA to expand the Mental and Behavioral Health Education and Training (MBHET), and $10.0 million for Peer Professionals Workforce Development.

Minority Fellowship Program – Youth (MFP-Y)

For FY 2014, SAMHSA requests $5.0 million for the Minority Fellowship Program (MFP-Y) to provide stipends to graduate students to increase the number of culturally competent behavioral health professionals who provide direct mental health and/or co-occurring substance abuse services to underserved minority populations. MFP-Y would utilize the existing infrastructure of the MFP to expand the focus of the program to support master's level trained behavioral health providers in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing. This support would increase the number of providers who are available to provide clinical services to underserved, at-risk children, adolescents, and populations

transitioning to adulthood (ages 16 – 25) in an effort to increase access to, and quality of, behavioral health services for this age group.

SAMHSA-HRSA Mental and Behavioral Health Education and Training (MBHET) Grant Program

In FY 2014, SAMHSA will collaborate with HRSA in expanding the Mental and Behavioral Education and Training (MBHET) Grant Program. This expansion will increase the clinical service capacity of the behavioral health workforce by supporting training for Master's level social workers, psychologists and marriage and family therapists as well as behavioral health paraprofessionals. This effort is critical to ensure that the behavioral health workforce is able to meet the needs of high need and high demand populations, including rural, vulnerable, and underserved populations. In FY 2014, the program will include an emphasis on training to address the needs of children, adolescents, and transition-age youth (ages 16-25) and their families. SAMHSA requests $35.0 million in FY 2014 for the SAMHSA-HRSA expansion of the MBHET grant program and will help increase the behavioral health workforce by 3,950.

Peer Professionals Workforce Development

For FY 2014, SAMHSA requests $10.0 million to strengthen the behavioral health workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16-25. Because of their lived experience with behavioral health conditions, and being able to build trust and foster connections with individuals accessing care, these entry entry-level providers play a significant role in the delivery of prevention and recovery support services. SAMHSA plans to award up to 19 grant awards to community colleges or community college networks, states and national organizations. These funds will provide tuition support and further establish the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education

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(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Substance Abuse Treatment Appropriation				
Substance Abuse Block Grant (SABG) Set Aside				
PHS Evaluation Funds				
NSDUH	$34,614	$33,532	$29,776	-$4,838
National Analytic Center	2,462	2,930	2,500	+38
DASIS/BHSIS	12,847	14,190	15,596	+2,749
C-EMS	418	500	500	+82
SAMHDA/Data Archive	1,295	1,294	1,291	-4
NREPP	---	3,000	---	---
DAWN	---	2,000	---	---
FTE/Operations/1	6,907	1,097	1,293	-5,614
Subtotal, PHS Evaluation Funds	**58,543**	**58,543**	**50,956**	**-7,587**
Budget Authority				
DAWN	148	---	3,300	+3,152
NREPP	1,163	1,342	1,716	+553
FTE/Operations	3,679	3,650	3,793	+114
Subtotal, Budget Authority	**4,989**	**4,992**	**8,809**	**-3,767**
Subtotal, SABG Set Aside	**63,532**	**63,535**	**59,765**	**-3,767**
Health Surveillance and Program Support Appropriation				
Health Surveillance				
Budget Authority				
CDC NHIS IAA	2,000	2,012	2,000	---
Subtotal, Budget Authority	**2,000**	**2,012**	**2,000**	**---**
PHS Evaluation Funds				
DAWN	5,000	---	6,700	+1,700
CDP Legacy Program (DCAR)	6	---	1,180	+1,174
NSDUH	14,137	10,833	14,844	+707
DASIS/BHSIS	---	2,002	7,488	+7,488
National Analytic Center	---	---	1,943	+1,943
C-EMS	---	500	500	+500
CDP Legacy Programs - SAIS and TRAC	---	8,300	1,800	+1,800
Grantee Data Development TA	---	---	5,000	+5,000
DASIS Modification	3,200	---	---	-3,200
BRFSS	---	---	---	---
FTE/Operations	5,085	5,960	5,973	+888
Subtotal, PHS Evaluation Funds	**27,428**	**27,595**	**45,428**	**+18,000**
Prevention and Public Health Fund				
National Analytic Center	460	N/A	---	-460
C-EMS	500	N/A	---	-500
DCAR	4,490	N/A	---	-4,490
NSDUH	10,650	N/A	---	-10,650
Behavioral Health U.S.	657	N/A	---	-657
BRFSS	600	N/A	---	-600
Operations	643	N/A	---	-643
Subtotal, Prevention and Public Health Fund [1/]	**18,000**	**---**	**---**	**-18,000**
Subtotal, Health Surveillance	**47,428**	**29,607**	**47,428**	**---**
Performance and Quality Information Systems (PQIS)				
Budget Authority				
NREPP	1,040	1,379	---	-1,040
CDP Legacy Programs (SAIS and TRAC)	10,900	---	---	-10,900
Common Data Platform (CDP)	---	10,900	---	---
Operations	1,000	772	---	-1,000
Subtotal, Budget Authority	**12,940**	**13,051**	**---**	**-12,940**
PHS Evaluation Funds				
NREPP	---	---	1,784	+1,784
Common Data Platform (CDP)	---	---	10,900	+10,900
Operations	---	---	312	+312
Subtotal, PHS Evaluation Funds	**---**	**---**	**12,996**	**+12,996**
Subtotal, PQIS	**12,940**	**13,051**	**12,996**	**+56**
Subtotal, Health Surveillance and Program Support	**60,368**	**42,658**	**60,424**	**+56**
Total, CBHSQ	**$123,901**	**$106,193**	**$120,189**	**-$3,711**

1/The FY 2013 Prevention and Public Health Funds are reflected in the Office of the Secretary.

Resources by Activity
(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR [1/]	FY 2014 President's Budget	FY 2014 +/- FY 2012
CBHSQ Activities				
NSDUH	$59,401	$44,365	$44,620	-$14,780
DAWN	5,148	2,000	10,000	+4,852
CDC NHIS IAA	2,000	2,012	2,000	---
DASIS/BHSIS	16,047	16,192	23,084	+7,037
C-EMS	918	1,000	1,000	+82
National Analytic Center	2,922	2,930	4,443	+1,521
SAMHDA/Data Archive	1,295	1,294	1,291	-4
Common Data Platform (CDP)	---	10,900	10,900	+10,900
Grantee Data Development TA	---	---	5,000	+5,000
CDP Legacy Program (DCAR)	4,496	---	1,180	-3,316
CDP Legacy Programs (SAIS and TRAC)	10,900	8,300	1,800	-9,100
NREPP	2,203	5,721	3,500	+1,297
BRFSS	600	---	---	-600
Behavioral Health U.S.	657	N/A	---	-657
FTE/Operations	17,313	11,479	11,371	-5,942
Total, CBHSQ	**$123,901**	**$106,193**	**$120,189**	**-$3,711**

[1/]The FY 2013 Prevention and Public Health Funds are reflected in the Office of the Secretary.

Authorizing Legislation.....Sections 501, 505, 1911, 1921 of the PHS Act

FY 2014 Authorization..... Expired

Allocation Method .....Contracts

Program Description and Accomplishments

Beginning in FY 2011 and FY 2012, and moving forward in FY 2013, SAMHSA undertook a new initiative focused on data, outcomes, and quality. The purpose of this initiative was to realize an integrated data strategy and a national framework for quality improvement in behavioral healthcare to help inform policy, measure program impacts, and lead to improved quality of services and outcomes for individuals, families, communities, and tribal communities. A major accomplishment that began in FY 2011 and was completed in FY 2012 was the realignment of a number of data and analytic activities within CBHSQ to improve accountability and transparency in the development and dissemination of information to support this behavioral health care transformation.

There are six functions coordinated through CBHSQ that provide significant support to SAMHSA's integrated data strategy: surveillance and data collection, evaluation, analysis, service systems research, performance and quality information systems, and statistical and analytic support. CBHSQ also supports SAMHSA's efforts to increase public access to data.

In FY 2013, CBHSQ ended or combined contracts to achieve better efficiency. This was the culmination of a comprehensive review of SAMHSA's contracts conducted in FY 2011 determining whether contracted activities were mission critical or would be less expensive to accomplish the Federal staff rather than contractors. For CBHSQ, this resulted in hiring for 36 positions where savings were possible.

Surveillance and Data Collection

SAMHSA manages a number of critical behavioral health data systems for HHS that provide high quality data on the incidence and prevalence of mental and substance use disorders, the use of emergency and specialty care, and more recently local indicators of behavioral health status of communities. The NSDUH serves as the nation's primary source for information on the incidence and prevalence of substance use and mental illness and related health conditions. A new NSDUH contract was awarded in FY 2013 that will finance the 2014, 2015, 2016, and 2017 annual surveys, pending the availability of funds. The Drug Abuse Warning Network (DAWN) is a national public health surveillance system that monitors drug-related emergency room visits for drug and mental illness related problems. SAMHSA partnered with the National Center for Health Statistics/CDC to better inform public policy and prevention and treatment initiatives. NCHS and CBHSQ are working under an Interagency Agreement (IAA) on the development and integration of DAWN into the emergency department (ED) component of the National Hospital Care Survey (NHCS). These changes are consistent with proposals presented in previous budgets. The IAA will allow SAMHSA to incorporate DAWN within the NCHS ED data collection system which will include data elements now collected by NCHS for the nation. CBHSQ provided $5.0 million to the IAA in FY 2012. Due to the slow start-up of the contract/IAA in FY 2012, CBHSQ plans to add only $2 million to the activity in FY 2013. NSDUH's anticipated funding for FY 2012 and FY 2014 is $59.4 million and $44.6 million respectively. In addition, CMHS will provide $1.0 million in both FY 2013 and FY 2014 for NSDUH to cover mental health related data collection.

In FY 2013, SAMHSA will modify the current Drug Abuse Services Information System (DASIS) contract to become the new Behavioral Health Services Information System (BHSIS). DASIS was the primary source of data on substance abuse treatment facilities and treatment admissions. One aspect of this program is the treatment locator, which is accessed more than two million times a year by individuals, families, community groups, and organizations to identify appropriate treatment services. By mid-2013, SAMHSA will post a new up-to-date mental health treatment locator that will provide accurate, timely, and regularly updated information on mental health treatment facilities across the country. The DASIS/BHSIS project is currently piloting the new program with the intention of integrating a mental health treatment admissions data set with its counterpart in substance abuse. This contract modification in 2013

and the new contract to be awarded in 2014 will be funded by both CBHSQ and CMHS. SAMHSA will be working closely with stakeholders including NASADAD, NASMHPD, and our state partners in the development and implementation of this integration effort which includes identifying metrics for reporting. In addition, SAMHSA will field integrated substance abuse and mental health facility surveys in FY 2013. Funding from CBHSQ in FY 2012 and FY 2014 provides for $16.2 million and $23.1 million respectively for DASIS/BHSIS. In addition, CMHS will provide $7.5 million in both FY 2013 and FY 2014 for DASIS/BHSIS.

With the implementation of health reform, new models for integrating behavioral health and primary health care are being developed. It is expected that these changes will have a profound impact on the currently separate systems of substance abuse and mental health treatment. SAMHSA will explore additional strategies to capture changes in the behavioral health systems resulting from reform efforts during 2013 with the expectation of expanding DAISIS/BHSIS' current facilities efforts during 2014. This expanded effort will provide decision makers and researchers enhanced information about how systems of care are organized and financed as well as the outcomes of care on treatment engagement, treatment outcomes, and recovery. This expansion of systems level data will provide information in the following areas:

- the structure and management of care across multiple modalities of care within selected markets;
- the availability, quality, and accessibility to behavioral health services delivered by providers who treat individuals who have substance use and/or mental disorders and related conditions;
- the costs, financing, and effectiveness of service delivery in terms of treatment access, entry, retention, and outcomes (i.e., reductions in substance use and/or symptoms of mental illness, criminal behavior, and other high risk behaviors, as well as improvements in social functioning);,
- the nature and function of collaborative relationships among behavioral health, primary care, and other service as they relate to meeting patient care needs; and
- how individuals progress over time through the recovery process.

It is expected that this data will allow work to be done to examine both treatment and recovery process and will work in concert with the National Survey of Drug Use and Health, the Community Early Warning and Monitoring System, the Financing Center of Excellence, and ongoing analytic projects within the Center for Behavioral Health Statistics and Quality to respond to critical questions related to parity, program effectiveness, financing, and access.

During FY 2012, in collaboration with NIH, CDC, the National Institute of Justice (NIJ), and the Office of National Drug Control Policy (ONDCP), SAMHSA developed the framework and baseline measures for the Community Early Warning and Monitoring System (C-EMS). The purpose of this system is to provide quality community-level behavioral health indicators to understand problems at a local level. This evidence is critical to develop effective prevention and wellness approaches to address specific community challenges. Such a system is necessary as national indicators may bear little resemblance to what is actually happening in any individual community. Meanwhile, many measures available at the local level (e.g., drug-related arrests and incarcerations, suicide, admissions to the hospital for behavioral health conditions, or

domestic violence) are not fully captured in national data sets, which impede the ability to detect emerging problems in particular states or regions.

In FY 2012, CBHSQ began working with the Agency for Healthcare and Quality (AHRQ) in the development and implementation of specific informational and data needs that will support both the C-EMS project and AHRQ's data collection in community emergency departments. CBHSQ will supplement a task order within AHRQ to develop a working definition of "community", as well as to identify and develop community indicators that CBHSQ could then pilot in the development of the C-EMS program. This is an opportunity to continue to enhance the integration of behavioral health measures in AHRQ's hospital, community, and insurance data collection efforts. Information from this system will help capture regional and local problems and provide a near real-time data network that warns of emerging threats from changes in the behavioral health status of communities.

Also, in FY 2012, CBHSQ funded a contract to support three expert panel meetings of fifty or fewer local government officials, community providers, and local evaluators to assist SAMHSA in identifying potential community-level indicators and data sources to understand emerging trends that can impact on community behavioral health. These meetings were planned to serve and highlight gaps in data collection efforts that impact on the understanding of behavioral health in the community. The resultant information will be developed into reports that will be provided to AHRQ in a joint effort to develop and implement a data warehouse for analytic efforts.

Evaluation

Consistent with the Administration's increased emphasis on the use of rigorous and independent program evaluation to determine if programs achieve the intended outcomes at a reasonable cost, SAMHSA will continue to support the systematic collection of data to assess its investments in discretionary and block grant programs. The evaluation policy was finalized in early 2012. In late 2012, CBHSQ conducted a review of all evaluation activity in the Agency. This process helped CBHSQ identify current evaluations which could be enhanced or improved with the support from evaluation experts. For all new program activity in which an evaluation is proposed, CBHSQ meets with program staff and the SAMHSA Evaluation Team (SET) to gather information about planned evaluation activities, program objectives, and budget estimates for evaluation. During this period, CBHSQ reviews the planned grant language to ensure there is sufficient description of evaluation and data collection plans for award. During this period and the time leading up to grant award, CBHSQ staff continues to meet and design the evaluation that will actually inform the stated objectives of the program. CBHSQ's role in the actual evaluation is to: 1) conduct an evaluation or 2) co-direct an evaluation using a contractor to gather data and assist with report writing or 3) serve as a consultant as needed on evaluations that are directed by an originating Center with in SAMHSA.

Through its evaluation guidance, SAMHSA proposes to expand its efforts to improve the quality of information on behavioral health investments by:

- providing uniform standards for evaluations;

- supporting rigorous evaluation designs;
- building a cadre of trained evaluators to oversee evaluations;
- providing a structure to assess environmental contexts that promote or impede program effectiveness;
- allowing for designs that enable adaptation and adjustments in the implementation process;
- producing timely results for decision makers; and
- creating an accessible, central repository for information related to SAMHSA evaluations.

Analysis

Funding is requested for a number of activities to support a broad range of analytic work to be carried out in the Center for Behavioral Health Statistics and Quality. These activities include support for the National Analytic Center (NAC) which undertakes a number of scientific and writing tasks on policy and practice related topics in response to requests from SAMHSA Centers, HHS agencies (CDC, AHRQ, FDA, and the Surgeon General's Office), the Office of National Drug Control Policy, and the Department of Justice. Work within CBHSQ will be coordinated with OPPI and the Financing Center of Excellence contract to ensure that critical health econometric work and systems analysis is prioritized in line with health reform goals. Funding will also support the outgoing Substance Abuse and Mental Health Data Archive (SAMHDA) which serves as SAMHSA's primary repository for public access data files. SAMHDA provides free access and on-line analytic tools to the public. Resources will also be used to develop a program for providing limited public access to files restricted for privacy or other reasons, serving to expand the use and application of data collected under the survey contracts.

Finally, funding will be utilized to support positions focused on analyzing and reporting on data collected within CBHSQ, SAMHSA and HHS, as well as identifying and analyzing information from other data sets that may help inform the work of SAMHSA. Staff will also respond to requests for data and explanations of existing data points, preparing internal reports, supporting SAMHSA staff in the development of materials that require statistical information, preparation of short reports and data spotlights, as well as preparing manuscripts for publication. These staff also support data needs by serving on workgroups that require data analysis as part of their function and will prepare data requests for departmental activities. Particularly important is the inclusion of a new Health Economics and Financing Team that will focus on studies related to cost and financing trends as health care delivery models change over the next several years. Some of these positions have been created by insourcing tasks that are most appropriately done by federal staff, are less expensive than contract staff, or are mission critical and thus improve SAMHSA's capacity to respond to data and information needs relevant to SAMHSA's mission.

The appropriations language proposed for the FY 2014 for SAMHSA includes a proposal to collect a small amount in fees to offset some cost of analyses of these data that would otherwise not be done within existing SAMHSA resources and that are requested by proprietary or other

private or public entities that are interested in additional data analyses that SAMHSA's NBHAC could provide if funds were available.

FY 2012 and FY 2014 provide for $2.9 million and $4.4 million respectively for the National Analytic Center.

Services Systems Research

Building on efforts begun in FY 2011 and FY 2012, SAMHSA proposes to continue to build its practice-based service systems research program which complements efforts in its sister agencies of NIH, AHRQ, and CDC. This will provide pilot data for full-scale research proposals to NIH or other practice settings in which to test models being developed through these agencies' research efforts. The program will focus on critical gaps in knowledge about prevention, wellness, treatment, and recovery services for individuals, families, and communities at risk for or suffering from mental illnesses, addictions, and related chronic conditions. Of particular interest to SAMHSA are issues of quality, cost, access to, and outcomes of behavioral health services both in the primary and specialty care service sectors as provisions for the Prevention Fund are implemented. Significant attention will be given to developing analyses that enhance understanding of the economic and cost implications of changes in health insurance access for behavioral health care within the larger SAMHSA analytic agenda coordinated through CBHSQ.

Performance and Quality Information Systems

Continued funding is requested for performance and quality information systems to phase in the implementation of SAMHSA's Common Data Platform (CDP) which will provide a uniform collection and reporting system providing SAMHSA management and staff with the ability to analyze programs at various levels (state, program, community, etc.), provide each Center with tailored information in real-time about the progress and activities of their grantees, and provide data to grantees to support them in the efficient and effective implementation of projects.

During 2013 and 2014, SAMHSA will be working closely with the National Association of State Alcohol and Drug Abuse Directors (NASADAD), the National Association of State Mental Health Directors (NASMHD), and state partners to identify, refine, and test measures that, where possible, build upon current efforts within states. Moving forward, SAMHSA is committed to harmonizing measures across data collection programs in a way that reduces burden, increases the quality of data collected, and provides necessary information to measure performance and manage grants

Funding is also requested for the continuation of the National Registry of Evidence-based Programs and Practices (NREPP), a searchable online system that supports states, communities, and tribes in identifying and implementing evidence-based mental health promotion, substance abuse prevention, and substance abuse and mental health treatment interventions. This registry is made up of interventions, mental health and substance abuse, that have been reviewed and rated by independent reviewers and is ready to assist the public in identifying scientifically based approaches to preventing and treating mental and/or substance use disorders that can be readily

disseminated to the field. This program is one way that SAMHSA is working to improve access to information on tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field. FY 2012 and FY 2014 provide for $2.2 million and $3.5 million respectively for NREPP.

Other SAMHSA activities related to the Strategic Initiative on Data, Outcomes and Quality include the development of the National Behavioral Health Quality Framework, stemming from the National Quality Strategy and coordination with Health Information Technology efforts and Meaningful Use Measures for application in electronic health records, led by ONC and CMS.

Statistical and Analytic Support

Funding is requested to continue support for statistical and analytic FTE's and operational needs consistent with the realignment of data collection, analytic, and measurement development tasks within the CBHSQ. As SAMHSA moves to implement its Strategic Initiative on Data, Outcomes, and Quality, 14 additional staff will be hired in 2013 to carry out the management of data collection activities as well as analysis and report development related to health and behavioral health reform.

Resource Summary

A total of $120.2 million is provided for CBHSQ, including $59.8 million from the Substance Abuse Treatment appropriation and $60.4 million from the Health Surveillance and Program Support appropriation. This reflects a net decrease of $3.7 million, including a decrease of $3.8 million from the Substance Abuse Treatment (SAT) appropriation and practically level funding from the Health Surveillance and Program Support (HSPS) appropriation. The source of funding for CBHSQ within HSPS has shifted from the Prevention Fund to the Public Health Service Evaluation Fund (PHS), reflecting a decrease of $18 million in Prevention Funds and an increase of $18 million in PHS Evaluation fund. Major increases include funding for DAWN to fully fund the IAA with CDC to incorporate DAWN within the NCHS ED data collection system, funding for grantee data collection technical assistance to transition to help grantees transition to the new Common Data Platform, and funding for the BHSIS contract. Decreases include funding for NSDUH, NAC, and funding for the Legacy data collection which will be phased out as the Common Data Platform becomes fully operational, and funding for FTE/operations.

The FY 2014 resources include increases from the FY 2012 funding level for the following activities (+29.1 million):

- DAWN: $10.0 million, an increase of $4.9 million from the FY 2012 funding level. This increase includes funding for an IAA with CDC to incorporate DAWN within the NCHS ED data collection system. In addition, other data sources will supplement ED reporting from the NHCS.
- DAISIS/BHSIS: $23.1 million, an increase of $7.0 million from the FY 2012 funding level. An additional $7.5 million will be provided from the mental health appropriation.
- C-EMS: $1.0 million, an increase of $0.082 million from the FY 2012 funding level. Funding will support ongoing analytic projects.

- National Analytic Center: $4.4 million, an increase of $1.5 million from the FY 2012 funding level. Increased funding will allow for the expanded use and application of data collected under the survey contracts.
- CDP: $10.9 million, an increase of $10.9 million from the FY 2012 funding level. This increase includes funding for implementation of the Common Data Platform.
- Grantee Data Development TA: $5.0 million, an increase of $5.0 million from the FY 2012 funding level.
- NREPP: $3.5 million, an increase of $1.3 million from the FY 2012 funding level. This increase will support and enhance the online public registry of ready to use approaches for treating and preventing mental and substance abuse disorders.

The FY 2014 resources also include same level funding as in FY 2012 for the following activity:

- CDC NHIS IAA: $2.0 million

The FY 2014 resources also include decreases from FY 2012 funding level for the following activities (-$32.8 million):

- NSDUH: $44.6 million, a decrease of $14.8 million from the FY 2012 funding level. Funding will support annual surveys. An additional $1.0 million dollars will be provided from the mental health appropriation.
- SAMHDA/Data Archive: $1.3 million, a decrease of $0.004 million from the FY 2012 funding level.
- DCAR- Legacy: $1.2 million, a decrease of $3.3 million from the FY 2012 funding level. Funding decrease attributed to the phasing out of legacy contracts and moving towards implementing CDP.
- SAIS/TRAC: $1.8 million, a decrease of $9.1 million from the FY 2012 funding level. Funding decrease attributed to phasing out of legacy contracts and moving towards implementing CDP.
- BRFSS: $0, a decrease of $0.600 million from the FY 2012 funding level. In FY 2014, funding for BRFSS will be provided by the mental health appropriation.
- Behavioral Health U.S.: $0, a decrease of $0.657 million from the FY 2012 funding level.
- FTE/Operations: $11.4 million, a decrease of $5.9 million from the FY 2012 funding level due to reduction in overhead costs.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

RESOURCE SUMMARY

	FY 2012 Actual	FY 2013 Annualized CR [2/]	FY 2014 President's Budget
Drug Resources by Function			
Prevention	$574,214	$573,976	$571,204
Treatment	1,982,013	1,950,351	1,917,369
Total, Drug Resources by Function	**2,556,227**	**2,524,327**	**2,488,572**
Drug Resources by Decision Unit			
Substance Abuse Prevention			
Programs of Regional and National Significance [1/]	185,885	187,076	175,560
Substance Abuse Prevention and Treatment Block Grant	360,066	362,270	363,971
Total, Substance Abuse Prevention	**545,951**	**549,346**	**539,531**
Substance Abuse Treatment			
Programs of Regional and National Significance [1/]	428,697	402,751	334,794
Substance Abuse Prevention and Treatment Block Grant	1,440,266	1,449,080	1,455,885
Total, Substance Abuse Treatment	**1,868,962**	**1,851,831**	**1,790,679**
Health Surveillance and Program Support			
Prevention	28,263	24,630	31,672
Treatment	113,050	98,520	126,690
Total, Health Surveillance and Program Support	**141,313**	**123,150**	**158,362**
Total, Drug Resources by Decision Unit	**2,556,227**	**2,524,327**	**2,488,572**
Drug Resources Personnel Summary			
Total FTEs (direct only)	**590**	**631**	**655**
Drug Resources as a Percent of Budget			
Total Agency Budget	**$3,568,687**	**$3,498,924**	**$3,572,209**
Drug Resources Percentage	**71.6%**	**72.1%**	**69.7%**

Footnotes

[1] A detailed breakout of programs within the Programs of Regional and National Significances can be found on the following page; does not include Mental Health Programs.

[2] The FY 2013 Prevention Fund Resources are reflected in the Office of the Secretary.

Drug Budget Split between Prevention and Treatment FY 2012-FY 2014

(Dollars in Thousands)

Substance Abuse Prevention	FY 2012 Actual	FY 2013 Annualized CR [1/]	President's Budget
Substance Abuse Prevention PRNS			
Strategic Prevention Framework	$109,754	$110,479	$109,754
Manadatory Drug Testing	5,196	5,228	4,906
Minority AIDS Initiative	41,307	41,560	41,307
STOP Act	6,987	7,030	7,000
Fetal Acohol Syndrome	9,802	9,862	1,000
Center for the Application of Prevention Technologies	8,059	8,108	7,511
Science and Service Program Coordination	4,780	4,809	4,082
Total, Substance Abuse Prevention PRNS	**$185,885**	**$187,076**	**$175,560**
Substance Abuse Prevention and Treatment Block Grant	$360,066	$362,270	$363,971
PHS Evaluation Funds (non-add)	*15,840*	*15,937*	*14,345*
Total, Substance Abuse Block Grant	**$360,066**	**$362,270**	**$363,971**
Health Surveillance and Program Support			
Health Surveillance and Program Support	$24,176	$20,515	$23,056
Prevention and Public Health Fund (non-add)	*3,218*	N/A	---
Budget Authority (non-add)	*15,778*	*15,874*	*14,946*
Data Request/Publication User Fees (non-add)	---	---	*300*
PHS Evaluation Funds (non-add)	*5,181*	*4,640*	*7,811*
Public Awareness and Support	1,355	1,363	1,357
PHS Evaluation Funds (non-add)	---	---	*1,357*
Performance and Quality Information Systems	1,812	1,827	1,819
PHS Evaluation Funds (non-add)	---	---	*1,819*
Agency Wide Initiatives	920	926	5,440
Workforce (non-add)	571	574	5,440
Military Families Initiative (non-add)	349	351	---
Total, Substance Abuse Prevention HSPS	**$28,263**	**$24,630**	**$31,672**
Total, Substance Abuse Prevention	**$574,214**	**$573,976**	**$571,204**

[1] The FY 2013 Prevention Fund Resources are reflected in the Office of the Secretary.

Drug Budget Split between Prevention and Treatment FY 2012-FY 2014

(Dollars in Thousands)

Substance Abuse Treatment	FY 2012 Actual	FY 2013 Annualized CR [1/]	FY 2014 President's Budget
Substance Abuse Treatment PRNS			
Opioid Treatment Programs/Regulatory Activities	$12,886	$8,941	$8,746
Prevention and Public Health Fund (non-add)	*4,000*	*N/A*	---
Screening, Brief Intervention and Referral to Treatment	53,187	28,360	30,000
Budget Authority (non-add)	26,187	26,348	---
Prevention and Public Health Fund (non-add)	*25,000*	*N/A*	*30,000*
PHS Evaluation Funds (non-add)	*2,000*	*2,012*	---
TCE - General	27,980	28,151	13,256
Pregnant & Postpartum Women	15,970	16,067	15,970
Strengthening Treatment Access and Retention	1,672	1,682	1,000
Recovery Community Services Program	2,445	2,460	2,562
Access to Recovery	98,268	98,869	65,000
Children and Family Programs	30,620	30,807	29,678
Treatment Systems for Homeless	41,571	41,826	41,571
Minority AIDS	65,863	66,266	52,359
Criminal Justice Activities	66,903	67,920	65,135
Addiction Technology Transfer Centers	9,064	9,119	8,081
Special Initiatives/Outreach	2,267	2,281	1,436
Total, Substance Abuse Treatment PRNS	**$428,697**	**$402,751**	**$334,794**
Substance Abuse Prevention and Treatment Block Grant	$1,440,266	$1,449,080	$1,455,885
PHS Evaluation Funds (non-add)	*63,360*	*63,748*	*57,379*
Total, Substance Abuse Block Grant	**$1,440,266**	**$1,449,080**	**$1,455,885**
Health Surveillance and Program Support			
Health Surveillance and Program Support	$96,706	$82,058	$92,226
Prevention and Public Health Fund (non-add)	*12,872*	*N/A*	---
Budget Authority (non-add)	*63,112*	*63,498*	*59,783*
Data Request/Publication User Fees (non-add)	---	---	*1,200*
PHS Evaluation Funds (non-add)	*20,722*	*18,560*	*31,242*
Public Awareness and Support	5,418	5,451	5,428
PHS Evaluation Funds (non-add)	---	---	*+5,428*
Performance and Quality Information Systems	7,247	7,308	7,278
PHS Evaluation Funds (non-add)	---	---	*+7,278*
Agency Wide Initiatives	3,680	3,702	21,758
Workforce (non-add)	*2,282*	*2,296*	*21,758*
Military Families Initiative (non-add)	*1,397*	*1,406*	---
Total, Substance Abuse Treatment HSPS	**$113,050**	**$98,520**	**$126,690**
Total, Substance Abuse Treatment	**$1,982,013**	**$1,950,351**	**$1,917,369**

[1] The FY 2013 Prevention Fund Resources are reflected in the Office of the Secretary.

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 2014 will include the Substance Abuse Block Grant, competitive grant programs reflecting Programs of Regional and National Significance (PRNS) and Health Surveillance and Program Support. These programs are administered through SAMHSA's Centers for Substance Abuse Prevention (CSAP) and Substance Abuse Treatment (CSAT) as well as through SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) and the Office of Communications.

METHODOLOGY

SAMHSA distributes drug control funding into two functions: prevention and treatment. Both functions include a portion from the Health Surveillance and Program Support appropriation. Since the PAS and PQIS programs represent the consolidation of funding from existing CSAT, CSAP and Center for Mental Health Services (CMHS) programs, 50 and 70 percents, respectively, of funding for these activities would be included in the drug budget which represents the substance abuse portion of split between substance abuse and mental health for the entire agency. The 50 and 70 percents are then divided 20 percent/80 percent into the two functions, prevention and treatment, respectively. The Health Surveillance and Program Support activities are split first between mental health and substance abuse (as determined by each activity) and then the substance abuse portion is split 80 percent and 20 percent between prevention and treatment. Agency-wide programs would be evenly split between mental health and substance abuse and then the substance abuse portion will be split the same 20 percent and 80 percent for prevention and treatment.

Included in the prevention functions are the funds in the Substance Abuse Prevention appropriation, including the Substance Abuse Prevention Programs of Regional and National Significance and 20 percent of the Substance Abuse Block Grant funds from the Substance Abuse Treatment appropriation. Also included in prevention are 20 percent of the substance abuse portions of Performance and Quality Information Systems (PQIS) and Public Awareness and Support (PAS) programs, a portion of the Agency-wide Initiatives, and 20 percent of the remaining funding in Health Surveillance and Program Support. Included in treatment are the funds in the Substance Abuse Treatment appropriation, including the Substance Abuse Treatment Programs of Regional and National Significance and 80 percent of the Substance Abuse Block Grant funds. Also included in treatment are 80 percent of the substance abuse portions of PQIS and PAS programs, a portion of the Agency-wide Initiatives, and 80 percent of the remaining funding in Health Surveillance and Program Support.

BUDGET SUMMARY

In FY 2014, SAMHSA requests a total of $2.489 billion for drug control activities, which is a decrease of $67.7 million from the FY 2012 level. The Budget directs resources to activities that have demonstrated improved health outcomes and that increase service capacity. SAMHSA has three major drug-related decision units: Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support. Each decision unit is discussed below:

Substance Abuse Prevention

Substance Abuse Prevention Programs of Regional and National Significance
Total FY 2014 Request: $175.6 million
(Reflects $10.3 million decrease from FY 2012)

The Substance Abuse Prevention Programs of Regional and National Significance (PRNS) support states and communities in carrying out an array of activities to improve the quality and availability of services in priority areas.

The FY 2014 President's Budget request for SAMHSA Substance Abuse Prevention PRNS includes $175.6 million which covers seven programmatic activities, a decrease of $10.3 million from the FY 2012 level. The request includes: $109.8 million for Strategic Prevention Framework; $41.3 million for Minority AIDS; $1.0 million for the Fetal Alcohol Spectrum Disorders (FASD) contract; $7.5 million to continue provision of technical assistance to maximize effectiveness through the Centers for the Application of Prevention Technologies; $4.9 million for Mandatory Drug Testing; $7.0 million for other Sober Truth on Preventing Underage Drinking; and $4.1 million for Science and Service Program Coordination.

Strategic Prevention Framework
Total FY 2014 Request: $109.8 million
(Reflects level funding from FY 2012)

Partnerships for Success

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

continuation grants. The FY 2011 data from the first cohort reporting show that 50 communities increased the number of activities supported through collaboration and leveraging. Grantees reported implementing almost two thousand evidence based programs during FY 2011. Thirty-two communities reported improvements on targeted National Outcome Measures indicators. The vast majority of communities (88 percent) targeted alcohol use.

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

In FY 2013, SAMHSA will support continuation awards for the initial cohort established in FY 2009 and FY 2010. SAMHSA will make a new SPF SIG award to Iowa, the last SPF SIG state remaining to receive one and will award up to 17 new PFS grants. In addition, SAMHSA will make funds available for grantees in the first cohort who meet their performance targets and are eligible to apply for the incentive supplement.

In FY 2014, SAMHSA requests $36.7 million to implement a new cohort of Partnerships for Success (PFS) grants, which will be consistent with the Prevention of Substance Abuse and Mental Illness Strategic Initiative. Similar to the previous cohorts, this PFS program will focus on implementing the Strategic Prevention Framework to strengthen prevention capacity and infrastructure at the state, territorial, and community levels; preventing the onset and reducing the progression of substance abuse; and leveraging, redirecting, and aligning statewide funding streams and resources to focus on promoting evidence-based substance abuse prevention. The new PFS grantees will also have the option of focusing on addressing trauma as one of the risk factors for substance abuse.. Up to 32 grants will be awarded to eligible states, territories and tribes who have completed SPF-SIG grants. Grant award amounts will be divided into tiers with a maximum grant of approximately $2.0 million per year for the top tier.

SAMHSA will also consider how best to help tribes committed to substance abuse prevention to strengthen their existing service delivery systems and/or to begin building the necessary capacity and/or infrastructure to successfully prevent substance abuse in their communities.

Minority AIDS Initiative
Total FY 2014 Request: $41.3 million
(Reflects level funding from FY 2012)

Implemented in FY 1999, SAMHSA/CSAP's Minority AIDS Initiative (MAI) supports efforts to increase access to substance abuse and HIV prevention services for the highest risk and hardest-to-serve racial and ethnic minority populations. Grantees must implement integrated, evidence-based substance abuse and HIV prevention interventions, including HIV testing, that target one or more high-risk populations such as African-American women, adolescents, individuals who have been released from prisons and jails within the past two years, or men having sex with men (MSM). In addition, the MAI supports partnerships between public and private nonprofit organizations to prevent and reduce the onset of substance abuse and transmission of HIV among high-risk populations.

Since its inception, CSAP has funded a total of ten cohorts. In FY 2011, SAMHSA/CSAP funded the Ready-To-Respond Initiative and the Capacity Building Initiative programs, and a total of 62 grants in these cohorts will continue to be funded in FY 2013. The Ready-To-Respond Initiative, targeted toward experienced MAI grantees, provides substance abuse and HIV prevention services to at-risk minority populations in communities disproportionately affected by HIV/AIDS. The Capacity Building Initiative focuses on using evidence-based prevention strategies and media technology to reach college students, who comprise one-third of the 18-24 year old population in the United States and are particularly at risk for substance use and HIV infection. Performance data for FY 2011, the most recent available showed that over 4,000 people received substance abuse prevention education services. Over 355,000 were reached through environmental approaches. Additionally, 95.5 percent of participants rated the risk of harm from substance abuse as great. Of those participants who were non-users, 92.5 percent remained non-users of drugs and 88.1 percent remained alcohol free. During FY 2011, over 11,000 participants were tested for HIV, of whom almost 4,000 were tested for the first time. SAMHSA has supported these grants in FY 2012 and will continue to do so in FY 2013.

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

In FY 2013, SAMHSA is awarding a new cohort of grants for the *MAI and HIV Prevention in High Risk Minority Serving Institutions (MSI) and Communities (MAI/MSI) program*. The purpose of the MAI/MSI program is to equip and empower high risk MSIs located in communities with the highest risk of substance abuse and HIV infections with evidence-based methodologies to increase access to comprehensive, integrated substance abuse and HIV prevention services on their campuses/institutions and in the surrounding community. High risk population are communities with higher prevalence rate of substance abuse, HIV/AIDS, underage drinking and/or prescription drug misuse and has limited resources or has had fewer opportunities or less success in identifying and bringing to bear resources to address the identified priorities. The MAI/MSI recipients also will be required to partner with local community organizations serving at-risk racial/ethnic minority young adults, MSMs, as well as (if applicable), other demonstrated high risk groups in communities disproportionately affected by SA and HIV/AIDS, i.e. Black/African American men and women, Latino(a), Hispanic and sexual minorities. The goal is to reduce the rate of new substance abuse and HIV infections on minority serving college/institution campuses and the surrounding at risk communities. SAMHSA will award up to 60 grants for three years.

SAMHSA supports the National HIV/AIDS Strategy through its grant programs, including the cross-Center Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements, the CSAT Targeted Capacity Expansion/HIV program, and the CSAP

Ready-to-Respond and Capacity Building Initiative programs, all described in their respective sections of this document. SAMHSA also provides technical assistance to its grantees to assure they are focusing on the goals of the Strategy and collaborates with other HHS Operating Divisions involved with the Strategy to assure a coordinated, Departmental approach.

Fetal Alcohol Spectrum Disorder
Total FY 2014 Request: $1.0 million
(Reflects $8.8 million decrease from FY 2012)

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

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

In FY 2011, the most recent year for which data is available, SAMHSA's FASD CFE screened 10,829 at-risk individuals and provided direct services to a total of 1,651 individuals. Over 90 percent of participants who used alcohol reported decreased current and binge drinking after program participation. In addition, SAMHSA's FASD provided 26 trainings to over 1,483 providers nationwide.

In FY 2012, SAMHSA continued to support the FASD CFE to work toward the prevention of FASD in communities throughout the nation. In FY 2013, SAMHSA will award a new FASD CFE to focus on identifying new methods for screening and providing preventive services and resources to women of childbearing age, as well as increasing collaboration and coordination of prevention efforts with other federal and national partners.

Center for the Application of Prevention Technologies
Total FY 2014 Request: $7.5 million
(Reflects a $0.6 million decrease from FY 2012)

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

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

During FY 2011, SAMHSA's CAPT delivered over 415 training events nationwide and trained over 10,060 substance abuse prevention professionals. During FY 2012, there was a slight decline to 9,041 in numbers. In addition, in FY 2012, SAMHSA's CAPT provided technical assistance services to 7,655 people. Over 96 percent of service recipients reported that their organization's capacity was increased as a result of the service. Almost half of the recipients reported fully implementing the training recommendations. Additional performance data for the CAPT is captured using common measures with other technical assistance activities in the Science and Service Program Coordination category.

Mandatory Drug Testing
Total FY 2014 Request: $4.9 million
(Reflects $0.3 million decrease from FY 2012)

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

Executive Order 12564, first signed on September 15, 1986, requires the head of each executive agency to establish a program to test for the use of illegal drugs by federal employees in sensitive

positions and requires the Secretary to promulgate scientific and technical guidelines for drug testing programs. The Executive Order also requires HHS to assist the Office of Personnel Management to develop and improve training programs for federal supervisors and managers on illegal drug use and to mount an intensive drug awareness campaign throughout the federal workforce.

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

The program is further supported by the CSAP Workplace Helpline, a toll-free telephone service for business and industry that answers questions about drug abuse in the workplace.

SAMHSA will continue these activities in FY 2013. In addition, the Drug Testing program is examining the scientific basis for oral fluid testing as an alternative specimen to urine, and also to include additional Schedule II prescription medications (e.g., oxycodone, oxymorphone, hydrocodone and hydromorphone) in the drug testing protocol. Any changes will be based on scientific supportability. SAMHSA continues to partner with NIH/NIDA, FDA, and other federal agencies to ascertain the scientific evidence needed to set standards for the Mandatory Guidelines.

Sober Truth on Preventing Underage Drinking (STOP Act)
Total FY 2014 Request: $7.0 million
(Reflects $0.013 million increase from FY 2012)

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 is the nation's first comprehensive legislation on underage drinking. One of the primary components of the Act is the STOP Act grant program, which provides additional funds to current or former grantees under the Drug Free Communities Act of 1997 to prevent and reduce alcohol use among youth age 12-20. The STOP Act grant program enables organizations to strengthen collaboration and coordination among stakeholders in order to achieve a reduction in underage drinking in their communities. Grants are limited by statute to $50,000 per year for four years. In FY 2012, 81 new grants were awarded. In FY 2011, performance data show that the STOP Act grant program has exceeded targets in all GPRA performance measures. Eighty-four percent of coalitions reported a reduction in the past 30 day use of alcohol, 75 percent of coalitions reported an increase in perceived risk, and 75 percent of coalitions reported an increase in perception of parental disapproval of alcohol use (69.6 percent). In FY 2013, SAMHSA will award up to 16 new grants.

Another component of the STOP Act is the National Adult-Oriented Media Public Service Campaign, which educates parents regarding how to speak with their 11- through 15-year-old children about underage drinking in order to delay the onset of, and ultimately reduce, underage drinking. Nationwide, 38.9 percent of the estimated 10 million underage drinkers were provided

free alcohol by adults 21 or older (2010 NSDUH). Further research continues to show that parents of teens generally underestimate the extent of alcohol used by youth and its negative consequences, with the vast majority viewing underage drinking as "inevitable."

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

Science and Service Program Coordination
Total FY 2014 Request: $4.1 million
(Reflects $0.7 million decrease from FY 2012)

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

The purpose of SAMHSA's NACE is to promote effective substance abuse prevention programs in tribal and urban American Indian and Alaska Native (AI/AN) communities throughout the United States. The NACE mission is to promote best practices in substance abuse prevention by disseminating information on cultural- and evidence-based programs, practices, and policies and providing training and technical assistance (TTA) to prevention programs and organizations serving urban and tribal Native American communities. The target audiences include the Native American SPF-SIG grantees, tribal nations and organizations, health and social service providers, federal and state level organizations, and community and faith-based providers serving Native Americans. It has provided TTA to 482 recipients and training to 213 people during FY 2011. Additionally 88 percent of recipients report that the NACE services increased their individual capacity to provide prevention services.

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

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

In FY 2013, SAMHSA's CSAP's NACE and CMHS's AI/AN Suicide Prevention programs will collaborate through braided funding to provide comprehensive, broad, focused, and/or intensive training and technical assistance to federally-recognized tribes and other American Indian/Alaska Native communities, seeking to address and prevent mental and substance use disorders, suicide, and promote mental health. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent.

The UADPEI engages parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences. Through this initiative, families, their children, and other youth-serving organizations have been reached through Town Hall Meetings (held in even-numbered years), technical assistance, trainings, and a variety of tools and materials. In FY 2011, more than 2,800 people were trained.

Performance data show that, collectively, the CAPT and Science and Service Program Coordination programs have exceeded their targets for customer satisfaction, and for the proportion of participants who report implementing recommendations. Efficiencies have been achieved from the growing focus on train-the-trainer models rather than training of individuals. In addition, since the Town Hall Meetings under the UADPEI contract occur biannually, numbers served expand in the years the meetings occur and contract in alternate years.

Substance Abuse Treatment

Substance Abuse Treatment Programs of Regional and National Significance
Total FY 2014 Request: $334.8 million
(Reflects $93.9 million decrease from FY 2012)

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 2014 President's Budget request for SAMHSA Substance Abuse Treatment PRNS includes $334.8 million which covers thirteen programmatic activities, a decrease of $93.9 million from the FY 2012 level. The request includes: $65.0 million for Access to Recovery; $30.0 million for Screening, Brief Intervention and Referral to Treatment; $41.6 million for Treatment Systems for Homeless; $52.4 million for Minority AIDS Initiative; $65.1 million for Criminal Justice Activities of which $41.3 million will fund Drug Courts and $11.9 million for Ex-Offender Reentry; and $80.7 million for Other PRNS Treatment Programs.

Access to Recovery
FY 2014 Request: $65.0 million
(Reflects $33.3 million decrease from FY 2012)

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

Since 2004, ATR has funded a total of 69 grants in a total of three cohorts: 15 three-year grants were awarded in FY 2004, 24 three-year grants were awarded in FY 2007, and 30 four-year grants were awarded in FY 2010. ATR is designed to: (1) allow recovery to be pursued through personal choice and many pathways; (2) require grantees to manage performance based on outcomes that demonstrate client successes; and (3) expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services. The target is 225,000 clients for the third cohort, which began in FY 2010, with approximately 33,500 to be served in the first year; 70,750 clients to be served in each of the two subsequent years; and 50,000 to be served in the final year. In its first year of operation this cohort of ATR has exceeded its target of 33,500, having served over 47,000 clients. SAMHSA funded the continuation of 30 grants and supported six contracts in FY 2012. SAMHSA will fund 30 grant continuations in the final year of the third cohort in FY 2013 as well as one contract.

The FY 2014 budget request includes $65.0 million for the ATR program. Although reduced in scale from past years, it will serve 21,000 individuals. In FY 2014, the program will preserve the core concepts embodied in the three previous ATR cohorts, while also striving to better support provisions of the Affordable Care Act.

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

SAMHSA plans to award 19 three-year grants of $3.2 million annually. The majority of services provided are expected to be recovery support not otherwise fundable through insurance mechanisms. These include services such as transportation, housing, and jobs support.

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

The ATR program will be better integrated into the fabric of health reform as it is implemented during 2014. At the same time, service gaps will be filled, especially in the area of recovery support, to help achieve comprehensive coverage for those with substance abuse disorders.

The proposed number of clients to be served with 2014 funding is 21,242. Outcomes including abstinence from substance use will also be tracked. By 2015, 80 percent of clients are expected to report being abstinent from substance use, 93 percent of clients are expected to report having no involvement with the criminal justice system, and 88 percent of clients are expected to report having improved social support.

Screening, Brief Intervention and Referral to Treatment
FY 2014 Request: $30.0 million
(Reflects $23.2 million decrease from FY 2012)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) was initiated by SAMHSA/CSAT in FY 2003, using cooperative agreements to expand and enhance a state or tribal organization's continuum of care. The purpose of the program is to integrate screening, brief intervention, referral, and treatment services within general medical and primary care settings.

The SBIRT program requires grant recipients to effect practice change throughout the spectrum of medical practice. This is achieved through implementation in all levels of primary care, including hospitals, trauma centers, health clinics, nursing homes, employee assistance programs, and school systems. Practice change also alters the educational structure of medical schools by developing and implementing SBIRT curricula as standard and permanent practice.
Research and clinical experience supports the use of the SBIRT approach to provide effective early identification and interventions in primary care and general medical settings. Early identification can decrease total healthcare costs by arresting progression toward addiction. SBIRT also can identify people, individuals with more serious problems and encourage them to obtain appropriate specialty treatment services. Funds may be used for the following services: pre/screening for substance use and co-occurring disorders; brief Interventions designed with client centered, non-judgmental, motivational interviewing techniques; brief treatment including the monitoring of individuals who misuse alcohol and other drugs but are not yet dependent; referral to treatment (when indicated) for those who have a substance use disorder; and when appropriate, referral to and expansion of specialty treatment services. Since the beginning of this

program, more than 1.7 million individuals have been screened. Of those, 19 percent required a brief intervention, brief treatment, or referral to specialty treatment programs.

In 2011, over 213,000 clients were served by the SBIRT Program. The percentage of clients reporting abstinence at follow-up tripled compared to the percentage reporting abstinence at baseline.

SBIRT has great future potential for promoting changes to the entire primary care medical service delivery system. Efforts are underway to identify other funding streams to help take this practice to scale. For example, new diagnostic codes have been adopted by 16 states, making it easier for doctors to get reimbursed for screening Medicaid patients. Likewise, alcohol screening is now available to Medicare beneficiaries as a preventive service without cost. In FY 2012, SAMHSA funded the continuation of 27 SBIRT grants, supported five contracts as well as three new multi-year grants funded out of the Prevention Fund, and continued to monitor the progress of the three FY 2011 multi-year Prevention Fund grants. In FY 2013 SAMHSA anticipates funding up to 19 new grants as well as 12 grant continuations and supporting three contracts.

In FY 2014, SAMHSA requests $30.0 million from the Prevention Fund for the SBIRT program (an increase of $5 million from the Prevention Fund, but an overall decrease of $23.2 million from FY 2012). This level of funding will further support the integration and use of the SBIRT model into states and tribal primary care settings. In FY 2014, an estimated 141,435 individuals will be served by the program. The request will support 41 grants (25 continuations and 16 new) and one contract. Grant funds will further integrate SBIRT within medical treatment settings to provide early identification and intervention to at-risk individuals within the context of their primary care provider.

Treatment Drug Courts
FY 2014 Request: $41.3 million
(Reflects $3.7 million decrease from FY 2012)

Drug Courts

Drug courts are designed to combine the sanctioning power of courts with effective treatment services for a range of populations and problems such as alcohol and/or drug use, child abuse/neglect or criminal behavior, mental illness, and veterans' issues. In 2010, the criminal justice system was the largest single source of referrals to substance abuse treatment. As treatment drug courts and other problem solving courts addressing drug and other behavioral health-related issues are being established at a high rate, communities are challenged to find sufficient substance abuse treatment and recovery support resources for people referred by the courts.

In FY 2010, SAMHSA/CSAT funded 10 new adult treatment drug court grants for three years at a cost of up to $325,000 per year. Also in FY 2010, SAMHSA and the Department of Justice (DOJ)/Office of Justice Programs (OJP)/Bureau of Justice Affairs (BJA) developed a joint program to enhance court services, coordination, and the substance abuse treatment capacity of

adult drug courts. The purpose of this joint initiative is for applicants to submit one application that outlines a comprehensive strategy for enhancing drug court capacity. SAMHSA and BJA jointly funded 20 new adult treatment drug court grants. Each grantee was awarded one separate grant from each agency, representing an innovative braided funding opportunity. Any braided amounts spent or awarded will be tracked as distinct funding streams and will only be used for purposes consistent with legislative direction and intent. This collaboration was modeled after the successful SAMHSA and DOJ/Office of Juvenile Justice and Delinquency Prevention (OJJDP) collaborative juvenile treatment drug court grant program.

Funding for both the SAMHSA/CSAT and the SAMHSA/OJP/BJA adult treatment drug court programs must be used primarily for the following: direct treatment or prevention services for diverse populations at risk; "wrap-around"/recovery support services designed to improve access and retention; to provide drug testing for illicit substances required for supervision, treatment compliance, and therapeutic intervention; education support; relapse prevention and long-term management; Medication-Assisted Treatment (MAT); and HIV testing conducted in accordance with state and local requirements.

In 2010 SAMHSA started the Children Affected by Methamphetamine/Family Treatment Drug Court program. These grants provide a child care coordinator to link available community-based social services resources that will focus on the trauma to the youngest victims caused by substance abuse/methamphetamine use in the family and concurrent criminal justice system involvement. In FY 2010, SAMHSA/CSAT funded 12 grants at up to $370,000 per year for up to four years.

The Children Affected by Methamphetamine (CAM) program delivers services to the children of parents participating in Family Drug Treatment Court (FDTC). This grant program has been instrumental in developing a FDTC model that includes services for children, as well as, parenting/family programs for the family. Examples of services and supports for children, parents and families include: identification of substance exposed newborns so that interventions can be initiated/enhanced with these infants at birth; coordination with child welfare agencies around services provided to the family and child; home visiting services or referrals and linkages for medical and/or developmental follow-up with pediatric specialists knowledgeable about exposure to methamphetamine; primary care coordination; developmental assessments and services, and intervention with children identified as needing services; mental health services to children; and case management services. Services and linkages for parents include: evidence-based strategies to promote parenting abilities and address trauma; ancillary services for families to provide assistance in securing needed services such as safe and drug-free housing, transportation, vocational training and education, government benefits, legal services and child care; family planning services to avoid future in-utero exposure to methamphetamine and other drugs; domestic violence prevention/intervention services; and training for foster parents, relatives, and other substitute caregivers about the special needs of children and youth who have suffered from abuse or neglect and whose parents have a substance use disorder. Services for families include: evidence-based family and parenting interventions designed for children of parents with substance use disorders and their parents; and family counseling to strengthen family functioning and assist with reunification of families when children have been in out-of-home placements.

In FY 2012, SAMHSA funded the continuation of 81 Drug Court grants and supported eight contracts, as well as 54 new grants. In FY 2013, SAMHSA will fund the continuation of 76 grants, support for five contracts, and 51 new grants.

Offender Re-Entry Program
FY 2014 Request: $11.9 million
(Reflects $1.5 million decrease from FY 2012)

The Offender Reentry Program (ORP) grants provide screening, assessment and comprehensive treatment and recovery support services to offenders reentering the community, as well as offenders who are currently on or being released from probation or parole. SAMHSA and the DOJ/BJA share a mutual interest in supporting and shaping offender re-entry-treatment services, as both agencies fund "offender reentry" programs. Formal agreements have been developed to further encourage and engage in mutual interests and activities related to criminal justice-treatment issues. ORP grantees are expected to seek out and coordinate with local federally-funded offender reentry initiatives, including the DOJ/BJA's Prisoner Reentry Initiative or "Second Chance Act" offender re-entry programs, as appropriate.

Funding for the ORP may be used for the following services/activities: screening, comprehensive individual assessment for substance use and/or co-occurring mental disorders, case management, program management and referrals related to substance abuse treatment for clients; alcohol and drug treatment; wraparound services supporting the access to and retention in substance abuse treatment or to address the treatment-specific needs of clients during or following a substance abuse treatment episode; individualized services planning; drug testing as required for supervision, treatment compliance, and therapeutic intervention; support in obtaining a GED and/or other necessary education; and relapse prevention and long-term management support.

Treatment Systems for Homeless Programs
FY 2014 Request: $41.6 million
(Reflects level funding from FY 2012)

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

The Treatment for Homeless-General grants, funded solely by CSAT, enable communities to expand and strengthen their substance abuse treatment services for individuals who are at risk for homelessness or have experienced homelessness (including chronic homelessness) who have substance use disorders or with co-occurring substance use and mental disorders, and move them to permanent supportive housing. In addition, CSAT provides funds for expanding and

strengthening substance abuse treatment services for homeless, alcohol-dependent people, individuals who have histories of public inebriation, frequent emergency room visits, arrests, mental illness, or co-occurring substance use and mental disorders.

In FY 2008, CSAT also funded grants that address services in supportive housing (SSH). The Treatment for Homeless-SSH grants seek to expand and strengthen treatment services for people, individuals who experience chronic homelessness by providing linkages to appropriate treatment for substance use or other support services. This approach combines long-term, community-based housing assistance and intensive individualized treatment and recovery support services to those experiencing chronic homelessness who have substance use disorders or co-occurring substance use and mental disorders. This is a cost-effective combination of affordable housing with substance abuse treatment services which helps people live more stable, productive lives and leads to reductions in substance use.

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

All programs funded under the GBHI authority (Treatment for Homeless (general and SSH) and CABHI) may purchase a number of services: outreach and direct treatment (including screening, assessment, and active treatment) for both mental and substance use disorders. Treatment must be provided in outpatient (including outreach-based services), day treatment or intensive outpatient, or short-term residential programs (90 days or less in duration and at a cost not to exceed 6.5 percent of total grant funds). Case management or other strategies to link with and retain clients in housing and other necessary services, including but not limited to primary care services, and to coordinate these services with other services provided to the client; engage and enroll individuals in Medicaid and other mainstream benefit programs (e.g., SSI/SSDI, TANF, SNAP, etc.); recovery support services designed to improve access to and retention in services and to continue treatment gains, which may include (as appropriate for each client) vocational, child care, educational and transportation services; independent living skills (e.g., budgeting and financial education); employment readiness, training, and placement; crisis care; medications management; self-help programs; discharge planning; psychosocial rehabilitation; and peer recovery support(s).

Grantees may also provide the following allowable services: education, screening, and counseling for hepatitis and other sexually transmitted infections; active steps to reduce HIV/AIDS risk behaviors by their clients. Active steps include client screening and assessment, and either direct provision of appropriate services or referral to and close coordination with other providers of appropriate services; trauma-informed services, including assessment and interventions for emotional, sexual, and physical abuse; and use of an integrated primary/substance abuse/mental health care approach in developing the service delivery plan. This approach involves screening for health issues and delivery of client-centered substance abuse and mental health services in collaboration and consultation with medical care providers. In FY 2012, SAMHSA funded the continuation of 95 grants and supported four contracts.

In FY 2013, SAMHSA anticipates funding 71 grant continuations and support five contracts. In addition, CSAT in collaboration with CMHS, also anticipates funding 12 new Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States). CABHI-States builds on the CABHI program by adding a state infrastructure improvement approach addressing chronic homelessness to the community-based behavioral health service component for newly housed individuals who experience chronic homelessness with substance use disorders or co-occurring substance use and mental disorders.

Minority AIDS Initiative
FY 2014 Request: $52.4 million
(Reflects $13.5 million decrease from FY 2012)

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

In addition to providing substance abuse treatment services, pre-treatment services are provided, including the provision of literature and other materials to support behavior change, facilitation of access to drug treatment, HIV/AIDS testing and counseling services, and other medical and social services in the local community.

In FY 2011, SAMHSA/CSAT's TCE/HIV program served approximately 6,200 individuals. Of these individuals, approximately 70 percent were between the ages of 25 and 54 years old. Approximately 31 percent identified themselves as Hispanic/Latino in ethnicity; 46 percent as African-American; 22 percent White; one percent Asian, Native Hawaiian, or Pacific Islander; and 4 percent as American Indian/Alaska Native.

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

In FY 2012, SAMHSA funded the continuation of 75 grants and supported five contracts as well as a new cohort of 52 grants to target areas of highest need based on the most recently available HIV epidemiological data.

In FY 2013, SAMHSA anticipates funding 79 grant continuations and supporting four contracts and 38 new grants. The 38 grants will support Targeted Capacity Expansion: Substance Abuse Treatment for Racial/Ethnic Minority Women at High Risk for HIV/AIDS (TCE-HIV: Minority Women). The purpose of this program is to expand substance abuse treatment and HIV services for African American, Hispanic/Latina, and other racial/ethnic minority women (ages 18 years and older), including heterosexual, lesbian, bisexual, previously incarcerated women, and these women's significant others, who have substance use or co-occurring substance use and mental disorders, and are living with or at risk for HIV/AIDS.

In FY 2014 SAMHSA will support the continuation of 87 grants and support 3 contracts. The proposed number of clients to be served with 2014 funds is 13,558. Outcomes including abstinence from substance use will also be tracked. By 2015, 62 percent of clients are expected to report being abstinent from substance use, 38 percent of clients are expected to report being employed or engaged in productive activities, 48 percent of clients are expected to report a permanent place to live in the community, and 96 percent of clients are expected to report having no involvement with the criminal justice system.

Other PRNS Treatment Programs
FY 2014 Request: $80.7 million
(Reflects $18.4 million decrease from 2012)

The FY 2013 Budget includes resources of $80.7 million for several other Treatment Capacity programs including: Strengthening Treatment Access and Retention; Children and Family Programs; Pregnant and Post-Partum Women (PPW); Recovery Community Services Program (RCSP); Special Initiatives/Outreach; Addiction Technology Transfer Centers; Opioid treatment Programs; and Targeted Capacity Expansion (TCE) General. The FY 2014 Budget includes funds for continuing grants and contracts in the various programs, and reflects discontinuation of one-time Congressional projects. Grant funding will be used to enhance overall drug treatment quality by incentivizing treatment and service providers to achieve specific performance targets. Examples of grant awards could include supplements for treatment and service providers who are able to connect higher proportions of detoxified patients with continuing recovery-oriented treatment; or for outpatient providers who are able to successfully retain greater proportions of patients in active treatment participation for longer time periods.

In FY 2014, SAMHSA anticipates funding the continuation of 165 grants and 15 contracts as well as 60 new grants.

Substance Abuse Block Grant
FY 2014 Request: $1.820 billion
(Reflects $19.5 million increase from 2012)

The Substance Abuse Prevention and Treatment Block Grant Program (SABG) distributes funds to 60 eligible states, territories, the District of Columbia, and the Red Lake Indian Tribe of

Minnesota to plan, carry out, and evaluate substance abuse treatment and recovery support services provided for individuals, families, and communities impacted by substance abuse and substance use disorders (SUD).

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

The program's overall goal is to support and expand substance abuse prevention and treatment services while providing maximum flexibility. States and territories may expend Block Grant funds only for the purpose of planning, carrying out, and evaluating activities related to these services. Targeted technical assistance is available for the states and territories through CSAT's State Systems Technical Assistance Project. The SABG requires states to maintain expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the state for the two year period preceding the year for which the state is applying for a grant. Given the current economic situation, a number of states experienced challenges meeting the maintenance of effort requirement in the federal FY 2012 grant cycle, and SAMHSA continues to monitor the situation closely.

Of the amounts appropriated for the SABG program, 95 percent are distributed to states and other eligible applicants through a formula prescribed by the authorizing legislation. Factors used to calculate the allotments include total personal income, state population data by age groups (total population data for territories), total taxable resources, and a cost of services index factor.

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

In FY 2011, SAMHSA redesigned the FY 2012/2013 MHBG and SABG applications to better align with the current federal/state environments and related policy initiatives, including the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Tribal Law and Order Act (TLOA). The new design offered states the opportunity to complete a combined application for mental health and substance abuse services, submit a bi-annual versus an annual plan, and provide information regarding their efforts to respond to various federal and state initiatives. Almost one-half of the states took advantage of this streamlined application and submitted combined plans for mental health and substance abuse services. Over 95 percent of the states provided specific information requested by SAMHSA regarding strategies to respond to a variety of areas including primary care and behavioral health integration, recovery support services, prevention of substance use, and promotion of emotional health. States continued to provide information regarding the spending of their Block Grant funds to support services identified in SAMHSA's Good and Modern Service System brief.[56]

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

The independent evaluation of the SABG program[57] demonstrated how states have leveraged the statutory requirements of this Block Grant to expand existing or establish new treatment capacity in underserved areas of states and territories and to improve coordination of services with other state systems.

As noted below, the SABG Program has been successful in expanding treatment capacity in the latest year for which actual data are available in FY 2011[58] by supporting approximately two million[59] admissions to treatment programs receiving public funding. Outcome data for the Block Grant program show positive results. In FY 2011, at discharge, clients have demonstrated high abstinence rates from both illegal drug (73.5 percent) and alcohol (81.7 percent) use.

State Substance Abuse Authorities reported the following outcomes for services provided during FY 2010, the most recent year data is available:

- For the 50 states[60] and D.C that reported data in the Abstinence from Drug/Alcohol Use Domain for alcohol use, 51 of 51 identified improvements in client abstinence.

[56] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf
[57] http://tie.samhsa.gov/SAPT2010.html#Evaluation
[58] Source: 2013 SABG Report – Tables 16-21. While this is referenced as FY 2011, the actual time period varies by State, e.g; CY 2011 (imported TEDS data); SFY 2011 (manually entered by States); SFY 2012 (manually entered by States.
[59] Source: 2013 SABG Report – Table II
[60] Source: West Virginia numbers have been included in the text, but appear lower than expected.

- Similarly, for the 50 states and D.C. that reported data in the Abstinence from Drug/Alcohol Use Domain for drug use, 50 of 51 identified improvements in client abstinence.
- For the 50 states and D.C. that reported data in the Employment Domain, 47 of 51 identified improvements in client employment.
- For the 50 states and D.C. that reported in the Criminal Justice Domain, 46 of 51 reported an increase in clients with no arrests based on data reported to TEDS.
- For the 49 states and D.C. that reported data in the Housing Domain, 42 of 49 identified improvements in stable housing for clients based on data reported to TEDS.

20 Percent Prevention Set-Aside

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

In an effort to streamline the application and reporting procedures for both the SABG and the Mental Health Block Grant programs, SAMHSA has developed a uniform application and reporting process to promote consistent planning, application, assurance, and reporting dates across both block grants. States are encouraged to make prevention a top priority, taking advantage of recent science, best practices in community coordination, proven planning processes, and the science articulated by the IOM report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*[61]. SAMHSA will work with states to increase their accountability systems for prevention and to develop necessary reporting capacities.

Synar

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

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

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

By regulation, states must achieve a retailer noncompliance rate of 20 percent or less. Since FY 2006, all 50 states, Puerto Rico, and the District of Columbia have been in compliance with the Synar requirements. In FY 2011, the most recent year available, the national weighted average retailer violation rate was 8.5 percent.

Enrollment and Provider Business Practices (3 Percent Block Grant Set-Aside)

Through the Affordable Care Act, up to 62 million people will benefit from Federal parity protections under the ACA. Up to 11 million of these individuals are estimated to have substance abuse and/or mental health conditions. Persons with mental and substance use disorders are uninsured at higher rates than the general population. The Qualified Health Plans (QHPs) to be offered by the new insurance marketplaces are required to have sufficient mental health and substance providers to assure timely access to mental health and substance services. However, many providers supported by SABG funds are not sufficiently prepared to be part of the network of providers under contract with QHPs, Medicaid and Medicare plans, and commercial insurance plans. It is critical for specialty behavioral health providers to be able to participate in integrated care models, utilize interoperable electronic health records (EHRs), and bill for and collect insurance resources for which persons they serve are eligible in order to maximize limited MHBG and SABG funds for those services and those persons not covered by public and commercial insurance plans.

After the full implementation of the Affordable Care Act, SAMHSA strongly recommends that MHBG and SABG funds be directed toward four purposes: (1) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods for time; (2) to fund priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery; (3) to fund primary prevention: universal, selective, and indicated prevention activities and services for people, individuals not identified as needing treatment; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis. State authorities should make every effort to ensure that the right recipient is receiving the right payment for the right reason at the right time.

Therefore, in FY 2014, the President's Budget includes a requirement that states set aside at least three percent of their SABG allocation to support providers of mental health services in improving their enrollment, billing, and business practices, and to support enrollment into health insurance for eligible individuals served in the public mental health system. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process for their funds. Major needs identified by both mental health and substance abuse providers are education and technical support to improve business management, integrate with primary care and develop the capability needed to effectively deploy electronic health records to meaningful use standards, billing and scheduling systems that are aligned with those in the commercial insurance and primary care environment. Particular concern was raised related to the lack of provider experience, especially peer, recovery, and opioid treatment

organizations, in negotiating contracts with and billing third party payers, ensuring compliance, revenue management, and accountability reporting.

Business operations practices needed include:

- Outreach and enrollment support for individuals in need of behavioral health services who may be eligible for Medicare, Medicaid, private insurance offered through the State and Federally Facilitated Marketplaces;
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA, (e.g., development of a strategic plan that is responsive to the changing marketplace, identification of new markets, revision of data management systems, integration of recovery support and treatment service payment systems, negotiating agreements/partnerships with primary care organizations, [e.g., Federally Qualified Health Centers (FQHCs)] and other provider networks to develop business operations systems that ensure appropriate care management across the continuum of services, (e.g. preventive clinical services, treatment, referral and recovery support services);
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billings, collections, risk management and compliance;
- Third-party contract negotiation; e.g., negotiating contracts for participation in a qualified health plan, or Medicaid managed care plan;
- Coordination of benefits among multiple funding sources, including insurance and SABG funding; and
- Adoption of health information technology that meets meaningful use standards.

The Affordable Care Act has already enhanced opportunities for individuals with behavioral health conditions to have continuous access to insurance and a benefit package that includes mental health and substance abuse services, as well as preventive, medical, and other health services. A series of immediate private insurance market reforms help to give individuals the stability and flexibility they need to make informed choices about their health care. Under these market reforms, individuals have a right to appeal health insurance plan decisions, including appeals to health plans when payment for a service or treatment is denied; helps children with pre-existing conditions gain and keep coverage, and will extend this protection to adults starting in 2014; allows individuals to continue to choose their primary care provider; keeps certain young adults covered up to age 26 on their parents' health plans; ends lifetime limits on coverage; provides for review of unreasonable increases in insurance premiums; and requires insurance companies to spend at least 80% or 85% of premium dollars on medical car, helping to ensure that premium dollars be primarily spent on health care (including behavioral health care).

Use of SABG dollars for these purposes will help states assist their specialty provider infrastructure to be prepared for the shifting funding environment and maximize limited SABG dollars for those individuals, services and activities not otherwise funded through other sources.

Health Reform

As a result of the analysis and examination of the various components of the Affordable Care Act beginning in 2010, SAMHSA has undertaken a major redesign of the planning section of the

application process for both the MHBG and SABG. SAMHSA is aligning the block grants to be critical components of the 2014 Affordable Care Act implementation in which state and federal responsibility is supporting behavioral health services and supports for those otherwise unable to receive services through Medicaid, Medicare, and/or private insurance plans offered through employers or through the new insurance marketplaces. Together, SAMHSA's block grants support the provision of services and related supports to approximately eight million individuals with mental and substance use conditions. With an estimated 11.4 million adults having a severe mental illness[62], 44.7 million adults having any mental illness[63], and another 22.1 million adults with substance abuse disorder[64], demand clearly outpaces the public behavioral health system's established capacity. Many of these individuals and some of the services they need will continue to be without coverage through public or private insurance mechanisms. Aligning and coordinating the SAMHSA block grants with the 2014 Affordable Care Act implementation process begins assembling a cohesive national service system that is responsive to potential gaps in service delivery and effectively provides needed behavioral health serves across sectors and across payment sources.

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

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

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

Health Surveillance and Program Support

The FY 2014 Request is $158.4 million, which represents the Substance Abuse portion of the HSPS appropriation and supports staffing and activities to administer SAMHSA programs. This includes:

Health Surveillance and Program Support
FY 2014 Request: $115.3 million
(Reflects $1.4 million decrease from 2012)

Health Surveillance and Program Support provides funding for personnel costs, building and facilities, equipment, supplies, administrative costs and associated overhead to support SAMHSA programmatic activities as well as providing funding for SAMHSA national data collection and survey systems, funding to support the CDC NHIS Survey, and the data archive. This represents the total funding available for these activities first split between mental health and substance abuse (as determined by each activity), then, of the amount for substance abuse is split 80/20 between Treatment and Prevention.

Public Awareness and Support
FY 2014 Request: $6.8 million
(Reflects $0.01 million increase from 2012)

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 split 50/50 between mental health and substance abuse, then, of the amount for substance abuse is split 80/20 between Treatment and Prevention.

Performance and Quality Information Systems
FY 2014 Request: $9.1 million
(Reflects $0.04 million increase from 2012)

Performance and Quality Information Systems provides funding to support the Consolidated Data Platform as well as the transition from legacy systems. This represents the total funding available for these activities first split 30/70 between mental health and substance abuse, then, of the amount for substance abuse is split 80/20 between Treatment and Prevention.

Agency-Wide Initiatives
FY 2014 Request: $27.2 million
(Reflects $22.6 million increase from 2012)

Agency-Wide Initiatives provides funding for across Agency initiatives such as Minority Fellowship Program which improves the quality of mental health and substance abuse prevention and treatment delivered to ethnic minorities by providing stipends to post-graduate students and other Behavioral Health Workforce programs. This represents the total funding available for

these activities first split 50/50 between mental health and substance abuse, then, of the amount for substance abuse is split 80/20 between Treatment and Prevention.

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SAMHSA
Prevention and Public Health Fund
Summary of Programs
(Dollars in Thousands)

Prevention and Public Health Fund	FY 2012 Actual	FY 2013 Annualized CR[1/]	FY 2014 President's Budget	FY 2014 +/- FY 2012
Screening, Brief Intervention, & Referral to Treatment	$25,000	N/A	$30,000	+$5,000
Garrett Lee Smith Youth Suicide Prevention	10,000	N/A	---	-10,000
Primary and Behavioral Health Care Integration	35,000	N/A	28,000	-7,000
Health Surveillance	18,000	N/A	---	-18,000
Prescription Drug Monitoring Program	4,000	N/A	---	-4,000
Total, Prevention and Public Health Fund	**$92,000**	**N/A**	**$58,000**	**-$34,000**

[1/] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

The FY 2014 Budget Request for the Prevention Fund is $58.0 million, a decrease of $34.0 million from the FY 2012 funding level. The FY 2014 request includes the following: $30.0 million for Screening, Brief Intervention, and Referral to Treatment and $28.0 million for Primary and Behavioral Health Care Integration. The funding for these programs is requested entirely from the Prevention Fund.

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Screening, Brief Intervention, and Referral to Treatment

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR[1/]	FY 2014 President's Budget	FY 2014 +/- FY 2012
Program Level	$53,187	$28,360	$30,000	-$23,187
PHS Evaluation Funds (non-add)	*2,000*	*2,012*	---	*-2,000*
Prevention & Public Health Fund (non-add).	*$25,000*	*N/A*	*$30,000*	+$5,000

[1/] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Authorizing Legislation..... Section 520A of the PHS Act and Section 4002 of the Patient and Protection and Affordable Care Act

FY 2014 Authorization..... Expired

Allocation Method ..... Competitive Grants and Contracts

Program Description and Accomplishments

Screening, Brief Intervention, and Referral to Treatment (SBIRT) was initiated by SAMHSA/CSAT in FY 2003, using cooperative agreements to expand and enhance a state or tribal organization's continuum of care. The purpose of the program is to integrate screening, brief intervention, referral, and treatment services within general medical and primary care settings.

The SBIRT program requires grant recipients to effect practice change throughout the spectrum of medical practice. This is achieved through implementation in all levels of primary care, including hospitals, trauma centers, health clinics, nursing homes, employee assistance programs, and school systems. Practice change also alters the educational structure of medical schools by developing and implementing SBIRT curricula as standard and permanent practice.
Research and clinical experience supports the use of the SBIRT approach to provide effective early identification and interventions in primary care and general medical settings. Early identification can decrease total healthcare costs by arresting progression toward addiction. SBIRT also can identify persons with more serious problems and encourage them to obtain appropriate specialty treatment services. Funds may be used for the following services: pre/screening for substance use and co-occurring disorders; brief Interventions designed with client centered, non-judgmental, motivational interviewing techniques; brief treatment including the monitoring of individuals who misuse alcohol and other drugs but are not yet dependent; referral to treatment (when indicated) for those who have a substance use disorder; and when appropriate, referral to and expansion of specialty treatment services. Since the beginning of this program, more than 1.7 million individuals have been screened. Of those, 19 percent required a brief intervention, brief treatment, or referral to specialty treatment programs.

In FY 2010, SAMHSA/CSAT supported continuation of eight SBIRT state grants and 17 medical residency SBIRT training grants. In 2011, over 213,000 clients were served by the SBIRT Program. The percentage of clients reporting abstinence at follow-up tripled compared to the percentage reporting abstinence at baseline.

SBIRT has great future potential for promoting changes to the entire primary care medical service delivery system. Efforts are underway to identify other funding streams to help take this practice to scale. For example, new diagnostic codes have been adopted by 16 states, making it easier for doctors to get reimbursed for screening Medicaid patients. Likewise, alcohol screening is now available to Medicare beneficiaries as a preventive service without cost. In FY 2012, SAMHSA funded the continuation of 27 SBIRT grants supported five contracts and as well as three new multi-year grants funded out of the Prevention Fund, and continued to monitor the progress of the three FY 2011 multi-year Prevention Fund grants. In FY 2013, SAMHSA anticipates funding up to 19 new grants as well as 12 grant continuations and supporting three contracts.

Budget Request

In FY 2014, SAMHSA requests $30.0 million from the Prevention Fund for the SBIRT program (an increase of $5 million from FY 2012). This level funding will further support the integration and use of the SBIRT model into states and tribal primary care settings. In FY 2014, an estimated 141,435 individuals will be served by the program. The request will support 41 grants (25 continuations and 16 new) and one contract. Grant funds will further integrate SBIRT within medical treatment settings to provide early identification and intervention to at-risk individuals within the context of their primary care provider.

Outcomes and Outputs

Program: Screening, Brief Intervention and Referral to Treatment

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.40 Number of clients served (Output)	FY 2012: 142,016 Target: 139,650 (Target Exceeded)	139,650	75,015	-64,635
1.2.41 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2012: 42.1% Target: 36% (Target Exceeded)	36%	36%	Maintain

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Primary & Behavioral Health Care Integration

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR[1/]	FY 2014 President's Budget	FY 2014 +/- FY 2012
Program Level.....	$67,745	$32,945	$28,000	-$39,745
Prevention & Public Health Fund (non-add).	*$35,000*	*N/A*	*$28,000*	-$7,000

[1/] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Authorizing Legislation.....Sections 520A and 520K of the PHS Act and Section 4002 of the Patient and Protection and Affordable Care Act

FY 2014 Authorization..... Such Sums As Necessary

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

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

The PBHCI program is comprised of competitive cooperative agreements and the PBHCI Training and Technical Assistance (TTA) Center which is co-funded with HRSA. The program supports the coordination and integration of primary care services into publicly-funded community behavioral health settings. This program is also a part of SAMHSA's Health Reform Strategic Initiative. The expected outcome of improved health status for people with SMI will be achieved by encouraging grantees to engage in necessary partnerships, expand infrastructure, and increase the availability of primary health care and wellness services to individuals with mental illness. Partnerships between primary care and behavioral health organizations, as well as information technology entities, are deemed crucial to the success of this program**.** The population of focus for this grant program is individuals with SMI and/or persons with co-

occurring disorders served by the public mental health system. Recipients are non-profit mental health provider agencies that will use these grant funds to develop and offer primary care as well as behavioral health services in an integrated manner.

In FY 2011, $35.0 million was allocated from the Prevention Fund for PBHCI to promote more integrated services between primary care services and mental health services. These funds were used to facilitate screening and referral for necessary primary care prevention and treatment needs. SAMHSA funded eight new PBHCI grants and 34 continuation grants with Prevention Funds and 22 grant and 1 contract continuations with Budget Authority.

In FY 2012, SAMHSA supported 56 existing grants and multi-year funded 20 new grants and 10 annually funded grants awarded from both SAMHSA Budget Authority and Prevention Funds ($30.5M - BA and $35M - PPHF) as well as $1.9 million for the PBHCI Training and Technical Assistance (TTA) Center. SAMHSA plans to continue the program in FY 2013. SAMHSA has awarded 94 PBHCI grants to date.

Since the program is new evaluation results are not yet complete. Over 23,000 consumers were served in FY 2012, an increase of 94.4 percent over FY 2011. Improvements in all four National Outcome Measures were consistently positive as a result of this intervention, with individual measure ratings improving an average of 13 percent. Of particular importance were the increases in measures of functioning and education/employment, demonstrating that the program supports health and productivity.

Budget Request

The Primary and Behavoiral Health Care Integration program request is $28.0 million from the Prevention Fund, which is a decrease of $7.0 million from the FY 2012 Prevention Fund level. This level of funding will support 22 continuation grants, 10 new grants as well as continue support for the Training and Technical Assistance Center and will support the coordination and integration of primary care services into publically funded behavioral health settings for adults with serious mental illnesses.

Outcomes and Outputs

Program: Mental Health - Other Capacity Activities[65]

NOTE: SAMHSA grant awards are made late in the year. FY 2012 funding is reflected in FY 2013 performance targets, FY 2014 funding is associated with FY 2015 targets.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2015 Target	FY 2015 Target +/- FY 2013 Target
1.2.05 Percentage of clients receiving services who report positive functioning at 6 month follow-up (Outcome)	FY 2012: 53.4% Target: 54% (Target Not Met but Improved)	54%	54%	Maintain
1.2.82 Percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up (Outcome)	FY 2012: 67.5% Target: 67.7% (Target Not Met)	67.7%	67.7%	Maintain
1.2.83 Percentage of clients receiving services who are currently employed at 6 month follow-up (Outcome)	FY 2012: 24.3% Target: 14% (Target Exceeded)	14%	14%	Maintain
1.2.88 Number of individuals screened for mental health or related interventions (Outcome)	FY 2012: 58,782 Target: 32,763 (Target Exceeded)	32,763	61,574	+28,811

[65] Includes the following programs: Jail Diversion, Older Adults, HIV/AIDS, Primary and Behavioral Health Care Integration, and Healthy Transitions.

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Object Classification Table – Mental Health

(Dollars in Thousands)

Object Class-Budget Authority	FY 2012 Actual *	FY 2013 Annualized CR	FY 2014 President's Budget *	FY 2014 +/- FY 2012
Direct Obligations:				
Personnel Compensation:				
Full Time Permanent (11.1)	$439	$819	$832	+$393
Other than Full-Time Permanent (11.3)	108	158	161	+53
Other Personnel Compensation (11.5)	152	3	3	-149
Military Personnel Compensation (11.7)	43	---	---	-43
Special personal services payments (11.8)	2	---	---	-2
Subtotal Personnel Compensation:	**744**	**981**	**995**	**+251**
Civilian Personnel Benefits (12.1)	150	454	461	+311
Military Personnel Benefits (12.2)	12	---	---	-12
Benefits for Former Personnel (13.1)	---	---	---	---
Subtotal Pay Costs:	**906**	**1,435**	**1,456**	**+550**
Travel (21.0)	49	44	45	-4
Transportation of Things (22.0)	43	---	33	-10
Rental Payments to GSA (23.1)	---	---	---	---
Rental Payments to Others (23.2)	---	---	---	---
Communications, Utilities and Misc. Charges (23.3)	6	5	6	-
Printing and Reproduction (24.0)	190	171	174	-16
Other Contractual Services:				
Advisory and Assistance Services (25.1)	7,077	16,291	16,500	+9,423
Other Services (25.2)	44,681	51,650	52,975	+8,294
Other Purchases of Goods & Svc from Govt Accts (25.3)	33,491	17,898	17,047	-16,444
Operation & Maintenance of Facilities (25.4)	647	850	868	+221
Medical Care (25.6)	---	---	---	---
Operation and Maintenance of Equipment (25.7)	---	29	30	---
Transfers (25.9)	---	200	200	+200
Subtotal Other Contractual Services:	**85,896**	**86,918**	**87,620**	**+1,694**
Supplies and Materials (26.0)	81	73	74	-7
Equipment (31.0)	---	---	---	---
Grants, Subsidies, and Contributions (41.0)	885,529	845,000	928,900	+43,371
Insurance Claims & Indemnities (42.0)	31	30	33	+2
Interest & Dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**971,825**	**932,241**	**1,016,884**	**+45,059**
Total Budget Authority	**$972,731**	**$933,676**	**$1,018,341**	**+$45,610**

* Includes $45 million in Prevention and Public Health Funding for FY 2012 Enacted and $28 million in FY 2014 President's Budget. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Object Classification Table – Substance Abuse Prevention

(Dollars in Thousands)

Object Class-Budget Authority	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget *	FY 2014 +/- FY 2012
Direct Obligations:				
Personnel Compensation:				
Full Time Permanent (11.1)	---	---	---	---
Other than Full-Time Permanent (11.3)	---	---	---	---
Other Personnel Compensation (11.5)	---	---	---	---
Military Personnel Compensation (11.7)	---	---	---	---
Special personal services payments (11.8)	---	---	---	---
Subtotal Personnel Compensation:	---	---	---	---
Civilian Personnel Benefits (12.1)	---	---	---	---
Military Personnel Benefits (12.2)	---	---	---	---
Benefits for Former Personnel (13.1)	---	---	---	---
Subtotal Pay Costs:	---	---	---	---
Travel (21.0)	---	---	---	---
Transportation of Things (22.0)	---	---	---	---
Rental Payments to GSA (23.1)	---	---	---	---
Rental Payments to Others (23.2)	---	---	---	---
Communications, Utilities and Misc. Charges (23.3)	---	---	---	---
Printing and Reproduction (24.0)	264	223	227	-37
Other Contractual Services:				
Advisory and Assistance Services (25.1)	3,794	3,501	2,980	-814
Other Services (25.2)	39,703	38,118	34,119	-5,584
Other Purchases of Goods & Svc from Govt Accts (25.3)	3,747	3,000	3,000	-747
Operation & Maintenance of Facilities (25.4)	---	64	64	---
Medical Care (25.6)	---	---	---	---
Operation and Maintenance of Equipment (25.7)	---	170	170	---
Transfers (25.9)				
Subtotal Other Contractual Services:	**47,244**	**44,853**	**40,333**	**-7,145**
Supplies and Materials (26.0)	---	---	---	---
Equipment (31.0)	---	---	---	---
Grants, Subsidies, and Contributions (41.0)	138,377	142,000	135,000	-3,377
Insurance Claims & Indemnities (42.0)	---	---	---	---
Interest & Dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**185,885**	**187,076**	**175,561**	**-10,558**
Total Budget Authority	**$185,885**	**$187,076**	**$175,561**	**-$10,324**

Object Classification Table – Substance Abuse Treatment

(Dollars in Thousands)

Object Class-Budget Authority	FY 2012 Actual *	FY 2013 Annualized CR	FY 2014 President's Budget *	FY 2014 +/- FY 2012
Direct Obligations:				
Personnel Compensation:				
Full Time Permanent (11.1)	$4,720	$4,064	$4,125	- 595
Other than Full-Time Permanent (11.3)	290	194	196	- 94
Other Personnel Compensation (11.5)	366	34	34	- 332
Military Personnel Compensation (11.7)	341	52	52	- 289
Special personal services payments (11.8)	5	---	---	- 5
Subtotal Personnel Compensation:	**5,722**	**4,343**	**4,408**	**- 1,314**
Civilian Personnel Benefits (12.1)	1,364	1,210	1,228	- 136
Military Personnel Benefits (12.2)	182	30	30	- 152
Benefits for Former Personnel (13.1)	---	---	---	---
Subtotal Pay Costs:	**7,268**	**5,583**	**5,666**	**- 1,602**
Travel (21.0)	46	41	42	- 4
Transportation of Things (22.0)	---	---	---	---
Rental Payments to GSA (23.1)	---	---	---	---
Rental Payments to Others (23.2)	---	---	---	---
Communications, Utilities and Misc. Charges (23.3)	145	131	133	- 12
Printing and Reproduction (24.0)	511	460	469	- 42
Other Contractual Services:				
Advisory and Assistance Services (25.1)	18,668	35,341	30,000	+ 11,332
Other Services (25.2)	65,862	57,500	55,266	- 10,596
Purchases from Government Accounts (25.3)	7,093	15,453	7,346	+ 253
Operation & Maintenance of Facilities (25.4)	331	298	304	- 27
Medical Care (25.6)	---	---	---	---
Operation and Maintenance of Equipment (25.7)	340	---	---	- 340
Transfers (25.9)	---	---	---	---
Subtotal Other Contractual Services:	**92,294**	**108,592**	**92,916**	**+ 622**
Supplies and Materials (26.0)	95	86	87	- 8
Equipment (31.0)	13	12	12	- 1
Grants, Subsidies, and Contributions (41.0)	2,047,457	2,017,500	1,983,600	- 63,857
Insurance Claims & Indemnities (42.0)	---	---	---	---
Interest & Dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**2,140,561**	**2,126,821**	**2,077,259**	**- 63,302**
Total Budget Authority	**$2,147,829**	**$2,132,404**	**$2,082,926**	**- 64,903**

* Includes $29 million in Prevention and Public Health Funding for FY 2012 Enacted and $30 million for FY14 President's Budget. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Object Classification Table – Health Surveillance and Program Support

(Dollars in Thousands)

Object Class-Budget Authority	FY 2012 Actual *	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Direct Obligations:				
Personnel Compensation:				
Full Time Permanent (11.1)	$42,694	$46,014	$48,047	+ $5,353
Other than Full-Time Permanent (11.3)	2,645	2,843	2,969	+ 324
Other Personnel Compensation (11.5)	3,360	923	964	- 2,396
Military Personnel Compensation (11.7)	2,985	3,373	3,522	+ 537
Special personal services payments (11.8)	42	76	79	+ 37
Subtotal Personnel Compensation:	**51,726**	**53,229**	**55,581**	**+ 3,855**
Civilian Personnel Benefits (12.1)	12,325	13,243	13,828	+ 1,503
Military Personnel Benefits (12.2)	1,577	1,740	1,817	+ 240
Benefits for Former Personnel (13.1)	---	---	---	---
Subtotal Pay Costs:	**65,628**	**68,212**	**71,226**	**+ 5,598**
Travel (21.0)	1,050	945	964	- 86
Transportation of Things (22.0)	44	5	7	- 37
Rental Payments to GSA (23.1)	5,687	6,918	6,964	+ 1,277
Rental Payments to Others (23.2)	---	---	---	---
Communications, Utilities and Misc. Charges (23.3)	2	---	---	- 2
Printing and Reproduction (24.0)	328	295	301	- 27
Other Contractual Services:				
Advisory and Assistance Services (25.1)	225	---	---	- 225
Other Services (25.2, 25.9)	11,338	25,412	24,094	+ 12,756
Other Purchases of Goods & Svc from Govt Accts (25.3)	40,018	5,100	4,255	- 35,763
Operation & Maintenance of Facilities (25.4)	1,587	1,619	1,651	+ 64
Medical Care (25.6)	---	---	---	---
Operation and Maintenance of Equipment (25.7)	63	64	66	+ 3
Transfers (25.9)	---	---	---	---
Subtotal Other Contractual Services:	**53,231**	**32,195**	**30,066**	**- 23,165**
Supplies and Materials (26.0)	330	337	343	+ 13
Equipment (31.0)	35	36	36	+ 1
Grants, Subsidies, and Contributions (41.0)	4,590	4,682	17,500	+ 12,910
Insurance Claims & Indemnities (42.0)	1,650	1,683	1,717	---
Interest & Dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**66,947**	**47,095**	**57,898**	**- 9,049**
Total Budget Authority	**$132,575**	**$115,307**	**$129,124**	**- $3,451**

* Includes $18 million in Prevention and Public Health Funding for FY 2012. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Salaries and Expenses Tables

(Dollars in thousands)

Direct BA Salaries and Expenses	FY 2012 Actual *	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Personnel Compensation:				
Full Time Permanent (11.1)	$47,853	$50,898	$53,004	+$5,151
Other than Full-Time Permanent (11.3)	3,043	3,195	3,326	+283
Other Personnel Compensation (11.5)	3,878	960	1,001	-2,877
Military Personnel Comprensation (11.7)	3,369	3,424	3,574	+205
Special personal services payments (11.8)	49	76	79	+30
Subtotal Personnel Compensation:	**58,192**	**58,553**	**60,985**	**+2,793**
Civilian Personnel Benefits (12.1)	13,839	14,907	15,517	+1,678
Military Personnel Benefits (12.2)	1,771	1,770	1,847	+76
Subtotal Pay Costs:	**73,802**	**75,230**	**78,349**	**+4,547**
Travel (21.0)	1,145	1,031	1,051	-94
Transportation of Things (22.0)	87	5	40	-47
Rental Payments to Others (23.2)	---	---	---	---
Communications, Utilities and Misc. Charges (23.3)	153	136	139	-14
Printing and Reproduction (24.0)	1,293	1,149	1,172	-121
Other Contractual Services:				
Advisory and Assistance Services (25.1)	29,764	55,133	49,480	+19,716
Other Services (25.2)	161,584	172,680	166,454	+4,870
Other Purchases of Goods & Svc from Govt Accts (25.3)	84,349	41,451	31,648	-52,701
Operation & Maintenance of Facilities (25.4)	2,565	2,831	2,887	+322
Operation and Maintenance of Equipment (25.7)	403	263	266	-137
Transfers (25.9)	---	200	200	+200
Subtotal Other Contractual Services:	**278,665**	**272,358**	**250,735**	**-27,931**
Supplies and Materials (26.0)	506	495	505	-1
Subtotal Non-Pay Costs	**355,651**	**350,403**	**331,990**	**-23,661**
Total, Salaries and Expenses	**$429,453**	**$425,633**	**$410,338**	**-19,114**
Rental Payments to GSA (23.1)	5,687	6,918	6,964	**+1,277**
Grand Total, Salaries, Expenses, and Rent	**$435,140**	**$432,551**	**$417,302**	**-17,837**
Total FTE	590	631	655	+65

1) FTE Forecast inclusive of Direct BA & Reimbursable Requirements

Substance Abuse and Mental Health Services Administration
Detail of Full Time Equivalent (FTE)

Appropriation	2012 Act. Civilian	2012 Act. Military	2012 Act. Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total
Health Surveillance & Program Support									
Direct:.....	456	32	488	471	29	500	472	29	501
Reimbursable:.....	21	8	29	21	2	23	40	2	42
Total:	477	40	517	492	31	523	512	31	543
Mental Health									
Direct:.....	6	3	9	6	3	9	10	3	13
Reimbursable:.....	17	3	20	20	3	23	20	3	23
Total:	23	6	29	26	6	32	30	6	36
Substance Abuse Prevention									
Direct:.....	---	---	---	---	---	---	---	---	---
Reimbursable:.....	8	4	12	16	4	20	16	4	20
Total:	8	4	12	16	4	20	16	4	20
Substance Abuse Treatment									
Direct:.....	28	3	31	38	9	47	38	9	47
Reimbursable:.....	1	---	1	9	---	9	9	---	9
Total:	29	3	32	47	9	56	47	9	56
Total Direct.....	**490**	**38**	**528**	**515**	**41**	**556**	**520**	**41**	**561**
Total Reimbursable.....	**47**	**15**	**62**	**66**	**9**	**75**	**85**	**9**	**94**
SAMHSA FTE Total.....	**537**	**53**	**590**	**581**	**50**	**631**	**605**	**50**	**655**

Substance Abuse and Mental Health Services Administration
Detail of Positions

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Executive Level IV	1	1	1
Subtotal	1	1	1
Total - Exec Level Salaries	**$146,091**	**$146,091**	**$146,091**
SES	13	13	13
Subtotal	13	13	13
Total, SES salaries	**$1,978,517**	**$1,998,302**	**$2,028,277**
GM/GS-15/EE	80	80	80
GM/GS-14	138	145	145
GM/GS-13	149	159	163
GS-12	51	55	61
GS-11	31	32	35
GS-10	7	10	10
GS-09	14	16	25
GS-08	19	20	22
GS-07	19	23	23
GS-06	15	15	15
GS-05	3	9	9
GS-04	1	2	2
GS-03	0	1	1
GS-02	0	1	1
Subtotal	527	568	592
Total, GS salaries	**$65,166,811**	**$69,731,395**	**$70,899,551**
CC-08/09	0	1	1
CC-07	1	0	0
CC-06	9	11	11
CC-05	14	16	16
CC-04	14	13	13
CC-03	11	9	9
CC-02	1	0	0
Subtotal	50	50	50
Total, CC salaries	**$5,032,339**	**$5,193,899**	**$5,420,999**
Total Positions	**590**	**631**	**655**
Average ES level	ES	ES	ES
Average ES salary	$146,091	$146,091	$146,091
Average SES level	SES	SES	SES
Average SES salary	$152,194	$153,716	$156,021
Average GS grade	13.3	13.7	13.7
Average GS salary	$123,656	$122,767	$119,763
Average CC level	4.5	4.6	4.6
Average CC salaries	$100,647	$103,878	$108,420

Programs Proposed For Elimination

There are no programs proposed for elimination or consolidation.

Federal Employment Funded by the Patient Protection and Affordable Care Act
P.L. 111-148
Substance Abuse Mental Health Services Administration
(Dollars in thousands)

Program	Section(s)	FY 2011			FY 2012			FY 2013			FY 2014		
		$	FTEs	CEs	$	FTEs	CEs	$	FTEs	CEs	$	FTEs	CEs
New programs authorized and funded by PPACA	0	0	0	0	0	0	0	0	0	0	0	0	0
Pre-existing programs funded by PPACA	0	0	0	0	0	0	0	0	0	0	0	0	0
Programs authorized by PPACA but funded by other sources	0	0	0	0	0	0	0	0	0	0	0	0	0
Oversight and administration activities	0	0	0	0	0	0	0	0	0	0	0	0	0

FY 2014 Budget by Strategic Goal

(Dollars in thousands)

HHS Strategic Goals	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
1.Strengthen Health Care	**$764,599**	**$705,762**	**$683,775**
1.A Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured	---	---	---
1.B Improve health care quality and patient safety	51,569	47,860	46,133
1.C Emphasize primary & preventative care linked with community	120,932	61,305	58,000
1.D Reduce growth of healthcare costs while promoting high-value, effective care	100,713	101,330	67,562
1.E Ensure access to quality, culturally competent care for vulnerable populations	491,385	495,267	512,079
1.F Promote the adoption and meaningful use of health information technology	---	---	---
2. Advance Scientific Knowledge and Innovation	**21,616**	**21,748**	**18,528**
2.A Accelerate the process of scientific discovery to improve patient care	---	---	---
2.B Foster innovation at HHS to create shared solutions	---	---	---
2.C Invest in the regulatory sciences to improve food & medical product safety	---	---	---
2.D Increase our understanding of what works in public health and human service services	21,616	21,748	18,528
3. Advance the Health, Safety and Well-Being of the American People	**2,751,637**	**2,740,358**	**2,829,045**
3.A Promote the safety, well-being, resilience, and healthy development of children and youth	205,636	196,833	276,707
3.B Promote economic & social well-being for individuals, families and communities	13,344	13,425	11,795
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults	---	---	---
3.D Promote prevention and wellness	2,531,606	2,529,041	2,537,593
3.E Reduce the occurrence of infectious diseases	---	---	---
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies	1,052	1,058	2,950
4. Increase Efficiency, Transparency and Accountability of HHS Programs	**12,940**	**13,051**	**14,496**
4.A Ensure program integrity and responsible stewardship of resources	---	---	---
4.B Fight fraud and work to eliminate improper payments	---	---	---
4.C Use HHS data to improve American health and well-being of the American people	12,940	13,051	14,496
4.D Improve HHS environmental, energy, and economic performance to promote sustainability	---	---	---
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**17,895**	**18,005**	**26,365**
5.A Invest in HHS workforce to meet America's health and human service needs today & tomorrow	---	---	---
5. B Ensure that the Nation's health care workforce meets increased demands	17,895	18,005	26,365
5.C Enhance the ability of the public health workforce to improve health at home and abroad	---	---	---
5.D Strengthen the Nation's human service workforce	---	---	---
5.E Improve national, state & local surveillance and epidemiology capacity	---	---	---
TOTAL	**$3,568,687**	**$3,498,924**	**$3,572,209**

Physicians' Comparability Allowance (PCA) Worksheet
SAMHSA

		CY 2012 (Estimates)	BY 2013 (Estimates)	PB 2014 (Estimates)
1) Number of Physicians Receiving PCAs		3	4	4
2) Number of Physicians with One-Year PCA Agreements		---	---	---
3) Number of Physicians with Multi-Year PCA Agreements		3	4	4
4) Average Annual PCA Physician Pay (without PCA payment)		$143,236	$143,236	$147,179
5) Average Annual PCA Payment		$19,333	$18,000	$18,000
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	---	---	---
	Category II Research Position	---	---	---
	Category III Occupational Health	---	---	---
	Category IV-A Disability Evaluation	---	---	---
	Category IV-B Health and Medical Admin.	3	4	4

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

N/A

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

$30.000.00 - based on years of education, experience and the position held by the incumbent. Amount is required to retain the employee.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

SAMHSA is in the process of filing the Chief Medical Officer Position, and is currently negotiating a PCA for this Critical Position

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

We have to offer PCAs in order to be competitive with private sector. Salaries being offered by the Government are usually lower than the candidates are making on the outside and a PCA is the only way to raise the income and make the offer attractive.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

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

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Base No.	FY 2013 Base Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
CAPACITY:						
Seclusion and Restraint						
Grants						
Continuations	---	$---	---	$---	---	$---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	2,444	---	---	1	1,149
New/Competing	---	---	1	2,459	---	---
Subtotal	1	2,444	1	2,459	1	1,149
Total, S & R	**1**	**2,444**	**1**	**2,459**	**1**	**1,149**
Youth Violence Prevention						
Grants						
Continuations	22	12,119	---	---	8	12,000
New/Competing	---	486	8	12,000	1	1,500
Subtotal	22	12,605	8	12,000	9	13,500
Contracts						
Continuations	3	6,217	1	1,781	2	8,195
New/Competing	3	4,335	4	9,516	3	1,461
Subtotal	6	10,551	5	11,298	5	9,656
Total, YVP	**28**	**23,156**	**13**	**23,298**	**14**	**23,156**
Project AWARE						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	15	30,000
Subtotal	---	---	---	---	15	30,000
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	5	25,000
Subtotal	---	---	---	---	5	25,000
Total, Project AWARE	**---**	**---**	**---**	**---**	**20**	**55,000**

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Base No.	FY 2013 Base Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
National Traumatic Stress Network						
Grants						
Continuations	3	1,792	78	41,538	78	42,358
New/Competing	78	41,397	---	800	---	---
Subtotal	81	43,188	78	42,338	78	42,358
Contracts						
Continuations	---	2,442	---	2,813	1	3,356
New/Competing	---	83	1	842	---	---
Subtotal	---	2,525	1	3,655	1	3,356
Total, NTSCI	**81**	**45,713**	**79**	**45,993**	**79**	**45,714**
Children and Family Programs						
Grants						
Continuations	14	5,336	14	4,982	---	212
New/Competing	---	---	---	---	12	4,300
Subtotal	14	5,336	14	4,982	12	4,512
Contracts						
Continuations	2	1,137	2	1,531	---	397
New/Competing	---	---	---	---	4	1,565
Subtotal	2	1,137	2	1,531	4	1,962
Total, CFP	**16**	**6,474**	**16**	**6,513**	**16**	**6,474**
Healthy Transitions						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	19	19,467
Subtotal	---	---	---	---	19	19,467
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	2	5,533
Subtotal	---	---	---	---	2	5,533
Total, Healthy Transitions	**---**	**---**	**---**	**---**	**21**	**25,000**
Consumer and Family Network Grants						
Grants						
Continuations	56	3,858	17	1,148	55	3,808
New/Competing	17	1,147	44	3,800	5	400
Subtotal	73	5,005	61	4,948	60	4,208
Contracts						
Continuations	1	1,220	1	1,314	---	655
New/Competing	---	---	---	1	---	103
Subtotal	1	1,220	1	1,315	---	758
Total, CFN	**74**	**6,224**	**62**	**6,262**	**60**	**4,966**

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Base No.	FY 2013 Base Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
Project LAUNCH						
Grants/Cooperative Agreements						
Continuations	25	21,300	29	23,312	25	20,157
New/Competing	11	9,158	7	7,100	13	10,123
Subtotal	36	30,457	36	30,412	38	30,280
Contracts						
Continuations	1	4,141	---	2,092	1	4,360
New/Competing	---	42	1	2,348	---	---
Subtotal	1	4,183	1	4,440	1	4,360
Total, LAUNCH	**37**	**34,640**	**37**	**34,852**	**39**	**34,640**
MH System Transformation and Health Reform						
Grants						
Continuations	31	8,610	31	8,703	20	6,458
New/Competing	---	---	---	---	5	1,987
Subtotal	31	8,610	31	8,703	25	8,445
Contracts						
Continuations	2	1,993	2	1,965	2	2,158
New/Competing	---	---	---	---	---	---
Subtotal	2	1,993	2	1,965	2	2,158
Total, MH-STHR	**33**	**10,603**	**33**	**10,668**	**27**	**10,603**
Primary and Behavioral Health Care Integration						
Grants						
Continuations	56	27,250	53	24,579	10	3,788
New/Competing	30	35,577	3	4,722	13	20,622
Subtotal	86	62,827	56	29,302	23	24,410
Contracts						
Continuations	---	2,921	---	1,635	---	1,595
New/Competing	---	---	---	---	---	---
Subtotal	---	2,921	---	1,635	---	1,595
Total, PBHCI [1/]	**86**	**65,749**	**56**	**30,937**	**23**	**26,004**
National Strategy for Suicide Prevention						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	1	2,000
Subtotal	---	---	---	---	1	2,000
Total, NSSP	**---**	**---**	**---**	**---**	**1**	**2,000**

[1/] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Base No.	FY 2013 Base Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
Suicide Lifeline						
Grants						
Continuations	12	726	7	4,059	7	4,060
New/Competing	1	4,200	6	360	7	420
Subtotal	13	4,926	13	4,419	14	4,480
Contracts						
Continuations	---	1,448	---	982	---	492
New/Competing	---	---	---	145	---	540
Subtotal	---	1,448	---	1,127	---	1,032
Total, Suicide Lifeline [1/]	**13**	**6,373**	**13**	**5,545**	**14**	**5,512**
GLS- Youth Suicide Prevention - States						
Grants						
Continuations	34	15,905	54	25,182	20	9,180
New/Competing	23	13,724	---	---	34	16,320
Subtotal	57	29,629	54	25,182	54	25,500
Contracts						
Continuations	1	4,016	1	4,295	---	2,247
New/Competing	---	357	---	386	1	1,935
Subtotal	1	4,372	1	4,681	1	4,182
Total, GLS-States [1/]	**58**	**34,002**	**55**	**29,863**	**55**	**29,682**
GLS- Youth Suicide Prevention - Campus						
Grants						
Continuations	16	1,549	40	3,776	23	2,138
New/Competing	39	6,383	---	---	18	1,800
Subtotal	55	7,932	40	3,776	41	3,938
Contracts						
Continuations	---	785	---	1,156	---	446
New/Competing	---	417	---	64	---	582
Subtotal	---	1,202	---	1,220	---	1,028
Total, GLS-Campus [1/]	**55**	**9,134**	**40**	**4,996**	**41**	**4,966**

[1/] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Base No.	FY 2013 Base Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
GLS - Suicide Prevention Resource Center						
Grants						
Continuations	1	4,471	1	4,471	1	4,471
New/Competing	---	800	---	244	---	172
Subtotal	1	5,271	1	4,715	1	4,643
Contracts						
Continuations	---	327	---	263	---	305
New/Competing	---	---	---	---	---	---
Subtotal	---	327	---	263	---	305
Total, SPRC [1/]	**1**	**5,598**	**1**	**4,978**	**1**	**4,948**
AI/AN Suicide Prevention Initiative						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	2,304	1	529	1	2,938
New/Competing	---	634	1	2,427	---	---
Subtotal	1	2,938	2	2,956	1	2,938
Total, AI/AN	**1**	**2,938**	**2**	**2,956**	**1**	**2,938**
Homelessness Prevention Programs						
Grants						
Continuations	74	20,311	79	23,387	25	6,674
New/Competing	8	3,991	12	686	25	18,759
Subtotal	82	24,302	91	24,074	50	25,433
Contracts						
Continuations	3	5,767	3	6,098	3	4,538
New/Competing	---	702	1	788	1	801
Subtotal	3	6,469	4	6,886	4	5,339
Total, HPP	**85**	**30,772**	**95**	**30,960**	**54**	**30,772**

[1/] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Base No.	FY 2013 Base Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
Minority AIDS						
Grants						
Continuations	11	8,497	11	7,866	---	---
New/Competing	---	---	---	---	20	19,561
Subtotal	11	8,497	11	7,866	20	19,561
Contracts						
Continuations	1	768	2	1,456	1	2,021
New/Competing	---	---	---	---	1	1,188
Subtotal	1	768	2	1,456	2	3,209
Total, MAI	**12**	**9,265**	**13**	**9,322**	**22**	**22,770**
Grants for Adult Trauma Screening & Brief Intervention						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	4	2,718
Subtotal	---	---	---	---	4	2,718
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	178
Subtotal	---	---	---	---	---	178
Total, GATSBI	**---**	**---**	**---**	**---**	**4**	**2,896**
Criminal and Juvenile Justice Programs						
Grants						
Continuations	13	5,231	7	2,754	1	394
New/Competing	---	---	4	2,760	---	---
Subtotal	13	5,231	11	5,514	1	394
Contracts						
Continuations	2	1,426	2	1,132	1	706
New/Competing	---	14	---	67	6	3,181
Subtotal	2	1,440	2	1,199	7	3,887
Total, CJJP	**15**	**6,671**	**13**	**6,712**	**8**	**4,281**
Subtotal, CAPACITY	**559**	**265,117**	**492**	**221,464**	**462**	**308,830**

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Base No.	FY 2013 Base Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
SCIENCE AND SERVICE:						
Practice Improvement Training						
Grants						
Continuations	1	215	1	215	1	215
New/Competing	---	---	---	---	8	3,013
Subtotal	1	215	1	215	9	3,228
Contracts						
Continuations	9	6,538	10	7,696	4	3,169
New/Competing	6	1,110	---	---	4	1,466
Subtotal	15	7,648	10	7,696	8	4,635
Total, PIT	**16**	**7,863**	**11**	**7,911**	**17**	**7,863**
Consumer and Consumer Supporter Technical Assistance Centers						
Grants						
Continuations	5	1,775	5	1,775	5	1,777
New/Competing	---	---	---	---	---	---
Subtotal	5	1,775	5	1,775	5	1,777
Contracts						
Continuations	---	148	---	160	---	146
New/Competing	---	---	---	---	---	---
Subtotal	---	148	---	160	---	146
Total, CCSTAC	**5**	**1,923**	**5**	**1,935**	**5**	**1,923**
Primary and Behavioral Health Care Integration TA						
Grants						
Continuations	1	1,996	1	1,902	---	---
New/Competing	---	---	---	---	1	1,874
Subtotal	1	1,996	1	1,902	1	1,874
Contracts						
Continuations	---		---	106	---	---
New/Competing	---	---	---	---	---	122
Subtotal	---		---	106	---	122
Total, PBHCI TA [1/]	**1**	**1,996**	**1**	**2,008**	**1**	**1,996**

[1/] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Base No.	FY 2013 Base Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
Disaster Response						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	1	2,000
Subtotal	---	---	---	---	1	2,000
Contracts						
Continuations	1	846	1	1,058	---	401
New/Competing	1	206	---	---	---	549
Subtotal	2	1,052	1	1,058	---	950
Total, Disaster Response	**2**	**1,052**	**1**	**1,058**	**1**	**2,950**
Homelessness						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	2,302	1	2,316	1	1,231
New/Competing	---	---	---	---	1	1,071
Subtotal	1	2,302	1	2,316	2	2,302
Total, Homelessness	**1**	**2,302**	**1**	**2,316**	**2**	**2,302**
HIV/AIDS Education						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	3	773	3	777	---	47
New/Competing	---	---	---	---	3	726
Subtotal	3	773	3	777	3	773
Total, HIV/AIDS	**3**	**773**	**3**	**777**	**3**	**773**
Subtotal, SCIENCE AND SERVICE	**28**	**15,909**	**22**	**16,006**	**29**	**17,807**
TOTAL, MH PRNS	**587**	**$281,026**	**514**	**$237,471**	**491**	**$326,637**

SAMHSA/Mental Health
CMHI Mechanism Table by SLOA
(Dollars in thousands)

	FY 2012 Actual		FY 2013 Annualized CR		FY 2014 President's Budget	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Children's Mental Health Services						
Grants/Cooperative Agreements						
Continuations	47	$76,720	62	$75,954	56	$57,695
New/Competing	22	19,292	26	23,583	42	42,004
Subtotal	69	96,012	88	99,537	98	99,700
Contracts						
Continuations	2	9,264	1	8,296	2	10,539
New/Competing	---	---	1	1,500	---	---
Subtotal	2	9,264	2	9,796	2	10,539
Technical Assistance	4	11,619	4	8,966	3	7,076
Report to Congress	---	420	---	---	---	---
Total, Children's Mental Health Services	**75**	**$117,315**	**94**	**$118,300**	**103**	**$117,315**

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

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Annualized CR No.	FY 2013 Annualized CR Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
CAPACITY:						
Strategic Prevention Framework						
Grants						
Continuations	40	$55,211	40	$60,068	30	$43,430
New/Competing	15	41,875	23	33,034	34	48,056
Subtotal	55	97,085	63	93,102	64	91,486
Contracts						
Continuations	9	12,074	5	8,977	9	18,269
New	1	594	4	8,400	---	---
Subtotal	10	12,669	9	17,377	9	18,269
Total, Strategic Prevention Framework	**65**	**109,754**	**72**	**110,479**	**73**	**109,754**
Mandatory Drug Testing						
Contracts						
Continuations	4	4,496	2	1,459	3	4,480
New	2	700	2	3,769	1	426
Subtotal	6	5,196	4	5,228	4	4,906
Total, Mandatory Drug Testing	**6**	**5,196**	**4**	**5,228**	**4**	**4,906**
Minority AIDS						
Grants						
Continuations	133	39,557	78	21,042	133	34,378
New/Competing	---	---	60	14,984	22	1,093
Subtotal	133	39,557	138	36,026	155	35,471
Contracts						
Continuations	---	1,750	1	5,533	1	5,836
New	---	---	---	---	---	---
Subtotal	---	1,750	1	5,533	1	5,836
Total, Minority AIDS	**133**	**41,307**	**139**	**41,560**	**156**	**41,307**
Sober Truth on Preventing Underage Drinking						
Grants						
Continuations	22	1,100	81	3,886	97	4,581
New/Competing	81	3,887	16	782	---	---
Subtotal	103	4,987	97	4,669	97	4,581
Contracts						
Continuations	1	1,000	1	1,372	2	2,419
New	1	1,000	1	989	---	---
Subtotal	2	2,000	2	2,361	2	2,419
Total, STOP	**105**	**6,987**	**99**	**7,030**	**99**	**7,000**
Subtotal, CAPACITY	**309**	**$163,244**	**314**	**$164,296**	**332**	**$162,967**

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Annualized CR No.	FY 2013 Annualized CR Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
SCIENCE AND SERVICE:						
Fetal Alcohol Center of Exellence						
Contracts						
Continuations	1	$1,485	1	$9,862	1	$1,000
New	1	8,317	---	---	---	---
Subtotal	2	9,802	1	9,862	1	1,000
Total, Fetal Alcohol Center of Exellence	**2**	**9,802**	**1**	**9,862**	**1**	**1,000**
Center for the Application of Prevention Technologies						
Contracts						
Continuations	1	8,059	1	8,108	1	7,511
New	---	---	---	---	---	---
Subtotal	1	8,059	1	8,108	1	7,511
Total, Center for the Application of Prevention Technologies	**1**	**8,059**	**1**	**8,108**	**1**	**7,511**
Science & Service Program Coordination						
Contracts						
Continuations	6	4,580	4	3,604	4	2,429
New	1	200	3	1,205	1	1,653
Subtotal	7	4,780	7	4,809	5	4,082
Total, Science & Service Program Coordination	**7**	**4,780**	**7**	**4,809**	**5**	**4,082**
Subtotal, SCIENCE AND SERVICE	**10**	**22,641**	**9**	**22,780**	**7**	**12,593**
Total, CSAP [1/]	**319**	**$185,885**	**323**	**$187,076**	**339**	**$175,560**

1/In the FY 2014 Request, the CSAP Minority Fellowship Program budget is reflected in the Health Surveillance and Program Support Appropriation under the Agency-Wide Initiatives Workforce program.

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

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Annualized CR No.	FY 2013 Annualized CR Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
CAPACITY:						
Opioid Treatment Programs/Regulatory Activities						
Grants						
Continuations	2	$999	1	$500	2	$1,494
New/Competing	9	3,439	46	3,000	40	1,947
Subtotal	11	4,438	47	3,500	42	3,441
Contracts						
Continuations	6	5,749	4	4,233	6	5,305
New/Competing	2	2,700	2	1,207	---	---
Subtotal	8	8,449	6	5,441	6	5,305
Total, Opioid Treatment Programs/Regulatory Activities [1/]	**19**	**12,886**	**53**	**8,941**	**48**	**8,746**
Screening, Brief Intervention and Referral to Treatment						
Grants						
Continuations	27	25,585	12	12,193	25	21,585
New/Competing	3	22,725	19	11,788	16	4,795
Subtotal	30	48,310	31	23,981	41	26,380
Contracts						
Continuations	1	4,877	---	4,179	1	3,620
New/Competing	---	---	1	200	---	---
Subtotal	1	4,877	1	4,379	1	3,620
Total, Screening, Brief Intervention and Referral to Treatment [1/]	**31**	**53,187**	**32**	**28,360**	**42**	**30,000**
TCE - General						
Grants						
Continuations	46	14,295	30	8,033	30	7,820
New/Competing	6	4,867	34	10,920	---	---
Subtotal	52	19,162	64	18,953	30	7,820
Contracts						
Continuations	7	8,818	4	7,103	3	5,436
New/Competing	---	---	1	2,096	---	---
Subtotal	7	8,818	5	9,199	3	5,436
Total, TCE - General	**59**	**27,980**	**69**	**28,151**	**33**	**13,256**

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Programs of Regional & National Significance	FY 2012 Actual		FY 2013 Annualized CR		FY 2014 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Pregnant & Postpartum Women						
Grants						
Continuations	20	9,687	27	13,362	7	3,597
New/Competing	7	3,664	---	---	14	7,106
Subtotal	27	13,351	27	13,362	21	10,703
Contracts						
Continuations	---	2,619	---	2,540	---	5,261
New/Competing	---	---	---	166	---	6
Subtotal	---	2,619	---	2,706	---	5,267
Total, Pregnant & Postpartum Women	**27**	**$15,970**	**27**	**$16,067**	**21**	**$15,970**
Strengthening Treatment Access and Retention						
Contracts						
Continuations	---	$1,672	---	$1,682	---	$1,000
New/Competing	---	---	---	---	---	---
Subtotal	---	1,672	---	1,682	---	1,000
Total, Strengthening Treatment Access and Retention	---	**1,672**	---	**1,682**	---	**1,000**
Recovery Community Services Program						
Grants						
Continuations	5	1,749	5	1,629	---	---
New/Competing	---	---	---	---	18	1,400
Subtotal	5	1,749	5	1,629	18	1,400
Contracts						
Continuations	---	696	---	831	---	856
New/Competing	---	---	---	---	1	306
Subtotal	---	696	---	831	1	1,162
Total, Recovery Community Services Program	**5**	**2,445**	**5**	**2,460**	**19**	**2,562**
Access to Recovery						
Grants						
Continuations	30	85,990	30	89,958	---	---
New/Competing	---	---	---	---	19	55,795
Subtotal	30	85,990	30	89,958	19	55,795
Contracts						
Continuations	2	12,278	1	8,911	---	4,986
New/Competing	---	---	---	---	1	4,219
Subtotal	2	12,278	1	8,911	1	9,205
Total, Access to Recovery	**32**	**98,268**	**31**	**98,869**	**20**	**65,000**

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Annualized CR No.	FY 2013 Annualized CR Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
Children and Family Programs						
Grants						
Continuations	32	9,446	13	12,837	24	23,847
New/Competing	13	12,744	11	11,000	---	---
Subtotal	45	22,190	24	23,837	24	23,847
Contracts						
Continuations	3	8,430	2	6,545	2	5,831
New/Competing	---	---	---	425	---	---
Subtotal	3	8,430	2	6,970	2	5,831
Total, Children and Family Programs	**48**	**30,620**	**26**	**30,807**	**26**	**29,678**
Treatment Systems for Homeless						
Grants						
Continuations	95	35,832	71	26,562	35	16,975
New/Competing	---	---	12	8,873	39	18,604
Subtotal	95	35,832	83	35,434	74	35,579
Contracts						
Continuations	2	5,739	2	6,391	2	5,992
New/Competing	---	---	---	---	---	---
Subtotal	2	5,739	2	6,391	2	5,992
Total, Treatment Systems for Homeless	**97**	**$41,571**	**85**	**$41,826**	**76**	**$41,571**
Minority AIDS						
Grants						
Continuations	75	$31,466	79	$35,954	87	$44,173
New/Competing	52	25,570	38	22,348	---	---
Subtotal	127	57,035	117	58,302	87	44,173
Contracts						
Continuations	3	8,828	2	6,715	3	8,186
New/Competing	---	---	---	1,249	---	---
Subtotal	3	8,828	2	7,964	3	8,186
Total, Minority AIDS	**130**	**65,863**	**119**	**66,266**	**90**	**52,359**
Criminal Justice Activities						
Grants						
Continuations	108	31,146	115	34,079	142	45,061
New/Competing	82	24,518	66	22,705	26	7,602
Subtotal	190	55,664	181	56,785	168	52,662
Contracts						
Continuations	3	11,239	3	10,936	2	12,273
New/Competing	---	---	---	200	---	200
Subtotal	3	11,239	3	11,136	2	12,473
Total, Criminal Justice Activities	**193**	**66,903**	**184**	**67,920**	**170**	**65,135**
Subtotal, CAPACITY	**641**	**$417,366**	**631**	**$391,351**	**545**	**$325,277**

Programs of Regional & National Significance	FY 2012 Actual No.	FY 2012 Actual Amount	FY 2013 Annualized CR No.	FY 2013 Annualized CR Amount	FY 2014 President's Budget No.	FY 2014 President's Budget Amount
SCIENCE AND SERVICE:						
Addiction Technology Transfer Centers						
Grants						
Continuations	---	---	15	$8,573	15	$7,585
New/Competing	15	8,570	---	---	---	---
Subtotal	15	8,570	15	8,573	15	7,585
Contracts						
Continuations	---	494	---	546	---	496
New/Competing	---	---	---	---	---	---
Subtotal	---	494	---	546	---	496
Total, Addiction Technology Transfer Centers	**15**	**9,064**	**15**	**9,119**	**15**	**8,081**
Special Initiatives/Outreach						
Grants						
Continuations	1	300	1	300	---	---
New/Competing	---	---	---	---	1	300
Subtotal	1	300	1	300	1	300
Contracts						
Continuations	1	1,967	---	956	1	1,136
New/Competing	---	---	1	1,025	---	---
Subtotal	1	1,967	1	1,981	1	1,136
Total, Special Initiatives/Outreach	**2**	**2,267**	**2**	**2,281**	**2**	**1,436**
Subtotal, SCIENCE AND SERVICE	**17**	**11,331**	**17**	**11,400**	**17**	**9,517**
Total,CSAT	**658**	**$428,697**	**648**	**$402,751**	**572**	**$334,794**

Substance Abuse and Mental Health Services Administration
SIGNIFICANT ITEMS IN SENATE REPORT

FY 2013 Consolidated Senate Report Language
(Senate Report 112-76)

General Items

Item

Child Trauma – The Committee reiterates its strong support for the National Child Traumatic Stress Initiative [NCTSI] and its work on behalf of children, families, and communities affected by a wide range of trauma, including physical and sexual abuse, natural disasters, sudden death of a loved one, and the impact of war on military families. The Committee provides $48,713,000 under section 582 of the PHS Act to support the continuance of the current model and mission of the NCTSI by providing grants to the National Center for Child Traumatic Stress [NCCTS] and academic, clinical, and community-based centers for the purposes of developing knowledge of best practices, offering trauma training to child-serving providers, and providing mental health services to children and families suffering from PTSD and other trauma-related disorders. The Committee is aware that SAMHSA is developing a new definition of trauma-informed services to be used by NCTSI grantees and expects to be informed of any major changes before they are implemented.

The Committee also recognizes the extraordinary value of the core data set developed by the NCCTS. Within the total provided, the Committee provides $1,500,000 to the NCCTS for the targeted collection of new outcome data from selected NCTSI centers and related analyses and reports.

Action taken or to be taken

SAMHSA will continue to build on the strong work of the Network and will improve and enhance the capacity of the NCTSI to deliver core practices developed by the NCTSN to children and youth in need. The additional appropriation for data collection will provide the resources for the National Center to institute a Network capacity to collect, aggregate, and analyze data on the characteristics of traumatized children and adolescents and the overall success of Network outcomes in intervention development and implementation, screening and assessment, trauma resources for service systems, training and dissemination.

SAMHSA acknowledges the Committee's request to be informed in advance of any major changes with the newly developed definition and framework for trauma informed services and how this will be implemented with NCTSI.

Item

Minority Fellowship Program – The Committee continues to be concerned that while minorities represent 30 percent of the population and are projected to increase to 40 percent by 2025, only 23 percent of recent doctorates in psychology, social work, and nursing were awarded

to minorities. The Committee has, therefore, continued funding at last year's level for the Minority Fellowship Program.

Action taken or to be taken

Since its start in 1973, the MFP has helped to enhance services to minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, marriage and family therapists were added and in 2012, counselors were included in the program. Since its inception, the MFP has supported about 1,700 MFP fellows. In 2012, the MPF supported 123 individuals across these disciplines. Working closely with the MFP grantee organizations, SAMHSA will continue to strengthen the MFP, diversify its fellows, foster collaboration among the grantee organizations and ensure that the MFP continues to make a significant impact in the development of the behavioral health workforce.

Item

Primary and Behavioral Healthcare Integration – The Committee continues to direct SAMHSA to ensure that new Integration grants awarded for fiscal year 2013, from both discretionary and PPH funds, are funded under the authorities in section 520K of the PHS Act.

Action taken or to be taken

Any Primary and Behavioral Healthcare Integration grants awarded in fiscal year 2013 will be awarded under the section 520K of the PHS Act authorities.

Item

Project LAUNCH – The Committee intends that funds provided to Project LAUNCH not duplicate activities eligible for funding elsewhere in the Department. The Committee reiterates its intention that funds provided to this program focus on mental health promotion and promotion strategies for children aged 0 to 8.

Action taken or to be taken

Project LAUNCH makes ongoing efforts at the national, state and local levels to ensure that grant activities expand and enhance other efforts and are not duplicative of them. Grantees are required to: (1) bring together a wide range of child- and family-serving agencies as part of the LAUNCH Councils at the state and local levels so that they are integrating programs, funding, and policies rather than acting in duplicative silos; (2) conduct environmental scans of existing state and community resources so that they are aware of what programs exist and design their strategic plans and implementation approaches to address gaps in service; and (3) at the local level, focus on enhancing existing services and systems by training the workforce, increasing access to care, increasing the quality of care, and raising awareness and knowledge of healthy child development.

Project LAUNCH leaders at the state level are integrally involved in work on other early childhood national initiatives such as the Maternal, Infant, and Early Childhood Home Visiting Initiative (MIECHV) and the Race to the Top Early Learning Challenge grants. Important goals

of this collaboration are to ensure that the programs are well coordinated and integrated, that there is no duplication, and that lessons learned can be shared.

Project LAUNCH remains committed to focusing on children birth through eight years old.

Item

Seclusion and Restraint – The Committee recommends $2,444,000 for seclusion and restraint activities at CMHS. The Committee is deeply concerned that a recent Department of Education report showed that tens of thousands of students with disabilities are physically restrained in school systems across the country. There are also widespread media reports of people with mental illnesses and developmental disabilities living in congregate care facilities who are subject to excessive use of seclusion and restraint causing psychological trauma, serious physical injury, and even death. The Committee urges SAMHSA to partner with other federal agencies to reduce and ultimately eliminate the use of seclusion and restraints in institutional, community, and educational settings, and to promote evidence-based alternatives to restraint and seclusion, including the use of positive behavioral interventions and supports.

Action taken or to be taken

SAMHSA continues to provide training and technical assistance to promote the dissemination, implementation and uptake of best practices to reduce and ultimately eliminate the use of restraints and seclusion in a broad range of institutional and community settings. SAMHSA's work continues in settings that provide services for individuals with mental health and co-occurring substance abuse disorders. However, this initiative has expanded beyond the behavioral health system, most notably in educational and criminal and juvenile justice settings. SAMHSA fosters a systematic, trauma-informed approach to the reduction of these coercive – seclusion and restraint – practices which have been identified as non-therapeutic and most often retraumatizing. SAMHSA worked with the U.S. Department of Education in the development of their "Restraint and Seclusion: Resource Document" issued by the Secretary of Education in 2012, which promotes 15 principles regarding the use of seclusion and restraint, much of which draws upon SAMHSA's work in this area in conjunction with the use of positive behavioral interventions and supports as alternatives to coercive practices.

In 2010, SAMHSA awarded a contract to establish the National Technical Assistance Center: Promoting Alternatives to Seclusion and Restraint Through Trauma-Informed Practices. The Center provides in-depth training and TA on preventing seclusion and restraint, and promoting trauma- informed approaches in a wide range of settings that provide services to children, youth and adults with mental and co-occurring disorders or conditions. Since October 2010, the Center has provided 116 technical assistance events in 32 states; more than 50 of these events included representatives of state education departments, public and private schools and residential programs for children and youth; 80 events focused on congregate living environments including residential programs for people with mental health and addictions, groups homes and congregate living environments for people with developmental disabilities, long-term care hospitals, prisons, jails and juvenile detention centers. The Center worked with the National Association of State Directors of Developmental Disabilities Services on reducing the use of seclusion and restraint in state run institutions and group homes. Most of these technical assistance events included multiple service systems in cross-training and collaborative systems planning. The goals of these

training and technical assistance efforts are to change policy and practice and promote trauma-informed care as an alternative and more effective approach to care than coercive practices and policies.

In FY 2013, SAMHSA will develop a core curriculum for a trauma-informed approach that includes strategies for eliminating seclusion and restraint and that can be adapted for multiple service sectors and settings. As SAMHSA continues to get requests for these trainings from a range of service sectors, a core evidence-supported curriculum readily adaptable to different settings will multiply the reach of this initiative.

Item

Suicide Prevention in Indian Populations – The Committee remains concerned about the high incidence of drug and alcohol abuse and suicide in American Indian populations. SAMHSA is encouraged to continue its efforts in providing culturally competent suicide prevention training courses to selected gatekeepers in Indian country. These courses should teach community leaders, school personnel, and families how to identify and talk with at-risk individuals to motivate them to seek help. Courses should also include mental health support services information tailored to the specific geographical location of the participants in each program. The Committee further urges SAMHSA to collaborate with the Indian Health Service to identify priority communities and help ensure sustainability within American Indian/Alaska Native communities.

Action taken or to be taken

SAMHSA has provided significant support for the provision of suicide prevention training in Indian Country to a broad array of gatekeepers. As of November 2012, Tribal Garrett Lee Smith grantees have conducted 980 trainings that have trained 21,372 people. Additionally, State and Campus Garrett Lee Smith grantees have trained an additional 18,378 people who are American Indian/Alaska Native. In addition, SAMHSA has funded the adaptation of an evidenced based intervention in Emergency Departments for youth suicide attempters for tribal use in the White Mountain Apache community; has funded the development of a dissemination manual for a comprehensive youth suicide prevention program developed in Indian Country and shown to reduce youth suicide attempts; and has created the resource "To Live To See The Great Day That Dawns" to assist tribes in adapting culturally competent suicide prevention practices in their communities.

In addition to SAMHSA's work through the Garrett Lee Smith Act programs, SAMHSA's Native Aspirations program identifies American Indian and Alaska Native communities hardest hit by suicide, bullying and violence through community-wide behavioral health infrastructure development, demonstrably increasing the collective readiness for effective prevention interventions and healing. Finally, SAMHSA participates in the HHS Annual Tribal Budget Consultation during March of each year, in HHS Regional Consultations between January and May of each year and in SAMHSA specific Tribal Consultations throughout the year as needed.

Item

Addiction Technology Transfer Centers [ATTCs] – The Committee continues to direct SAMHSA to ensure that ATTCs maintain a primary focus on addiction treatment and recovery services in order to strengthen the addiction workforce. As more individuals become eligible for substance abuse services through Medicaid and private insurance, the ATTC network is critical to ensure there are enough skilled workers to meet the demand in substance use disorder services.

Action taken or to be taken

SAMHSA continues to direct attention to strengthening the addiction workforce. The ATTC program is expected to directly support and enhance SAMHSA's new regional presence. Through the funding of this effort, SAMHSA expects to provide training and technical assistance (TA) which will ultimately lead to a more educated and capable addictions workforce equipped to meet the upcoming challenges and requirements of health reform. SAMHSA recognizes the critical role the ATTC Network plays in preparing the workforce for the changes health reform will bring. The ATTCs develop and conduct training and technology transfer activities for the substance use disorders workforce to meet identified needs by raising awareness of and improving skills in using evidence-based and promising treatment and recovery practices in recovery-oriented systems of care. The program was restructured in 2012 to better align with the HHS Regions and 15 grants were awarded including 10 Regional Centers, four Focus Area Centers and one National Office.

Item

Addiction Workforce – As the provision of quality substance use disorder services is dependent on an adequate, qualified workforce and SAMHSA is the lead federal agency charged with improving these services, the Committee directs SAMHSA to continue to focus on developing the addiction workforce and identifying ways to address the current and future workforce needs of the addiction prevention, treatment, and recovery fields.

Action taken or to be taken

SAMHSA's primary vehicle for addressing addiction workforce issues is the Addiction Technology Transfer Centers program. ATTCs develop and conduct training and technology transfer activities for the substance use disorders workforce to meet identified needs by raising awareness of and improving skills in using evidence-based and promising treatment and recovery practices in recovery-oriented systems of care. The program was restructured in 2012 to better align with the HHS Regions and 15 grants were awarded including 10 Regional Centers, four Focus Area Centers and one National Office. Recent activities and projects include an ATTC curriculum was created for workforce development for "Medication-Assisted Treatment with Special Populations" (MAT Project), which involves developing outreach materials, piloting prototypes and designing and implementing online courses. The Clinical Supervision Foundation's Suite of Training has been developed. The target audience is professionals interested in the fundamentals of supervision, and a variety of training modules have been developed to address their training needs.

In addition to this expansive effort, other examples of SAMHSA's continued addiction workforce development activities include programs such as Partners for Recovery, Minority Fellowship Program, and its work with Historically Black Colleges and Universities.

Item

Drug Treatment Courts – The Committee continues to direct SAMHSA to ensure that all funding appropriated for drug treatment courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. In addition, the Committee urges CSAT to ensure that state substance abuse agencies are eligible to apply for all drug treatment court grant programs in its portfolio. The Committee expects CSAT to ensure that non-state substance abuse agency applicants for any drug treatment court grant in its portfolio continue to demonstrate evidence of working directly and extensively with the corresponding state substance abuse agency in the planning, implementation, and evaluation of the grant.

Action taken or to be taken

In FY 2013 SAMHSA funding appropriated to CSAT for drug treatment courts will continue to support and provide technical assistance to state and community programs where substance abuse is the primary focus. State substance abuse agencies will continue to be eligible to apply for all drug treatment court grant programs and non-state substance abuse agency applicants for drug treatment court grants continues to demonstrate evidence of working directly and extensively with the corresponding state substance abuse agency in the planning, implementation, and evaluation of the grant. In 2013 SAMHSA plans to fund additional cohorts of SAMHSA/BJA Drug Courts and SAMHSA Adult and Family Drug Courts. The purpose of the Adult and Family Drug Courts program is to expand and/or enhance substance abuse treatment services in existing adult and family "problem solving" courts which use the treatment drug court model in order to provide alcohol and drug treatment to defendants/offenders. Services include recovery support services for substance abuse treatment, screening, assessment, case management, and program coordination. The purpose of the SAMHSA/BJA program is the provision of services to populations for which primary issues are substance abuse related. This joint initiative allows applicants to submit a comprehensive strategy for enhancing drug court services and capacity by permitting applicants to compete for both criminal justice and substance abuse treatment funds with one application. This jointly managed program provides resources to state, local and tribal governments, and drug courts to enhance drug court programs and systems for nonviolent substance-abusing offenders.

Item

Hepatitis Testing – The Committee notes the high incidence of hepatitis among injection drug users and urges SAMHSA to implement viral hepatitis testing as a standard of care in drug-treatment programs, consistent with the HHS Action Plan for the Prevention, Care and Treatment of Viral Hepatitis. The Committee encourages SAMHSA to use established best practices for infectious disease testing, including rapid tests.

Action taken or to be taken

SAMHSA recognizes the importance of addressing the high incidence of hepatitis among injection drug users and has taken steps to incorporate or encourage rapid testing in many of the agency's programs. SAMHSA continues to support testing of opioid treatment program (OTP) patients for hepatitis C virus (HCV) and the vaccination of HIV/HCV co-infected individuals through the bulk purchase and distribution of HCV test kits and a hepatits B vaccine for maintenance and detoxification programs. In addition, the current hepatitis curriculum is being updated. The curriculum, titled *Enhancing Substance Abuse Treatment Services to Promote Healthy Lifestyles through Addressing Hepatitis Infection among Injection Drug Users*, will be implemented in designated OTPs. The focus of the course will be on screening, patient education, and treatment of hepatitis infection.

SAMHSA is a lead or partnering agency in at least 23 strategies specified in the HHS Viral Hepatitis Plan. To promote the awareness of viral hepatitis, CSAT, in collaboration with the Centers for Disease Control and Prevention (CDC), issued a dear colleague letter to OTPs encouraging their participation in the first National Hepatitis Testing Day on May 19. The Viral Hepatitis Education Work Group is continuing to develop educational materials to support testing activities, including a new online risk assessment tool.

In 2012, SAMHSA required the 10 new regional ATTC programs to work with federally qualified health centers to provide training/TA specific to the development of the workforce regarding issues related to serving clients with hepatitis. In 2012, the grant announcement for *Targeted Capacity Expansion Program: Substance Abuse Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS* contains the following statement: All clients who are considered to be at risk for viral hepatitis (B and C) as specified by CDC recommendations for hepatitis B (CDC, 2008) and hepatitis C (CDC, 1998) must be tested for viral hepatitis (B and C) in accordance with state and local requirements, either onsite or through referral. No more than 5 percent of grant funds may be used for viral hepatitis (B and C) testing, including purchase of test kits and other required supplies (e.g., gloves, biohazardous waste containers, etc.) and training for staff related to viral hepatitis (B and C) testing. Grantees must report all positive viral hepatitis test results to the local and state health department, as appropriate.

Item

HIV Testing – The Committee urges SAMHSA to expand voluntary routine HIV-testing services at substance abuse and mental health treatment clinics, consistent with the National HIV/AIDS Strategy Implementation Plan. The Committee requests an update on the implementation of these activities in SAMHSA's fiscal year 2014 congressional budget justification.

Action taken or to be taken

SAMHSA recognizes the need and continues to support the expansion of voluntary routine HIV-testing services at substance abuse and mental health treatment clinics, consistent with the National HIV/AIDS Strategy Implementation Plan. From March through June 2012, 6,853 Rapid HIV Testing (RHT) forms were collected and submitted for preliminary analyses. The

forms included all demographic, substance abuse and sexual risk variables for those clients who a) are newly diagnosed as preliminarily HIV-positive and b) were previously diagnosed as HIV-positive. All 6,853 were offered a rapid HIV test. The number of individuals who accepted the test was 6,085 (88.8 percent) and the number who refused testing was 768 (11.2 percent). A total of 274 (4 percent) RHT forms were from clients diagnosed as HIV-positive. Of HIV-positive clients, 255 (3.7 percent of all clients tested) were previously diagnosed as positive and 19 (0.3 percent of clients tested) were newly diagnosed as HIV-positive.
Additionally, SAMHSA received $1.6 million from the Secretary's Minority AIDS Initiative Fund in FY 2012 to expand the capacity of Minority AIDS Initiative grantees in CSAT and CSAP, and for criminal justice grantees in CSAT and CMHS. These funds will provide rapid HIV testing, counseling, and referral to care. SAMHSA funded 21 one-year supplements.

Item

Minority AIDS – The Committee is concerned by SAMHSA's proposal to transfer funds to CMHS from the Minority Aids Initiative [MAI] administered by CSAT. According to NIDA, 1 in 4 of those living with HIV in 2009 reported use of alcohol or drugs at a level that warranted treatment. In addition, research shows alcohol and drug use are major risk factors for HIV/AIDS. The Committee directs SAMHSA to maintain funding for CSAT's MAI and to focus on building capacity and outreach efforts to individuals with, or at risk of developing, a primary substance use disorder and to improve efforts to identify such individuals to prevent the spread of the disease.

Action taken or to be taken

In accordance with the Committee, in FY 2013 SAMHSA plans to maintain funding for CSAT's MAI and to focus on building capacity and outreach efforts to individuals with, or at risk of developing, a primary substance use disorder and to improve efforts to identify such individuals to prevent the spread of the disease. To support already ongoing efforts, SAMHSA plans to issue a new TCE-HIV program of which the primary focus will be substance abuse treatment for racial/ethnic minority women at high Risk for HIV/AIDS. The proposed purpose of this program is to expand substance abuse treatment and HIV services for African American, Hispanic/Latina and other racial/ethnic minority women (ages 18 years and older), including heterosexual, lesbian, bisexual, and previously incarcerated women and their significant others, who have substance use or co-occurring substance use and mental disorders, and are living with or at risk for HIV/AIDS, tuberculosis, and other sexually transmitted diseases.

Item

Oral Fluid Testing – The Committee commends SAMHSA for updating its substance abuse testing guidelines to include oral fluid and encourages the agency to continue to advance oral fluid testing guidelines.

Action taken or to be taken

The CSAP Drug Testing Advisory Board (DTAB) is responsible for evaluating the scientific sufficiency of oral fluid and providing advice to the SAMHSA Administrator on the federal workplace drug testing programs. In July 2011, the DTAB deliberated in open session on the

scientific sufficiency of oral fluid as an alternative specimen in the federal drug testing program and unanimously voted that SAMHSA include oral fluid as an alternative specimen in the Mandatory Guidelines for Federal Workplace Drug Testing Programs.

In April 2012, CSAP completed the draft proposed revisions to the Mandatory Guidelines for Federal Workplace Drug Testing Programs to include oral fluid as an alternative specimen. These proposed revisions were written in a question/answer format to harmonize with the 2008 urine Mandatory Guidelines. For the first time, this preamble to the proposed oral fluid Mandatory Guidelines has its discussion points supported by scientific peer-reviewed literature references. This proposed draft was reviewed by the DTAB on September 24, 2012 in closed session.

Item

Screening, Brief Intervention, and Referral to Treatment [SBIRT] – The Committee continues to direct SAMHSA to ensure that funds provided for SBIRT are used for existing evidence-based models of providing early intervention and treatment services to those at risk of developing substance abuse disorders.

Action taken or to be taken

All SBIRT funds utilize the existing evidence base and provide funds to applicants who demonstrate the ability to provide early intervention and substance abuse treatment referral services to those in need.

Item

Underage Drinking – The Committee provides a total of $5,000,000 for Sober Truth on Preventing Underage Drinking [STOP] Act Community Based Coalition Enhancement Grants. The Committee understands that building on the infrastructure of current and past Drug Free Communities grantees is the most effective way to invest limited federal dollars to deal with underage drinking issues at the community level.

Action taken or to be taken

In fiscal year 2012, SAMHSA awarded 81 new STOP Act grants to current and former Drug Free Communities coalitions that had not received STOP Act funding in prior years. CSAP will continue to focus these community grants on using coalitions to implement effective strategies for preventing and reducing underage drinking as well as other substance use and abuse issues. In fiscal year 2013 SAMHSA will award up to 16 new STOP Act grants to prevent and reduce alcohol use among youth ages 12-20 in communities throughout the United States.

Item

Overdose Prevention — Accidental deaths from overdose, particularly from prescription drugs such as opioids, are on the rise and have become the leading cause of preventable death for individuals under the age of 65 in the United States. The Committee strongly encourages the Secretary to launch a public awareness campaign to educate the public and health professionals about the signs, symptoms, and risk factors for overdose, as well as how individuals can make

linkages to recovery and treatment services. The Committee urges the Secretary to develop the campaign with the participation of federal agencies including SAMHSA, NIDA, HRSA, FDA, and the Office of National Drug Control Policy.

Action taken or to be taken

SAMHSA/CSAT has developed an overdose prevention and reversal toolkit which is currently undergoing internal clearance. Should the toolkit be approved, the recommendation is to distribute it through the SAMHSA website and to provide limited technical assistance to users. However, at this time SAMHSA/CSAT does not possess the resources or expertise to conduct a public awareness campaign as envisioned in the congressional provision.

Item

SPFSIG/PFS - The Committee reiterates its strong support for SPFSIG/PFS programs, which are promising approaches to preventing the onset and reducing the progression of substance abuse, including childhood and underage drinking. The Committee intends that continuation awards for SPFSIG/PFS grantees should be made at amounts no less than what grantees received in fiscal year 2012. Furthermore, SAMHSA shall use any additional funding to provide new grants under SPFSIG/PFS. The Committee intends that these new grants shall be awarded as the program was originally designed prior to fiscal year 2011, with similar eligible applicants, a multiyear project period, reliance on epidemiological workgroups, and financial incentives for grantees that meet performance targets. The Committee expects SAMHSA to awards these multiyear grants on an annual, incremental basis rather than fully funding them in fiscal year 2013.

Action taken or to be taken

The SPF SIG and PFS programs are flagship SAMHSA prevention programs that help to prevent substance abuse, including underage drinking and misuse, use in states, jurisdictions, and tribes across America. SAMHSA intends to provide full continuation funding for SPF SIG and PFS grants in fiscal year 2013. SAMHSA also plans to fund additional PFS grants in 2013 for states and jurisdictions that have completed SPF SIG. These grants will be for a multiyear project period and rely on epidemiological workgroups. The FY 2013 PFS grants will be funded on an annual, incremental basis.

Item

PRNS – The Committee continues to provide funding for Programs of Regional and National Significance [PRNS] under each of SAMHSA's statutorily created centers and directs that SAMHSA shall account for all of its PRNS funding in this manner, which shall include future budget requests. SAMHSA's authorization states that the agency's work to improve the provision of mental health and substance abuse services shall be established and carried out by the agency's three centers. Therefore, SAMHSA shall account for the funding for all of its programs, contracts and activities through the accounts, budget line items, and categories identified in this act and the accompanying Senate report. The Committee requests that the fiscal year 2014 congressional justification include budgetary and programmatic information on programs as they

existed in fiscal year 2013, even if the budget request proposes a new structure or consolidation in fiscal year 2014.

Action taken or to be taken

SAMHSA will continue to account for the funding of all its programs, contracts, and activities supported through the three centers.

Item

Block Grants – The Committee is extremely concerned that the increases provided to the Community Mental Health Services Block Grant [MHBG] and SAPT Block Grant in last year's conference report were eroded by the administration's decision to tap 1.25 percent of both block grants for program evaluation transfers pursuant to section 241 of the PHS Act. In prior years the administration has exempted these block grants from being used as a source for these evaluation transfers. The Committee directs SAMHSA and the Department to exempt these two programs from being used as a source for PHS evaluation transfers in fiscal year 2013, as was done prior to fiscal year 2012.

Action taken or to be taken

The PHS Evaluation Set Aside, authorized by Congress in 1970, funds critical evaluation activities through a set aside of up to 1 percent of PHS Act authorized activities. As you know, both the set-aside rate and the uses of the funds generated by the set-aside are currently specified by Congress in the annual appropriations bill. The FY 2012 set-aside rate specified by Congress required assessing this activity, and in total was 2.5%. This funding is used to support critical public health and evaluation activities across HHS in a centralized and coordinated manner. However, Congress specifies these uses, including to assess performance and assist grantees with activities such as the technical assistance provided to states in implementing the Mental Health and Substance Abuse Block Grants, and other activities that presented HHS with new challenges in financing these activities, which required the Department to include the Mental Health block grant in the assessment along with other Public Health Service Act authorized programs. The PHS Evaluation set aside is increased from 1.25 percent in the FY 2013 to 3 percent for FY 2014.

Item

CMHI – The Committee rejects the administration's proposed cut to this important program. The Committee notes that in the United States every year 5,000 young people between the ages of 14 and 24 commit suicide, and 600,000 make an attempt that is serious enough to require an emergency room visit. Furthermore, the Committee understands that 75 percent of psychiatric illness occurs before the age of 24. This public health crisis is exacerbated by the fact that there are only 7,500 child and adolescent psychiatrists and 3,500 child psychologists nationwide to treat this vulnerable population. The Committee encourages SAMHSA to seek innovative means to increase the number of children's mental health professionals, including efforts to develop bachelor's degree and master's level training curricula focusing on evidence-based interventions.

Action taken or to be taken

The Children's Mental Health Initiative continues to develop and implement innovative strategies to improve services and systems to help children and youth who have serious mental health challenges and their families. In response to the Committee's inquiry, SAMHSA will issue a request for application as part of the Comprehensive Community Mental Health Services for Children's and their Families Program to develop and test a specialized curricula that will focus on ensuring that bachelor's and master's prepared children's mental health professionals have access to training on the delivery of appropriate evidence based practices. In addition, in support of the Administration's plan to address the needs of transition age youth, SAMHSA proposes to invest new resources in workforce activities to train more than 5,000 additional professionals to work with students and young adults with mental illnesses and other behavioral health problems.