DEPARTMENT of HEALTH and HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

FY 2010 Online Performance Appendix

Introduction

The FY 2010 Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2010 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Citizens' Report. These documents are available at http://www.hhs.gov/asrt/ob/docbudget/index.html.

The FY 2010 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2008 Annual Performance Report and FY 2010 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Citizens' Report summarizes key past and planned performance and financial information.

Message from the Administrator

I am pleased to present the FY 2010 Online Performance Appendix for the Substance Abuse and Mental Health Services Administration (SAMHSA). The report represents the monitoring and management of SAMHSA programs in the area of substance abuse prevention, substance abuse treatment, and mental health services programs.

SAMHSA has established a clear vision for its work -- a life in the community for everyone. To realize this vision, the Agency has sharply focused its mission on building resilience and facilitating recovery for people with or at risk for mental or substance use disorders. SAMHSA is gearing all of its resources -- programs, policies and grants -- toward that outcome. Through the use of performance data, SAMHSA can monitor these programs, policies and grants and ensure a life in the community for everyone.

To the best of my knowledge, the performance data reported by SAMHSA for inclusion in the FY 2010 Online Performance Appendix is accurate, complete, and reliable.

//s//
Eric B. Broderick, D.D.S., M.P.H.
Acting Administrator
Assistant Surgeon General

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Summary of Performance Targets and Results

Table 1: Summary of Targets and Results for SAMHSA[1]

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2005	78	77	99%	50	65%
2006	88	85	97%	50	59%
2007	126	123	98%	81	66%
2008	153	99	65%	69	70%
2009	158	0	N/A	0	N/A
2010	150	0	N/A	0	N/A

[1] Run on Program Performance Tracking System 4/27/09.

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Center for Mental Health Services (CMHS)

Mental Health Programs of Regional and National Significance (PRNS)

Suicide Prevention

Table 2: Measure 2.3.57: Reduce the number of suicide deaths (Outcome)

FY	Target	Result
Out-Year Target	30,584 (2012)	Apr 30, 2015
2010	30,684	Apr 30, 2013
2009	30,784	Apr 30, 2012
2008	30,984	Apr 30, 2011
2007	31,084	Apr 30, 2010
2006	N/A	33,300 (Historical Actual)
2005	N/A	32,637 (Historical Actual)

Table 3: Measure 2.3.58: Increase the number of students exposed to mental health and suicide awareness campaigns on college campuses (Outcome)

FY	Target	Result
2010	681,425	Dec 31, 2010
2009	662,774	Dec 31, 2009
2008	662,774	681,425 (Target Exceeded)
2007	Set Baseline	662,774 (Baseline)

Table 4: Measure 2.3.59: Increase the total number individuals trained in youth suicide prevention: cumulative (Outcome)

FY	Target	Result
2010	212,226	Dec 31, 2010
2009	127,065	Dec 31, 2009
2008	97,742	176,855 (Target Exceeded)
2007	Set Baseline	75,186 (Baseline)

Table 5: Measure 2.3.60: Increase the total number of youth screened: cumulative (Output)

FY	Target	Result
2010	20,160	Apr 30, 2011
2009	16,800	Apr 30, 2010
2008	Set Baseline	13,618 (Baseline)

Table 6: Measure 2.3.61: Increase the number of calls answered by the suicide hotline (Output)

FY	Target	Result
2010	555,132	Dec 31, 2010
2009	538,963	Dec 31, 2009
2008	Set Baseline	513,298 (Baseline)

Table 7: Data Source and Validation for Performance Measures from CMHS's Suicide Prevention Programs

Measure	Data Source	Data Validation
2.3.57	National Vital Statistics Report, Centers for Disease Control and Prevention	See Technical Notes in National Vital Statistics Reports at the following link: http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_16.pdf Data reporting for this survey has a three year lag time. Due to the lag in "number of suicide deaths" data reporting, measuring performance of the programs in real time or setting realistic targets for out years is difficult.
2.3.58	Suicide Prevention Exposure, Awareness and Knowledge Survey (SPEAKS). This survey is part of the Garrett Lee Smith program cross-site evaluation, and is conducted annually.	Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
2.3.59	Training Exit Survey (TES) and a Training Activity Report (TAR) as part of the GLS cross-site evaluation	Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
2.3.60	Data for the number of youth screen are reported in the Early Identification Referral and Follow-up (EIRF) Aggregate and Individual Forms from 14 Cohort 1 & 2 sites	Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
2.3.61	The number of calls answered is reported in the National Suicide Prevention LifeLine Monthly Report	Specialists in information technology at the National Suicide Prevention LifeLine evaluation center validate phone records received from Sprint to determine the number of calls received and answered at 1-800-273-TALK.

SAMHSA's Suicide Prevention portfolio includes campus, State, and tribal activities related to the Garrett Lee Smith Memorial Act, as well as the Suicide

Prevention Hotline, Suicide Prevention Resource Center and an American Indian/Alaska Native Suicide Prevention Initiative.

Baseline data have been reported for both outcome and output measures. The number of suicide deaths (2.3.57) represents national data. FY 2008 data for measure 2.3.57 will not be available until FY 2011. Measure 2.3.57 (suicide deaths) was developed as an indicator for the HHS strategic plan based on the long-term goals of SAMHSA.

Measure 2.3.58 is a key performance output measure for the program. Suicide prevention efforts are measured by the number of students who are exposed to mental health and suicide awareness campaigns on grantee college campuses. The number of individuals trained (2.3.59) includes mental health professionals as well as teachers, police officers, social service providers, advocates, coaches, and other individuals who frequently interact with youth.

Two new output measures were added in FY 2008: Increase the Total Number of Youth Screened (2.3.60), and Increase the Number of Calls Answered by the Suicide Hotline (2.3.61). Baselines for both measures were captured in FY 2008. All targets, for which data were available, were met for this program in 2008. Ambitious targets for all measures were set for FY 2009 and FY 2010.

Youth Violence (Safe Schools/Healthy Students – SS/HS)

Table 8: Measure 3.2.04: Increase the number of children served (Outcome)

FY	Target	Result
2010	2,328,500	Dec 31, 2010
2009	2,328,500	Dec 31, 2009
2008	1,062,963	2,328,500 (Target Exceeded)
2007	1,062,963	1,845,110[2] (Target Exceeded)
2006	Set Baseline	1,062,963 (Baseline)

[2] The result for 2007 reported in the FY 2009 Congressional Justification was preliminary. Additional data has been reported by grantees and the final result is reported here.

Table 9: Measure 3.2.05: Improve student outcomes and systems outcomes: a) Decrease the percentage of middle school students who have been in a physical fight on school property (Outcome)[3]

FY	Target	Result
2010	35%	Dec 31, 2010
2009	34.4%	Dec 31, 2009
2008	36%	34.4% (Target Exceeded)
2007	30%	36.6% (Target Not Met)
2006	Set Baseline	30.8% (Baseline)

Table 10: Measure 3.2.06: Improve student outcomes and systems outcomes: a) Decrease the percentage of high school students who have been in a physical fight on school property (Outcome)

FY	Target	Result
2010	28%	Dec 31, 2010
2009	23.7%	Dec 31, 2009
2008	29%	23.7% (Target Exceeded)
2007	24%	29.8% (Target Not Met)
2006	Set Baseline	24.2% (Baseline)

Table 11: Measure 3.2.07: Improve student outcomes and systems outcomes: b) Decrease the percentage of middle school students who report current substance use (Outcome)

FY	Target	Result
2010	15%	Dec 31, 2010
2009	13.7%	Dec 31, 2009
2008	16%	13.7% (Target Exceeded)
2007	16%	16% (Target Met)
2006	Set Baseline	16.9% (Baseline)

[3] Successful result is below target

Table 12: Measure 3.2.08: Improve student outcomes and systems outcomes: b) Decrease the percentage of high school students who report current substance use (Outcome)[4]

FY	Target	Result
2010	34%	Dec 31, 2010
2009	33%	Dec 31, 2009
2008	35%	33% (Target Exceeded)
2007	35%	35% (Target Met)
2006	Set Baseline	35.3% (Baseline)

Table 13: Measure 3.2.09: Improve student outcomes and systems outcomes: c) Increase the percentage of student's attending school (Outcome)[5]

FY	Target	Result
2009	93%	Dec 31, 2009
2008	93%	93% (Target Met)
2007	93%	95.1% (Target Exceeded)
2006	Set Baseline	92.6% (Baseline)

Table 14: Measure 3.2.10: Increase the percentage of students who receive mental health services (Outcome)

FY	Target	Result
2010	66%	Dec 31, 2010
2009	66%	Dec 31, 2009
2008	46%	66% (Target Exceeded)
2007	46%	46% (Target Met)
2006	Set Baseline	45.5% (Baseline)

[4] Successful result is below target

[5] Measure 3.2.10 will be retired from public reporting in FY 2010. The FY 2009 data will be available in December 2009 and thus will be reported publicly in the FY 2011 Congressional Justification.

Table 15: Measure 3.2.21: Percentage of grantees that provided screening and/or assessments that is coordinated among two or more agencies or shared across agencies (Output)

FY	Target	Result
2010	69%	Dec 31, 2010
2009	68.1%	Dec 31, 2009
2008	67.1%	62.4% (Target Not Met)
2007	Set Baseline	66.1% (Baseline)

Table 16: Measure 3.2.22: Percentage of grantees that provide training of school personnel on mental health topics (Output)

FY	Target	Result
2010	67%	Dec 31, 2010
2009	66.4%	Dec 31, 2009
2008	65.4%	64% (Target Not Met)
2007	Set Baseline	64.4% (Baseline)

Table 17: Data Source and Validation for Performance Measures from CMHS's Safe Schools/Healthy Students Program

Measure	Data Source	Data Validation
3.2.04	Grantee reports	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things.
3.2.05 3.2.06 3.2.07 3.2.08 3.2.09 3.2.10 3.2.21 3.2.22	Data on children's outcomes were reported in the grantees' ED524 Bi-Annual Report submitted to their GPO every six months. The methods for collecting these measures varied by grantee, but were generally student self-report for the violence and substance use measures and school records for attendance and mental health services.	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things.

Number of children served (3.2.04): The performance target for this measure was set at an approximate target level. Subsequently, more grants were awarded than anticipated and the number of children served was significantly higher than the target. All targets for student outcomes were met in FY 2008.

GPRA measures are defined as follows: Violent incidents (3.2.06) are defined by the percentage of students that have experienced violence at least once in the past 12 months as measured by a student survey item. Substance use (3.2.07) is defined as the percentage of students that report having used alcohol in the past 30 days. For the "Increase mental health services to students and families (3.2.10)" measure, the definition of mental health services is determined by the grantee with guidance from their project officer. This measure represents the percentage of students that receive services following a mental health referral.

School attendance (3.2.09) is defined as the average attendance rate among the schools served by this program. This measure has been problematic in that districts calculate attendance differently, particularly with distinctions between "excused" and "unexcused" absences. Also, some sites track classes missed rather than days missed. The cohort funded in FY 2007 was not required to report on this measure so data presented are from the FY 2005 and FY 2006 cohorts. The program plans to retire this measure in FY 2010.

Trends across years are difficult to interpret as data include grantees from different award years and are thus in different stages of implementation. However, recent improvements in the various measures are likely the result of the program managing to targeted outcomes. As such, extensive technical assistance is provided to help grantees achieve positive outcomes.

Trauma-Informed Services (National Child Traumatic Stress Initiative – NCTSI)

Table 18: Measure 3.2.01: Increase the estimated number of children and adolescents receiving trauma-informed services (Outcome)

FY	Target	Result
2010	29,000	Dec 31, 2010
2009	16,955	Dec 31, 2009
2008	33,910	28,878 (Target Not Met)
2007	33,910	31,446 (Target Not Met)
2006	39,600	33,910 (Target Not Met)
2005	53,860	50,660 (Target Not Met)

Table 19: Measure 3.2.02: Improve children's outcomes (percent showing clinically significant improvement) (Outcome)

FY	Target	Result
2010	69%	Dec 31, 2010
2009	69%	Dec 31, 2009
2008	37%	69% (Target Exceeded)
2007	37%	56% (Target Exceeded)
2006	37%	35% (Target Not Met)
2005	Set Baseline	37% (Baseline)

Table 20: Measure 3.2.03: Dollars spent per person served (Efficiency)[6]

FY	Target	Result
2010	$718	Dec 31, 2010
2009	$718	Dec 31, 2009
2008	$774	$948 (Target Not Met)
2007	$480	$774 (Target Not Met)
2006	$493	$741 (Target Not Met)
2005	Set Baseline	$497 (Baseline)

Table 21: Measure 3.2.23: Increase the unduplicated count of the number of children and adolescents receiving trauma-informed services (Outcome)

FY	Target	Result
2010	3,217	Dec 31, 2010
2009	2,925	Dec 31, 2009
2008	Set Baseline	975 (Baseline)

Table 22: Measure 3.2.24: Increase the number of child-serving professionals trained in providing trauma-informed services. (Outcome)

FY	Target	Result
2010	100,800	Dec 31, 2010
2009	96,000	Dec 31, 2009
2008	Set Baseline	91,517 (Baseline)

[6] Successful result is below target

Table 23: Data Source and Validation for Performance Measures from CMHS's Trauma-Informed Services Program

Measure	Data Source	Data Validation
3.2.01	Data for number of children served are reported quarterly by grantees utilizing a program-wide electronic Service Utilization Form (eSUF).	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. "Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected. Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.
3.2.02	Baseline and follow-up data are collected through the Core Data Set (CDS), a secure web-based system, and three standardized behavioral/symptomology measures (CBCL, TSCC, and PTSD-RI) are used to assess improvement in children's outcomes. Data for training are based on General Adoption Assessment Survey (GAAS) results from the Adoption of Methods/Practices component of the NCTSI National Cross-Site Evaluation.	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. "Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected. Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.

Table 24: Data Source and Validation for Performance Measures from CMHS's Trauma-Informed Services Program (continued)

Measure	Data Source	Data Validation
3.2.03	The Efficiency Measure is calculated by dividing the budget devoted to clinical services by the number of children and adolescents receiving trauma-informed services. Data for number of children served are reported quarterly by grantees utilizing a program-wide electronic Service Utilization Form (eSUF).	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. "Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected. Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.
3.2.23	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.2.24	Data for number of professional trained is reported quarterly by grantees utilizing a program-wide electronic Service Utilization Form (eSUF).	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. "Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected. Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.

The National Traumatic Stress Network (NCTSN) is a nationwide collaborative network of organizations involved in the evaluation, treatment, and support of children and their families impacted by traumatic stress. The Network includes three components: (1) the National Center for Child Traumatic Stress (NCCTS, Category 1), (2) Intervention Development and Evaluation Centers (Category 2), and (3) Community Treatment and Services Centers (Category 3). The NCTSN is currently comprised of 48 funded Centers.

In FY 2008, the reported estimated number of children receiving services (measure 3.2.01) was 15 percent lower than the projected target for that year. This number is down approximately 8 percent from FY 2007 primarily due to the relatively large number of established NCTSN centers that provided direct services that are no longer funded from the FY 2003 Cohort (14 Category-3 centers).

Although there were several new centers added during FY 2007 (15 sites total, 10 Category-3 sites and 5 Category-2 sites), this decrease in number of children served also reflects: 1) start-up time needed to establish direct services at these new sites, 2) a change in focus of previously funded sites from providing direct clinical services to training, and 3) the actual number of new centers providing direct clinical services. It should also be noted that this number does not include the more than four thousand children and families served by formerly funded centers that mobilized to respond to natural disasters including Hurricanes Gustav and Ike. Currently, this measure is an estimate of clients served based on quarterly reports from grantees. As this does not allow for a true unduplicated count, SAMHSA will be retiring this measure in FY 2011. The NCTSI began using a web-based GPRA data collection system called Transformation Accountability (TRAC) System in FY 2008 which ensures the capture of an unduplicated count of children served. In FY 2008, the baseline for this new measure (3.2.23) was 975. This result is significantly lower than the estimated number served in measure 3.2.01 due to the fact that not all grantees are fully utilizing the TRAC system. This is the result of factors such as delays in human subjects review at some sites and various staffing/budget constraints. The target for 2009 anticipates significant improvement in compliance with the use of the TRAC system. SAMHSA expects compliance to continue to improve considerably over time as we are providing additional technical assistance and working aggressively with grantees to improve compliance with TRAC.

The target for improving children's outcomes was exceeded considerably again in FY 2008. Clinically significant improvement is demonstrated as an improvement of a standard deviation or more (10-15+) on at least one of the three standardized assessment measures given to children. The program examined this result, and it appears to be a result of the maturation of the grant program.

The NCTSN efficiency measure (3.2.03, dollars spent per person served) is calculated by dividing the total dollar amount awarded to grantees by the number who received direct services from those grantees. As discussed above, the number of children served decreased in FY 2008 due to fluctuations in the grant cycle, and that direct service provision may not be a grantee's primary strategy for increasing access of children and their families to trauma-informed interventions. Since this measure is calculated using the current estimated client count, SAMHSA intends to retire it in FY 2011 and replace it with a new cost per client measure which would include an unduplicated count of number served (3.2.23) in the denominator.

Co-Occurring State Incentive Grants (COSIG)

Table 25: Measure 1.2.17: Increase the number of persons with co-occurring disorders served (Output)

FY	Target	Result
2010	103,679	Oct 31, 2010
2009	103,679	Oct 31, 2009
2008	Set Baseline	103,679 (Baseline)

Table 26: Measure 1.2.18: Increase the percentage of treatment programs that a) Screen for co-occurring disorders (Outcome)

FY	Target	Result
2010	68%	Oct 31, 2010
2009	68%	Oct 31, 2009
2008	Set Baseline	68% (Baseline)

Table 27: Measure 1.2.19: b) Assess for co-occurring disorders (Outcome)

FY	Target	Result
2010	32%	Oct 31, 2010
2009	32%	Oct 31, 2009
2008	Set Baseline	32% (Baseline)

Table 28: Measure 1.2.20: c) Treat co-occurring disorders through collaborative, consultative, and integrated models of care (Outcome)

FY	Target	Result
2010	53%	Oct 31, 2010
2009	53%	Oct 31, 2009
2008	Set Baseline	53% (Baseline)

Table 29: Data Source and Validation for Performance Measures from CMHS's Co-Occurring State Incentive Grant Program

Measure	Data Source	Data Validation
1.2.17 1.2.18 1.2.19 1.2.20	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

This program is jointly administered by CMHS and CSAT.

People with co-occurring substance abuse and mental disorders are individuals who have at least one psychiatric disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms) at least one disorder of each type can be diagnosed independently of the other. The first three years of these grants focus on infrastructure development and enhancements. Grantees have the flexibility to identify specific infrastructure development and enhancement activities that support the goals selected and respond to the needs and priorities they have identified. Certain areas of infrastructure development (e.g., standardized screening and assessment, complementary licensure and credentialing requirements, service coordination and network building, financial planning, and information sharing) reflect critical pathways for establishing complementary service delivery capacity in substance abuse and mental health service systems. After this period, grantees implemented service pilot programs, which generated data for the above outcome measures. In July 2007, COSIG States were required to begin collecting the necessary data, with the first reports due in October 2008. FY 2008 is the first year the data is available and baselines have been established. Grants will end at the close of FY 2010. Data is being collected from grantees through CSAT's Services Accountability Improvement System (SAIS).

Remaining Capacity Programs[7]

Table 30: Measure 1.2.03: Rate of consumers reporting positively about perception of care (program participants) (Outcome)[8]

FY	Target	Result
2010	98%	Dec 31, 2010
2009	98%	Dec 31, 2009
2008	98%	94.8% (Target Not Met)
2007	Set Baseline	98%[9] (Baseline)

Table 31: Measure 1.2.05: Increase the percentage of clients receiving services who report improved functioning (Outcome)

FY	Target	Result
2010	54%	Dec 31, 2010
2009	54%	Dec 31, 2009
2008	93%	50.5% (Target Not Met)
2007	Set Baseline	93%[10] (Baseline)

Table 32: Measure 1.2.07: Percentage of people in the United States with serious mental illnesses in need of services from the public mental health system, who receive services from the public mental health system (Outcome)

FY	Target	Result
Out-Year Target	50% (2015)	Dec 31, 2015
2005	Set Baseline	44% (Baseline)

[7] Includes Jail Diversion, Older Adults, HIV/AIDS, and Services in Supportive Housing programs.
[8] Measure has been changed from Rate of consumers/family members reporting positively about outcomes (program participants). CMHS dropped measure 1.2.04 and change measure 1.2.03 to "Rate of consumers reporting positively about perception of care."
[9] Due to the implementation of the TRAC reporting system midyear FY 2007, data reported for FY 2007 will only contain a partial year.
[10] In December 2007, the TRAC reporting capability was incomplete. Once the system was completed, SAMHSA noted that the earlier manual calculation was done incorrectly. The correct formula is now programmed into the reporting system, which should minimize future reporting errors.

Table 33: Measure 1.2.06: Number of a) evidence based practices (EBPs) implemented (Output)

FY	Target	Result
2010	4.1 per State	Dec 31, 2011
2009	4 per State	Dec 31, 2010
2008	4 per State	Dec 31, 2009
2007	3.8 per State	4 per State (Target Exceeded)
2006	3.3 per State	3.9 per State (Target Exceeded)
2005	2.8 per State	3.9 per State[11] (Target Exceeded)

Table 34: 1.2.08: b) Adults: percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice) (Output)

FY	Target	Result
2010	10.5%	Dec 31, 2011
2009	10.8%	Dec 31, 2010
2008	10.8%	Dec 31, 2009
2007	10.8%	9.4% (Target Not Met)
2006	10.3%	9.5% (Target Not Met)
2005	9.8%	9.7% (Target Not Met but Improved)

Table 35: Measure 1.2.09: c) Children: percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice) (Output)

FY	Target	Result
2010	3.5%	Dec 31, 2011
2009	3.5%	Dec 31, 2010
2008	3.5%	Dec 31, 2009
2007	2.6%	3.2% (Target Exceeded)
2006	2.3%	2.2% (Target Not Met)
2005	2%	3.4% (Target Exceeded)

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

Table 36: Data Source and Validation for Performance Measures from CMHS's Remaining Capacity Programs

Measure	Data Source	Data Validation
1.2.03 1.2.05	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.07	For the long term measure, the numerator is the number of people receiving services through the state public mental health system, as reported by the Uniform Reporting System (http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics) The denominator is derived from the National Co-morbidity Study Replication http://archpsyc.ama-assn.org/cgi/content/full/62/6/593 , census data, and the 1997 CMHS Client-Patient Sample Survey, as reported in Mental Health 2000 and Mental Health 2002 (see http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/)	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp. Data validation for the Co-Morbidity Study is available at http://archpsyc.ama-assn.org/cgi/content/full/62/6/593
1.2.06 1.2.08 1.2.09	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp

Measures 1.2.01 and 1.2.02 represent the results for the *nationwide public mental health system*, as reflected in data from the Uniform Reporting System, and includes people receiving services in State psychiatric hospitals as well as those receiving services through community mental health programs. The performance target for consumers and family members reporting positively about outcomes pertaining to the consumer's perception of the services he/she received during the last 30 calendar days were set at an approximate target level and the deviation from that level is slight. There was no effect on overall program or activity performance. These measures will be retired in FY 2010 as they were

included in the 2005 performance assessment as temporary measures until the PRNS was able to produce data from TRAC.

Measures 1.2.03, although worded identically to the long-term measure, reflects results for *participants in CMHS PRNS service programs*. Baseline data for consumers has been reported. The target for FY 2008 was missed slightly.

Measure 1.2.05 is to increase the percentage of clients receiving services who report improved functioning. This outcome is comprised of responses to the questions about how effectively the consumer is able to deal with daily problems, the ability to control his or her life, the ability to deal with crisis, how well he or she is getting along with family members, how well he or she does in social situations and at work or school; and if symptoms are bothersome. In December 2007, the TRAC reporting capability was incomplete. Once the system was completed, SAMHSA noted that the earlier manual calculation was done incorrectly which accounts for the missing the target by 42.5 percent. The correct formula is now programmed into the reporting system, which should minimize future reporting errors. Subsequent targets will be set accordingly.

Measure 1.2.08 is the percentage of adult service population receiving any evidence-based practice. The evidence-based practices measures reflect the program's efforts to improve the efficiency and effectiveness of mental health services. For FY 2007, the target for the number of evidence-based practices was exceeded. The evidence based practice percentage of coverage for adults was missed by just one percent while the target was exceeded by half of one percent for children. These targets were set at an approximate target level, and the deviation from that level is slight.

Mental Health Programs of Regional and National Significance – Science and Service Activities[12]

Table 37: Measure 1.4.06: Number of people trained by CMHS Science and Service Programs (Output)

FY	Target	Result
2010	4,237	Dec 31, 2010
2009	4,237	Dec 31, 2009
2008	N/A	4,036 (Historical Actual)
2007	N/A	4,852 (Historical Actual)
2006	N/A	4,647 (Historical Actual)

Table 38: Measure 1.4.07: Percentage of those trained by the program who report they were very satisfied with training (Output)

FY	Target	Result
2010	80%	Dec 31, 2010
2009	80%	Dec 31, 2009
2008	N/A	76% (Historical Actual)
2007	N/A	79% (Historical Actual)
2006	N/A	70% (Historical Actual)

[12] Programs included in reporting are the HIV/AIDS education, the Historically Black Colleges and Universities National Resource Center for Substance Abuse and Mental health, and the Statewide Family Network Training and Technical Assistance Center.

Table 39: Data Source and Validation for Performance Measures from CMHS's Science and Service

Measure	Data Source	Data Validation
1.4.06 1.4.07	Participants direct report on standardized questionnaires administered at the completion of each training course.	HBCU data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database. HIV/AIDS Education and Statewide Family Network Training and Technical Assistance Center data validation procedures involve initial review and consultation with the site representative to resolve obvious discrepancies; double data entry and comparison; and several rounds of logical and edit checks. Note: These measures should be available through the TRAC system starting next year.

SAMHSA's Science and Service programs are complements to the Capacity programs. The mental health programs within Science and Service include HIV/AIDS Education, Statewide Family and Consumer Network Technical Assistance Center, and Historically Black Colleges and Universities (HBCU) Center of Excellence. These programs disseminate best-practices information to grantees and the field, helping to ensure that SAMHSA's Capacity programs build and improve services capacity in the most efficient, effective and sustainable way possible. The Science and Service programs are also an essential and cost-effective support to building effective capacity in communities that do not receive grant funds from SAMHSA. SAMHSA hopes to include additional data from more of its science and service activities in the future.

The Mental Health Care Provider Education in HIV/AIDS Program (MHCPE) disseminates knowledge and training on the treatment of the neuropsychiatric and psychological sequelae of HIV/AIDS. Untreated and unidentified neuropsychiatric and mental health complications related to HIV/AIDS lead to more serious problems, delayed care, non-adherence to care, impaired quality of life and increased morbidity and mortality. In FY 2008, 2,236 front line providers were trained (face-to-face) with MHCPE, including psychiatrists, psychologists, social workers, care managers, nurses, primary care practitioners, and medical students, as well as clergy, and other workers in the mental health arena.

The Statewide Family and Consumer Network Technical Assistance Center provides individualized, developmentally sensitive, strength-based training and technical assistance in the context of peer-to-peer learning environments to promote the development of autonomous Statewide Family and Consumer

Networks. The National Center focuses on the 42 SAMHSA funded Statewide Family/Consumer Networks (SFN) within five categories of training and technical assistance activities, which include production and dissemination of education and resource materials, technical assistance, training development teams, educational and resource materials and training include topics related to the needs of the SFN as determined through a three Phase Organizational Assessment process. All training and technical assistance activities are driven by a set of operating principles designed to increase organizational capacity of Networks, so that they can sponsor and sustain a continuum of activities that transform their state mental health service systems, which in turn will improve outcomes for children with mental health conditions and their families.

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

Comprehensive Community Mental Health Services for Children and Their Families (Children's Mental Health Initiative – CMHI)

Table 40: Measure 3.2.11: Increase the percent of funded sites that will exceed a 30 percent improvement in behavioral and emotional symptoms among children receiving services for 6 months (Outcome)[13]

FY	Target	Result
2010	60%	Dec 31, 2010

Table 41: Measure 3.2.12: Improve children's outcomes and systems outcomes: a) Increase percentage of children attending school 80% or more of time after 12 months (Outcome)[14]

FY	Target	Result
2010	86.3%	Dec 31, 2010
2009	86.3%	Dec 31, 2009
2008	84%	86.3% (Target Exceeded)
2007	84%	87% (Target Exceeded)
2006	84%	89.7% (Target Exceeded)
2005	83%	80.2% (Target Not Met)

Table 42: Measure 3.2.13: Improve children's outcomes and systems outcomes: b) Increase percentage with no law enforcement contacts at 6 months (Outcome)

FY	Target	Result
2010	71.7%	Dec 31, 2010
2009	71.7%	Dec 31, 2009
2008	69%	71.7% (Target Exceeded)
2007	70%	71% (Target Exceeded)
2006	68%	69.3% (Target Exceeded)
2005	53%	68.3% (Target Exceeded)

[13] Long-term measure only. No annual targets have been set.
[14] This measure has been slightly revised. It was previously reported as "75% or more of the time." However, the measure has been calculated using an 80% threshold since 2004. Therefore, this revision brings the measure text in line with the calculation.

Table 43: Measure 3.2.14: Decrease average days of inpatient facilities among children served in systems of care at 6 months (Outcome)[15]

FY	Target	Result
2010	-2	Dec 31, 2010
2009	-2	Dec 31, 2009
2008	-2	-1.05 (Target Not Met)
2007	-2	-1.78 (Target Not Met but Improved)
2006	-3.65	-1 (Target Not Met)
2005	-3.65	-1.75 (Target Not Met)

Table 44: Measure 3.2.15: Percent of systems of care that are sustained 5 years post Federal Funding (Outcome)

FY	Target	Result
Out-Year Target	90% (2013)	Dec 31, 2013
2009	85%	Dec 31, 2009
2008	80%	77.8% (Target Not Met)

Table 45: Measure 3.2.16: Increase number of children receiving services (Output)

FY	Target	Result
2010	13,051	Dec 31, 2010
2009	13,051	Dec 31, 2009
2008	10,000	13,051 (Target Exceeded)
2007	9,120	10,871 (Target Exceeded)
2006	9,120	10,339 (Target Exceeded)
2005	9,120	9,200 (Target Exceeded)

[15] Successful result is *below* target. For example, FY 2007 the target was -2. To have achieved the target, the program would need a smaller number (i.e. -2.5 or -3).

Table 46: Measure 3.2.17: Increase total savings for in-hospital patient care costs per 1,000 children served (Efficiency)[16]

FY	Target	Result
2010	$2,376,000	Dec 31, 2010
2009	$2,376,000	Dec 31, 2009
2008	$2,670,000	$1,401,750 (Target Not Met)
2007	$2,670,000	$2,376,000 (Target Not Met but Improved)
2006	Set Baseline	$1,335,000 (Baseline)

Table 47: Data Source and Validation for Performance Measures from CMHS's Comprehensive Community Mental Health Services for Children and Their families

Measure	Data Source	Data Validation
3.2.11	Data on children's outcomes are collected from a multi-site outcome study. Data on clinical outcomes were derived from Reliable Change Index scores (Jacobson & Truax, 1991), calculated from entry into services to six months for the Total Problem scores of the Child Behavior Checklist (CBCL, Achenbach, 2001)	The Reliable Change Index is a standardized method developed by Jacobson and his colleagues to measure change between two data points. The Reliable Change Index has a clear-cut criterion for improvement that has been psychometrically tested and found to be sound (Jacobson & Truax, 1991).
3.2.12	Data on children's attendance are collected from a multi-site outcome study.	Validity analyses were conducted for school attendance and law enforcement contacts. School attendance was found to have a positive relationship with school performance. Children who attended school frequently also had some tendency to receive good grades. The correlation between the two was .313 (p = .000).
3.2.13	Delinquency is reported using a self-report survey	Validity analyses were conducted for school attendance and law enforcement contacts.

[16] Wording for this measure has changed slightly to make the measure more clear.

Table 48: Data Source and Validation for Performance Measures from CMHS's Comprehensive Community Mental Health Services for Children and Their families (continued)

Measure	Data Source	Data Validation
3.2.14	The decrease in days of inpatient facilities utilization per child is calculated for a sample of children with complete data on inpatient hospitalization use at both intake and 6 months assessment points. Decrease in inpatient hospitalization days = total number of inpatient days at 6 months – total number of inpatient days at intake. The scale used to assess inpatient-residential treatment is the Living Situations Questionnaire, was adapted from the Restrictiveness of Living Environments Scale and Placement Stability Scale (ROLES) developed by Hawkins and colleagues (1992)	Data are validated by evaluation contractor and subject to project officer review.
3.2.15	Former grantee communities are surveyed 5 years after funding ends	Data are validated by evaluation contractor and subject to project officer review
3.2.16	Grantee reports	Data are validated by evaluation contractor and subject to project officer review
3.2.17	The efficiency measure is computed by calculating the average decrease in days of inpatient facilities utilization per child at six months and multiplying the decrease by the average daily hospitalization charges. The cost savings figure is then converted to a rate per 1,000 children served by the program across all sites. The average daily hospitalization charges = $1,335. National estimates of average daily hospitalization charges were obtained from Health Care Utilization Project Nationwide Inpatient Sample (NIS) 2001	Data are validated b y evaluation contractor and subject to project officer review

Measure 3.2.11 is a long-term measure only. No annual targets have been set. The behavioral and emotional functioning of children, youth and families is a key outcome of the CMHI program. This long-term indicator reports the percent of funded sites that exceed a 30 percent improvement in behavioral and emotional symptoms for children and youth who have received program services for six months. The baseline obtained for 2001 indicated that 30 percent of funded grantees satisfied the criteria of a 30 percent improvement established for this important long-term outcome indicator. The program seeks to double this percentage to 60 percent of funded grantee sites. Accordingly, the target set for

2010 represents an increase of 100 percent in performance over the baseline obtained when this indicator was initiated. This is a very ambitious increase in target for this CMHI indicator, particularly given that data collected at program entry indicate that some children and youth entering CMHI services are demonstrating more clinically significant behavioral and emotional symptomology in recent years compared to earlier program funding years. There have also been other shifts and changes in populations of focus for some communities funded in FY 2005 and FY 2008, including an emphasis on serving very young children.

The FY 2008 target for increase school attendance among clients of the CMHI program, measure 3.2.12, was set at an approximate level and the deviation from that level is slight. The target was exceeded by 2.3 percent. Targets have been maintained level for a number of reasons: grantees vary in the populations they serve, and those grantees that serve high-risk and/or older children may be less able to achieve these high levels of school attendance. Performance for this measure will vary somewhat depending on the mix of grantees and individuals served in any given year.

The FY 2008 target for no law enforcement contact after six months of enrollment in the program among clients in the CMHI program (3.2.13) was set at an approximate level, and the deviation from that level is slight. The FY 2008 target was exceeded by 2.7 percent. However, grantees vary in the populations they target, and those grantees that serve youth in the juvenile justice system may be less able to achieve reductions in law enforcement contacts. Performance for this measure will vary somewhat depending on the mix of grantees and individuals served in any given year. The FY 2010 targets are set at the performance level that was achieved in FY 2008.

The performance target for reduction in days of inpatient care (3.2.14) was set at an approximate target level. The FY 2008 target was not achieved. This can be partially explained by the use of inpatient hospitalization prior to enrollment which changes from year to year due to the population of children enrolling in services during each fiscal year. The number of children hospitalized before they are enrolled in the program differs from year to year and can result in smaller or larger decreases observed. If the average utilization prior to program intake is relatively low, then the decreases in average number of days per child that can be achieved by the program will be low as well. When *percentage* change in use is examined, the percentage decrease in FY 2008 (66 percent) is greater than the percentage decrease achieved in FY 2007 (62 percent), demonstrating a positive change in the grantees' ability to reduce the utilization of inpatient care.

Grantees funded in FY 2005 serve proportionately larger numbers of very young children who generally have shorter and less frequent hospitalizations. Given this change in populations served, and the sensitivity of the measure to the length of hospitalization *prior to service intake*, the targets for this measure remain stable through 2009.

The efficiency measure (3.2.17) reflects per-unit savings in costs. The wording of the measure was changed to better reflect the intent of this measure (total in-patient care cost savings). The FY 2008 target for reduction in costs of inpatient care was not met. Although one of the main goals of the program is to provide least restrictive services to children and youth served by the grantees, more restrictive services, like inpatient hospitalization, which are also among the most expensive to provide, are sometimes required. This measure is also reflective of the variability of each cohort of grantees' utilization of in-hospital care services. Although alternatives to in-hospital care are used by CMHI systems of care whenever possible, this level of care may be necessary for some children. The 2008 result is tied to the reduction to in-hospital days as reported in measure 3.2.14; both of the 2008 targets were not met, but did exceed the percentage decrease baseline set in FY 2007.

Measure 3.2.15 is a long-term measure to assess sustainability of Federally-funded communities after Federal funding ceases. Former grantee communities are surveyed five years after funding ends. The baseline set in 2004 was a result of an assessment of the performance of grantee sites funded in 1994. Since 1994, an additional 123 communities have been funded to provide mental health services for children, youth and their families through the CMHI program. These communities are located throughout the United States and the territories and there is substantial variation in the economic, socio-cultural and other needed resources to ensure that a Federally-funded CMHI grantee community can remain sustained after Federal funding ends. Given the proportion of sites that were able to remain sustained five years after Federal program funding ended for communities funded by CMHI in 1994, 80 percent was set as an ambitious target for performance on this long-term indicator for 2008.

The long-term sustainability indicator (3.2.15) was estimated using data from the nine communities funded in 1997. The data on whether communities were sustained were collected through a Web-based survey administered to four key stakeholders in each grant community (e.g., the current or former site project director, a key person responsible for children's mental health in the community, a family member, and a representative from another child-serving agency). A community was defined as sustained if the community retained flexible funds and sustained at least 50 percent of non-restrictive services, 50 percent of system-of-care features and mechanisms, and 50 percent of system of care goals. The definition accounts for changes in both the (a) system of care relative to the grant period and (b) the absolute level at which the system of care operates 5 years post-funding.

The target of 80 percent was nearly achieved, with 78 percent of communities funded in 1997 (7 out of 9) achieving sustainability five years past the cessation of federal grant funding. The two communities whose systems of care were not sustained were both Tribal communities which, historically, have had limited access to Federal funding alternatives which promote the sustainability of

programs. According to the Tribal Financing Study, conducted by the National Evaluation, financial sustainability of Tribal system of care communities can be challenging, because tribes often do not have much infrastructure in place for providing mental health services, especially getting those services reimbursed by Medicaid. Remote locations impact everything from fund availability to Internet connectivity (which has implications for timely billing). Financing of Tribal systems of care is further complicated by the impact of Tribal–State history on the willingness and ability to pursue financial partnerships.

The FY 2008 target for the number of children served (3.2.16) was exceeded by over 30 percent, reflecting a level of effort by grantee communities and a greater need for services. In FY 2008, 16 grantees completed their grant funding cycle and CMHS awarded 18 new grants. The targets for FY 2009 and FY 2010 are especially ambitious given that the first year of the grant is a planning year, and grantees do not enroll children in services.

One of the main goals of CMHI is to provide least restrictive services to children and youth served by the grantees (3.2.17). More restrictive services, like inpatient hospitalization, are also among the most expensive services to provide. Fewer children are receiving inpatient/residential treatment services as community-based care increases its reach throughout the nation, partly because fewer children are receiving inpatient/residential treatment services as community-based care increase its reach throughout the nation. This change in the service delivery approach is for mental health care for children is partly due to the success for the CMHI program and its system of care community-based model of care and services.

It should be noted that grantees funded in FY 2005 and FY 2008 are serving proportionately larger numbers of very young children who generally have shorter and less frequent hospitalizations. Accordingly, fewer children entering CMHI program services have required inpatient/residential treatment services which can affect the estimates generated for this indicator.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year.

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

Table 49: Measure 3.4.08: Increase percentage of complaints of alleged abuse not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as result of PAIMI involvement (Outcome)

FY	Target	Result
Out-Year Target	88% (2013)	Jul 31, 2014
2010	84%	Jul 31, 2011
2009	84%	Jul 31, 2010
2008	84%	Jul 31, 2009
2007	85%	83% (Target Not Met)
2006	84%	84% (Target Met)
2005	83%	78% (Target Not Met)

Table 50: Measure 3.4.09: Increase percentage of complaints of alleged neglect substantiated not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement (Outcome)

FY	Target	Result
Out-Year Target	94% (2013)	Jul 31, 2014
2010	88%	Jul 31, 2011
2009	85%	Jul 31, 2010
2008	85%	Jul 31, 2009
2007	84%	88% (Target Exceeded)
2006	89%	88% (Target Not Met but Improved)
2005	88%	83% (Target Not Met but Improved)

Table 51: Measure 3.4.10: Increase percentage of complaints of alleged 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

FY	Target	Result
Out-Year Target	95% (2013)	Jul 31, 2014
2010	90%	Jul 31, 2011
2009	90%	Jul 31, 2010
2008	90%	Jul 31, 2009
2007	90%	86% (Target Not Met but Improved)
2006	95%	85% (Target Not Met)
2005	95%	87% (Target Not Met)

Table 52: Measure 3.4.11: Percent of interventions on behalf of groups of PAIMI-eligible individuals that were concluded successfully (Outcome)

FY	Target	Result
Out-Year Target	95% (2013)	Jul 31, 2014
2010	97%	Jul 31, 2011
2009	95%	Jul 31, 2010
2008	95%	Jul 31, 2009
2007	95%	97% (Target Exceeded)
2006	Set Baseline	95% (Baseline)

Table 53: Measure 3.4.12: Increase in the number of people served by the PAIMI program (Outcome)

FY	Target	Result
2010	22,325	Jul 31, 2011
2009	22,325	Jul 31, 2010
2008	22,325	Jul 31, 2009
2007	23,500	18,694 (Target Not Met)
2006	23,500	18,998 (Target Not Met)
2005	23,100	21,371 (Target Not Met)

Table 54: Measure 3.4.13: Ratio of persons served/impacted per activity/intervention (Outcome)

FY	Target	Result
2010	430	Jul 31, 2011
2009	420	Jul 31, 2010
2008	420	Jul 31, 2009
2007	420	473 (Target Exceeded)
2006	410	407 (Target Not Met)
2005	390	411 (Target Exceeded)

Table 55: Measure 3.4.14: Cost per 1,000 individuals served/impacted (Efficiency)[17]

FY	Target	Result
2010	$1,950	Jul 31, 2011
2009	$2,000	Jul 31, 2010
2008	$2,000	Jul 31, 2009
2007	$2,000	$1,989 (Target Exceeded)
2006	$2,100	$2,316 (Target Not Met)
2005	$2,200	$2,072 (Target Exceeded)

Table 56: Measure 3.4.19: The number attending public education/constituency training and public awareness activities (Output)

FY	Target	Result
2010	120,000	Oct 31, 2011
2009	120,000	Oct 31, 2010
2008	120,000	Oct 31, 2009
2007	Set Baseline	119,423 (Baseline)

[17] Successful result is *below* target

Table 57: Data Source and Validation for Performance Measures from CMHS's Protection and Advocacy for Individuals with Mental Illness Program

Measure	Data Source	Data Validation
3.4.08 3.4.09 3.4.10 3.4.11 3.4.12	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation).	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews.
3.4.13	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation). The ratio measure is calculated by using the total number of persons served and impacted as the numerator and the total number of complaints addressed and intervention strategies conducted as the denominator	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews
3.4.14 3.4.19	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation). The cost measure is calculated by using the total PAIMI allotment as the numerator and the total number of persons served/impacted as the denominator.	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews

Measure 3.4.08 is to increase percentage of complaints of alleged abuse, not withdrawn by the client that resulted in positive change for the client in the safety or welfare of their environment, as a result of PAIMI involvement (same as long-term measure). The FY 2007 target was missed by two percent. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

Measure 3.4.09 is the percentage of cases of alleged neglect resolved in client's favor. The FY 2007 target was exceeded.

Measure 3.4.10 is the percentage of cases of alleged rights violations resolved in client's favor. The FY 2007 target was not met. Using what appears to have been an atypical outcome for FY 2004, the targets set for this measure were

overly ambitious for FY 2005 and FY 2006 as demonstrated by the actuals for those years. Targets for FY 2008 – 2009 are ambitious at 90 percent compared to the 4-year average of 86 percent.

Measure 3.4.11, the percentage of interventions on behalf of groups of PAIMI-eligible individuals that were concluded successfully, was exceeded. Successful conclusion would include positive change in a policy, law, regulation, or other barrier for persons with disabilities, change in the environment to increase safety or welfare for persons with disabilities, positive change through the restoration of client rights, the expansion or maintenance of personal decision-making, or the elimination of other barriers to personal decision-making for persons with disabilities, securing access to administrative or judicial processes, securing information about their rights and strategies to enforce their rights, or persons with disabilities taking action to advocate on their own behalf.

Measure 3.4.12 is to increase in the number of people served by the PAIMI program. The FY 2007 target was not met. This measure is the most volatile because of the number of factors that can influence the outcome. Part of this volatility is inherent in the nature of the PAIMI Program which includes both an individual case and systemic focus. This balance shifts over time from a more individual case emphasis to a more systemic emphasis not only within individual programs but nationally across all programs as well. Also, the case-mix can impact this outcome, as individuals with more complex and extensive needs will require more time and resources which will reduce the total number of persons that can be served. Finally, although the program provides education and outreach, the number of persons served is ultimately determined by the number of persons who seek services which may vary over time. Because of all of these factors, the targets for FY 2008-2009 have been maintained at 22,325, which is still well above the 4-year average of 21,059.

Both efficiency measures exceeded their targets for FY 2007 (3.4.13 ratio of persons served/impacted per activity/intervention and 3.4.14, Cost per 1,000 individuals served/impacted). These measures demonstrate how the program is able to maximize the number of persons who benefit from the services provided, with emphasis on those services that impact the largest number of individuals and at the least cost.

Steps are being taken to improve the program performance for the PAIMI Program. A PAIMI Program Peer Review process is in place for the Annual Program Performance Report which assesses and provides specific feedback regarding strengths and weaknesses of the program as well as specific recommendations for ongoing quality improvement. Also, the PAIMI Programs within each State Protection & Advocacy (P&A) agency are monitored via on-site reviews on a regular schedule. These on-site monitoring reviews are conducted by independent consultants and provide SAMHSA with an assessment of key areas: governance, legal, fiscal and consumer/constituent services/activities of

the State's PAIMI Program. Following these site visits, the consultants issue a report that summarizes its program findings and when appropriate, may include recommendations for technical assistance and/or corrective action. These steps are expected to improve performance so that annual and long-term targets can be met.

A baseline was set for measure 3.4.19, the number attending public education/ constituency training and public awareness activities, in FY 2007. An FY 2009 target has been established at 120,000.

Projects for Assistance in Transition from Homelessness (PATH)

Table 58: Measure 3.4.15: Increase the percentage of enrolled homeless persons who receive community mental health services (Outcome)

FY	Target	Result
Out-Year Target	50% (2013)	Jul 31, 2014
2010	47%	Jul 31, 2011
2009	46%	Jul 31, 2010
2008	45%	Jul 31, 2009
2007	45%	37% (Target Not Met)
2006	N/A	38% (Historical Actual)
2005	N/A	41% (Historical Actual)

Table 59: Measure 3.4.16: Increase number of homeless persons contacted (Outcome)

FY	Target	Result
2010	160,000	Jul 31, 2011
2009	151,000	Jul 31, 2010
2008	150,000	Jul 31, 2009
2007	157,500	142,352 (Target Not Met)
2006	157,000	148,655 (Target Not Met)
2005	154,500	148,679 (Target Not Met)

Table 60: Measure 3.4.17: Increase percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome)

FY	Target	Result
2010	55%	Jul 31, 2011
2009	55%	Jul 31, 2010
2008	55%	Jul 31, 2009
2007	45%	55%[18] (Target Exceeded)
2006	45%	52% (Target Exceeded)
2005	47%	48%[18] (Target Exceeded)

Table 61: Measure 3.4.18: Average Federal cost of enrolling a homeless person with serious mental illness in services (Efficiency)[19]

FY	Target	Result
2010	$668	Jul 31, 2011
2009	$668	Jul 31, 2010
2008	$668	Jul 31, 2009
2007	$668	$674 (Target Not Met)
2006	$668	$623 (Target Exceeded)
2005	$668	$668[20] (Target Met)

[18] Revised from previously reported result. In order to more accurately reflect the true outcome of the measure Percentage of contacted persons with SMI who are enrolled in services, the calculation has been revised. Prior calculations used the entire number contacted as the denominator. The revised calculation will use only those who are eligible for services as the denominator. Eligibility criteria are defined as consumers who are experiencing homelessness or are at imminent risk of homelessness and have Serious Mental Illness (SMI) including co-occurring substance use disorders

[19] Successful result is *below* target.

[20] Actuals for FY 2005 are different from those reported in previous Congressional Justifications. The previous figure, $950 for FY 2005, were calculated incorrectly

Table 62: Measure 3.4.20: Provide training for PATH providers on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits (Output)

FY	Target	Result
2010	4,927	Dec 31, 2010
2009	4,927	Dec 31, 2009
2008	Set Baseline	4,927 (Baseline)

Table 63: Data Source and Validation for Performance Measures from CMHS's Projects for Assistance in Transition from Homelessness

Measure	Data Source	Data Validation
3.4.15 3.4.16 3.4.17 3.4.18 3.4.20	Data are submitted annually to CMHS by States, which obtain the information from local human service agencies that provide services	CMHS has developed additional error checks to screen data and contacts States and local providers concerning accuracy when data is reported outside expected ranges. CMHS has also issued guidance to all States and localities on data collection and monitors compliance with data collection through increased site visits to local PATH-funded agencies.

Measure 3.4.15 reflects the PATH program's legislative intent that it will provide a link to, and depend upon, community-based services, particularly mental health services, funded primarily by States. An analysis of data for this measure indicated that some States were performing poorly on this measure. As a result, the FY 2007 target was not met. In response, the PATH TA Center determined that many States do not accurately collect information about the number of persons who receive community mental health services. The PATH TA Center has begun providing on-site and online assistance to help programs better understand how to report on this measure. A new long-term target for FY 2013 has been set at 50 percent.

In addition, SAMHSA awarded a contract in FY 2008 to begin working with States to utilize the Department of Housing and Urban Development Homeless Management Information System (HMIS) to assist in obtaining individual level outcome data from PATH-funded efforts. In FY 2009 CMHS will redesign the PATH Annual Report. This process will enable the program to transition the report to a more outcome-based reporting system that is responsive to the needs of SAMHSA as well as the PATH providers, reflect real consumer outcomes, and will complete the program's alignment with HMIS data elements.

The number of individuals served is a key measure for SAMHSA programs that fund services. The target for Measure 3.4.16 was not met for FY 2007, which triggered a re-examination of how this measure is calculated. The PATH program

is planning to request permission to collect data on all persons served using both Federal and match funds. As part of its data collection package renewal of the PATH data collection tool in 2009, the program will redesign it to collect data on all services provided with PATH Federal and matching funds. Currently the report requires providers to report on only the proportion of services provided with PATH Federal funds. Our analysis of the data indicates that there are inconsistencies in how this is applied and that we are missing critical information on services delivered. We believe that the provision of a full instead of a partial report will improve the quality of the data and improve the measures for the program. Using the Federal-only calculation is an incomplete indicator for performance as the States serve more PATH-eligible consumers than is currently being reported.

Measure 3.4.17 is an indicator of enrollment of PATH-eligible clients in supportive services other than mental health services. The calculation for this measure was revised to more accurately reflect the true outcome. Prior calculations used the entire number contacted in the calculation. The revised calculation uses only those eligible for services, which explains why the 2007 target was exceeded by 10 percent. Future targets have been adjusted upward. Eligibility criteria are defined as consumers who are experiencing homelessness or are at imminent risk of homelessness and have serious mental illness including co-occurring substance use disorders.

The target for the PATH efficiency measure (3.4.18) was not met for FY 2007. This measure will also be affected by the proposed change to collect information on all persons served and not just persons served by Federal PATH funds.[21] The current calculation uses the Federal appropriation divided by the number of persons served by Federal PATH funds only. Because the current data only includes the number of persons served with Federal funds, this measure is currently reported as the total cost, including the Federal grant and matching funds, of enrolling a person in services. If programs begin to report information on all persons served including those served with funding from other sources, PATH will be able to accurately capture the Federal cost per person served in addition to the total cost per person served.

Measure 3.4.20 is a measure of a key output of the program: The number of PATH providers trained on Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR). This output is important in that once PATH providers acquire this training; they are

[21] PATH funds represent over 23 percent of the total dollar amount earmarked by provider agencies for serving homeless people with mental illnesses. These funds are worth more than their face value because they must be matched by State and local resources. For every $3 in Federal funds, State or local agencies must put forward $1 in cash or in-kind services.

better able to assist PATH clients in applying and getting income benefits for which they are eligible.[22]

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year.

Community Mental Health Services Block Grant (MHBG)

Table 64: Measure 2.3.07: Reduce rate of adult readmissions to State psychiatric hospitals within 30 days; and within 180 days: 1) Adults: a) 30 days (Outcome)[23]

FY	Target	Result
2010	9.3%	Sep 30, 2011
2009	8.5%	Sep 30, 2010
2008	8.5%	Sep 30, 2009
2007	8.7%	9.8% (Target Not Met)
2006	8.3%	9.4% (Target Not Met)
2005	7.6%	9% (Target Not Met)

Table 65: Measure 2.3.08: 1) Adults: b) 180 days (Outcome)

FY	Target	Result
2010	20%	Sep 30, 2011
2009	19%	Sep 30, 2010
2008	19%	Sep 30, 2009
2007	19.1%	20.3% (Target Not Met)
2006	19.2%	19.6% (Target Not Met)
2005	17%	19.6% (Target Not Met but Improved)

[22] 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.

[23] Successful result is performance *below* target.

Table 66: Measure 2.3.09: 2) Children/adolescents: a) 30 days (Outcome)[24]

FY	Target	Result
2010	6.5%	Sep 30, 2011
2009	5.8%	Sep 30, 2010
2008	5.8%	Sep 30, 2009
2007	5.9%	6.7% (Target Not Met)
2006	6%	6.4% (Target Not Met but Improved)
2005	6.4%	6.6% (Target Not Met)

Table 67: Measure 2.3.10: 2) Children/adolescents: b) 180 days (Outcome)

FY	Target	Result
2010	14.5%	Sep 30, 2011
2009	13.9%	Sep 30, 2010
2008	13.9%	Sep 30, 2009
2007	14%	15.3% (Target Not Met)
2006	13.6%	14.2% (Target Not Met but Improved)
2005	12.9%	14.5% (Target Not Met but Improved)

Table 68: Measure 2.3.11: Number of a) evidence based practices (EBPs) implemented (Output)[25]

FY	Target	Result
2010	4.1 per State	Sep 30, 2011
2009	4.0 per State	Sep 30, 2010
2008	4.0 per State	Sep 30, 2009
2007	4.0 per State	4.0 per State (Target Met)
2006	3.3 per State	3.9 per State (Target Exceeded)
2005	2.8 per State	3.9 per State (Target Exceeded)

[24] Successful result is performance *below* target.
[25] National average of evidence-based practices per state, based on 35 states reporting. Excludes Medication Management and Illness Self-Management, which continue to undergo definitional clarification

Table 69: Measure 2.3.12: b) Adults-percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice) (Output)[26]

FY	Target	Result
2010	10.5%	Sep 30, 2011
2009	10.5%	Sep 30, 2010
2008	10.5%	Sep 30, 2009
2007	10.4%	9.4% (Target Not Met)
2006	10.3%	9.5% (Target Not Met)
2005	9.8%	9.7% (Target Not Met but Improved)

Table 70: Measure 2.3.13: c) Children-percentage of population coverage for each (reported as percentage of service population receiving any evidence-based practice) (Output)

FY	Target	Result
2010	3.5%	Sep 30, 2011
2009	3.5%	Sep 30, 2010
2008	3.5%	Sep 30, 2009
2007	3.4%	3.2% (Target Not Met but Improved)
2006	2.3%	2.2% (Target Not Met)
2005	2%	3.4% (Target Exceeded)

Table 71: 2.3.15: Increase rate of consumers/family members reporting positively about outcomes (a) Adults (Outcome)

FY	Target	Result
2010	72%	Sep 30, 2011
2009	72%	Sep 30, 2010
2008	72%	Sep 30, 2009
2007	73%	71% (Target Not Met)
2006	74%	71% (Target Not Met)
2005	73%	71% (Target Not Met)

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

Table 72: Measure 2.3.16: Increase rate of consumers/family members reporting positively about outcomes (b) Children/adolescents (Outcome)

FY	Target	Result
2010	73%	Sep 30, 2011
2009	73%	Sep 30, 2010
2008	73%	Sep 30, 2009
2007	68%	65% (Target Not Met)
2006	67%	73% (Target Exceeded)
2005	65%	73% (Target Exceeded)

Table 73: Measure 2.3.17: Number of persons receiving evidence-based practices per $10,000 of mental health block grant dollars spent (Efficiency)

FY	Target	Result
2010	7.0	Sep 30, 2011
2009	6.5	Sep 30, 2010
2008	4.0	Sep 30, 2009
2007	4.0	6.5 (Target Exceeded)
2006	4.0	5.7 (Target Exceeded)
2005	N/A	4.0 (Historical Actual)

Table 74: Measure 2.3.14: Increase number of people served by the public mental health system (Output)

FY	Target	Result
2010	6,300,000	Sep 30, 2011
2009	6,250,000	Sep 30, 2010
2008	6,200,000	Sep 30, 2009
2007	5,753,633	6,121,641 (Target Exceeded)
2006	5,725,008	5,979,379 (Target Exceeded)
2005	5,227,437	5,878,035 (Target Exceeded)

Table 75: Data Source and Validation for Performance Measures from CMHS's Community Mental Health Services Block Grant Program

Measure	Data Source	Data Validation
2.3.07 2.3.08 2.3.09 2.3.10 2.3.11 2.3.12 2.3.13 2.3.15 2.3.16 2.3.14	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.17	Uniform Reporting System. This measure is calculated by dividing the number of adults with SMI and children/adolescents with SED who received evidence based practices during the FY by the MHBG allocation for the FY in question, multiplied by 10,000	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp

Measure 2.3.07 is to reduce the rate of readmissions to State psychiatric hospitals for adults within 30 days from their discharge from the hospital. The FY 2007 target was not met. Readmission rates were slightly above target levels. It appears that the initial targets for FY 2003 – FY 2005, which were set from the FY 2002 baseline, may have been too ambitious since the targets have not been met in any of the previous fiscal years. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2007 was increased to 8.7 percent, but this also proved to be too ambitious. FY 2010 targets have been increased to allow time for states to make adjustments to service planning in response to the existing rates.

Measure 2.3.08 is the readmission rate for adults within 180 days from their discharge from the hospital. The FY 2007 target was not met. Readmission rates were slightly above target levels. It appears that the initial targets for FY 2003 – FY 2005, which were set from the FY 2002 baseline, may have been too ambitious since the targets have not been met in any of the previous fiscal years. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2007 was increased to 19.1 percent, but this also proved to be too ambitious. FY 2010 targets have been increased to allow time for states to make adjustments to service planning in response to the existing rates.

Measure 2.3.09 is the readmission rate for children within 30 days from their discharge from the hospital The FY 2007 target was not met. Readmission rates were slightly above target levels. It appears that since the actuals for FY 2004 and FY 2005 were just above the targets, the targets for FY 2006 and FY 2007 were lowered with the expectation that the rate would continue to fall. Unfortunately that is not the case since the rates have been increasing. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2010 was increased to 6.5 percent, to allow time for states to make adjustments to service planning in response to the existing rates.

Measure 2.3.10 is the readmission rate for children within 180 days from their discharge from the hospital. The FY 2007 target was not met. It appears that the targets that were set from the FY 2003 baseline may have been too ambitious since the targets have not been met in any of the previous fiscal years. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2007 was increased to 14.0 percent, but this also proved to be too ambitious. FY 2010 targets have been increased to allow time for states to make adjustments to service planning in response to the existing rates.

Measures 2.3.15 and 2.3.16 reflect the rate of consumers (adults) and family members (children) reporting positively about the outcomes of the services that they received in helping to the problems that brought them into treatment. The performance target for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance. The target for adults and children were slightly missed. Future targets for adults have been reduced on the basis of prior year performance. Targets for children were raised based on performance in FY 2005 and 2006 but may need to be reconsidered based on performance in FY 2007.

The evidence-based practices measures reflect the program's efforts to improve the efficiency and effectiveness of mental health services. The efficiency measure was exceeded (2.3.17). This indicator provides a measure of the number of evidence-based practices (EBPs) implemented per State. The use of EBPs allows mental health providers and programs to more reliably improve services, achieve optimal outcomes and has demonstrated a consistent, positive impact on of the lives of people who have experienced mental health problems. The target was exceeded. For FY 2007, the target for the number of evidence based practices was exceeded (2.3.11). The evidence based practice percentage of coverage for adults (2.3.12) was missed by just one percent and for children (2.3.13) the target was missed by just two-tenths of one percent. It appears that the program over-estimated the level of progress that states could make in the access of these programs for these populations in the allotted time. Measure 2.3.14 provides a measure of the number of consumers served by the public mental health system. Targets for 2006 and 2007 were met.

Steps are being taken to improve the program performance for the MHBG Program. A Program Peer Review process is in place for the Annual Plan and Implementation Report which assesses and provides specific feedback regarding strengths and weaknesses of the program as well as specific recommendations for ongoing quality improvement. Also, the State Mental Health Authorities within each State are monitored via on-site reviews on a regular schedule. These on-site monitoring reviews are conducted by independent consultants and provide an assessment of key areas of service delivery and infrastructure. Following these site visits, the consultants issue a report that summarizes its program findings and when appropriate, may include recommendations for technical assistance. All of these activities allow CMHS to identify areas of under performance and target improvement through provision of technical assistance and training.

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Center for Substance Abuse Prevention (CSAP)

Prevention Programs of Regional and National Significance (PRNS) – Capacity

Strategic Prevention Framework State Incentive Grants (SPF SIG)[27]

Table 76: Measure 2.3.19: 30-day use of alcohol among youth age 12-17 (Outcome)

FY	Target	Result
Out-Year Target	15% (2013)	Dec 31, 2014
2010	15%	Dec 31, 2011
2005	Set Baseline	18.6% (Baseline)

Table 77: Measure 2.3.20: 30-day use of other illicit drugs age 12 and up (Outcome)

FY	Target	Result
Out-Year Target	5% (2013)	Dec 31, 2014
2010	5%	Dec 31, 2011
2005	Set Baseline	8.6% (Baseline)

Table 78: Measure 2.3.21: Percent of SPF SIG States showing a decrease in state level estimate of percent of survey respondents who report 30-day use of alcohol a) age 12-20 (Outcome)

FY	Target	Result
2010	50.4%	Dec 31, 2011
2009	51.8%	Dec 31, 2010
2008	51.8%	47.1% (Target Not Met)
2007	Set Baseline	47.1% (Baseline)

[27] Target decreases are due to budget decreases

Table 79: Measure 2.3.22: Percent of SPF SIG States showing a decrease in state level estimate of percent of survey respondents who report 30-day use of alcohol b) age 21 and up (Outcome)

FY	Target	Result
2010	31.4%	Dec 31, 2011
2009	32.3%	Dec 31, 2010
2008	32.3%	41.2%[28] (Target Exceeded)
2007	Set Baseline	29.4% (Baseline)

Table 80: Measure 2.3.23: Percent of SPF SIG states showing a decrease in state level estimates of survey respondents who report 30-day use of other illicit drugs a) age 12-17 (Outcome)

FY	Target	Result
2010	59.8%	Dec 31, 2011
2009	61.5%	Dec 31, 2010
2008	61.5%	55.9% (Target Not Met)
2007	Set Baseline	55.9% (Baseline)

Table 81: Measure 2.3.24: Percent of SPF SIG states showing a decrease in state level estimates of survey respondents who report 30-day use of other illicit drugs b) age 18 and up (Outcome)

FY	Target	Result
2010	47.2%	Dec 31, 2011
2009	48.5%	Dec 31, 2010
2008	48.5%	29.4%[29] (Target Not Met)
2007	Set Baseline	44.1% (Baseline)

[28] Data revised from previously reported.
[29] Data revised from previously reported.

Table 82: Measure 2.3.25: Percent of SPF SIG states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great a) age 12-17 (Outcome)

FY	Target	Result
2010	78.7%	Dec 31, 2011
2009	80.9%	Dec 31, 2010
2008	80.9%	50% (Target Not Met)
2007	Set Baseline	73.5% (Baseline)

Table 83: Measure 2.3.26: Percent of SPF SIG states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great b) age 18 and up (Outcome)

FY	Target	Result
2010	50.4%	Dec 31, 2011
2009	51.8%	Dec 31, 2010
2008	51.8%	29.4% (Target Not Met)
2007	Set Baseline	47.1% (Baseline)

Table 84: Measure 2.3.27: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who somewhat disapprove or strongly disapprove of substance use. (Outcome)

FY	Target	Result
2010	84.9%	Dec 31, 2011
2009	87%	Dec 31, 2010
2008	87.3%	67.6% (Target Not Met)
2007	Set Baseline	79.4% (Baseline)

Table 85: Measure 2.3.28: Number of evidence-based policies, practices, and strategies implemented: cumulative (Output)

FY	Target	Result
2010	1400	Dec 31, 2011
2009	1166	Dec 31, 2010
2008	470	781 (Target Exceeded)
2007	Set Baseline	396 (Baseline)

Table 86: Measure 2.3.29: Percent of grantee states that have performed needs assessments (Output)

FY	Target	Result
2010	97%[30]	Dec 31, 2011
2009	100%	Dec 31, 2010
2008	100%	100% (Target Met)
2007	100%	100% (Target Met)
2006	100%	92.3% (Target Not Met)
2005	Set Baseline	100% (Baseline)

Table 87: Measure 2.3.30: Percent of grantee States that have submitted State plans (Output)

FY	Target	Result
2010	60%[31]	Dec 31, 2011
2009	95.2%	Dec 31, 2010
2008	100%	95.2%[32] (Target Not Met)
2007	85%	96.2% (Target Exceeded)
2006	50%	92.3% (Target Exceeded)
2005	Set Baseline	28% (Baseline)

Table 88: Measure 2.3.31: Percent of grantee States with approved plans (Output)

FY	Target	Result
2010	54%[33]	Dec 31, 2011
2009	85.7%	Dec 31, 2010
2008	100%	85.7%[34] (Target Not Met)
2007	85%	88.5% (Target Exceeded)
2006	25%	69.2% (Target Exceeded)
2005	Set Baseline	9% (Baseline)

[30] Cohort 1: 100%; Cohort 2: 100%; Cohort 3: 94%
[31] Cohort 1: 100%; Cohort 2: 100%;Cohort 3: 63%
[32] Includes 100% of Cohort I and 2 and 88% of Cohort 3
[33] Cohort 1: 100%; Cohort 2: 100%;Cohort 3: 63%
[34] Includes 100% of Cohort I and 2 and 88% of Cohort 3

Table 89: Data Source and Validation for Performance Measures from CSAP's Strategic Prevention Framework State Incentive Grant Program

Measure	Data Source	Data Validation
2.3.19 2.3.20	Long term national measures are obtained from published National Survey on Drug Use and Health reports	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by state grantees to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works with them to insure that data are complete and accurate.
2.3.21 2.3.22 2.3.23 2.3.24 2.3.25 2.3.26 2.3.27	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by state grantees to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works with them to insure that data are complete and accurate.
2.3.28 2.3.29 2.3.30 2.3.31	Output measures are obtained from grantee administrative reports	Data related to state activities are submitted by state grantees to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with them to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance monitoring.

The Strategic Prevention Framework State Incentive Grant Program (SPF SIG) is a program that supports the delivery of effective programs, policies, and practices to prevent substance use through a five-step process of the Strategic Prevention Framework (SPF). The SPF SIG grants are awarded to States and territories that are required to go through multiple stages of the SPF process before they begin to fund communities that also go through the SPF steps before implementing services. These initial steps lead to a substantial delay between the time the grants are awarded and the time that community change is observable. Results of these services are reflected by state estimates published in surveys such as the National Survey on Drug Use and Health (NSDUH).

The SPF SIG grantees met or exceeded their FY 2008 outcome/output targets on three measures. These included measure 2.3.22, the percent of SPF SIG states showing a

decrease in state level estimate of percent of survey respondents who report 30-day use of alcohol for ages 21 and up, and measure 2.3.28, number of evidence-based programs implemented. They also met their target on Measure 2.3.29 on percent of States that performed their needs assessments. It could be that these targets were more sensitive to change and/or more easily achieved than other targets. The reduction in use could also be related to the increased numbers of EBPs being implemented.

At the same time, the SPF SIG States failed to meet their targets for the other measures. These failures resulted from a variety of methodological and statistical issues. The data used to determine the percent of States improving on each measure are from 2004/2005 and 2005/2006. Since the initial Cohort 1[35] grantees were funded in 2005, these data cannot reflect actual SPF SIG impacts. Lastly, State-level percentages of use and non-use are affected by numerous factors external to prevention programs, such as state-level demographic and socioeconomic changes. Such changes include raising unemployment, the population make-up and family stability which all contribute to increased substance use and are outside the control of this program.

Targets for some of the measures are lower for 2009 because they include both earlier and later cohorts of SPF SIG states. The earlier cohorts will have completed several of the initial SPF steps, but the later cohorts are just beginning the SPF implementation process.

The SPF concept has expanded beyond the current SPF SIG grantee States and territories to other States and territories. For example, 51 States/territories now use SPF or the equivalent for conducting needs assessments, 53 for building State capacity; 53 for planning; 43 for program implementation and 29 use SPF or the equivalent for evaluation efforts.

[35] SPF-SIG grants were awarded over several different years in cohorts. Cohort 1 (21 States) was funded at the end of FY 2004. Cohort 2 (5 States) was funded in FY 2005. All States in Cohorts 1 and 2 have now funded sub-recipient communities. Cohort 3 (16 total, including 5 tribes and 1 jurisdiction) was funded in September 2006.

Minority AIDS Initiative: Substance Abuse Prevention, HIV Prevention and Hepatitis Prevention for Minorities and Minorities Re-entering Communities Post-Incarceration (HIV) (Cohort 6)[36]

Table 90: Measure 2.3.35: Percent of program participants that rate the risk of substance abuse as moderate or great a) age 12-17 (Outcome)

FY	Target	Result
2010	87%	Aug 31, 2011
2009	76.6%	Aug 31, 2010
2008	75.8%	Aug 31, 2009
2007	89%	87.6%[37] (Target Not Met)
2006	Set Baseline	88.6% (Baseline)

Table 91: Measure 2.3.38: Percent of program participants that rate the risk of substance abuse as moderate or great b) age 18 and up (Outcome)

FY	Target	Result
2010	93%	Aug 31, 2011
2009	85.1%	Aug 31, 2010
2008	84.2%	Aug 31, 2009
2007	Set Baseline	94.4%[38] (Baseline)

Table 92: Measure 2.3.39: Percent of participants who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease): a) age 12-20 (Outcome)

FY	Target	Result
2010	76.6%	Aug 31, 2011
2009	76.6%	Aug 31, 2010
2008	75.1%	Aug 31, 2009
2007	Set Baseline	74.4% (Baseline)

[36] HIV Cohort 7 serves different population groups so baseline data from this cohort will be established and entered in FY 2010.
[37] Final FY 2007 result. Data in the 09CJ was preliminary.
[38] Final FY 2007 result. Data in the 09CJ was preliminary.

Table 93: Measure 2.3.40: Percent of participants who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease): b) age 21 and up (Outcome)

FY	Target	Result
2010	60.8%	Aug 31, 2011
2009	60.8%	Aug 31, 2010
2008	59.6%	Aug 31, 2009
2007	Set Baseline	59% (Baseline)

Table 94: Measure 2.3.41: Percent of participants who report no alcohol use at pre-test who remain non-users at post-test (non-user stability): a) age 12-20 (Outcome)

FY	Target	Result
2010	95.3%	Aug 31, 2011
2009	95.3%	Aug 31, 2010
2008	93.4%	Aug 31, 2009
2007	Set Baseline	92.5% (Baseline)

Table 95: Measure 2.3.42: Percent of participants who report no alcohol use at pre-test who remain non-users at post-test (non-user stability): b) age 21 and up (Outcome)

FY	Target	Result
2010	92%	Aug 31, 2011
2009	92%	Aug 31, 2010
2008	90.2%	Aug 31, 2009
2007	Set Baseline	89.3% (Baseline)

Table 96: Measure 2.3.43: Percent of participants who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease): a) age 12-17 (Outcome)

FY	Target	Result
2010	92.3%	Aug 31, 2011
2009	92.3%	Aug 31, 2010
2008	90.5%	Aug 31, 2009
2007	Set Baseline	89.6% (Baseline)

Table 97: Measure 2.3.44: Percent of participants who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease): b) age 18 and up (Outcome)

FY	Target	Result
2010	70.6%	Aug 31, 2011
2009	70.6%	Aug 31, 2010
2008	69.2%	Aug 31, 2009
2007	Set Baseline	68.5% (Baseline)

Table 98: Measure 2.3.45: Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability): a) age 12-17 (Outcome)

FY	Target	Result
2010	94.9%	Aug 31, 2011
2009	94.9%	Aug 31, 2010
2008	93%	Aug 31, 2009
2007	Set Baseline	92.1% (Baseline)

Table 99: Measure 2.3.46: Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability): b) age 18 and up (Outcome)

FY	Target	Result
2010	94.6%	Aug 31, 2011
2009	94.6%	Aug 31, 2010
2008	92.7%	Aug 31, 2009
2007	Set Baseline	91.8% (Baseline)

Table 100: Measure 2.3.47: Percent of program participants (age 12-17) who somewhat disapprove or strongly disapprove of substance use (Outcome)

FY	Target	Result
2010	82.8%	Aug 31, 2011
2009	82.8%	Aug 31, 2010
2008	81%	Aug 31, 2009
2007	Set Baseline	70.3%[39] (Baseline)

[39] Final FY 2007 result. Data in the 09CJ was preliminary.

Table 101: Measure 2.3.48: Number of evidence-based policies, practices, and strategies implemented by HIV program grantees: cumulative (Output)

FY	Target	Result
2010	545	Aug 31, 2011
2009	394	Aug 31, 2010
2008	243	Aug 31, 2009
2007	Set Baseline	162 (Baseline)

Table 102: Measure 2.3.56: Number of individuals exposed to substance abuse/hepatitis education services (Outcome)

FY	Target	Result
2010	2,327	Aug 31, 2011
2009	2,305	Aug 31, 2010
2008	2,283	Aug 31, 2009
2007	Set Baseline	2,260 (Baseline)

Table 103: Measure 2.3.70: Cost per participant improved on one or more measures between pre-test and post-test (Output)[40]

FY	Target	Result
2010	$20,167	Aug 31, 2011
2009	$20,167	Aug 31, 2010
2008	Set Baseline	$22,189[41] (Baseline)

[40] Successful result is performance *below* target.
[41] Calculations are extremely over-inflated due to exclusion of participant counts in other than direct services. Efforts are being made to gather those data which will then be used to provide more realistic projected targets.

Table 104: Data Source and Validation for Performance Measures from CSAP's Programs of Regional and National Significance: Other Capacity Activities: Minority AIDS Initiative

Measure	Data Source	Data Validation
2.3.35 2.3.38 2.3.39 2.3.40 2.3.41 2.3.42 2.3.43 2.3.44 2.3.45 2.3.46 2.3.47 2.3.56	Data are provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center (DACCC). After data are entered, the DACCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project Officer (GPO) who works with the Program Directors (PD's) to resolve. The Data Management Team then makes any required edits to the files. The edited files are then sent to CSAP staff and the DACCC Data Analysis Team for analysis and reporting.
2.3.48	Data are provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center (DACCC). After data are entered, the DACCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project Officer (GPO) who works with the Program Directors (PD's) to resolve. The Data Management Team then makes any required edits to the files. The edited files are then sent to CSAP staff and the DACCC Data Analysis Team for analysis and reporting.

Table 105: Data Source and Validation for Performance Measures from CSAP's Programs of Regional and National Significance: Other Capacity Activities: Minority AIDS Initiative (continued)

Measure	Data Source	Data Validation
2.3.70	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analysis Coordination and Consolidation Center (DACCC). After data are extracted from the web-based data entry system, the DACCC's Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DACCC's Data Analysis Team for analysis and reporting. The Data Analysis Team compares participants' baseline and exit responses to survey items measuring past-30-day use, disapproval of use, and perception of risk of substance use. A participant who improved on at least one measure and did not become worse on any of the other measures is defined as "improved." Total program cost for the Fiscal Year is divided by the number of improved participants to construct the measure.

The goal of the HIV cohort 6 program is to increase the capacity of communities serving the target populations to deliver evidence-based substance abuse prevention, HIV and Hepatitis prevention services. Evidence-based interventions are defined by inclusion in one or more of the three categories: a) included in Federal registries of evidence-based interventions; b) reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or c) documented effectiveness supported by other sources of information and the consensus judgment of informed experts.[42]

The program also incorporates SAMHSA's National Outcome Measures (NOMs), which is SAMHSA's core data collection requirement for all grant programs. This program is also using an approved efficiency measure (2.3.70) and a new measure on the number of individuals exposed to substance abuse/hepatitis education services. These measures will illustrate the impact of outreach efforts. Other measures reflect use for

[42] Examples of HIV EBP's include Voices/Voces and the Sista Program which is listed in the CDC Directory of Evidence Based Interventions (DEBI). More information on EBP's can be found in *Identifying and Selecting Evidence-Based Interventions Revised Guidance document for the Strategic Prevention Framework State Incentive Grant Program.* HHS Pub. No. (SMA-4205). CSAP/SAMHSA, 2009. http://www.samhsa.gov/shin/

both those who had used drugs before entering the program and those who had not. This last set of measures require person-level matched data to assess person-level program outcomes on non-user stability and user decrease to assess "improvement" and are used as a basis for calculating effectiveness. These matched data apply to clients who have participated in prevention interventions lasting at least 30 days. Change is assessed by following each client from program entry to program exit and to 3 to 6 months follow-up. These matched data will be reported in August 2009.

As a part of CSAP's NOMs, cost efficiency is very important and therefore, CSAP has added a cost per improved client measure in order to monitor cost effectiveness. This measure is defined as the total cost of the HIV program divided by the number of participants who "improved." A program participant is considered "improved" if baseline-to-exit comparisons indicate improvement on at least one NOM ATOD[43] measure. These include non-user stability, reduction in 30-day use, increase in perception of harm or perceived disapproval or non-user stability on at least one 30-day substance use measure and no worse on any other NOM. Since estimating the number of persons served by environmental strategies is extremely difficult, the cost per client calculation currently includes only those directly served by a program lasting over 30 days. This has resulted in a significant overestimation in the cost per person served. For the HIV cohort 6 program, cost per improved participant (direct services only) was $22,189. SAMHSA is working on ways to better estimate the number served by environmental strategies and shorter programs, and hopes to incorporate a more representative estimate of persons served in the cost per client measure in the future.

Since this program has changed substantially by focusing on much higher risk minority and re-entry populations and including the SPF, CSAP has had to establish new baseline measures for FY 2008. However, CSAP will not be able to assess progress on them until FY 2009 in August, when the program will be able to report actual HIV cohort 6 data. The delay in data availability allows for complete online submission of grantee data and time for required cleaning and analysis.

[43] Alcohol, Tobacco, or Other Drugs

Sober Truth on Preventing Underage Drinking (STOP Act)

Table 106: Measure 3.3.01: Percentage of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades (Outcome)

FY	Target	Result
2010	41%	Dec 31, 2010
2009	40%	Dec 31, 2009
2008	Set Baseline	40% (Baseline)

Table 107: Measure 3.3.02: Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades (Outcome)

FY	Target	Result
2010	63.4%	Dec 31, 2010
2009	62.2%	Dec 31, 2009
2008	Set Baseline	60.9% (Baseline)

Table 108: Measure 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	Target	Result
2010	56.7%	Dec 31, 2010
2009	55.6%	Dec 31, 2009
2008	Set Baseline	54.5% (Baseline)

Table 109: Data Source and Validation for Performance Measures from STOP Act

Measure	Data Source	Data Validation
3.3.01 3.3.02 3.3.03	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 alcohol-related performance data using a variety of school and community surveys and report them online with the COMET (Coalition Online Management and Evaluation Tool) system every two years. According to the Act, STOP Act grantees cannot be required to collect data other than already being collected for DFC program.	The baseline measures for three alcohol use measures, namely, past 30 day use, perception of risk and parent disapproval were developed as follows: each grantees was scored as a success (improved as described) or not a success for each of these alcohol measures. The number of successes was divided by the number of grantees for whom data were available and multiplied by 100 to arrive at these baseline numbers. Additional information on COMET can be found at http://www.ondcp.gov/dfc/comet.html These data are submitted to DACCC for cleaning, editing and analysis before being used by CSAP for performance requirements and additional analyses.

The Sober Truth on Preventing Underage Drinking (STOP Act) program provides current or previously funded Drug Free Community grantees with an additional $50,000 funding to support substance abuse prevention environmental strategies targeted to stop underage drinking. The purpose of this program is to prevent and reduce alcohol use among youth in communities throughout the United States. It was created to strengthen collaboration among communities, the Federal Government, and State, local and tribal governments; to enhance intergovernmental cooperation and coordination; to serve as a catalyst for increased citizen participation and greater collaboration among all sectors and organizations of a community that first demonstrates a long-term commitment to reducing alcohol use among youth; and to disseminate to communities timely information regarding state-of-the-art practices and initiatives that have proven to be effective in preventing and reducing alcohol use among youth.

STOP Act grantees are required to report performance on three core measures. These are 1) 30 day alcohol use, 2) perception of harm from alcohol use and 3) parental disapproval of alcohol use. These measures are consistent with Drug Free Community program measures, as instructed by Congressional language.

Prevention Programs of Regional and National Significance (PRNS) – Science and Service

Table 110: Measure 2.3.71: Number of people provided technical assistance (TA) Services (Output)[44]

FY	Target	Result
2010	21,117	Dec 31, 2010
2009	21,117	Dec 31, 2009
2008	Set Baseline	21,117 (Baseline)

Table 111: Measure 2.3.72: Percentage of TA recipients who reported that they are very satisfied with the TA received (Outcome)[45]

FY	Target	Result
2010	69.1%	Dec 31, 2010
2009	69.1%	Dec 31, 2009
2008	Set Baseline	69.1% (Baseline)

Table 112: Measure 2.3.73: Percentage of TA recipients who reported that their ability to provide effective services improved a great deal (Outcome)

FY	Target	Result
2010	53.4%	Dec 31, 2010
2009	53.4%	Dec 31, 2009
2008	Set Baseline	53.4% (Baseline)

Table 113: Measure 2.3.74: Percentage of TA recipients who reported that the TA recommendations have been fully implemented (Outcome)[45]

FY	Target	Result
2010	54%	Dec 31, 2010
2009	54%	Dec 31, 2009
2008	Set Baseline	54% (Baseline)

[44] Includes CAPTs and FASD programs
[45] Includes only the CAPT program

Table 114: Measure 2.3.75: Number of persons receiving prevention information directly (Output)[46]

FY	Target	Result
2010	120,223	Dec 31, 2010
2009	120,223	Dec 31, 2009
2008	Set Baseline	120,223 (Baseline)

Table 115: Measure 2.3.76: Number of persons receiving prevention information indirectly from advertising, broadcast, or website (Output)

FY	Target	Result
2010	906,707	Dec 31, 2010
2009	906,707	Dec 31, 2009
2008	Set Baseline	906,707 (Baseline)

[46] Includes contract activities under the Best practices component of PRNS

Table 116: Data Source and Validation for Performance Measures from CSAP's Programs of Regional and National Significance: Science and Service Activities

Measure	Data Source	Data Validation
2.3.71	The number of persons provided direct technical assistance (TA) includes those served by several CSAP initiatives. These include: 1) the Centers for the Application of Prevention Technology (CAPTs) which provide TA to the CSAP discretionary program grantees, including the SPF-SIG, HIV and Methamphetamine grantees; and 2) the Fetal Alcohol Spectrum Disorder (FASD) Center of Excellence which provides TA to the FASD program.	Each of these activities uses a quality control protocol for collecting and submitting its data and is overseen by CSAP staff. These data are then submitted to the Data Analytic Coordination and Consolidation Center (DACCC) for cleaning, editing and analysis before being used by CSAP for performance reporting and other analyses. More information can be found on the following websites: http://captus.samhsa.gov/home.cfm http://www.fasdcenter.samhsa.gov/
2.3.72 2.3.73 2.3.74	The CAPTs collect data 2 months after the TA completion either on site or electronically.	These data are then submitted to the Data Analytic Coordination and Consolidation Center (DACCC) for cleaning, editing and analysis before being used by CSAP for performance reporting and other analyses.
2.3.75	The participating Community-based organizations (CBOs) collect this information by using an OMB approved evaluation form.	These forms are sent with a coded postage-paid envelope, used for receipt tracking. Clarification of fields entered on the evaluation form is sought from the respondents and/or the website: www.stopalcoholabuse.gov/townhall/. The data are entered into SPSS and MS Word for analysis and then submitted to DACCC for cleaning, editing and analysis before being used by CSAP for analyses.
2.3.76	Participating Community-based organizations (CBOs) collect this information from the media	These forms are sent with a coded postage-paid envelope, used for receipt tracking. Clarification of fields entered on the evaluation form is sought from the respondents and/or the website: www.stopalcoholabuse.gov/townhall/. The data are entered into SPSS and MS Word for analysis and then submitted to DACCC for cleaning, editing and analysis before being used by CSAP for analyses.

SAMHSA has introduced six new measures to reflect CSAP's substantial and increasing role in training, technical assistance and prevention information dissemination. Previously in this document, CSAP included data from the Centers for

Application of Prevention Technologies (CAPT), but those measures have been retired in favor of aggregate reporting across several of the technical assistance activities. While these are not always construed as direct services programs, TA programs serve many more persons at a much lower cost and play an important role in advancing the field of substance abuse prevention. The measures include several of the CSAP technical assistance activities and there are plans to incorporate more activities in the near future. Newer service and science technical assistance contracts data will be combined in the future with CAPT data.

Substance Abuse Prevention and Treatment Block Grant – 20% Prevention Set-Aside

Synar Amendment Implementation Activities

Table 117: Measure 2.3.49: Increase number of States (including Puerto Rico) whose retail sales violations is at or below 20% (Outcome)[47]

FY	Target	Result
2010	52	Jun 30, 2011
2009	52	Jun 30, 2010
2008	52	52 (Target Met)
2007	52	52 (Target Met)
2006	52	52 (Target Met)
2005	52	50 (Target Not Met but Improved)

Table 118: Measure 2.3.62: Number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% (Outcome)

FY	Target	Result
2010	28	Jun 30, 2011
2009	29	Jun 30, 2010
2008	28	26 (Target Not Met but Improved)
2007	Set Baseline	25[48] (Baseline)

[47] The 20% retail sales violation data apply to the 50 States, D.C., and Puerto Rico
[48] FY 2007 Actual was inadvertently reported as 27 (the FY 2006 Actual)

Table 119: Data Source and Validation for Performance Measures from CSAP's SAPTBG: Synar Amendment Implementation Activities

Measure	Data Source	Data Validation
2.3.49 2.3.62	The data source is the Synar report, part of the SAPT Block Grant application submitted annually by each State.	States must certify that Block Grant data are accurate. The validity and reliability of the data are ensured through technical assistance, conducting random unannounced checks, and the confirmation of the data by scientific experts, site visits and other similar steps. CSAP is able to provide leadership and guidance to States on appropriate sample designs and other technical requirements, based on scientific literature and demonstrated best practices for effective implementation of Synar. Data sources for the baseline and measures are derived from State project officers' logs and from organizations that were awarded State technical assistance contracts. The analysis is based upon the actual requests/responses received, therefore providing a high degree of reliability and validity.

The Synar Regulation requires the 50 States, the District of Columbia and the 8 U.S. Territories to: 1) have in effect a law prohibiting any manufacturer, retailer, or distributor of tobacco products from selling or distributing such products to any individual younger than age 18; 2) Enforce this law; 3) Conduct annual, unannounced inspections (referred to as the Synar survey) in a way that provide a valid probability sample of tobacco sales outlets accessible to minors; 4) Negotiate interim targets and a date to achieve a noncompliance rate (or retailer violation rate) of no more than 20 percent (SAMHSA required that each State reduce its retailer violation rate (RVR) to 20 percent or less by FY 2003); and 5) Submit an annual report detailing State activities to enforce its law. The measures in these tables refer to the results of each State's Synar survey and reflect the percentage of retail outlets in the survey that sold tobacco to youth.

The Synar program has been successful in reducing youth access to tobacco through retail sources. While the national weighted average retailer violation rate for the 50 States and the District of Columbia (weighted by State population) was 40.1 percent in FY 1997, the rate has steadily fallen since then, to 9.9 percent in FY 2008. Since FY 2006, all 50 States, the District of Columbia and Puerto Rico have been in compliance with the Synar requirements.

Because of such significant improvement, CSAP has set a new program goal to encourage all States to reduce the sales rate to less than 10 percent which is in keeping with the initial intent of the Synar legislation, to reduce minors' access to tobacco products. It is also consistent with research[49] suggesting that effectively reducing youth

[49] Jason LA, Ji PY, Anes MD, Birkhead SH. Active enforcement of cigarette control laws in the prevention of cigarette sales to minors. JAMA. 1991; 266:3159-3161.Forster JL, Murray DM. Wolfson M, Blaine TM, Wagenaar AC, Hennrikus DJ. The effects of community policies to reduce youth access to tobacco. AM J Public Health. 1998; 88:1193-1198.

access requires rates lower than the 20 percent target. The second measure (retailer violation rate of less than 10%) only includes the 50 States and D.C. because these are the entities included when SAMHSA publishes the annual national weighted retailer violation rate.

While this does not change the legally required target rate of 20 percent, it provides CSAP and States with a program goal that fits the legislative intent. In FY 2007, 25 States reported rates below 10 percent and in FY 2008, 26 States reported rates below 10 percent.

In addition to setting targets for State, the Synar Amendment established penalties for noncompliance. The penalty for a State is loss of up to 40 percent of its Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. In lieu of this penalty, in every year since 2000, Congress has provided an alternative penalty (Section 214/Section 218/Section 213/Section 212) mechanism by which a State can avoid the 40% reduction in its SAPT Block Grant if the State stipulates that it will spend its own funds to improve compliance with the law. The alternative penalty also stipulates that SAPT BG funds can not be withheld from a U.S. Territory that receives less than $1,000,000 in SAPT Block Grant funds for failing to meet the Synar requirements. The first measure (retailer violation rate of 20% or less) includes Puerto Rico because Puerto Rico is subject to a monetary penalty for failing to meet the Synar requirements because it receives more than $1,000,000 in SAPT BG funds, while the other U.S. Territories are not. The second measure ((retailer violation rate of less than 10%) only includes the 50 States and DC because these are the entities included when SAMHSA publishes the annual national weighted retailer violation rate.

Other Set-Aside Activities

Table 120: Measure 2.3.53: Number of evidence-based policies, practices, and strategies implemented, cumulative (Output)

FY	Target	Result
2010	37,044	Aug 31, 2011
2009	24,022	Aug 31, 2010
2008	11,000	17,056 (Target Exceeded)
2007	Set Baseline	10,090 (Baseline)

Table 121: Measure 2.3.69: Percent of program costs spent on evidence-based practices (EBP) (Outcome)

FY	Target	Result
2010	71%	Aug 31, 2011
2009	70%	Aug 31, 2010
2008	Set Baseline	69% (Baseline)

Table 122: Measure 2.3.54: Number of participants served in prevention programs (Outcome)

FY	Target	Result
2010	17,482,060	Aug 31, 2011
2009	17,482,060	Aug 31, 2010
2008	17,482,060	25,258,287 (Target Exceeded)
2007	Set Baseline	6,322,551 (Baseline)

Table 123: Measure 2.3.63: Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17) (Outcome)

FY	Target	Result
2010	45.1%	Aug 31, 2011
2009	45.1%	Aug 31, 2010
2008	Set Baseline	45.1% (Baseline)

Table 124: Measure 2.3.64: Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 18+) (Outcome)

FY	Target	Result
2010	27.5%	Aug 31, 2011
2009	27.5%	Aug 31, 2010
2008	Set Baseline	27.4% (Baseline)

Table 125: Measure 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	Target	Result
2010	51%	Aug 31, 2011
2009	51%	Aug 31, 2010
2008	Set Baseline	51% (Baseline)

Table 126: Measure 2.3.66: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 21+) (Outcome)

FY	Target	Result
2010	37.3%	Aug 31, 2011
2009	37.3%	Aug 31, 2010
2008	Set Baseline	37.3% (Baseline)

Table 127: Measure 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	Target	Result
2010	52.9%	Aug 31, 2011
2009	52.9%	Aug 31, 2010
2008	Set Baseline	52.9% (Baseline)

Table 128: Measure 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	Target	Result
2010	33.3%	Aug 31, 2011
2009	33.3%	Aug 31, 2010
2008	Set Baseline	33.3% (Baseline)

Table 129: Data Source and Validation for Performance Measures from CSAP's SAPTBG 20% Set-aside Activities

Measure	Data Source	Data Validation
2.3.53	Reported by States in the Block Grant Applications	Data, as well as the entire SAPT application, are reviewed jointly by CSAT and CSAP project officers for accuracy and compliance. Discussions between project officers and states are scheduled to clarify ambiguities or inconsistencies in data which are resolved prior to approval. The Data Analytic Coordination and Consolidation Center (DACCC) Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the DACCC Government Project Officer who works with the Program Project Officers and grantees to identify a resolution. Communications are supported by regularly submitted program data inventories, preliminary reports and variable by variable cleaning sheets. The Data Management team then makes any required edits to the files. The edited files are then available to the DACCC Data Analysis Team for analysis and reporting. Grantees are instructed in the use of data collection protocols through grantee meetings and questionnaire administrative guides. The Block Grant Technical Assistance providers have also received training and have begun providing TA to the states.
2.3.69 2.3.54	Reported by States in the Block Grant Applications.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data, as well as the entire SAPT application, are reviewed jointly by CSAT and CSAP project officers for accuracy and compliance. Discussions between project officers and states are scheduled to clarify ambiguities or inconsistencies in data which are resolved prior to approval. The Data Analytic Coordination and Consolidation Center (DACCC) Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the DACCC Government Project Officer who works with the Program Project Officers and grantees to identify a resolution. Communications are supported by regularly submitted program data inventories, preliminary reports and variable by variable cleaning sheets. The Data Management team then makes any required edits to the files. The edited files are then available to the DACCC Data Analysis Team for analysis and reporting. Grantees are instructed in the use of data collection protocols through grantee meetings and questionnaire administrative guides. The Block Grant Technical Assistance providers have also received training and have begun providing TA to the states.

Table 130: Data Source and Validation for Performance Measures from CSAP's SAPTBG 20% Set-aside Activities (continued)

Measure	Data Source	Data Validation
2.3.63 2.3.64 2.3.65 2.3.66 2.3.67 2.3.68	Outcome data are from the National Survey on Drug Use and Health.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data, as well as the entire SAPT application, are reviewed jointly by CSAT and CSAP project officers for accuracy and compliance. Discussions between project officers and states are scheduled to clarify ambiguities or inconsistencies in data which are resolved prior to approval. The Data Analytic Coordination and Consolidation Center (DACCC) Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the DACCC Government Project Officer who works with the Program Project Officers and grantees to identify a resolution. Communications are supported by regularly submitted program data inventories, preliminary reports and variable by variable cleaning sheets. The Data Management team then makes any required edits to the files. The edited files are then available to the DACCC Data Analysis Team for analysis and reporting. Grantees are instructed in the use of data collection protocols through grantee meetings and questionnaire administrative guides. The Block Grant Technical Assistance providers have also received training and have begun providing TA to the states.

Former measures 2.3.50, 2.3.51, and 2.3.52 have been used in recent years as proxy measures for the Substance Abuse and Prevention Block Grant 20% Prevention Set-aside. They were national population-based measures taken from the National Survey on Drug Use and Health (NSDUH) and did not reflect change at the State/grantee level (each State is a grantee so the terms are interchangeable). As a result, they have been retired. They have been replaced with separate measures reflecting the percentage of States/grantees improving on State-level estimates from the NSDUH. The table includes FY 2008 actual data for these measures.

We have added a new efficiency measure (2.3.69), the percent of block grant dollars spent on evidence-based practices (EBPs)[50]. In FY 2008, this was 69 percent. These programs have been demonstrated to be effective. Thus the proportion of total grant dollars spent on EBPs is an indicator of the ability of the program to channel resources towards proven-effective strategies, that is, an indicator of the efficient use of resources.

[50] Evidence-based interventions are defined by inclusion in one or more of the three categories: a) included in Federal registries of evidence-based interventions; b) reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or c) documented effectiveness supported by other sources of information and the consensus judgment of informed experts.

The remaining measures have reported baseline data for FY 2008 and have set targets for FY 2009 and FY 2010. The targets for numbers served reflect projections based on the 2007 baseline which aggregates the results from 28 voluntary State reports. The projection assumes that all states will report on this new data reporting requirement and takes into account the size of States who did/did not voluntarily report for 2007. The target for numbers served for FY 2008 was exceeded substantially as was the number of EBPs implemented.

There are a total of 60 States/territories that receive the SAPT BG 20% Prevention Set-aside funds. FY 2008 is the first year that numbers served data are being reported after the full implementation of the NOMs when this reporting became required. The baseline and target for this year were based on numbers obtained from 28 States/territories that voluntarily submitted these data before the reporting became required of all grantees. Every effort was made to extrapolate from the voluntarily submitted data to project FY 2008 numbers that would be supplied by all 60 grantees. The extrapolation corrected for the population sizes of the reporting and non-reporting States/territories in FY 2007 but did not take into consideration differences across States/territories in the status of their data collection infrastructure or other factors that might influence the completeness of the reported data. This may explain why the actual figure exceeded the projected target.

Results for the 20% prevention set-aside activities in the SAPT Block Grant are reported for the compliance year of the program. Output results are aligned with NSDUH state outcome estimates for a comparable timeframe. For example, output data reported in 2009 reflect the compliance year of 2006. Outcome data reported in 2009 reflect data reported in the 2008 NSDUH, which are based on pooled 2006-2007 data.

Center for Substance Abuse Treatment (CSAT)

Treatment Programs of Regional and National Significance (PRNS) - Capacity

Access to Recovery (ATR)

Table 131: Measure 1.2.32: Increase the number of clients gaining access to treatment (Output)[51]

FY	Target	Result
2010	65,000	Oct 31, 2010
2009	65,000	Oct 31, 2009
2008	30,000	50,845 (Target Exceeded)
2007	50,000	79,150 (Target Exceeded)
2006	50,000	96,959 (Target Exceeded)
2005	25,000	23,138 (Target Not Met)

Table 132: Measure 1.2.33: Increase the percentage of adults receiving services who a) had no past month substance use (Outcome)

FY	Target	Result
2010	82%	Oct 31, 2010
2009	81%	Oct 31, 2009
2008	80%	82.3% (Target Exceeded)
2007	81%	84.7% (Target Exceeded)
2006	79%	81.4% (Target Exceeded)
2005	Set Baseline	78% (Baseline)

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

Table 133: Measure 1.2.34: Increase the percentage of adults receiving services who b) had improved family and living conditions (Outcome)

FY	Target	Result
2010	53%	Oct 31, 2010
2009	52%	Oct 31, 2009
2008	52%	52.9% (Target Exceeded)
2007	52%	59.9% (Target Exceeded)
2006	63%	51% (Target Not Met)
2005	Set Baseline	62% (Baseline)

Table 134: Measure 1.2.35: Increase the percentage of adults receiving services who c) had no/reduced involvement with the criminal justice system (Outcome)

FY	Target	Result
2010	96.0	Oct 31, 2010
2009	96.0	Oct 31, 2009
2008	96.0	96.0 (Target Met)
2007	97.0	97.6 (Target Exceeded)
2006	95.0	96.8 (Target Exceeded)
2005	Set Baseline	95.0 (Baseline)

Table 135: Measure 1.2.36: Increase the percentage of adult receiving services who d) had improved social support (Outcome)

FY	Target	Result
2010	91%	Oct 31, 2010
2009	90%	Oct 31, 2009
2008	90%	91.7% (Target Exceeded)
2007	90%	75.1% (Target Not Met)
2006	90%	90% (Target Met)
2005	Set Baseline	89% (Baseline)

Table 136: Measure 1.2.37: Increase the percentage of adults receiving services who are) were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2010	54%	Oct 31, 2010
2009	53%	Oct 31, 2009
2008	53%	59.1% (Target Exceeded)
2007	50%	61.7% (Target Exceeded)
2006	57%	50% (Target Not Met)
2005	Set Baseline	56% (Baseline)

Table 137: Measure 1.2.39: Cost per client served (Efficiency)[52]

FY	Target	Result
2010	$1,572	Oct 31, 2010
2009	$1,588	Oct 31, 2009
2008	$1,605	$1,888 (Target Not Met)
2007	N/A	$1,605 (Historical Actual)

Table 138: Data Source and Validation for Performance Measures from CSAT's Access to Recovery Program

Measure	Data Source	Data Validation
1.2.32 1.2.33 1.2.34 1.2.35 1.2.36 1.2.37 1.2.39	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

CSAT uses a series of key output and outcome measures to assess the effectiveness of its Services Programs. The primary key output measure used is the number of clients served. This measure represents an unduplicated count of individuals who have received services through grants in CSAT's Access to Recovery Program. All outcome measures are based on a follow-up assessment conducted six months post admission to the program. Abstinence from substance use is a key outcome of the Program. This measure examines the substance use patterns of the clients. The percent reported

[52] Successful result is *below* target.

reflects the percent of individuals who have reported no use of alcohol or illegal drugs in the past 30 days at follow-up. The measure of employment/education shows the percent of people employed or in school or a job training program. The criminal justice measure refers to those clients who have reported no arrests in the past 30 days. Social connectedness measures the percent of people who attend self-help or support groups in support of their recovery. Stability in housing refers to the percent of people who own/rent their own house or apartment. These measures combined provide a holistic view of the effectiveness of the services being provided by this program.

All FY 2008 outcome targets for this program were met or exceeded. Based on data, targets were set at appropriate levels and were neither missed nor substantially exceeded.

The target for number of clients served was substantially exceeded. Grantees performed exceptionally well once infrastructure and program processes were fully in place. Eleven (out of 24) cohort 2 grantees had experience implementing ATR as they had also received cohort 1 grants. This accounted for a very quick start-up for these 11 grantees. Grantees were able to begin serving clients within three months post award which accounts for the spike in client numbers as compared to the original target set.

The first cohort of grantees ended in FY 2007. The second cohort of ATR grantees began providing services in FY 2008. Targets for FY 2008 were set lower to allow the new grantees to develop the appropriate infrastructure for a voucher-based system. In addition, the focus on methamphetamine users in the second cohort may have led to more significant barriers to service than the ATR population at large; therefore, targets have been kept at levels that are achievable but still ambitious. Targets for FY 2008 and FY 2009 were set during ATR's performance assessment in CY 2007.

In conjunction with the ATR performance assessment, an efficiency measure has been established. This measure, cost-per-client served, has been implemented with the second cohort of ATR grantees that were awarded in September 2007. SAMHSA is developing further refinements in this efficiency measure. The FY 2008 target for this measure was not met.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. It is expected that with the funds available for reinvestment in the Access to Recovery Program, the 2011 target for number of clients served will be approximately 33,500.

Screening, Brief Intervention, Referral and Treatment (SBIRT)

Table 139: Measure 1.2.40: Increase the number of clients served (Output)

FY	Target	Result
2010	139,650	Oct 31, 2010
2009	139,650	Oct 31, 2009
2008	139,650	192,840 (Target Exceeded)
2007	184,597	138,267 (Target Not Met)
2006	156,820	182,770 (Target Exceeded)
2005	70,544	155,267 (Target Exceeded)

Table 140: Measure 1.2.41: Increase the percentage of clients receiving services who had no past month substance use (Outcome)

FY	Target	Result
2010	50%	Oct 31, 2010
2009	50%	Oct 31, 2009
2008	48%	46.5% (Target Not Met but Improved)
2007	48%	45.7% (Target Not Met)
2006	41.8%	47.5% (Target Exceeded)
2005	Set Baseline	39.8% (Baseline)

Table 141: Data Source and Validation for Performance Measures from CSAT's Screening, Brief Intervention, Referral and Treatment Program

Measure	Data Source	Data Validation
1.2.40 1.2.41	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

The target for numbers served in FY 2008 was substantially exceeded. This measure reflects the number of clients who were screened through the SBIRT program. These clients may have screened negative, required a brief intervention, a brief treatment or a referral to treatment. As seen in the data above, the target for FY 2007 was missed due to a grantee experiencing issues with a subcontractor which ultimately led to the termination of the subcontract. SAMHSA worked with the grantee to address and resolve the issue. As

evidenced in the data for FY 2008, the issue has been resolved and grantees exceeded the target for number of clients to be served.

The target for number of clients receiving services who had no past month substance use, i.e., reported no use of alcohol or illegal drugs in the past 30 days at the six month follow-up assessment, was set at an appropriate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Criminal Justice - Substance Abuse Drug Courts

Table 142: Measure 1.2.62: Juvenile Drug Courts: Percentage of clients that complete treatment (Outcome)

FY	Target	Result
2009	75%	Oct 31, 2009
2008	74%	75.1% (Target Exceeded)
2007	69%	73% (Target Exceeded)
2006	N/A	68% (Historical Actual)

Table 143: Measure 1.2.63: Juvenile Drug Courts: Increase percentage of clients receiving services who: a) Were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2009	88%	Oct 31, 2009
2008	87%	86% (Target Not Met)
2007	87%	86% (Target Not Met)
2006	N/A	86% (Historical Actual)

Table 144: Measure 1.2.64: Juvenile Drug Courts: Increase percentage of clients receiving services who: b) Had a permanent place to live in the community (Outcome)

FY	Target	Result
2009	82%	Oct 31, 2009
2008	81%	81% (Target Met)
2007	78%	80% (Target Exceeded)
2006	N/A	77% (Historical Actual)

Table 145: Measure 1.2.65: Juvenile Drug Courts: Increase percentage of clients receiving services who: c) Had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2009	93%	Oct 31, 2009
2008	92%	94.3% (Target Exceeded)
2007	91%	91% (Target Met)
2006	N/A	90.3% (Historical Actual)

Table 146: Measure 1.2.66: Juvenile Drug Courts: Increase percentage of clients receiving services who: d) Experienced no/reduced alcohol or illegal drug related health, behavioral or social consequences (Outcome)

FY	Target	Result
2009	93%	Oct 31, 2009
2008	92%	92% (Target Met)
2007	90%	91.2% (Target Exceeded)
2006	N/A	89% (Historical Actual)

Table 147: Measure 1.2.67: Juvenile Drug Courts: Increase percentage of clients receiving services who: e) Had no past month substance use (Outcome)

FY	Target	Result
2009	73%	Oct 31, 2009
2008	72%	69% (Target Not Met)
2007	69%	71% (Target Exceeded)
2006	N/A	68% (Historical Actual)

Table 148: Measure 1.2.68: Juvenile Drug Courts: Percent of drug court participants who exhibit a reduction in substance use while in the drug court program. Measured in conjunction with DOJ. (Outcome)

FY	Target	Result
2010	N/A	Oct 31, 2010

Table 149: Measure 1.2.69: Juvenile Drug Courts: Reduce cost-per-client served (Outcome)[53]

FY	Target	Result
2009	$5,610	Oct 31, 2009
2008	$5,905	$6,790 (Target Not Met)
2007	$6,742	$6,463 (Target Exceeded)
2006	N/A	$8,742 (Historical Actual)

Table 150: Measure 1.2.70: Juvenile Drug Courts: Increase number of clients served (Output)

FY	Target	Result
2009	449	Oct 31, 2009
2008	929	783 (Target Not Met)
2007	821	856 (Target Exceeded)
2006	N/A	477 (Historical Actual)

Table 151: Measure 1.2.71: Adult Drug Courts: Percentage of clients that complete treatment (Outcome)

FY	Target	Result
2010	67%	Oct 31, 2010
2009	67%	Oct 31, 2009
2006	N/A	66% (Historical Actual)
2005	N/A	61% (Historical Actual)

Table 152: Measure 1.2.72: Adult Drug Courts: Increase percentage of clients receiving services who: a) Were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2010	89%	Oct 31, 2010
2009	88%	Oct 31, 2009
2006	N/A	86% (Historical Actual)
2005	N/A	70% (Historical Actual)

[53] Successful result is *below* target.

Table 153: Measure 1.2.73: Adult Drug Courts: Increase percentage of clients receiving services who b) Had a permanent place to live in the community (Outcome)

FY	Target	Result
2010	82%	Oct 31, 2010
2009	82%	Oct 31, 2009
2006	N/A	77% (Historical Actual)
2005	N/A	69.9% (Historical Actual)

Table 154: Measure 1.2.74: Adult Drug Courts: Increase percentage of clients receiving services who: c) Had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2010	93%	Oct 31, 2010
2009	93%	Oct 31, 2009
2006	N/A	90.3% (Historical Actual)
2005	N/A	89% (Historical Actual)

Table 155: Measure 1.2.75: Adult Drug Courts: Increase percentage of clients receiving services who: d) Experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences (Outcome)

FY	Target	Result
2010	93%	Oct 31, 2010
2009	93%	Oct 31, 2009
2006	N/A	89% (Historical Actual)
2005	N/A	86.6% (Historical Actual)

Table 156: Measure 1.2.76: Adult Drug Courts: Increase percentage of clients receiving services who: e) Had no past month substance use (Outcome)

FY	Target	Result
2010	73%	Oct 31, 2010
2009	73%	Oct 31, 2009
2006	N/A	68% (Historical Actual)
2005	N/A	67% (Historical Actual)

Table 157: Measure 1.2.77: Adult Drug Courts: Percent of drug court participants who exhibit a reduction in substance use while in the drug court program. Measured in conjunction with DOJ. (Outcome)

FY	Target	Result
2010	N/A	Oct 31, 2010

Table 158: Measure 1.2.78: Adult Drug Courts: Reduce cost-per-client served (Outcome)

FY	Target	Result
2010	$5,554	Oct 31, 2010
2009	$5,610	Oct 31, 2009

Table 159: Measure 1.2.79: Adult Drug Courts: Increase number of clients served (Output)[54]

FY	Target	Result
2010	2832	Oct 31, 2010
2009	960	Oct 31, 2009
2006	N/A	357 (Historical Actual)
2005	N/A	796 (Historical Actual)

Table 160: Data Source and Validation for Performance Measures from CSAT's Substance Abuse Treatment Drug Courts Program

Measure	Data Source	Data Validation
1.2.62 1.2.63 1.2.64 1.2.65 1.2.66 1.2.67 1.2.69 1.2.70 1.2.71 1.2.72 1.2.73 1.2.74 1.2.75 1.2.76 1.2.78 1.2.79	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

[54] Successful result is *below* target.

Table 161: Data Source and Validation for Performance Measures from CSAT's Substance Abuse Treatment Drug Courts Program (continued)

Measure	Data Source	Data Validation
1.2.68 1.2.77	To be determined	To be determined

The Treatment Drug Court program funds several types of grants including those specifically for juvenile or adult clients and those focused on families. SAMHSA reports performance data for the adult and juvenile drug courts separately. As a result, the juvenile and adult measures are both included in this document, but data and targets are reported separately based on which grants are currently funded (adult or juvenile). The last cohort of adult drug court grants was funded in FY 2005 and FY 2006. During FY 2007 and FY 2008, no adult drug courts were funded by SAMHSA. The current juvenile drug court grantees have been funded since FY 2006, but that funding will end in FY 2009. SAMHSA intends to award grants for both juvenile and adult drug courts in FY 2009.

CSAT uses a series of key output and outcome measures to assess the effectiveness of its Services Programs. The primary key output measure used is the number of clients served. This measure represents an unduplicated count of individuals who receive services through grants in CSAT's Treatment Drug Court Program. All outcome measures are based on a follow-up assessment conducted six months post admission to the program. Abstinence from substance use is a key outcome of the Program. This measure examines the substance use patterns of the clients. The percent reported reflects the percent of individuals who have reported no use of alcohol or illegal drugs in the past 30 days at follow-up. The measure of employment/education shows the percent of people employed or in school or a job training program. The criminal justice measure refers to those clients who have reported no arrests in the past 30 days. Stability in housing refers to the percent of people who own/rent their own house or apartment. These measures combined provide a holistic view of the effectiveness of the services being provided by this program.

The Treatment Drug Court Program met or exceeded its housing, criminal justice, social consequences, and treatment completion targets. Employment and abstinence targets were slightly missed. The targets were missed by a small amount and program performance was not affected.

The targets for number served and cost per client served were missed. This was due to the fact that the juvenile drug court grants in this program were in their last year and were phasing out their projects during FY 2008. As adult drug court grants were not funded for 2008, data are not available for this group. Data for the adult drug court program will be reported in FY 2009.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, adjustments to 2010 funding will be reflected in the targets set for 2011. The increase in funds in the Criminal Justice portfolio will result in a target of approximately 7,000 clients (including Drug Courts and Ex-Offender Re-Entry)."

Criminal Justice – Ex-Offender Re-Entry Program

Table 162: Measure 1.2.80: Number of clients served (Outcome)

FY	Target	Result
2010	1,312	Oct. 31, 2010

Table 163: Measure 1.2.81: Percentage of clients who had no past month substance use (Outcome)

FY	Target	Result
2010	68.9%	Oct. 31, 2010

Table 164: Data Source and Validation for Performance Measures from CSAT's Ex-Offender Re-Entry Program

Measure	Data Source	Data Validation
1.2.80 1.2.81	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

CSAT uses a series of key output and outcome measures to assess the effectiveness of its Services Programs. The primary key output measure used is the number of clients served. This measure represents an unduplicated count of individuals who have received services through grants in CSAT's Ex-Offender Re-Entry Program. All outcome measures are based on a follow-up assessment conducted six months post admission to the program. Abstinence from substance use is a key outcome of the program. This measure examines the substance use patterns of the clients. The percent reported reflects the percent of individuals who have reported no use of alcohol or illegal drugs in the past 30 days at follow-up.

Baseline data for these two measures has been determined based on the previous cohort of grantees. Targets for 2010 have been set in accordance with the baseline data.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes

associated with activities supported by funding from the prior fiscal year. Therefore, adjustments to 2010 funding will be reflected in the targets set for 2011. The increase in funds in the Criminal Justice portfolio will result in a target of approximately 7,000 clients (including Drug Courts and Ex-Offender Re-Entry)."

All Other Capacity[55]

Table 165: Measure 1.2.25: Increase percentage of adults receiving services who: Had no past month substance use (Outcome)

FY	Target	Result
2010	62%	Oct 31, 2010
2009	61%	Oct 31, 2009
2008	63%	62% (Target Not Met but Improved)
2007	63%	59% (Target Not Met)
2006	67%	63% (Target Not Met)
2005	65%	64.1% (Target Not Met but Improved)

Table 166: Measure 1.2.26: Increase the number of clients served (Output)

FY	Target	Result
2010	34,784	Oct 31, 2010
2009	31,659	Oct 31, 2009
2008	35,334	33,446 (Target Not Met)
2007	35,334	35,516 (Target Exceeded)
2006	34,300	35,334 (Target Exceeded)
2005	30,761	34,014 (Target Exceeded)

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

Table 167: Measure 1.2.27: Increase percentage of adults receiving services who: a) Were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2010	51%	Oct 31, 2010
2009	50%	Oct 31, 2009
2008	52%	54.3% (Target Exceeded)
2007	52%	57% (Target Exceeded)
2006	49%	52% (Target Exceeded)
2005	47%	48.9% (Target Exceeded)

Table 168: Measure 1.2.28: Increase percentage of adults receiving services who: b) Had a permanent place to live in the community (Outcome)

FY	Target	Result
2010	49%	Oct 31, 2010
2009	49%	Oct 31, 2009
2008	51%	47% (Target Not Met but Improved)
2007	53%	46% (Target Not Met)
2006	51%	49.3% (Target Not Met but Improved)
2005	Set Baseline	49.2% (Baseline)

Table 169: Measure 1.2.29: Increase percentage of adults receiving services who: c) Had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2010	95%	Oct 31, 2010
2009	94%	Oct 31, 2009
2008	96%	96% (Target Met)
2007	96%	96% (Target Met)
2006	98%	96% (Target Not Met)
2005	98%	96% (Target Not Met but Improved)

Table 170: Measure 1.2.30: Increase percentage of adults receiving services who: d) Experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences (Outcome)

FY	Target	Result
2010	66%	Oct 31, 2010
2009	65%	Oct 31, 2009
2008	67%	68% (Target Exceeded)
2007	67%	65% (Target Not Met)
2006	67%	67% (Target Met)
2005	85%	65% (Target Not Met)

Table 171: Measure 1.2.31: Increase the percentage of grantees in appropriate cost bands (Outcome)

FY	Target	Result
2010	79%	Oct 31, 2011
2009	78%	Oct 31, 2010
2008	80%	Oct 31, 2009
2007	80%	80% (Target Met)
2006	80%	81% (Target Exceeded)
2005	80%	81% (Target Exceeded)

Table 172: Data Source and Validation for Performance Measures from CSAT's Programs of Regional and National Significance: Other Capacity Activities

Measure	Data Source	Data Validation
1.2.25 1.2.26 1.2.27 1.2.28 1.2.29 1.2.30 1.2.31	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

CSAT uses a series of key output and outcome measures to assess the effectiveness of its Services Programs. The primary key output measure used is the number of clients served. This measure represents an unduplicated count of individuals who have received services through grants in CSAT's Other Capacity programs. All outcome measures are based on a follow-up assessment conducted six months post admission

to the program. Abstinence from substance use is a key outcome of these programs. This measure examines the substance use patterns of the clients. The percent reported reflects the percent of individuals who have reported no use of alcohol or illegal drugs in the past 30 days at six month follow-up. The measure of employment/education shows the percent of people employed or in school or a job training program. The criminal justice measure refers to those clients who have reported no arrests in the past 30 days. Social connectedness measures the percent of people who attend self-help or support groups in support of their recovery. Stability in housing refers to the percent of people who own/rent their own house or apartment. These measures combined provide a holistic view of the effectiveness of the services being provided by the Other Capacity Programs. The efficiency measure of grantees in appropriate cost bands gives the percent of grantees that fall into acceptable cost ranges for each modality of treatment provided.

The targets for employment, criminal justice, health consequences and social connectedness were either met or exceeded. The targets for abstinence, housing and number served were missed; however, the deviation is slight and does not affect overall program performance. Targets for FY 2009 are lower than FY 2008 target due to anticipated funding decreases. In addition, the target for the efficiency measure was met.[56]

Treatment Programs of Regional and National Significance (PRNS) – Science and Service[57]

Table 173: Measure 1.4.01: Report implementing improvements in treatment methods on the basis of information and training provided by the program (Outcome)

FY	Target	Result
2010	90%	Oct 31, 2010
2009	90%	Oct 31, 2009
2008	90%	92% (Target Exceeded)
2007	93%	90% (Target Not Met)
2006	89%	93% (Target Exceeded)
2005	85%	87% (Target Exceeded)

[56] Percentage of grantees that provide drug treatment services within approved cost per person bands is measured by the type of treatment including outpatient non-methadone, outpatient methadone, and residential treatment services. The cost ranges are for outpatient non-methadone $1000-$5000, outpatient methadone $1500-$8000, and residential $3000-$10,000.

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

Table 174: Measure 1.4.02: Increase the number of individuals trained per year (Output)

FY	Target	Result
2010	20,516	Oct 31, 2010
2009	20,516	Oct 31, 2009
2008	20,516	21,490 (Target Exceeded)
2007	23,141	20,516 (Target Not Met)
2006	28,916	23,141 (Target Not Met)
2005	36,077	28,630 (Target Not Met)

Table 175: Measure 1.4.03: Increase the percentage of drug treatment professionals trained by the program who a) Would rate the quality of the events as good, very good, or excellent (Outcome)

FY	Target	Result
2010	96%	Oct 31, 2010
2009	96%	Oct 31, 2009
2008	96%	95% (Target Not Met)
2007	96%	95% (Target Not Met)
2006	96%	96% (Target Met)
2005	93%	95% (Target Exceeded)

Table 176: Measure 1.4.04: Increase the percentage of drug treatment professionals trained by the program who b) Shared any of the information from the events with others (Outcome)

FY	Target	Result
2010	92%	Oct 31, 2010
2009	92%	Oct 31, 2009
2008	90%	93.5% (Target Exceeded)
2007	90%	89% (Target Not Met but Improved)
2006	88%	87% (Target Not Met but Improved)
2005	86%	86% (Target Met)

Table 177: Measure 1.4.05: Increase the percentage of grantees in appropriate cost bands (Outcome)

FY	Target	Result
2010	100%	Oct 31, 2011
2009	100%	Oct 31, 2010
2008	100%	Oct 31, 2009
2007	100%	100% (Target Met)
2006	100%	100% (Target Met)
2005	100%	100% (Target Met)

Table 178: Data Source and Validation for Performance Measures from CSAT's Programs of Regional and National Significance: Science and Service Activities

Measure	Data Source	Data Validation
1.4.01 1.4.02 1.4.03 1.4.04 1.4.05	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

The output measure used for this program is number of participants trained, which reflects the total number of participants who attended a CSAT-funded training, meeting, or received technical assistance. The outcome measures used reflect the percent of people who reported sharing information with others, whether or not the participants applied the information, and whether there was overall satisfaction with the event quality. All output and outcome targets except one were either met or exceeded, including: implementing improvements in treatment methods; sharing information from events with others; increasing the percentage of grantees in appropriate cost bands, which reflects a range of cost appropriate for a Science and Service participant; and increasing the number of clients served. The target for 1.4.03 (increasing percentage of treatment professionals who rate the quality of events highly) was missed; however, the deviation is slight and does not affect overall program performance.

Substance Abuse Prevention and Treatment Block Grant (SAPTBG) – Treatment Activities

Table 179: Measure 1.2.43: Number of admissions to substance abuse treatment programs receiving public funding (Output)[58]

FY	Target	Result
2010	1,881,515	Nov 30, 2012
2009	1,881,515	Nov 30, 2011
2008	1,881,515	Nov 30, 2010
2007	2,003,324	2,372,302 (Target Exceeded)[59]
2006	1,983,490	1,849,891 (Target Not Met but Improved)
2005	1,963,851	1,849,528 (Target Not Met)

Table 180: Measure 1.2.45: Increase the percentage of States and Territories that express satisfaction with Technical Assistance (TA) provided (Output)

FY	Target	Result
2010	97%	Nov 30, 2011
2009	97%	Nov 30, 2010
2008	97%	Nov 30, 2009
2007	97%	92% (Target Not Met but Improved)
2006	97%	83% (Target Not Met)
2005	97%	91% (Target Not Met but Improved)

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

[59] Prior to FY 2007, the data for this measure came from the Treatment Episode Data Set component of the SAMHSA Drug and Alcohol Services Information System. Beginning in FY 2007, the data source is the State data repository of the Web Block Grant Application System.

Table 181: Measure 1.2.47: Increase the percentage of States in appropriate cost bands (Outcome)

FY	Target	Result
2010	68%	Nov 30, 2011
2009	68%	Nov 30, 2010
2008	67%	Nov 30, 2009
2007	67%	65% (Target Not Met)
2006	100%	65% (Target Not Met)
2005	Set Baseline	100% (Baseline)

Table 182: Measure 1.2.48: Percentage of clients reporting abstinence from drug use at discharge (Outcome)

FY	Target	Result
2010	70.3%	Nov 30, 2011
2009	69.3%	Nov 30, 2010
2008	69.3%	Nov 30, 2009
2007	68.3%	73.7% (Target Exceeded)
2006	N/A	68.3% (Historical Actual)

Table 183: Measure 1.2.49: Percentage of clients reporting abstinence from alcohol at discharge (Outcome)

FY	Target	Result
2010	74.7%	Nov 30, 2011
2009	74.7%	Nov 30, 2010
2008	74.7%	Nov 30, 2009
2007	73.7%	80.9% (Target Exceeded)
2006	N/A	73.7% (Historical Actual)

Table 184: Measure 1.2.50: Percentage of clients reporting being employed/in school at discharge (Outcome)

FY	Target	Result
2010	43.9%	Nov 30, 2011
2009	42.9%	Nov 30, 2010
2008	42.9%	Nov 30, 2009
2007	N/A	42.9% (Historical Actual)
2006	N/A	40.9% (Historical Actual)

Table 185: Measure 1.2.51: Percentage of clients reporting no involvement with the criminal justice system (Outcome)

FY	Target	Result
2010	88.9%	Nov 30, 2011
2009	88.9%	Nov 30, 2010
2008	88.9%	Nov 30, 2009
2007	N/A	88.9% (Historical Actual)
2006	N/A	88.9% (Historical Actual)

Table 186: Data Source and Validation for Performance Measures from CSAT's SAPTBG – Treatment Activities

Measure	Data Source	Data Validation
1.2.43	Data are collected through standard instruments and submitted through the Treatment Episode Set. Data are then uploaded to CSAT's State data repository, the Web Block Grant Application System (WEBBGAS). In addition, States can make direct updates to data in WebBGAS and are required to verify that the data in the system are correct.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.45	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database
1.2.47 1.2.48 1.2.49 1.2.50 1.2.51	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

The long-term measure of change in abstinence at discharge is being retired and being replaced with two annual measures; one reflects abstinence from drug use at discharge and the other one reflects abstinence from alcohol at discharge. Discharge is defined as the date of last service and abstinence is defined as no reported use of either alcohol or drugs in the past 30 days. Baseline data have been reported and both measures exceeded their FY 2007 targets. Measures have also been added for employment and criminal justice involvement.

The performance target for admissions for FY 2006 was set at an approximate appropriate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance. The target of number of admissions was exceeded with a total of 2.3 million admissions reported. The number of admissions reflects the number of entrances into services provided under the block grant program. All outcome targets (abstinence from drugs and alcohol use) were either met or

exceeded. The measure related to percentage of grantees in cost bands[60] was missed by a slight deviation which did not affect overall program performance.

Prior to FY 2007, the data for this measure (1.2.43) came from the Treatment Episode Data Set component of the SAMHSA Drug and Alcohol Services Information System. Beginning in FY 2007, the data source is the State data repository of the Web Block Grant Application System. This system contains more comprehensive and verified information on the measure.

[60] Percentage of states that provide drug treatment services within approved cost per person bands is measured by the type of treatment including outpatient non-methadone, outpatient methadone, and residential treatment services. The cost ranges are for outpatient non-methadone $1000-$5000, outpatient methadone $1500-$8000, and residential $3000-$10,000.

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Office of Applied Studies (OAS)

Substance Abuse Prevention and Treatment Block Grant (SAPTBG) - National Surveys

Table 187: Measure 4.4.01: Availability and timeliness of data for the a) National Survey on Drug Use and Health (NSDUH) (Output)

FY	Target	Result
2010	8 months	Sep 30, 2010
2009	8 months	Sep 30, 2009
2008	8 months	8 months (Target Met)
2007	8 months	8 months (Target Met)
2006	8 months	8 months (Target Met)
2005	8 months	8 months (Target Met)

Table 188: Measure 4.4.02: Availability and timeliness of data for the b) Drug Abuse Warning Network (DAWN) (Output)

FY	Target	Result
2010	10 months	Oct 31, 2010
2009	10 months	Oct 31, 2009
2008	10 months	22 months (Target Not Met)
2007	12 months	14 months (Target Not Met but Improved)
2006	15 months	16 months (Target Not Met)
2005	9 months	12 months (Target Not Met)

Table 189: Measure 4.4.03: Availability and timeliness of data for the c) Drug and Alcohol Services Information System (DASIS) (Output)

FY	Target	Result
2010	10 months	Sep 30, 2010
2009	10 months	Sep 30, 2009
2008	10 months	10 months (Target Met)
2007	15 months	8 months (Target Exceeded)
2006	15 months	9 months (Target Exceeded)
2005	16 months	13 months (Target Exceeded)

Table 190: Data Source and Validation for Performance Measures from OAS's National Surveys

Measure	Data Source	Data Validation
4.4.01	Publication date of "Results from the National Survey on Drug Use and Health: National Findings"	Project officer review
4.4.02	Publication date of "Drug Abuse Warning Network: National Estimates of Drug-Related Emergency Department Visits"	Project officer review
4.4.03	Publication date of the "Inventory of Substance Abuse Treatment Services" report	Project officer review

The target for the National Survey on Drug Use and Health was met. The performance target for the Drug Abuse Warning Network System was set at an approximate target level, and the deviation from that level was 12 months. There was an effect on overall program or activity performance. The delay in publication occurred because the national estimates were calculated incorrectly by the contractor. This required a detailed examination of their process for weighting and estimation. New weights had to be produced. These required extensive quality assurance. The publication had to be rewritten. The target for the Drug and Alcohol Services Information System was met.

Agency Support for the Strategic Plan

Table 191: SAMHSA linkages with Goal 1 Health Care: Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.

HHS Strategic Goals	SAMHSA Goal 1: Accountability: Measure and Report Program Performance	SAMHSA Goal 2: Capacity: Increase Service Availability	SAMHSA Goal 3: Effectiveness: Improve Service Quality
1.1 Broaden health insurance and long-term care coverage.			
1.2 Increase health care service availability and accessibility.		X	
1.3 Improve health care quality, safety and cost/value.			X
1.4 Recruit, develop, and retain a competent health care workforce.		X	

Table 192: SAMHSA linkages with Goal 2 Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness: Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.

HHS Strategic Goals	SAMHSA Goal 1: Accountability: Measure and Report Program Performance	SAMHSA Goal 2: Capacity: Increase Service Availability	SAMHSA Goal 3: Effectiveness: Improve Service Quality
2.1 Prevent the spread of infectious diseases.			
2.2 Protect the public against injuries and environmental threats.			
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.		X	
2.4 Prepare for and respond to natural and man-made disasters.		X	

Table 193: SAMHSA linkages with Goal 3 Human Services: Promote the economic and social well-being of individuals, families, and communities.

HHS Strategic Goals	SAMHSA Goal 1: Accountability: Measure and Report Program Performance	SAMHSA Goal 2: Capacity: Increase Service Availability	SAMHSA Goal 3: Effectiveness: Improve Service Quality
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.		X	
3.2 Protect the safety and foster the well being of children and youth.		X	
3.3 Encourage the development of strong, healthier and supportive communities.		X	
3.4 Address the needs, strengths and abilities of vulnerable populations.		X	

Table 194: SAMHSA linkages with Goal 4 Scientific Research and Development: Advance scientific and biomedical research and development related to health and human services.

HHS Strategic Goals	SAMHSA Goal 1: Accountability: Measure and Report Program Performance	SAMHSA Goal 2: Capacity: Increase Service Availability	SAMHSA Goal 3: Effectiveness: Improve Service Quality
4.1 Strengthen the pool of qualified health and behavioral science researchers.			
4.2 Increase basic scientific knowledge to improve human health and human development.			
4.3 Conduct and oversee applied research to improve health and well-being.			
4.4 Communicate and transfer research results into clinical, public health and human service practice.	X		

Summary of Full Cost

(Budgetary Resources in Thousands)

Table 195: SAMHSA program full cost associated with HHS Goal 1 Health Care

HHS Strategic Goals	FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request
1.1 Broaden health insurance and long-term care coverage.	0.000	0.000	0.000
1.2 Increase health care service availability and accessibility.	1,885,737	1,933,313	1,994,874
1.3 Improve health care quality, safety and cost/value.	1,255	1,673	1,672
1.4 Recruit, develop, and retain a competent health care workforce.	48,030	44,912	44,861
Agency Subtotal Goal 1	1,935,022	1,979,898	2,041,407
Agency Total	**3,356,329**	**3,466,491**	**3,525,467**

Table 196: SAMHSA program full cost associated with HHS Goal 2 Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness

HHS Strategic Goals	FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request
2.1 Prevent the spread of infectious diseases.	0.000	0.000	0.000
2.2 Protect the public against injuries and environmental threats.	0.000	0.000	0.000
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	949,478	972,551	963,756
2.4 Prepare for and respond to natural and man-made disasters.	0.000	0.000	0.000
Agency Subtotal Goal 2	949,478	972,551	963,756
Agency Total	**3,356,329**	**3,466,491**	**3,525,467**

Table 197: SAMHSA program full cost associated with HHS Goal 3 Human Services

HHS Strategic Goals	FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.	0.000	0.000	0.000
3.2 Protect the safety and foster the well being of children and youth.	140,761	148,612	148,919
3.3 Encourage the development of strong, healthier and supportive communities.	148,452	157,520	154,990
3.4 Address the needs, strengths and abilities of vulnerable populations.	109,667	139,367	147,856
Agency Subtotal Goal 3	398,880	445,499	451,765
Agency Total	**3,356,329**	**3,466,491**	**3,525,467**

Table 198: SAMHSA program full cost associated with HHS Goal 4 Scientific Research and Development

HHS Strategic Goals	FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request
4.1 Strengthen the pool of qualified health and behavioral science researchers.	0.000	0.000	0.000
4.2 Increase basic scientific knowledge to improve human health and human development.	0.000	0.000	0.000
4.3 Conduct and oversee applied research to improve health and well-being.	0.000	0.000	0.000
4.4 Communicate and transfer research results into clinical, public health and human service practice.	72,949	68,543	68,539
Agency Subtotal Goal 4	72,949	68,543	68,539
Agency Total	**3,356,329**	**3,466,491**	**3,525,467**

Summary of Findings and Recommendations from Completed Program Evaluations

Further details on SAMHSA's completed evaluations completed during any fiscal year can be found at the HHS Policy Information Center website (http://aspe.hhs.gov/pic/performance)

Title: Evaluation of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program: Phase III Evaluation Report
Coordinating Office: SAMHSA's Center for Mental Health Services

The independent evaluation of the PAIMI Program found that individual PAIMI programs provide those individuals with psychiatric disability a voice in the exercise of their rights and are highly successful in achieving client and system goals and objectives. Findings show that PAIMI clients are very satisfied with the individual advocate or attorney who provided their services. Of the PAIMI clients surveyed: 82 percent believe the advocate/attorney listened to their story and truly understood their circumstance; 92 percent believe their advocate/attorney did everything they could do to obtain the outcome s/he wanted; 70 percent felt the quality of their representation was "excellent," and 24 percent felt it was "good." Twenty percent of grantees sampled report that they met or partially met all projected goals and objectives, and overall, grantees reported having met 93 percent of targeted goals and objectives. The evaluation also found that P&A Executive Directors felt that resource levels influence PAIMI's capability for work in vital areas such as jail advocacy, outreach, hospital monitoring, and housing.

Title: HIV Cohort 4 and 5 APR Evaluation
Coordinating Office: SAMHSA's Center for Substance Abuse Prevention

These two programs were designed to address the following three goals:

1. Increase provision of effective integrated substance abuse and HIV prevention services to minority youth and adults at-risk for substance abuse and HIV infection.
2. Increase number of community-based organizations that provide effective integrated substance abuse and HIV prevention services to minority youth and adults at-risk for substance abuse and HIV infection.
3. Increase the capacity of community-based organizations to successfully sustain their integrated prevention services. –

There were 22 cohort 4 and 45 cohort 5 grantees totaling 67. Nineteen or 86 percent of the cohort 4 and 33 or 73 percent of the cohort 5 grantees submitted data abstract forms totaling 52 or 78 percent. About 50 percent of them were community-based organizations located primarily in urban areas. More than half implemented evidence-based programs with the two most popular ones being "Be Proud, Be Responsible," and "Street Smart." For the most part, social learning and cognitive theory served as their theoretical framework. Most program participants were in the 12-17 and 18-25 year-old

age groups. The majority were Black and Hispanic and there were slightly more females than males. The most commonly used recruitment strategies were word-of-mouth, telephone, radio and community outreach. Both individual and group interventions were used. The individual interventions included risk reduction counseling, education, health education, peer education and mentoring. The most commonly employed group interventions were skill building, health education, and cultural enhancement activities. Thirteen of the grantees conducted HIV testing and 27 provided other health care services.

Sixteen or (73 percent) of the 22 cohort 4 and 40 or 89 percent of the 45 cohort 5 grantees submitted participant level data equaling 56 or 84 percent of the total 67 grantees. From this pool of data, 48 percent could be used to assess program outcomes. This equals 3,207 participants of whom 61.9 percent were from cohort 4 and 38.1 percent from cohort 5. At baseline, these participants exhibited lower perception of risk attitudes towards smoking and binge drinking as well as disapproval of substance use by peers than did National Survey of Drug Use and Health (NSDUH), respondents. On the other hand the participants reported higher past 30 day substance use rates than did the NSDUH respondents.

In order to determine how effective the program was only data from matched participant pairs could be used. The number of matched pairs of program entry and exit for youth ranged from 3,400 to 2,620, and for adults they ranged from 300 to 350. For perception of harm, the program demonstrated positive change for all measures except for adults and drinking to 4-5 drink/day. Likewise for disapproval of substance use, the program demonstrated positive increases for all measures except for adults in regard to smoking 1-2 packs/day and smoking marijuana once per twice/day. The numbers of matched pairs for non-user stability and user decrease declined substantially. For non-user stability the number of youth matched pairs ranged from 1,065 to 2,080, however the rates of non-user stability remained high ranging from 90-99 percent. For adults the number of matched pairs declined to 70 to 380, but here too the non-user percentages remained high ranging from 83-100 percent For past 30 day user decrease, the number of youth matched pairs declined further, but the results were impressive ranging from 60 percent for alcohol to 100 percent for heroin. For adults the declines were also impressive ranging from 31 percent for cigarettes to 59 percent for cocaine.

Title: National Survey of Substance Abuse Treatment Services (N-SSATS): 2007. Data on Substance Abuse Treatment Facilities
Coordinating Office: SAMHSA's Office of Applied Studies

This report presents results from the 2007 National Survey of Substance Abuse Treatment Services (N-SSATS), an annual census of facilities providing substance abuse treatment. Conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), N-SSATS is designed to collect data on the location,

characteristics, and use of alcoholism and drug abuse treatment facilities and services throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.

A total of 14,359 facilities completed the survey. The 13,648 facilities eligible for this report had a one-day census of 1,135,425 clients enrolled in substance abuse treatment on March 30, 2007. There were 85,518 clients under age 18 in treatment on March 30, 2007, making up 8 percent of the total population in treatment on that date. Forty five percent of all clients were in treatment for both alcohol and drug abuse, 36 percent were in treatment for drug abuse only, and 19 percent were in treatment for abuse of alcohol alone. Eighty-seven percent of facilities had clients in treatment for co-occurring mental health and substance abuse disorders. Forty percent of all clients were in treatment for these disorders.

Title: Results from the 2007 National Survey on Drug Use and Health: National Findings
Coordinating Office: SAMHSA's Office of Applied Studies

The 2007 National Survey on Drug Use and Health was administered to a sample of 67,870 persons representative of the U.S. civilian, non-institutional population aged 12 or older. This initial report on the 2007 data provided national estimates of rates of use, numbers of users, persons meeting criteria for substance use disorders, substance use treatment, and other measures related to illicit drugs, alcohol, and tobacco products. Results also were presented for measures of mental health problems, including major depressive episode and serious psychological distress, as well as data on the co-occurrence of substance use disorders and mental health problems. In 2007, an estimated 19.9 million Americans aged 12 and older (8.0 percent) were current (past month) illicit drug users, a rate similar to that in 2006 (8.3 percent or 20.4 million users) and in 2002-2005. Among youths aged 12 to 17, 9.5 percent were current illicit drug users, down from 11.6 percent in 2002. Current marijuana use among youths aged 12-17 declined from 8.2 percent in 2002 to 6.7 percent in 2007. In 2007, 127 million persons aged 12 or older (51.1 percent) were current alcohol users; 57.8 million (23.0 percent) engaged in binge drinking at least once in the past month. Underage drinking (ages 12-20) has remained unchanged since 2002, and was 27.9 percent in 2007. The rate of current use of any tobacco product among persons aged 12 or older decreased from 29.6 percent in 2006 to 28.6 percent in 2007; current cigarette smoking declined from 26.0 percent in 2002 to 24.2 percent in 2007. Among youths aged 12-17, the rate changed little from 2006 (10.4 percent) to 2007 (9.8 percent) but is lower than the rate in 2002 (13.0 percent). In 2007, an estimated 23.2 million persons aged 12 or older (9.4 percent) needed treatment for an alcohol or illicit drug problem. Of those persons, 2.4 million (10.4 percent) received treatment at a specialty facility; 20.8 million in need of treatment did not receive care. In 2007, an estimated 16.5 million adults aged 18 or older (7.5 percent) and 2.0 million youths aged 12 to 17 (8.2 percent) had a major depressive episode (MDE) in the past year. Around 24.3 million adults aged 18 or older (10.9 percent) had serious psychological distress (SPD) in the past year.

Title: Treatment Episode Data Set (TEDS) –1996-2006. National Admissions to Substance Abuse Treatment Services
Coordinating Office: SAMHSA's Office of Applied Studies

This report presents results from the Treatment Episode Data Set (TEDS) for 2006, and trend data for 1996 to 2006. The report provides information on the demographic and substance abuse characteristics of the 1.8 million annual admissions to treatment for abuse of alcohol and/or drugs in facilities that report to individual State administrative data systems. Between 1996 and 2006, TEDS treatment admissions were dominated by five substances: alcohol, opiates (primarily heroin), marijuana, cocaine, and stimulants (primarily methamphetamine). These substances together consistently accounted for between 95 and 96 percent of all TEDS admissions from 1996 through 2006. The age distribution of TEDS admissions changed between 1996 and 2006. The proportion of TEDS admissions aged 25 to 34 years declined from 34 percent in 1996 to 25 percent in 2006. This decline was offset by overall increases in the proportions of both older and younger admissions. The proportion of older admissions (aged 45 and older) increased from 13 percent in 1996 to 22 percent in 2006. The proportion of younger admissions (less than 25 years of age) increased from 22 percent in 1996 to 26 percent in 2006.

Title: Treatment Episode Data Set (TEDS) Highlights - 2007
Coordinating Office: SAMHSA's Office of Applied Studies

This report presents summary results from the Treatment Episode Data Set (TEDS) for 2007. The report provides information on the demographic and substance abuse characteristics of the 1.8 million annual admissions to treatment for abuse of alcohol and drugs in facilities that report to individual State administrative data systems. This summary report is issued in advance of the full TEDS report for 1997-2007. It includes demographic data and all items from the TEDS Minimum Data Set. The full report also will include data from the Supplemental Data Set, State data, and State rates.

Five substances accounted for 96 percent of all TEDS admissions in 2007: alcohol (40 percent); opiates (19 percent; primarily heroin); marijuana/hashish (16 percent); cocaine (13 percent); and stimulants (8 percent, primarily methamphetamine). Sixty-two percent of TEDS admissions in 2007 entered ambulatory treatment, 20 percent entered detoxification, and 18 percent entered rehabilitation/residential treatment. In 2007, more than one-third (37 percent) of TEDS admissions were referred to treatment through the criminal justice system. One-third (33 percent) of TEDS admissions represented self or individual referrals.

Title: Assessment of California's Mental Health Parity Law: A Step Toward Broader Mental Health System Reform
Coordinating Office: SAMHSA's Center for Mental Health Services

This study addressed various questions: what are issues/problems in legislation implementing parity (equivalence between mental health benefits and general health care benefits in health insurance plans); how have costs and use changed as a result of parity; and what are consumer, employer, insurer, and provider opinions about the effects of the law? Federal and state legislation require benefit parity. The scope and application of these legislative efforts are often limited. California implemented parity legislation in 2000 that provides for equal coverage for severe mental illnesses and covers children with one or more mental disorders. Unlike the parity legislation enacted in many other states, small businesses are not exempt. The size and complexity of California's economy and health care market make its parity mandate especially important to understand.

- Health plans reported that outpatient mental health utilization increased following passage of the law requiring parity
- Cost increases were reported to be nominal due to the use of managed care
- Stakeholders did not feel that parity relieved the financial burden on the public mental health system

Discontinued Performance Measures

The following table includes a list of performance measures which have been discontinued since being reported in the Online Performance Appendix of the FY 2009 Congressional Justification available on the SAMHSA website at http://www.samhsa.gov/Budget/FY 2009/SAMHSA_Online_appendix.pdf. Measures which are planned for retirement, but which still have data to report have been included in the program performance data tables on preceding pages.

Table 199: Discontinued Performance measures

Center	Program	Measure Unique Identifier
CMHS	PRNS - Remaining Capacity	1.2.04
CMHS	COSIG	1.2.21
CSAP	PRNS - Capacity	2.3.18
CSAP	PRNS – Minority AIDS	2.3.34
CSAP	PRNS Science and Service: CAPTs	2.3.32 2.3.33
CSAP	SAPTBG – 20% Prevention Set-Aside	2.3.55
CSAT	ATR	1.2.38
CSAT	Substance Abuse Drug Courts	1.2.56 1.2.57 1.2.58 1.2.59 1.2.60 1.2.61
CSAT	SAPTBG – Treatment Activities	1.2.46

New Performance Measures

The following table includes a list of performance measures which have been added since the publication of the Online Performance Appendix of the FY 2009 Congressional Justification (available on the SAMHSA website at http://www.samhsa.gov/Budget/FY2009/SAMHSA_Online_appendix.pdf).

Table 200: New Performance Measures

Center	Program	Measure Unique Identifier
CMHS	Suicide Prevention	2.3.60 2.3.61
CMHS	Trauma-Informed Services	3.2.23 3.2.24
CMHS	PRNS - Science and Service	1.4.06 1.4.07
CSAP	PRNS – Minority AIDS	2.3.70
CSAP	PRNS - STOP Act	3.3.01 3.3.02 3.3.03
CSAP	PRNS - Science & Service	2.3.71 2.3.72 2.3.73 2.3.74 2.3.75 2.3.76
CSAT	Criminal Justice - Substance Abuse Drug Courts	1.2.62 1.2.63 1.2.64 1.2.65 1.2.66 1.2.67 1.2.68 1.2.69 1.2.70 1.2.71 1.2.72 1.2.73 1.2.74 1.2.75 1.2.76 1.2.77 1.2.78 1.2.79
CSAT	Criminal Justice – Ex-Offender Re-Entry	1.2.80 1.2.81

Disclosure of Assistance by Non-Federal Parties

No non-Federal entities were involved in any significant role in the preparation of SAMHSA's 2008 Annual Performance Report.