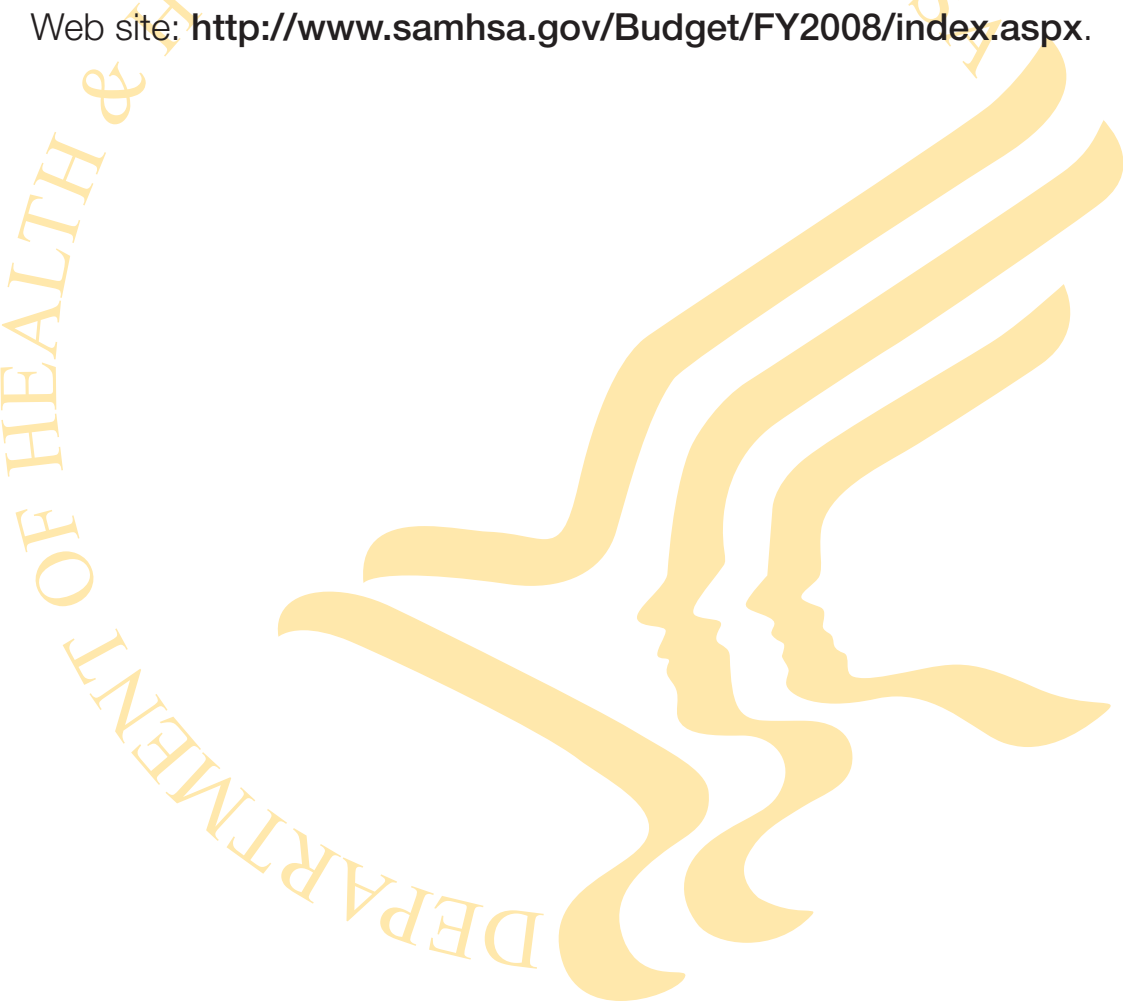
Programs in Brief

October 2007

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Preface

The Substance Abuse and Mental Health Services Administration (SAMHSA) is pleased to present the 2007 edition of *Programs in Brief*. On the following pages, you will find descriptions of many of SAMHSA's major grant and contract programs funded in 2007. The programs are organized and presented according to the SAMHSA Matrix of Program Priorities. A brief description of each program includes an overview of the significant mental health or substance abuse problem to be addressed, how SAMHSA has addressed that problem, and the results that have been achieved to date by the program. More information about these and other grant and contract programs can be found at SAMHSA's Web site: **http://www.samhsa.gov**. More information about SAMHSA's budget can be found at the following Web site: **http://www.samhsa.gov/Budget/FY2008/index.aspx**.



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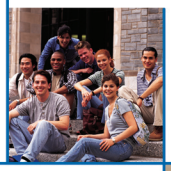
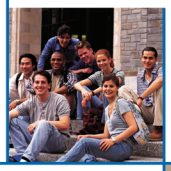




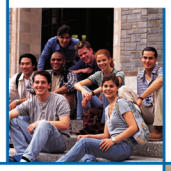
DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Matrix Area—
Co-Occurring Disorders

To expand and improve prevention, appropriate treatment, and other supportive services to individuals with or at risk for co-occurring disorders. Approximately 5.6 million individuals in the United States are estimated to be affected by co-occurring mental and substance abuse disorders. However, only a small percentage of these individuals receive treatment that addresses both disorders.

Co-Occurring State Incentive Grants[1]

(CSAT & CMHS)



The Challenge

The Co-Occurring State Incentive Grant (COSIG) builds on SAMHSA's *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. The report concluded that many persons with co-occurring disorders (CODs) are only treated for one disorder, if they are treated at all.

The Response

The COSIG program has two primary goals: 1) to develop and enhance the infrastructure of States and their treatment service systems; and 2) to increase the capacity of States to provide accessible, effective, comprehensive, coordinated/integrated, evidence-based treatment services to persons with CODs and their families.

The Results

Seventeen States are implementing programs through these grants. South Dakota and Delaware will receive COSIG awards in 2007. Activities include the following:

- Alaska established an integrated planning and implementation structure, and a detailed strategic planning and quality improvement process to monitor and promote integrated treatment for individuals with CODs.
- Arizona extended its existing co-occurring infrastructure to the State's adult and juvenile criminal justice systems.
- Arkansas instituted standardized screening and assessment and trained caregivers from both systems to better recognize CODs and create treatment plans.
- Connecticut's goals are to establish standardized screening and assessment to identify and treat persons with CODs; coordinate and integrate across modalities; and disseminate information for data-based decisionmaking.
- The District of Columbia is focusing on expanding COD competencies by training mental health and substance use clinicians; capacity building; and systems change to create an integrated service delivery approach.
- Hawaii provided integrated evidence-based treatment services to people with CODs; the State also created a seamless and comprehensive system of care for people with CODs.
- Louisiana developed cross-agency screening and assessment tools; they also integrated management information and program evaluation systems, innovative funding structures for substance abuse services, and licensing standards that support integrated treatment.
- Maine's COSIG project functions at two levels: 1) developing and enhancing State infrastructure to accept a single service system for COD; and 2) implementing capacity-building goals in a variety of settings throughout the State.
- Minnesota will use the COSIG grant to achieve systems transformation through the implementation of Integrated Dual Disorder Treatment in both mental health settings and chemical dependency settings.
- Missouri developed infrastructure and services for clients with CODs and a standardized screening and assessment system, implemented evidence-based treatment practices, and trained staff to operate the new systems.
- New Mexico is expanding integrated treatment for CODs to increase the identification and assessment of persons with this condition and to increase provision of integrated treatment services.
- Oklahoma is developing an integrated system of care for persons with CODs that is accessible to consumers and their families, culturally competent, and grounded in evidence-based practices.
- Pennsylvania integrated mental health and substance abuse treatment by creating a permanent State-level infrastructure and by enhancement activities to implement a comprehensive, integrated approach to serving persons with CODs.
- South Carolina's goal is to improve recognition, diagnosis, and treatment of CODs through uniform screening and assessment, intensive cross-training of staff in best practices, and better collaboration and information sharing.
- Texas increased capacity by building on existing services, ensuring greater competencies among service providers through training, and evaluating the State's current practice for serving these clients.
- Vermont's primary goals are to redesign information and business systems to support integrated treatment services, train local clinical and administrative leaders, and create community-based programs.
- Virginia is enhancing the data infrastructure capacity for the State's public substance abuse and mental health service system by building on existing data collection and reporting systems.

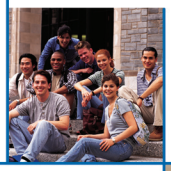
[1] Budget Category—PRNS—Co-Occurring SIG

Matrix Area—Substance Abuse Treatment Capacity

To expand and enhance clinical substance abuse treatment services and recovery support services to build resilience and facilitate recovery for those with substance use problems. In 2006, the number of persons aged 12 or older needing treatment for an alcohol or illicit drug use problem was 23.6 million. Of these, 2.5 million received treatment at a specialty facility in the past year. Of the 21.1 million people who needed but did not receive treatment in 2006, an estimated 940,000 reported that they felt they needed treatment for their alcohol or drug use problem, and of these, 314,000 (33.5%) reported they made an effort but were unable to get treatment, while 625,000 (66.5%) reported making no effort to get treatment.

Substance Abuse Prevention and Treatment Block Grant[1]

(CSAT)



The (Treatment) Challenge

According to the National Survey on Drug Use and Health, in 2005, 21.1 million people needed substance use treatment but did not receive treatment at a specialty facility. Only 940,000 people reported that they felt they needed treatment for their illicit drug or alcohol use problem, and only 314,000 made an effort to get treatment. For youth, the perceived availability of drugs increased with age—with 22.0 percent of 12 or 13 year olds saying it would be fairly or very easy to obtain marijuana compared with 75.5 percent of those aged 16 or 17.

In FY 2007, the following challenges were most frequently identified by the States and territories in their Annual Synar Reports, regarding compliance with tobacco regulations: limited resources for law enforcement of youth access laws (64.4%); limited resources for activities to support enforcement of and compliance with youth tobacco access laws (64.4%); and, geographic, demographic, and logistical considerations in conducting inspections (50.9%).

The Response

The overall goal of the Substance Abuse Prevention and Treatment (SAPT) Block Grant is to support and expand substance abuse prevention and treatment services. Under the authorizing legislation, States and territories have great flexibility in obligating and spending their block grant funds. Funds must be used to support treatment and prevention services for people who are currently or who are at risk of abusing or becoming dependent on alcohol and other drugs. States also are required to implement the Synar youth anti-tobacco statute and regulation under this program.

The SAPT Block Grant accounts for approximately 42 percent of public funds expended at the State and local level on substance prevention activities and treatment services. The grant funds are disbursed to the States, the District of Columbia, territories[2], and the Red Lake Band of Chippewa Indians, based on a congressionally mandated formula. The SAPT Block Grant empowers States to design solutions to address specific local substance abuse problems through a variety of means. Both the authorizing legislation and implementing regulations place special emphasis on the provision of treatment to injecting drug users, to substance-using pregnant women and women with dependent children, and on making primary prevention services available to individuals not in need of substance abuse treatment.

The Results

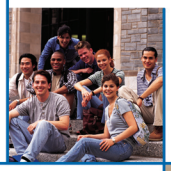
Performance outcome measures, designed to assess the effectiveness of prevention and treatment activities, have been reported voluntarily since FY 2000. In addition, 43 States/territories use these data to allocate funding to treatment service providers; 39 to plan services; 34 for public education; and 32 for legislative initiatives. State substance abuse agencies reported the following outcomes for services provided: During 2004, 34 of 35 States identified improvements in client abstinence from alcohol and other substances; 33 of 38 States identified improvements in client employment; 26 of 27 States reported a reduction in arrests; 27 of 31 States identified improvements in stable housing for clients.

[1] Budget Category—SAPTBG

[2] The term territories means American Samoa, Commonwealth of Puerto Rico, Commonwealth of the Northern Marianas Islands, Federated States of Micronesia, Guam, the Virgin Islands, Republic of the Marshall Islands, and Palau.

Grants to Strengthen Substance Abuse Treatment Access and Retention—State Implementation[1]

(CSAT)



The Challenge

Outpatient treatment providers face tremendous challenges in their efforts to serve populations in need of treatment. States are in a unique position to effect system change by working together with outpatient substance abuse treatment providers to remove systems barriers, streamline administrative procedures, provide incentives, and assist provider networks in their efforts to improve access and retention performance outcomes.

The Response

The Strengthening Treatment Access and Retention—State Implementation (STAR-SI) program builds on the innovative work of the Network for the Improvement of Addiction Treatment (NIATx), a joint initiative of SAMHSA's Center for Substance Abuse Treatment (CSAT) and The Robert Wood Johnson Foundation that focuses on process improvements to enhance treatment access and retention. Funded in 2006 by CSAT, the program is a cooperative agreement that promotes State level implementation of process improvement methods to improve access to and retention in outpatient treatment.

Under STAR-SI, States partner with substance abuse treatment organizations to demonstrate how quality improvement methods (i.e., process improvement) can be used to improve access and retention of clients in treatment. States learn how to effectively disseminate process improvement methods, partner with substance abuse treatment providers in the operation of peer-learning networks, and implement administrative and regulatory changes that support system-level access and retention improvements. Through STAR-SI, States develop the infrastructure and technical expertise needed to implement process improvement methods.

In the first year of this program, $2.2 million was distributed to seven States for the STAR-SI program (FL, SC, IL, IA, OH, ME, and WI). As part of their process improvement efforts, grantees implement fiscal, regulatory, and policy changes to remove barriers and create incentives to improve treatment access and retention.

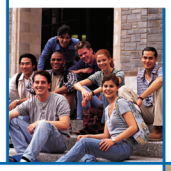
The Results

In FY 2006, 43 outpatient treatment providers participated in STAR-SI. Each participating provider received training in the NIATx process improvement model, implemented two or more access and retention improvements as part of the project, and participated in two peer-learning network meetings. At the State level, each grantee identified peer mentors, hosted two peer-learning network meetings, and implemented a change project to remove barriers to treatment. Grantees developed partnerships with outpatient treatment providers, State treatment provider associations, and fiscal intermediaries to design and implement the program. In addition, grantees implemented performance management systems to track progress toward goals and provided feedback to participating treatment agencies.

[1] Budget Category—PRNS—Strengthening Treatment Access and Retention

Access to Recovery[1]

(CSAT)



The Challenge

The economic costs associated with drug abuse are estimated at $110 billion. The human costs are measured in lost jobs, lost families, and lost lives. With treatment, even hard-to-reach populations reduce their illegal drug use, and criminal activity is decreased. Addiction treatment markedly increases employment and decreases homelessness, results in substantially improved physical and mental health, and reduces risky sexual behaviors. When tailored to the needs of the individual, addiction treatment is as effective as treatments for other illnesses, such as diabetes, hypertension, and asthma.

The Response

To increase the Nation's capacity to provide substance abuse treatment, President Bush announced a new initiative, Access to Recovery (ATR) in 2003. ATR ensures free and independent client choice of providers through the use of vouchers and improves access to a comprehensive array of clinical treatment and recovery support services (including faith- and community-based options). Recovery Support Services include medical care, housing, basic needs, childcare, transportation, employment training, education, recovery mentors/peer coaching, spiritual counseling, etc. In August 2004, SAMHSA announced 15 grant awards to: California, Connecticut, Florida, Idaho, Illinois, Louisiana, Missouri, New Jersey, New Mexico, Tennessee, Texas, Washington, Wisconsin, Wyoming, and the California Rural Indian Health Board. Grantees were encouraged to support a balanced mixture of clinical treatment and recovery support services to achieve the program's goal of achieving cost-effective, successful outcomes for the largest number of people over a 3-year period from August 2004 to August 2007. In March 2007, the second ATR RFA was released to the public. Up to $96 million will be awarded—$25 million of these funds must be spent on addressing methamphetamine issues. This cohort of ATR grantees will be funded for up to 3 years.

The Results

The ATR program was designed to ensure accountability and effectiveness in the use of Federal funds by monitoring outcomes; tracking costs; and preventing waste, fraud, and abuse.

The following preliminary data were reported by grantees through March 31, 2007:

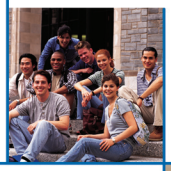
- 170,120 clients have received clinical treatment and/or recovery support services, exceeding the target of 125,000 expected to be served over three years.
- 63% of clients for whom all data are available received Recovery Support Services.
- Approximately 48% of dollars redeemed were for Recovery Support Services.
- About 31% of the dollars paid for services went to faith- and community-based organizations.
- Faith-based providers account for 22% of all recovery support providers and 31% of all clinical treatment providers with a voucher redemption in the Services Accountability Improvement System (SAIS).

ATR quarterly outcome data reflect changes over time from intake to discharge from services. Through March 31, 2007, ATR grantees have collected discharge data on 105,873 clients:

- 71.4% of the substance using clients were abstinent from substance use at discharge.
- 22.3% of the non-housed reported being stably housed at discharge.
- 29.3% of those unemployed reported being employed at discharge.
- 59.5% of those not socially connected were socially connected (attended self help groups or had someone to whom to turn in times of trouble) by discharge.
- 84.7% of those involved with the criminal justice system reported no involvement with the criminal justice system at discharge.

[1] Budget Category—PRNS—Access to Recovery

DATA Physician Clinical Support System[1] (CSAT)



The Challenge

According to the 2006 National Survey on Drug Use and Health, there are an estimated 323,000 persons dependent on or abusing heroin and 1.6 million dependent on or abusing prescription pain relievers that they had used nonmedically. With 260,000 patients in methadone maintenance programs and another 170,000 receiving buprenorphine treatment, one could roughly estimate a treatment gap of around 1.2 million persons aged 12 or older. To address this longstanding problem, Congress enacted the Drug Addiction Treatment Act of 2000 (DATA) to allow trained, qualified physicians to prescribe or dispense certain Schedule III, IV, or V opioid medications in their office practices or in clinic settings for the treatment of opioid dependence. In 2002, the U.S. Food and Drug Administration approved the first of these medications—Suboxone and Subutex—to treat opioid dependence. SAMHSA has the responsibility to grant waivers to physicians and to conduct activities intended to expand the number of physicians who are treating patients with the provisions of the DATA. Over 15,695 physicians have been trained, and nearly 12,000 have been waived by SAMHSA to prescribe these medications. Yet, the stigma of addiction tends to discourage primary care physicians from obtaining training and treating this population. Also, the lack of physician experience, concerns over practical issues, and limited understanding of the appropriate role of medication in opioid treatment all appear to be factors in the slow adoption of this form of treatment intervention by the general medical profession.

The Response

The goal of the DATA Physician Clinical Support System (PCSS) program is to develop a coordinated, clinical support program for physicians who are treating addicted patients with buprenorphine products. The target participants are primary care physicians, pain specialists, psychiatrists, and other non-addiction medicine specialists, who are often reluctant to treat addicted patients and are not as familiar with opioid dependence treatment as others with addiction treatment experience. Addiction medicine and psychiatric specialists are encouraged to participate in the DATA Physician Clinical Support System or to serve as mentors. The maximum allowable award for this program is $500,000 in total funding per year for up to 3 years. Grantee efforts may include the following infrastructure development activities, as appropriate to each proposed project: provider/network development (i.e., clinical support network/system development to inform physicians of established standards of care); organizational/structural change (e.g., to increase access to and efficiency of services); development of the physician workforce; development of interagency coordination mechanisms (between national professional medical organizations or related organizations); and quality improvement efforts.

The Results

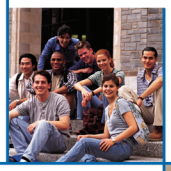
The PCSS continues to meet or exceed all program goals. In the third year of the project, the PCSS is approaching 2,000 participants. As of July 2007, there were 1,979 participants in the project with 78 mentors, including 5 clinical experts and a medical director. Mentors provide services to participants in all 50 States, the District of Columbia, and Puerto Rico. In addition, the program has participants from Canada, Japan, and Ireland.

A number of new online resources have been created and are being used, including the web site (**www.pcssmentor.org**), the downloading of self-study materials such as seven Clinical Guidances, and active daily exchanges among mentors on the PCSS listserv. The PCSS operates a warmline, which registers participants and matches them with an appropriate mentor within 48 hours. In addition, the warmline fields approximately 25 inquiries a week from individuals seeking general information about buprenorphine. Positive mention or full descriptions of the program have appeared in over 38 different publications, including the American Medical Association News, USA Today, and 16 State Medical Association newsletters. The PCSS has developed a 1-hour slide presentation on treating opioid addiction using buprenorphine in an office-based setting. This presentation is delivered at annual meetings of the State Chapters of the American Academy of Family Physicians and American College of Physicians. Since 2005, 30 presentations have been conducted.

[1] Budget Category—PRNS—Opioid Treatment Program/Regulatory Activities

Grants for Opioid Treatment Program Accreditation[1]

(CSAT)



The Challenge

The new Opioid Treatment Program (OTP) regulations establish a certification program managed by SAMHSA's Center for Substance Abuse Treatment (CSAT). The regulations became effective on May 18, 2001, and require OTPs to be certified. Certification is the process by which SAMHSA determines that an OTP is qualified to provide opioid treatment under the Federal standards established by the Secretary of Health and Human Services. To become certified, an OTP must be accredited by a SAMHSA-approved accreditation body and must comply with any other conditions for certification established by SAMHSA. The new system also provides standards for such services as individualized treatment planning, increased medical supervision, and assessment of patient outcomes. The accreditation process involves OTPs becoming reaccredited at least every 3 years and is an ongoing, continuous quality improvement process.

The Response

The purposes of OTP Accreditation grants are to: 1) reduce the costs of basic accreditation education and accreditation surveys and ongoing reaccreditation for OTPs; 2) ensure that new OTPs and OTPs that did not become fully accredited before the May 19, 2004, regulatory target date become fully accredited under 42 C.F.R. Part 8; and 3) ensure that OTPs maintain their accreditation by undergoing the reaccreditation process at least every 3 years. SAMHSA introduced an accreditation requirement under regulations finalized in 2001. Accreditation was introduced as a requirement to improve quality, and move opioid-assisted treatment further into mainstream medicine.

Grantees will be SAMHSA-approved accreditation bodies and will be expected to—

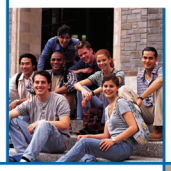
- Use grant funds to prepare OTPs for accreditation through education.
- Conduct accreditation/reaccreditation surveys using a peer-review process.
- Use grant funds to subsidize a portion of accreditation fees.
- Report accreditation/reaccreditation survey findings to OTPs and to SAMHSA, and use these survey findings for constructive feedback to OTPs.
- Follow up to ensure corrective action has been taken to optimize program functioning and treatment processes and to improve patient outcomes for the targeted population (i.e., persons addicted to opiates).
- Conduct "for cause" surveys of OTPs at the request of SAMHSA ("for cause" surveys are required to follow up on allegations of regulatory noncompliance or a pattern of complaints about an OTP).

The Results

The accreditation program has been successful in fulfilling its purpose of improving the quality of care in OTPs and monitoring program conformance with Federal regulatory treatment standards. Results from a formal CSAT study indicate that 86 percent of OTPs in the study reported that the accreditation process improved their programs. In addition, "look behind" inspections by an independent agency indicates that the Accreditation Organizations identify regulatory compliance in OTPs at least 90 percent of the time.

[1] Budget Category—PRNS—Opioid Treatment Program/Regulatory Activities

Opioid Screening, Brief Intervention, Referral, and Treatment[1] (CSAT)



The Challenge

According to the 2006 National Survey on Drug Use and Health (NSDUH), approximately 21 million individuals could benefit from treatment for their drug or alcohol use but don't believe that they have a substance use problem. Unfortunately, excessive drinking and drug use often go undetected in medical settings: because practitioners are seldom adequately educated in efficient means to identify and treat problems and disorders related to substance use. Early identification can decrease total healthcare costs by arresting progression toward addiction.

The Response

There is an emerging body of research and clinical experience that supports the use of the Screening, Brief Intervention, Referral, and Treatment (SBIRT) approach to provide effective early identification and interventions in primary care and general medical settings (e.g., community health centers, emergency departments, primary care offices, trauma centers) for persons who are nondependent users of alcohol and illicit drugs.

SBIRT was initiated at the end of FY 2003, using cooperative agreements to States and tribal organizations to expand and enhance the continuum of care by adding SBIRT services within primary care and general medical settings, early and brief interventions and treatment, and linkages with the specialty treatment system. Implementing the SBIRT approach should lead to systems and policy changes that will increase access to treatment in both the generalist and specialist settings.

Grantees must commit to and report performance against targets for the following: 1) reducing drug use by patients receiving treatment through the SBIRT project; 2) increasing the number of persons with substance use disorders who receive treatment in each subrecipient community; 3) increasing the number of community settings where SBIRT services are provided; and 4) providing treatment services within approved cost parameters for a given treatment modality.

The Results

Awards were given in September 2003 to California, Illinois, New Mexico, Pennsylvania, Texas, and Washington, and to the Cook Inlet Tribal Council, Inc. In September 2006, awards were given to Colorado, Florida, Massachusetts, and Wisconsin.

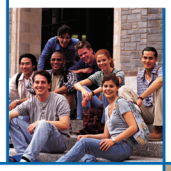
As of July 2007, SBIRT has achieved the following results since the inception of the program:

- There have been 522,782 persons served by the currently active SBIRT grantees.
- Abstinence increased by 149.2% from intake to 6 months.
- The percentage reporting no involvement in the criminal justice system increased by 3.5% from intake to 6 months.
- Employment increased by 16.7% from intake to 6 months.
- The percentage reporting social connectedness increased by 3.5% from intake to 6 months.
- The percentage reporting being housed increased by 6.0% from intake to 6 months.

[1] Budget Category—PRNS—Screening, Brief Intervention, Referral, and Treatment

Targeted Capacity Expansion General Program[1]

(CSAT)



The Challenge

A significant gap exists between the demand for treatment services for alcohol and drug abuse and their availability. Substance abuse patterns and service needs vary geographically, further complicating efforts to end the disparity. Because Substance Abuse Prevention and Treatment Block Grant funds typically provide operational support for baseline services nationwide, these funds are difficult to deploy quickly to meet unanticipated or emerging demands for specific treatments in particular areas of the country.

The Response

The Targeted Capacity Expansion (TCE) General program was introduced by CSAT in FY 1998 to help communities bridge gaps in treatment services. In general, TCE funding supports grants to units of State and local governments, tribal entities, and, as appropriate, domestic public and private, nonprofit organizations to expand or enhance a community's ability to provide a rapid, strategic, comprehensive, integrated, creative, community-based response to a specific, well-documented substance abuse capacity problem.

This program fosters the provision of evidence-based treatment practices. Since FY 1998, approximately 266 TCE-General grants have been awarded by SAMHSA/CSAT, addressing the following targeted populations or urgent, unmet, and emerging treatment needs: American Indians and Alaska Natives, racial and ethnic minority populations, rural areas, campus screening and brief intervention, methamphetamine abuse, innovative treatment methods, e-therapy, grassroots partnerships, and other populations.

The Results

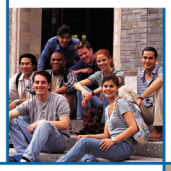
As of July, 2007, data from the currently active grantees indicate these initial results:

- There have been 8,117 persons served.
- Abstinence increased by 45.8% from intake to 6 months.
- The percentage reporting no involvement in the criminal justice system increased by 7.2% from intake to 6 months.
- Employment increased by 16.2% from intake to 6 months.
- The percentage reporting social connectedness increased by 8.0% from intake to 6 months.
- The percentage reporting being housed increased by 8.3% from intake to 6 months.

[1] Budget Category—PRNS—TCE—General

Recovery Community Services Program[1]

(CSAT)



The Challenge

The Recovery Community Services Program (RCSP) responds to a need, consistently voiced by people in recovery and their families, for community-based recovery support services that help prevent relapse and promote long-term recovery. Such services can reduce the strain that relapse places upon the already overburdened treatment system, and helps minimize the negative effects of relapse when it does occur, as well as contribute to the quality of life for people in recovery and their families and communities. The purpose of the RCSP is to deliver and evaluate peer-to-peer recovery support services that help prevent relapse and promote sustained recovery from alcohol and drug use disorders.

The Response

The RCSP builds upon the desire of many people in recovery and their families to "give back" by becoming a part of an expanded continuum of recovery in their communities. RCSP projects strengthen the continuum by bringing together peers (i.e., people who share the experience of addiction and recovery) to provide social support for each other's recovery. Peer recovery support services include the various forms of social support cited in the literature:

- **Emotional support**—demonstrations of support that bolster self-esteem and confidence; peer mentoring, peer coaching, and peer-led support groups are examples.
- **Informational support**—assistance with knowledge, information, and skill development; examples include life skills training, job skills training, citizenship restoration, educational assistance, and health and wellness information.
- **Instrumental support**—concrete assistance in helping others to do things; examples include providing transportation to get to support groups, childcare, clothing closets, and help in filling out job applications or obtaining entitlements.
- **Affiliational support**—offers the opportunity to establish positive social connections with other recovering people; it is important for people in recovery to learn pro-social and recreational skills in an alcohol and drug-free environment.

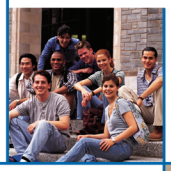
The Results

RCSP grantees are expected to maintain abstinence, improve family and living conditions, demonstrate gains in employment and/or education, reduce criminal justice involvement, and show improvements in mental and physical health status.

Data on the RCSP show very positive outcomes. There have been over 3,700 people in recovery from addiction that RCSP has served since 2004. In addition, the RCSP program provides support to family members or significant others of recovering individuals. As of July 2007, data indicate the following results: at 6 months post admission to services, 91% of clients report maintaining their sobriety; employment increased by 20%; stability in housing increased by 16%; and 94% reported a feeling of social connectedness.

[1] Budget Category—PRNS—Recovery Community Services Program

Residential Treatment for Pregnant and Postpartum Women and Residential Treatment for Women and Their Children[1]



(CSAT)

The Challenge

Scientific evidence indicates women with substance use disorders and their children, particularly those living at or near the poverty line, are among the most vulnerable populations. Women with substance use disorders often have histories of physical violence, sexual abuse, co-occurring mental health disorders, and HIV/AIDS. Their children often have multiple health, developmental, and social problems, and they are at risk for neglect, abuse, and removal from their families and communities.

The national treatment infrastructure has not kept pace with the demand or complexity of needs experienced by this population. The substance abuse treatment infrastructure needs to increase access to primary health, mental health, and social and recovery support services for pregnant, postpartum, and other parenting women who suffer from alcohol and drug use problems, as well as for their minor children impacted by the perinatal and environmental effects of maternal substance use and abuse. In addition, the infrastructure must be designed to address the needs of fathers of the children, partners of the women, and extended family members of the women and children to improve the overall treatment outcomes for the family unit as a whole. Meeting the needs of the entire family requires coordination of services with multiple agencies and across systems that often have different philosophies and approaches.

The Response

The Residential Treatment for Pregnant and Postpartum Women and Residential Treatment for Women and their Children (PPW/RWC) grant program is designed to strengthen the substance abuse treatment infrastructure that serves women, children, and families by expanding and enhancing treatment capacity. To promote and accomplish a comprehensive service system, substance abuse treatment providers and organizations are expected to partner with others in the public and private sectors to ensure that treatment services are well-coordinated, integrated, and comprehensive. These partnerships should include agencies/organizations such as local public housing authorities (for permanent housing for families), child welfare, health, mental health, family court, criminal justice, employment, education programs, and child-serving agencies.

The Results

The goals of this program are the following: 1) to develop cost-effective, comprehensive residential substance abuse treatment services for women and their minor children that can be sustained over time, beyond the period of Federal support; 2) to increase the capacity of the service systems to address the individual needs of the target population and preserve and support the family unit, while creating a safe and healthy environment for family members; 3) to develop documented models of effective service delivery that can be replicated in similar communities; and 4) to increase the use of evidence-based treatment practices to strengthen comprehensive systems beyond the treatment phase to include transitional resources.

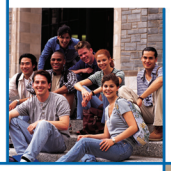
Since FY 2003, based on the Government Performance and Results Act (GPRA) data as of July 25, 2007, the PPW program has served a total of 1,841 pregnant, postpartum, and other parenting women. Outcomes reported for these women, from intake to 6 months include the following: abstinence increased by 111.9%; the percentage reporting no involvement in the criminal justice system increased by 9.0%; employment increased by 195.2%; the percentage reporting social connectedness increased by 6.5%; and the percentage reporting being housed increased by 7.0%.

[1] Budget Category—PRNS—Pregnant and Postpartum Women

Matrix Area—
Seclusion & Restraint

To provide training, technical assistance, and other support to States, providers, facilities, and consumers and families in order to reduce and ultimately eliminate seclusion and restraint in mental health and substance abuse care. Deaths due to seclusion and restraint are estimated at approximately 150 per year across the Nation. In addition to the very real risk of death and injury, individuals who have experienced previous physical or sexual abuse, can suffer further trauma when subject to these practices.

Alternatives to Seclusion and Restraint—State Incentive Grants[1] (CMHS)



The Challenge

In 1998, a prominent New England newspaper published an exposé documenting deaths directly associated with the inappropriate use of seclusion and restraint by staff in care and treatment facilities. Congress directed the Government Accountability Office (GAO) to investigate. In 1999 the GAO findings report noted that the inappropriate use of seclusion and restraint resulted in a disproportionate number of deaths involving children and identified other serious physical and psychological injuries associated with the use of seclusion and restraint. The report concluded that the full extent of injuries and deaths related to the inappropriate use of seclusion and restraint is unknown and that there is no comprehensive national reporting system to track injuries, deaths, or rates of seclusion and restraint.

Enactment of the Children's Health Act of 2000 provided rights to residents of certain facilities against the inappropriate use of seclusion and restraint. HHS was authorized to develop guidelines to assist States in establishing appropriate staff training models, licensure/certification standards, and effective State monitoring processes focused on improved outcomes for residents and staff that reduce/eliminate the misuse of seclusion and restraint.

The Response

In 2001, SAMHSA funded six competitive 3-year demonstration grants. Five were for State and private nonprofit entities to develop effective evidence-based best-practice alternative behavioral management training models, such as conflict resolution or de-escalation, to reduce the inappropriate use of seclusion and restraint in nonmedical, community-based residential and day treatment facilities for children and youth. The sixth grant funded a coordinating center (CC) to collect and analyze grantee data and prepare reports on data, outcomes, exemplary training models, and recommendations.

In 2004, SAMHSA funded another 3-year grant initiative, this one exclusively for eight States to develop alternatives to seclusion and restraint. These grants were to support States in their efforts to adopt best practices to reduce and ultimately eliminate the use of seclusion and restraint in institutional and community-based settings that provide mental health services (including services for people with co-occurring substance abuse and mental health disorders). States grantees were expected to do the following: 1) increase the number of programs that adopt best practices involving alternative approaches to reduce seclusion and restraint, including staff training models and other multifaceted approaches; and 2) collect data to document the program's impact on reducing seclusion and restraint use and on the adoption of alternative practices. The CC developed a methodology for analysis, collection, coordination, and dissemination of seclusion and restraint data; established common performance outcome indicators to facilitate comparison of State seclusion and restraint data; identified evidence-based practice criteria; etc. The CC also served as the SAMSHA resource center for seclusion and restraint and developed a seclusion and restraint web site that is accessible to other constituencies, and the general public.

To continue its efforts, in 2007 SAMHSA funded eight additional 3-year Alternatives to Seclusion and Restraint State Incentive Grants (SIG) that support State efforts to adopt best practices to reduce and ultimately eliminate the use of seclusion and restraint in institutional and community-based settings that provide mental health services.

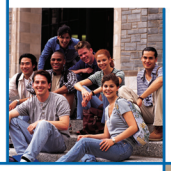
The Results

The FY 2007–09 grantees will collect data and report on performance indicators, such as the number of programs that adopted the best practices proposed in the SIG application, the use of seclusion and restraint, frequency, episode location and precipitants, gender, age, race/ethnicity, developmental/cognitive age, and unit/program where the individual is housed or treated. The CC will collect and analyze SIG grantee data, assess the SIG impact, serve as seclusion and restraint issue resource center to the States and others, and periodic progress reports to SAMHSA's Center for Mental Health Services (CMHS).

[1] Budget Category—PRNS—Seclusion & Restraint

Coordinating Center to Support Alternatives to Seclusion & Restraint State Incentive Grants[1]

(CMHS)



The Challenge

In FY 2001, SAMHSA sponsored an initiative to gather data and assess the issues related to the use of seclusion and restraint by awarding grants to five demonstration sites and a coordinating center. Each site developed and implemented best-practice models focused on alternative training approaches to be used by facility staff to reduce the inappropriate use of seclusion and restraint of children and/or youth with serious emotional disorders and behavioral management issues. These approaches emphasized the use of alternative behavioral management, such as conflict resolution or de escalation.

In FY 2004, SAMHSA funded a 3-year grant program, the Alternatives to Restraint and Seclusion State Incentive Grants (SIG), whose purpose was to support States in their efforts to adopt best practices to reduce and ultimately eliminate the use of seclusion and restraint in institutional and community-based settings that provide mental health services. Through this program, States worked to increase the number of programs that adopt best practices involving alternative approaches to reduce seclusion and restraint, including staff training models and other multifaceted approaches, and collected data to document the program's impact on reducing seclusion and restraint use and adopting alternative practices. A coordinating center was created to provide support to the grantees and to prepare a report on exemplary training models, and recommendations.

In FY 2007, SAMHSA once again funded the Alternatives to Restraint and Seclusion SIG to State mental health agencies, which builds on the work of the FY 2004 grant program.

The Response

The Coordinating Center to Support the Alternatives to Restraint and Seclusion State Incentive Grants has been funded to continue providing onsite technical assistance to and working in close collaboration with the eight grant recipients of the FY 2007–09 grants. As it did with the previous grantees, the Coordinating Center will develop and support a Steering Committee composed of representatives of various stakeholder groups to provide advice and guidance to the project; utilize consultants with expertise to provide technical assistance and training to the grantees; arrange for onsite reviews of the grantee sites to assess performance and provide direct training and consultation; and provide written reports of the site visits and progress of the project.

The Results

Through the Coordinating Center's support of the grantees' efforts toward implementation of alternative models to reduce and ultimately eliminate the use of seclusion and restraint in institutional and community-based settings that provide mental health services (including services for people with co-occurring substance abuse and mental health disorders), the grantees will adopt best practices that reduce and ultimately eliminate the use of restraint and seclusion in these settings.

[1] Budget Category—PRNS—Seclusion & Restraint

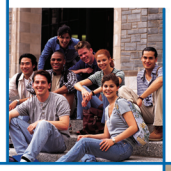
DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Matrix Area—Strategic Prevention Framework

To build the capacity of States, tribes, territories, and communities to decrease substance use and abuse, promote mental health, and reduce disability, comorbidity, and relapse related to mental and substance use conditions. The Strategic Prevention Framework (SPF) implements the following five-step process: 1) conduct a community needs assessment, 2) mobilize and/or build capacity, 3) develop a comprehensive strategic plan, 4) implement evidence-based prevention programs and infrastructure development activities, and 5) monitor process and evaluate effectiveness. The SPF approach to prevention supports the President's vision of a healthier U.S. in States, tribes, territories, and communities.

Substance Abuse Prevention and Treatment Block Grant[1]

(CSAP)



The Prevention Challenge

The challenge with the prevention set-aside portion (20%) of the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) is to develop and implement comprehensive substance abuse prevention plans and strategies that meet the diverse needs of each eligible State and territory. The absence of a common prevention planning framework in States and separate funding silos have frustrated the systems approach required to implementing effective health promotion and disease prevention in communities. As a part of the SAPT BG, the Youth Tobacco Access Regulation (Synar) requires States to report on their effort to reduce access of tobacco products to minors. In the FY 2007 Annual Synar Reports, States reported that a) limited resources for law enforcement of youth access laws; b) limited resources for activities to support enforcement of and compliance with youth tobacco access laws; and c) geographic, demographic, and logistical challenges in conducting inspections continue to hamper States' efforts to sufficiently address the Synar requirement.

The Response

The overall goal of the prevention set-aside of the SAPT BG is to support and expand substance abuse prevention services. Under the authorizing legislation, States and territories have great flexibility in obligating and spending their block grant funds. The SAPT BG accounts for approximately 42 percent of all public funds expended at the State and local level on substance prevention activities and treatment services. The grant funds are disbursed based on a congressionally-mandated formula. As a condition of this funding, States are required to implement the Synar youth anti-tobacco statute and regulation.

The SAPT BG requires that States submit an assessment of State prevention needs and describe its sub-State area planning process to determine which areas have the highest incidence and prevalence and the greatest need for prevention programs, policies, and practices. Thus, States are systematically assessing their prevention needs based on the five steps of the SPF: developing epidemiological data; building prevention capacity; developing a comprehensive strategic planning process; implementing effective community prevention programs, policies, and practices; and evaluating their efforts for outcomes. States are currently implementing the SPF as a planning, systems change, and community development process. States are also required to implement the Synar youth anti-tobacco statute and regulation under the substance abuse prevention portion of the SAPT BG program and continue to enforce the laws, educate communities, and assess the rate of sale of tobacco products to minors.

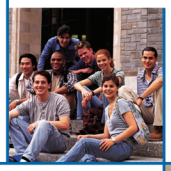
The Results

States and territories will begin reporting on the prevention National Outcomes Measures (NOMs) for the SAPT BG in FY 2008. In the States reporting on voluntary measures between 2005 and 2007, the following percentage changes were cited: number of people served increased from 29 percent in 2005 to 57 percent in 2007; number of evidence-based programs increased from 17 percent in 2005 to 48 percent in 2007; perception of risk increased from 0 percent in 2005 to 23 percent in 2007; reporting of 30-day use increased from 12 percent in 2005, to 28 percent in 2007. As of May 31, 2007, 48 States use the SPF (or equivalent) in their SAPT BG for State prevention assessment, 42 States use the SPF (or equivalent) for building State capacity, 51 States use the SPF (or equivalent) in planning, 34 States use the SPF (or equivalent) for prevention program implementation, and 22 States use the SPF (or equivalent) for evaluation efforts. The Strategic Prevention Framework is being embraced and implemented on a broad scale throughout the country, resulting in more effective and efficient substance abuse prevention plans for States and communities. These accomplishments reveal substantial progress in meeting the diverse needs of the SAPT BG recipients.

In spite of the challenges of meeting Synar requirements, States have maintained or lowered their tobacco retailer violation rates (RVR). In FY 2006, all 50 States met the Synar compliance measure by reporting less than a 20 percent sales rate of tobacco products to minors. Since the late 1990s, the RVR has dropped 30 percentage points, from 40.1 percent in 1997 to over 10 percent in FY 2006.

[1] Budget Category—SAPTBG

Strategic Prevention Framework—State Incentive Grants[1] (CSAP)



The Challenge

Many communities lack effective prevention programs to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; reducing substance-abuse-related problems in the communities; and building prevention capacity and infrastructure at the State/tribe and community levels.

The Response

To accomplish these goals of creating and providing effective prevention programs, SAMHSA implemented the SPF State Incentive Grants (SIGs) in 2004. The SPF SIGs are 5 year grants, which were awarded to the Office of the Governors in 19 States and 2 Pacific territories in 2004 and to an additional 5 States in 2005. The 2006 SPF SIG announcement offered the opportunity for federally recognized tribes and tribal organizations to apply for this grant for the first time. Ten additional States, one territory and five tribes were awarded grants in 2006.

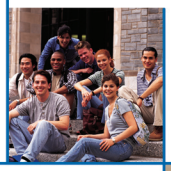
The SPF SIG is a data-driven, outcome-focused substance abuse prevention initiative designed to ensure that States and communities are making funding decisions based on priorities that are determined by the collection and analysis of comprehensive data. Supported by epidemiological workgroups, the SPF SIG is implemented through strong partnerships between the grantee States/tribes and their communities. The goals are achieved through the implementation of a Strategic Prevention Framework (SPF), which is a five-step State/tribe and community prevention planning process. The SPF expects every SPF SIG grantee to carry out a needs assessment; mobilize and build capacity; develop a comprehensive strategic plan; implement evidence-based programs, practices, and policies along with the community-level infrastructure to support them; and to monitor and evaluate effectiveness and sustain effective, culturally competent programs, practices, and policies. Each SPF SIG is guided by an Advisory Committee that includes the applicant agency, community, and private sector representation. The Drug Enforcement Agency and the State's lead agency on underage drinking are also members of the Advisory Committee.

The Results

SPF SIGs support an increasing number of States/tribes in their efforts to implement the five step SPF, SAMHSA's Center for Substance Abuse Prevention's (CSAP's) key mechanism for building prevention capacity. The program improves the capacity of States/tribes and communities to identify and address their most critical prevention needs. The SPF enables awardees to better use prevention resources; implement effective prevention programs, practices, and policies; and coordinate prevention among different agencies and funding streams. Eighty-five percent of program funds provided under the SPF SIGs are channeled to local community organizations, such as community coalitions, to respond to the challenge of bringing effective prevention to every community.

[1] Budget Category—PRNS—Strategic Prevention Framework

Centers for the Application of Prevention Technologies[1] (CSAP)



The Challenge

Research and documented experience at the Federal, State, and local levels provide clear evidence that substance abuse prevention works. However, identifying and selecting evidence-based programs, practices, and strategies that are appropriate to meet community needs and effective in addressing priority substance abuse problems remains a challenge for prevention planners at the State and community levels.

The Response

The role of the Centers for the Application of Prevention Technologies (CAPTs) is to enhance the organizational and technical capacity of State prevention systems to assist communities in implementing the SPF. CAPT program goals are to 1) expand capacity, increase effectiveness, and strengthen the performance and accountability of substance abuse prevention services at the State, community, and discretionary grant levels, and 2) provide training and technical assistance to support effective evidence-based substance abuse prevention programs, practices, and strategies that can be applied successfully within the diverse contexts of life within U.S. communities, States, tribes, other U.S. jurisdictions, and to CSAP's discretionary grantees.

The five regional CAPTs are attuned and responsive to their respective regional needs, yet function as a single integrated system. Their clients include CSAP's SPF SIG recipients, other States and jurisdictions, and CSAP's discretionary grantees. Each CAPT works to 1) increase the transfer and application of substance abuse prevention knowledge; 2) help clients identify and select appropriate evidence-based prevention practices; 3) make use of online, interactive technology assistance programs, including those available on CSAP's Prevention Platform Web site **http://preventionplatform.samhsa.gov** and **http://CAPTUS.gov**; and 4) provide technical assistance and training to enhance the knowledge, skills, and expertise of prevention planners in State and community prevention systems.

The Results

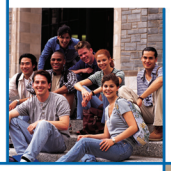
CAPTs serve to support the implementation of SAMHSA's SPF by—

- Promoting the adoption of best practices to improve State and community substance abuse prevention capacity, working in collaboration with SPF SIG projects, their subrecipients, and other States and jurisdictions to apply evidence-based substance abuse prevention knowledge and technology at the local level.
- Providing training and technical skill development to help States and localities identify and adapt best practices to match individualized community needs; address cultural competence issues; conduct evaluations; better understand prevention fundamentals, including how prevention works best in different settings, and risk and protective factors; and how to utilize new technology to deliver prevention messages.
- Identifying the most effective delivery methods for communities to promote adoption and sustainability of evidence-based prevention programs, practices, and policies that produce the greatest systems change and positive prevention outcomes.

[1] Budget Category—PRNS—CAPT

Prevention of Methamphetamine and Inhalant Abuse[1]

(CSAP)



The Challenge

Based on SAMHSA's 2003 National Survey on Drug Use and Health, lifetime use of methamphetamines was reported by 12.3 million Americans (5.2% of the population). Seven out of 10 people who abused inhalants—which can include such common substances as glue, gasoline, and household chemicals—were under the age of 18. Methamphetamine abuse spread east from Hawaii and is a serious addiction problem on the West Coast, in the Mountain States, and in parts of the Midwest. Both inhalant and methamphetamine abuse is increasing in small towns and rural areas.

The Response

CSAP supports the expansion of prevention interventions and/or infrastructure development targeting methamphetamine and inhalants through its grant programs.

By the end of FY 2004, CSAP funded 28 cooperative agreements in 16 States to assist localities to develop infrastructure or conduct targeted capacity expansion of prevention interventions that are effective and evidence-based. Twelve initial cooperative agreements were awarded by the end of FY 2002. Each initial grantee received a 1-year grant to pilot-test new prevention interventions or to expand or develop infrastructure for the prevention of methamphetamine and inhalant use. By the end of FY 2003, 16 projects were awarded 3-year cooperative agreements. States that have received funding to prevent the use of methamphetamine or inhalants include Alaska, Arizona, California, Hawaii, Iowa, Kansas, Maine, Michigan, Missouri, Nevada, New Mexico, New York, Ohio, Oregon, Pennsylvania, and Texas. The State of Iowa received extra funding for 1 year at $200,000 in FY 2004.

Under a new grant program, CSAP funded 10 Prevention of Methamphetamine Abuse grants in FY 2006. These new grants are located in the states of Washington, Colorado, Tennessee (2), Oklahoma (2), Oregon, Illinois, Massachusetts, and Texas. This new grant program focuses on methamphetamine abuse and addiction by assisting localities to expand prevention interventions that are effective and evidence-based, and/or to increase capacity through infrastructure development. These grants may provide community-based prevention programs, assist local government entities to conduct appropriate methamphetamine prevention activities, and train and educate State and local law enforcement officials on innovative approaches in working with drug-endangered children. Funds also may be used to target prevention and education officials, members of community anti-drug coalitions, and parents on the signs of methamphetamine use/abuse and addiction. Grantees are expected to develop options for prevention; plan, administer, and conduct educational activities related to the prevention of methamphetamine abuse and addiction; monitor and evaluate methamphetamine prevention activities; and report and disseminate evaluation results to the public to educate about the adverse consequences these drugs have on children, families, and communities.

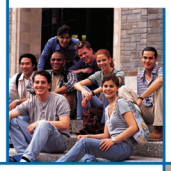
The Results

Key outcomes are not expected until late 2007.

[1] Budget Category—PRNS—Methamphetamine

Older Americans Substance Abuse and Mental Health Technical Assistance Center[1]

(CSAP)



The Challenge

The Older Americans Substance Abuse and Mental Health Technical Assistance Center was launched in 2004 and is dedicated to the prevention and treatment of substance abuse/misuse and mental health disorders within the older adult population. The significant impact of these disorders on the health and functioning of older people, their families, and communities and the associated increases in healthcare use and costs demonstrate a critical need for the identification, organization, dissemination, and implementation of evidence-based prevention and intervention programs in this area.

The Response

The mission of the Older Americans Substance Abuse and Mental Health Technical Assistance Center is to enhance the quality of life and promote the physical and mental well-being of older Americans by reducing the risk for and incidence of substance abuse/misuse and mental health issues later in life. Through partnerships with State and Federal agencies and health and social service providers, the Center will serve as a national repository to disseminate information, training, and direct assistance in the prevention and intervention of substance abuse/misuse and mental health disorders. Priorities for the Center include—

- Substance abuse/misuse
- Medication misuse and abuse
- Mental health disorders
- Co-occurring disorders

The Results

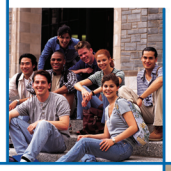
The Older Americans Substance Abuse and Mental Health Technical Assistance Center contract has conducted State planning meetings with Washington, Oregon, Ohio, Connecticut, Maryland, and Hawaii, along with American Samoa and the Northern Mariana Islands to help these States and territories identify substance abuse and mental health programs that currently exist as well as plan for needed services. Through a Memorandum of Understanding with the Administration on Aging (AoA), these meetings bring together service providers from the substance abuse, mental health, and geriatric fields. These meetings also provide an opportunity for these service providers to work together. The Center has also trained over 300 health and service providers on the Get Connected Toolkit and has made several presentations at gerontological, substance abuse, and mental health conferences.

In May 2007, the Louisiana and Mississippi State planning meeting, which uniquely focused on disaster preparedness and response, was held jointly with SAMHSA's Center for Mental Health Services' (CMHS's) 2005 Hurricanes Behavioral Health Lessons Learned/Reflections on the Crisis Counseling Program meeting. The "Louisiana and Mississippi State Planning Meeting: Older Adult, Substance Abuse, and Mental Health Disaster Response Meeting" engendered discussion between key State and Federal stakeholders invested in disaster preparation and older adult behavioral health long-term planning.

[1] Budget Category—PRNS—Evidence-based Practices

Federal and Other Drug-Free Workplace Programs[1]

(CSAP)



All CSAP workplace programs are combined under this header. They included Drug-Free Federal Workplace, Workplace Resource Center, Workplace Helpline, Mandatory Guidelines for Federal Workplace Drug Testing Programs (Current Requirements and Proposed Alternative Specimens and Testing Technologies), Workplace Prevention Research and Application, and related Workplace Health/Wellness Prevention initiatives.

The Challenge

The Nation's workplace has been and continues to be an excellent venue to address drug and alcohol use issues. Approximately 9.4 million illicit drug users and 10.1 million heavy drinkers have full-time jobs according to the "Worker Substance Use and Workplace Policies and Programs" report, SAMHSA 2007. Places of employment are also critical components of welfare-to-work initiatives, community redevelopment activities, and correction system reintegration programs. In September 1986, Executive Order 12564, Drug-Free Federal Workplace, required that the Department of Health and Human Services develop and oversee implementation of a Drug-Free Workplace Program in all Federal executive branch agencies. Under this continuing mandate, CSAP's Division of Workplace Programs provides day-to-day leadership in and oversight of this Federal Drug-Free Workplace program.

The Response

CSAP's Federal and Other Drug-Free Workplace Program includes—

- Publication in the *Federal Register of the Mandatory Guidelines for Federal Workplace Drug Testing Programs*. These Guidelines have been revised over time to address new testing issues, such as urine specimen validity testing. Proposed changes to these Guidelines asked for public comment on the use of alternative specimens including hair, oral fluid, and sweat patch, in addition to urine drug testing. Also proposed is the use of the Food and Drug Administration (FDA)-cleared Point of Collection drug testing devices used for testing urine and oral fluid, including testing for ecstasy. Additional guidance in the form of a Urine Specimen Collection Handbook and Medical Review Officer Manual has been developed. As of this writing, 45 laboratories are certified by the National Laboratory Certification Program (NLCP) to perform urine drug testing; over 60 percent of NLCP's operating revenue is derived from user fees paid by participating laboratories.
- Ongoing expertise to Federal agencies developing and refining Drug-Free Workplace Programs required by Executive Order and Public Law.
- Annually, each Executive Branch Agency is required to submit to Congress information about their Drug-Free Workplace Program, including drug testing results and implementation costs. That information is collected and summarized by the Division.
- *The Workplace Helpline,* (1–800–WORKPLACE) which provides callers from business, labor, and community organizations of all sizes with comprehensive, telephone consultations on how to establish drug-free workplace programs.
- Workplace Resource Center (**http://workplace.samhsa.gov**), including the Workplace Kit and health/wellness prevention resource (**http://GetFit.SAMHSA.Gov**).
- Social marketing of and guidance and support to workplaces adopting workplace programs in the SAMHSA National Registry of Evidence-based Programs & Practices (NREPP). For example, NREPP's workplace program, "Team Awareness" has adapted its program with SAMHSA to meet program needs of the National Guard.
- Service to Science Young Adult in the Workplace (YIW) demonstration grant program designed to discern and disseminate best practices related to substance abuse prevention and early intervention.

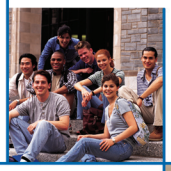
The Results

- Deters illicit drug use in Federal workplaces by promoting clear no-use policies, educating employees on consequences of illicit drug use, training supervisors about their responsibilities to help curb employee drug use, access to employee assistance programs, and using state-of-the-art drug testing technologies for mandated drug testing.
- Provides national leadership and advice on developing comprehensive drug-free and health/wellness prevention workplace programs for use in both public and private sectors.
- Provides national leadership in establishing and maintaining accurate and reliable workplace drug testing technologies and methods for Federal agencies and other federally mandated applications in transportation and nuclear power industries.
- Provides national leadership in developing and disseminating knowledge on drug-free workplace issues including secondary analysis of large data bases, writing and publication of peer-reviewed articles, dissemination of results through the SAMHSA Workplace Resource Center, Medical Review Officer Training, Knowledge Exchange Meetings, and other national, state and local conferences and meetings.

[1] Budget Category—PRNS—Workplace

Alcohol and Youth Programs[1]

(CSAP)



The Challenge

CSAP funds a range of programs designed to reduce underage alcohol use focused on community outreach, education and awareness, binge drinking, Fetal Alcohol Spectrum Disorders (FASD), and prevention policies.

The Response

CSAP's alcohol and youth programs include the following:

- **SAMHSA FASD**—addresses prevention of prenatal alcohol exposure among women of childbearing age. Communities, States, and juvenile justice systems use evidence-based screening, diagnosis, programs, and services in existing systems for children, youth, and adults. The program includes an FASD Center for Excellence.
- **Health Communication Initiative for the Prevention of Underage Alcohol Use**—this effort provides approaches that communities can use to build resiliency, enhance protective factors and reduce risk factors associated with underage alcohol use. It also assists the Interagency Coordinating Committee for Preventing Underage Drinking Prevention (ICCPUD), supporting the Surgeon General's *Call to Action to Prevent and Reduce Underage Drinking*.
- **Too Smart To Start**—Too Smart To Start (TSTS) is a national community education program targeting children and youth 9- to 13-years-old. The program includes materials and flexible strategies for use in communities of all sizes and actively involves entire communities in sending clear, consistent messages about why children should reject underage drinking. This program draws to completion September 2007. However, TSTS products and materials will be available through SAMHSA's Clearinghouse.
- **SAMHSA Reach Out Now National Teach-Ins**—SAMHSA encourages prominent national, State, and local leaders in every State to conduct teach-ins for fifth- and sixth-grade classrooms nationwide in April in conjunction with Alcohol Awareness Month.
- **SAMHSA Reach Out Now Fifth- and Sixth-Grade Scholastic Supplements**—SAMSHA and Scholastic, Inc. developed materials on underage drinking targeting 10- to 11-years-olds and their parents. The materials include a classroom discussion guide, activity sheet for students, and a take-home packet for parents.
- **SAMHSA Building Blocks for a Healthy Future**—an early childhood substance abuse prevention program to educate parents and caregivers about the basics of risk and protective factors, ways to reduce risk factors, and how to reinforce skills that will enable caregivers to promote healthy lifestyles.
- **State and Community-wide Town Hall Meetings**—national effort to prevent underage drinking and help educate young people and caring adults about the risks associated with underage alcohol use. SAMHSA and ICCPUD support recurring town hall meetings to increase the understanding and awareness of underage alcohol use and its consequences.

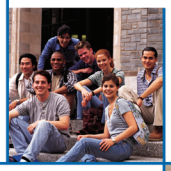
The Results

CSAP's alcohol-related programs are designed to help reduce underage alcohol use and adult alcohol abuse by enabling States, communities, and their providers to apply research findings, raising awareness through education and health promotion activities.

[1] Budget Category—PRNS—FASD & Best Practices Program Coordination

Drug-Free Communities[1]

(CSAP)



The Challenge

In 2006, 57.8 percent of first-time users of any illicit drug were under the age of 18. In the same year, 89.2 percent of the 4.4 million recent alcohol initiates were under the age of 21. Preventing initiation of use for both illicit drugs and alcohol requires the marshalling of resources from many sectors of a community. Thus, Congress signed the Drug-Free Communities Act (P.L. 105–20) into law on June 27, 1997. The Act provides financial assistance and support to community coalitions to carry out the mission of reducing substance abuse among the Nation's youth. On December 14, 2001, P.L. 107–82, 115 Stat. 814 (2001), reauthorized the program for 5 years. SAMHSA first entered into an interagency agreement with the Office of National Drug Control Policy (ONDCP) to administer the Drug-Free Communities (DFC) Support Program in FY 2004, and has continued to manage this important initiative to reduce/prevent substance abuse among our Nation's youth.

The Response

The DFC program is a collaborative initiative sponsored by ONDCP in partnership with SAMHSA to support community-based coalitions to achieve two primary goals. The first goal is to reduce substance abuse among youth and, over time, among adults by 1) addressing the factors in a community that increase the risk of substance abuse; and 2) promoting the factors that minimize the risk of substance abuse (substances include, but are not limited to, narcotics, depressants, stimulants, hallucinogens, cannabis, inhalants, alcohol and tobacco, where their use is prohibited by Federal, State, or local law). The second DFC goal is to establish and strengthen collaboration among communities; private nonprofit agencies; and Federal, State, local, and tribal governments to support the efforts of community coalitions to prevent and reduce substance abuse among youth.

The DFC provides grants to community coalitions to mobilize their communities to prevent youth substance abuse. The grants support coalitions of youth; parents; media; law enforcement; school officials; faith-based organizations; fraternal organizations; State, local, and tribal government agencies; healthcare professionals; and other community representatives. The program enables community coalitions to strengthen their coordination and prevention efforts, encourage citizen participation in substance abuse reduction efforts, and disseminate information about effective programs. DFC grantee coalitions must use the SPF. The DFC program also has a DFC mentoring program to provide grant funds to existing DFC grantees (mentors) to support the development and/or expansion of new community coalitions (mentees) that are focused on substance abuse prevention. In addition, SAMHSA/CSAP, with funds provided through an interagency agreement (IAG) with ONDCP, funded the Coalition Institute (through the Community Anti-Drug Coalitions of America) to provide training and technical assistance to drug-free coalitions.

The Results

DFC grantees are required to provide data on the following measures for the coalition's target community: age of onset of any drug use (including alcohol, marijuana, and tobacco); frequency of use in the past 30 days (including alcohol, marijuana, and tobacco); perception of risk and harm (including alcohol, marijuana, and tobacco); perception of disapproval of use by parents (including alcohol, marijuana, and tobacco).

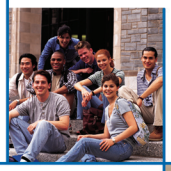
[1] Funded by an interagency agreement with ONDCP

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Matrix Area—
Children & Families

To improve outcomes for children (and families of children) with and/or at risk for mental, substance use, and/or co-occurring disorders, by increasing access to a continuum of comprehensive, integrated, culturally and linguistically competent services and supports, which include prevention, early intervention, treatment, and recovery. Approximately 5 to 9 percent of children (aged 9–17) have a serious emotional disturbance, many of whom have a co-occurring substance abuse disorder. In addition, 8.0 percent of adolescents (aged 12–17) have met the criteria for dependence and/or abuse of illicit drugs or alcohol. Adolescents who had experienced a past year major depressive episode were more than twice as likely to have used illicit drugs in the past month than their peers who had not (19.1% vs. 8.7%).

Assertive Adolescent- and Family-Centered Treatment[1] (CSAT)



The Challenge

Based on SAMHSA's National Survey on Drug Use and Health, 1.5 million youths (6.1% of youths aged 12 to 17) were classified as needing alcohol treatment in the past year but only about 111,000 youth (7.2% of those needing alcohol treatment) received specialty treatment for alcohol in the past year. About 1.4 million youths (5.4%) were classified as needing illicit drug use treatment in the past year but only 124,000 (9.1% of those needing illicit drug treatment) received specialty treatment for an illicit drug in the past year.

The Response

These grants are part of the SAMHSA program to target unmet needs for substance abuse treatment. The program is designed for youth aged 12 to 21 who meet the criteria for a substance use disorder. In the first year of the program, $4.5 million was awarded to 15 projects that provide treatment to youth within their communities. The grants are renewable for 2 years, depending on outcomes and the availability of funding. This program is designed to increase the provision and effectiveness of alcohol and drug abuse treatment for adolescents through the adoption and implementation of the Assertive Community Reinforcement Approach (ACRA) combined with the Assertive Continuing Care (ACC) approach. This treatment intervention has been tested in SAMHSA's Center for Substance Abuse Treatment's (CSAT's) Cannabis Youth Treatment program and has proven to be effective in terms of both individual outcomes and cost.

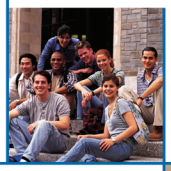
The Results

- All sites have adopted and implemented the treatment protocol; 360 youth have received this evidenced based treatment protocol.
- As of July 2007, data indicate that abstinence rates from use of alcohol and drugs increased by 233.3% from intake to 6 months post-intake.
- All youth were assessed and assisted in developing treatment plans that included sessions with the adolescent and one or more caregivers individually or conjointly. ACRA also teaches them how to find/use reinforcers for staying substance free, and to support positive change in a community setting. ACC addresses the important role of continuing care following what is traditionally thought of as the active phase of treatment.;
- Clinicians from all sites have been trained and certified to replicate the treatment protocol
- ACRA combined with ACC, a proven effective treatment intervention for youth, has been provided to all youth served in this grant program.
- Local systems of service available to juvenile court populations have improved by using a proven evidence-based practice for youth with substance use disorders.

[1] Budget Category—PRNS—Children and Families

Comprehensive Community Mental Health Services for Children and Their Families Program[1]

(CMHS)



The Challenge

In many communities, services for young people with serious emotional disturbances (SED) are unavailable, unaffordable, or inappropriate. An estimated two-thirds of the young people who need mental health services in the United States do not get them. As a result, many children and adolescents with mental health issues do poorly in school and/or become involved with the juvenile justice system. Sometimes, parents must relinquish custody of their children to the State in order to obtain services. There can be long waiting lists for services, and when children and their families do receive help, several different providers, with different treatment plans, may become involved.

The Response

Implemented in 1993, the Comprehensive Community Mental Health Services for Children and Their Families program provides cooperative agreements to public entities, tribes, and tribal organizations for the improvement and expansion of systems of care to meet the needs of the estimated 4.5 million to 6.3 million children with SED and their families. The goal of the program is to develop, implement, and support individualized, community-based systems of care to reduce impairment, improve short- and long-term mental health, and enhance both educational and social functioning of youth with SED. The program improves the delivery of mental health services to children, youth, and their families by promoting more effective ways to organize, coordinate, and deliver services and by tying together children's mental health programs into a single plan of care.

The program promotes the development of service delivery systems through an approach that includes the following: mental health service systems driven by the needs and preferences of the child and family (addressed through a strengths-based approach); the focus and management of services occur within a multi-agency collaborative environment and are grounded in a strong community base; the services offered, the agencies participating, and the programs generated are responsive to the cultural and linguistic context and characteristics of the populations served; and, families and youth are partners in planning, implementing, and evaluating the system of care.

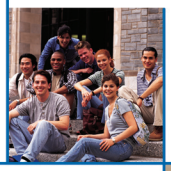
The Results

Since 1993, the program has funded 126 grantees across the country; there are currently 51 grant communities and 64 former grant projects. In FY 2006, SAMHSA awarded five cooperative agreements to develop systems of care that deliver community-based, family-driven, youth-guided and culturally competent mental health services and supports for children and adolescents with SED.

[1] Budget Category—Children's Mental Health Services Program

National Child Traumatic Stress Initiative[1]

(CMHS)



The Challenge

In a nationally representative sample of 12- to 17-year-old youth, 8 percent reported a lifetime prevalence of sexual assault, 17 percent reported physical assault, and 39 percent reported witnessing violence. Many children and youth experience multiple and repeated traumas.

The Response

In recognition of the serious impact that trauma can have on children, adolescents, and families exposed to traumatic events, Congress in FY 2001 authorized SAMHSA's Center for Mental Health Services (CMHS) to develop a national grant program, the *National Child Traumatic Stress Initiative* (NCTSI), focused on addressing child trauma issues by providing Federal support. It is designed to improve treatment and services for child trauma, to expand availability and accessibility of effective community services, and to promote better understanding of clinical and research issues relevant to providing effective interventions for children and adolescents exposed to traumatic events.

As of September 2006, the NCTSI funded 45 cooperative agreement awards for three types of trauma centers. These 4-year funded sites of excellence comprise the National Child Traumatic Stress Network. The Network is made up of three types of child trauma centers: The National Center for Child Traumatic Stress provides national leadership and focus to the initiative; Treatment and Service Adaptation (TSA) Centers are charged with identifying, developing, supporting, and improving treatment and service approaches for different types of child and adolescent traumatic events; and Community Treatment and Service (CTS) Centers implement and evaluate treatment and services in community settings.

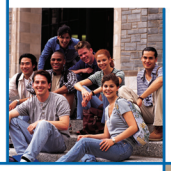
The Results

In FY 2006, the National Child Traumatic Stress Network served 33,910 children. Of the children receiving ongoing clinical treatment in FY 2006, 34.8 percent (N=451) showed clinically significant improvement. In addition, since the inception of the program, nearly 600,000 mental health professionals, primary care providers, other professionals in child-serving systems, consumers, and members of the public have been trained on the treatment, assessment, and/or education of child traumatic stress in approximately 13,000 sessions or events sponsored by the Network. Through accelerated cross-Network collaborations, Network groups have developed products now being tested and implemented to increase awareness and improve the standard of care in children's medical trauma, refugee trauma, child welfare, domestic violence, and traumatic grief.

[1] Budget Category—PRNS—Post Traumatic Stress Disorder
[2] National Child Traumatic Stress Network < http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_gnrl_facts>

Safe Schools/Healthy Students Grants[1]

(CMHS)



The Challenge

Between 1997 and 1999, school shootings in Kentucky, Arkansas, Oregon, and Colorado served as the impetus for a national response to the issue of youth violence. Although the majority of American schools are among the safest places, some schools have serious violence problems that compromise learning and leave students and teachers feeling vulnerable. Research shows that school violence is generally a symptom of larger community problems, such as substance abuse, depression, other mental health problems, and poor academic achievement. As a result of communities undertaking a comprehensive approach that builds connections between students, families, and caring adults, the risk of mental illness can be reduced and academic success can be improved. Schools alone cannot effectively address these problems but must come together with parents, law enforcement, juvenile justice agencies, mental health organizations, community groups, and elected officials to develop and carry out a comprehensive plan of action.

The Response

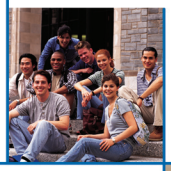
In 1999, the U.S. Departments of Education, Health and Human Services, and Justice responded to rising concerns about youth violence and school safety by creating the Safe Schools/Healthy Students (SS/HS) initiative. This unique collaboration recognizes that violence among young people can have many causes and that no single activity can be counted on to prevent violence. Thus, SS/HS takes a broad approach, drawing on the best practices and the latest thinking in education, justice, social services, and mental health to help communities take action. Since its inception, this grant program has supported 249 school geographically, ethnically, and economically diverse districts. Through the efforts of local education agencies, formal partnerships with local mental health service systems and local law enforcement agencies have become key to an effective program. Comprehensive plans are developed and implemented with the goals of promoting the healthy development of children and youth, fostering their resilience in the face of adversity, and preventing youth violence. Grantees implement comprehensive programs that provide 1) a safe school environment and violence prevention activities; 2) alcohol, tobacco, and other drug prevention activities; 3) student behavioral, social, and emotional supports; 4) mental health services; and 5) early childhood social and emotional learning programs.

The Results

The program has strengthened communities across the country by providing the following: family and student-centered assistance; comprehensive violence prevention and intervention programs; referrals to appropriate mental health services; significant and sustained decreases in school violence and youth arrests; successful social marketing, such as anti-bullying campaigns; visits to homes in the community to offer help; increased academic performance; and creative yet sound approaches to comprehensive services. Data from the 1999–2001 cohorts indicate that SS/HS is an effective intervention. In Poway, CA, the percent of students reporting they felt unsafe at school decreased by 70 percent for middle school students and 81 percent for high school students. In Toledo, OH, there was a 69.9 percent decrease in safety-related concerns for intervention schools with onsite mental health professionals, and a 75.6 percent decrease in safety-related concerns for schools implementing the Families and Schools Together (FAST) program. A national cross-site evaluation found that the SS/HS program reported a 5.66 percent decrease in students feeling unsafe at school and a 10.19 percent decrease in the number of students who reported being victimized by knife or gun violence at school.

[1] Budget Category—PRNS—School Violence Prevention

Circles of Care Grants: Native American Children's Services[1] (CMHS)



The Challenge

A decade ago, the Office of Technology Assessment noted that American Indian and Alaska Native (AI/AN) youth have more serious mental health problems than the general U.S. population and limited access to mental health services in their home communities. More recent studies funded by SAMHSA have found AI/AN youth to have suicide rates 2.4 times the corresponding rates for all U.S. populations. Jurisdictional, cultural, and linguistic differences between tribal and State governments, communities, and funding streams contribute to the disparities in treatment resources and effectiveness. Approximately 60 percent of the AI/AN population live in urban areas, maintain cultural ties, and utilize urban Indian programs in preference to mainstream social service programs.

At the same time, a growing body of literature has found that children with serious emotional disturbances do better with an integrated, individualized set of services—social, emotional, educational, and vocational—provided in their community that engages them and their families. Such a system of care approach also needs to be sensitive to differing cultural norms and expectations of the youth and families involved.

The Response

In FY 1999, multi-agency collaboration among CMHS, the Indian Health Service, the National Institute of Mental Health, and the Department of Justice's Office of Juvenile Justice and Delinquency Prevention created the Circles of Care program. The program provides 3-year grants to tribal and urban Indian programs to plan and evaluate culturally appropriate systems of mental health care for AI/AN children, adolescents, and their families. The program initiative—with nine grantees in FY 1998–2001 and an additional seven in FY 2001–04—was designed by a team of tribal leaders and providers. Technical assistance continues to be provided to grantee organizations by the National Indian Child Welfare Association. The National Center on American Indian and Alaska Native Research is providing technical assistance for a cross-site evaluation. In FY 2005, seven additional 3-year grants were awarded.

The Results

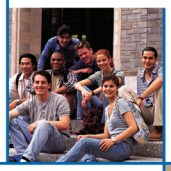
This program has increased the grantees' ability to—

- Develop a systems of care model designed by AI/AN community members to achieve their selected emotional, behavioral, educational, vocational, and spiritual outcomes for their children.
- Implement the models, evaluate the models' effectiveness, and develop a body of knowledge about culturally respectful treatment methods for children with serious emotional disturbances.

[1] Budget Category—PRNS—Children's Programs

Statewide Family Networks[1]

(CMHS)



The Challenge

Mental health services in many States and communities are fragmented and difficult to navigate for family members and their children. Furthermore, services are often not family-driven or family-friendly and do not permit sufficient input from family members. Information and access to the array of services and resources needed by families is often difficult to obtain.

Today, nearly every State has active family organizations dedicated to promoting systems of care that are responsive to the needs of children and adolescents with serious emotional disturbances and their families. Although significant progress has been made, further support will ensure self-sufficient, empowered networks that will effectively participate in State and local mental health services planning and healthcare reform activities related to improving community-based services for children and adolescents with serious emotional disturbances and their families.

The Response

The Statewide Family Network Grant program is designed to strengthen coalitions among family members with policymakers and service providers. The Family Network program is providing the families of children and adolescents with serious emotional disturbances grant support for the development of effective statewide family networks, which are critical to the integration of families into the planning, design, implementation, and evaluation of services for children and adolescents with sever emotional disturbances.

Forty-two awards were given nationwide in FY 2007. The program supports State-level family network organizations to manage a set of activities to assist family members to participate in the development of policy, programs, and quality assurance activities related to children's mental health. Network activities included developing support groups; disseminating information and technical assistance; maintaining toll-free telephone numbers; information and referral networks; newsletters; sponsoring conferences and workshops; outreach activities; serving as a liaison with various human service agencies; developing skills in organizational management and financial independence; and training and advocacy for children's services.

The Results

Through the Family Network program, grantees are able to—

- Strengthen organizational relationships by improving collaboration among families, advocates, networks, and coalitions dedicated to empowering families and strengthening their ability to participate in State and local mental health service-planning and healthcare reform policy activities on behalf of their children.
- Maintain effective working relationships with other State child-serving agencies including mental health, other health services, education, child welfare, substance abuse, and juvenile justice.
- Identify technical assistance needs for family-controlled organizations and implement a strategy to meet those needs.

[1] Budget Category—PRNS—Children's Programs

National Technical Assistance Center for Children's Mental Health[1] (CMHS)

The Challenge

National data show that an estimated 4.5 to 6.3 million children and youth in the United States suffer from a serious emotional disturbance and approximately 65 to 80 percent of these children and youth do not receive the specialty mental health services and supports they need. The final report of the President's New Freedom Commission on Mental Health—Achieving the Promise: Transforming Mental Health Care in America—calls for the development of more accessible and appropriate home- and community-based mental health service delivery systems for children, adolescents, and their families. Significant advances have been achieved, through research and practice, in understanding what comprises an effective network of services and supports. Several States and territories have adopted statutes mandating this kind of "system of care" approach to treat children and adolescents with serious emotional disturbances and their families.

The Response

Activities carried out by the National Training and Technical Assistance Center (NTTAC) at Georgetown University are aligned with the six goals of the President's New Freedom Commission Report and focus on strengthening the capacity of States, territories, tribes, and communities to transform their mental health systems to meet the complex needs of children and youth (and families of children and youth) with or at risk for serious emotional disturbances and/or co-occurring substance abuse and mental disorders, within home- and community-based settings. NTTAC, established over 25 years ago, serves as a national resource and training center to promote the planning and development of child- and family-centered, culturally and linguistically competent, and cross-agency systems of care for children and adolescents with or at risk for a serious emotional disturbance and their families. NTTAC provides targeted technical assistance to State and local child-serving agencies, Indian tribes and tribal organizations, and Pacific Island jurisdictions to support integrated, responsive mental health delivery systems for children, adolescents, and their families.

The Results

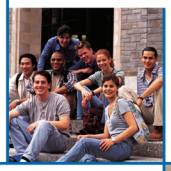
NTTAC provides a broad range of training, technical assistance, and knowledge development activities for its national audience. Examples of activities include—

- **National Training Institutese**—The premier national best practices conference on implementing systems of care, drawing over 2,100 people.
- **Transformation Facilitatione**—Individual, ongoing support is provided for 10 State child mental health directors on implementing their transformation agendas.
- **National Policy Academiese**—Opportunities for a small number of high-level cross-agency delegations (35 people) to work on designing and implementing policy and practice reforms.
- **Primer Hands On: Systems of Care Training For Leaderse**—In both English and Spanish, teaches the structural, process, and operational components of building effective systems of care.
- **Technical Assistance**—Assists seven SAMHSA-funded State and tribal grantees to improve service systems for youth with co-occurring mental health and substance abuse disorders.
- **National Conference Call Series**—Provides information on national trends and promising approaches to State and local policymakers, administrators, family members, and providers.
- **National Pre-Institutes On Cultural And Linguistic Competence And Addressing Disparities**—Brings together 160 leaders to facilitate their transformation of mental health and substance abuse services for culturally and linguistically diverse populations.
- **Building Early Childhood Systems Of Care**—Technical assistance and training on program development and practice is provided to SAMHSA-funded Comprehensive Community Systems of Care grant sites focusing on early childhood services and supports.

[1] Budget Category—PRNS—Children's Programs

Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grants[1]

(CMHS & CSAT)



The Challenge

For over a decade, SAMHSA has funded local demonstrations of promising treatment, and continuing services and supports for children, adolescents, and youth in transition who have a serious emotional disturbance, substance abuse disorder, and/or co-occurring disorders and their families. A critical lesson provided by the local demonstrations is the difficulty of expanding and sustaining local capacity without the investment of key State-level stakeholders. Partnership between State and local stakeholders is essential to the development, sustainability, and growth of effective early intervention and treatment services.

The Response

Seven 5-year grants were awarded for the first time in FY 2004. These funds will be used to increase the capacity of mental health and/or substance abuse service systems to support programs and services. A priority focus of this grant program is to strengthen the infrastructure in States, territories, and Native American tribes where there are existing local SAMHSA grant projects to ensure the sustainability and growth of these initiatives. This initiative is jointly funded by CMHS and CSAT.

The Results

Under this program, States, territories, and Native American tribal governments will—

- Strengthen their capacity to transform their mental health systems to meet the complex needs of children/youth with serious emotional disturbances and/or co-occurring substance abuse and mental health disorders and their families within home and community-based settings.
- Build the infrastructure necessary to promote, support, and sustain local service and treatment intervention capabilities for the target population across service delivery systems.
- Determine whether to focus on the entire target population or demographic/geographic subsets of the population.

[1] Budget Category—CMHS—PRNS—Children's SIG; CSAT—PRNS—Children and Families

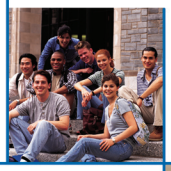
DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Matrix Area—Mental Health Systems Transformation

To ensure that mental health services and treatments 1) are consumer and family-centered; and 2) focus on increasing consumers' ability to successfully manage life's challenges, on facilitating recovery, and on building resilience. This purpose is consistent with the goals of mental health system transformation outlined in the Federal Mental Health Action Agenda.

Community Mental Health Services Block Grant[1]

(CMHS)



The Challenge

The Community Mental Health Services Block Grant (CMHBG) supports comprehensive, community-based systems of care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Under the 1981 Act establishing the block grant, authority for disbursement was vested in the individual States, providing them with a flexible funding source. The CMHBG program has become a cornerstone of Federal-State partnership to develop effective mental health systems of care for adults with SMI and children with SED, in the communities in which they live. SAMHSA's Center for Mental Health Services (CMHS) uses its oversight of the Mental Health Block Grant (MHBG) program to serve as a catalyst for States to make systems of care affordable, accessible, and available to the most vulnerable populations with mental illness.

The Response

The CMHS awards grants to States and Territories on the basis of a legislated formula. With input from State Mental Health Planning Councils, the States and Territories must submit annual plans that articulate specific goals, objectives, and performance indicators. State plans must meet specific statutory requirements before being approved for funding. States are also required to submit annual reports summarizing the extent to which they have implemented their plans. Additionally, CMHS's monitoring process identifies the strengths, challenges, and opportunities for improvement of community mental health systems in a minimum of 10 States each year.

CMHS uses the mandatory 5 percent set-aside fund for technical assistance, data collection, and program evaluation activities. These funds are used to improve the effectiveness and cost-efficiency of community mental health systems supported by the MHBG. In addition, State Mental Health Data Infrastructure Grants have been awarded to 49 States, the District of Columbia, and 8 territories to enhance their capacity to gather uniform data on access to services, readmission rates, utilization of evidenced-based practices, and important consumer survey information. The FY 2008–10 MHBG Application Guidance and Instructions for State plans have been revised to integrate mental health transformation goals into the guidance. The FY 2008 plans will provide a description of the States' transformation activities, reporting on MHBG and State expenditures for transformation activities, and thorough construction of a performance indicator related to transformation.

The Results

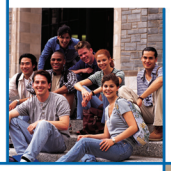
As a flexible funding source, these funds are used by the State for needs/activities described in the State mental health plan (with the exclusion of five legislative prohibitions), for which other Federal funds may not be used. States can and do use these funds in activities ranging from strategic/transformational planning, outreach to SMI and SED populations, and infrastructure development, to individualized supports, rehabilitation, employment, housing, and education.

The efficiency and effectiveness of the program is monitored through the following the U.S. Office of Management and Budget (OMB) PART/Government Results Performance Act measures: increase number of people served by the public mental health system; reduce rate of readmissions to State psychiatric hospitals within 30 days; within 180 days, increase rate of consumers/family members reporting positively about outcomes for adults and children/adolescents; and increase the number of SAMHSA-identified evidence-based practices (EBPs) in each State and the percentage of service population coverage for each EPB.

[1] Budget Category—MH Block Grant

National Technical Assistance Centers on Consumer/ Peer-Run Programs[1]

(CMHS)



The Challenge

In a transformed mental health system, mental health care will be consumer- and family-driven. At present, consumers are not the leaders in directing the blueprint for a transformed system. Better results will be achieved when consumers are more knowledgeable about and involved with designing and developing programs and interventions. In partnership with mental health and allied service providers, consumers and families need to play a larger role in their services, treatment, and supports. Consumers' and families' full involvement orients the mental health care system toward recovery. (Goal 2, Achieving the Promise: Transforming Mental Health Care in America.) To fulfill these needs, programs must be created to meet the following goals: promote skills development for consumers with an emphasis on leadership, business, and management; strengthen consumer organizations and leadership in communities; improve collaboration among consumers, families, advocates, providers, and administrators and build coalitions to transform community mental health services and supports; increase the opportunities for knowledge application and field-based skill building of self-management/self-help approaches; increase consumer participation in all aspects of mental health system transformation, including planning, development, evaluation, and policy formation; and provide opportunities for meaningful paid employment.

The Response

As authorized under section 520A of the Public Health Service Act, as amended, SAMHSA provides grants to support the National Technical Assistance Centers on Consumer/Peer-Run Programs (Consumer/Peer-Run TACs). The Consumer/Peer-Run TACs support the work of CMHS to transform the mental health system through changes that help adults with severe mental illnesses recover and live independently and productively in the community. CMHS fosters consumer involvement in the planning, delivery, and evaluation of mental health services and recognizes the role of self-help, mutual support, and empowerment in the recovery of persons with a severe mental illness. In 1992, Federal funding was used to support the first national self-help TACs directed by and for mental health consumers. Assistance to supporters of consumers was added to the program in 1998. Consumer/Peer-Run TACs must prove they can meet the five goals outlined for this program. They must also select two of the following program foci as areas of concentration for the proposed project: self-care/self-management; employment; program management and administration; cultural outreach and self-help administration; and recovery.

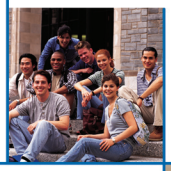
The Results

The Consumer/Peer-Run TACs assist in the transformation of the mental health system by providing consumers with necessary skills to foster these programs. These programs maximize consumer self-determination and recovery and assist people with severe mental illness to decrease their dependence on expensive social services and avoid psychiatric hospitalization. Findings from an external evaluation of TACs include the following: 1,113 individuals contacted the TACs in 1 month and made 1,586 requests for technical assistance. TACs users made 1,964 topical requests, of which 54.5 percent were about clinical issues. The study demonstrated that the TACs have a wide outreach into the community, make a significant amount of referrals to professionals, and are the source of substantial amount of materials and information to their constituents and to the general public. The study established that the TACs addressed all of the goals of the President's New Freedom Commission on Mental Health, as they had previously, "and exemplified a type of successful, consumer and family-driven, recovery oriented-services that was transforming the nation's mental health system."

[1] Budget Category—PRNS—Mental Health Systems Transformation Activities

Statewide Consumer Networks[1]

(CMHS)



The Challenge

The Statewide Consumer Network Grant Program builds on the work of the Federal Community Support Program (CSP), which for many years has supported the empowerment of mental health consumers and the involvement of consumers and families in the mental health system. For many years, consumers have been unable to meaningfully participate in policy, planning, and program development around the mental health services they receive due to stigma, lack of encouragement, lack of infrastructure, and other barriers. This program educates and assists consumer organizations dedicated to promoting systems of care that are responsive to the needs of people with a serious mental illness. By providing appropriate training and tools in the development of individualized mental health plans, understanding the need and use of accountability and evaluation measures, and many other self-help skills, consumers can guide and provide foresight into changing the present system to a recovery-oriented system for all peers and thereby ensure the implementation of the goals of the Final Report of the President's New Freedom Commission on Mental Health. Statewide Consumer Network grants have been supported since 1995. The current program is designed to enhance State capacity and infrastructure by supporting statewide consumer organizations to target recovery and resiliency and by promoting the use of consumers as agents of transformation.

The Response

In FY 2007, CMHS funded 20 grant recipients, with only one award made per State. Grantee organizations have the following characteristics: 1) they are controlled and managed by mental health consumers; 2) they are dedicated to the improvement of mental health services statewide; 3) they have a board of directors comprised of more than 51 percent consumers; and 4) they have completed and signed a Certificate of Eligibility and provided necessary supportive documentation.

The Results

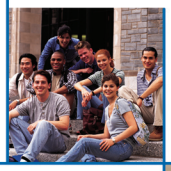
This program assists consumer organizations around the country to work with policymakers and service providers to improve services for consumers with serious mental illness. The program will also strengthen consumer coalitions to work with policymakers and service providers, recognizing that consumers are often the best and most effective change agents.

The expected results of the program will be to—

- Strengthen organizational relationships.
- Promote skill development with an emphasis on leadership and business management.
- Identify technical assistance of consumers.
- Provide training and support to consumers to ensure that they are the catalysts for transforming the mental health and related systems in their State.

[1] Budget Category—PRNS—Mental Health Systems Transformation Activities

Mental Health State Incentive Grant Program[1] (CMHS)



The Challenge

Mental Health Transformation is the broad-based approach SAMHSA has adopted to introduce fundamental change in the way our Nation perceives, accesses, delivers, and finances mental health services. The Mental Health State Incentive Grant (MHTSIG) program implements SAMHSA's commitment to providing national leadership in transforming the mental health system in the United States. The Program provides infrastructure funds to State Offices of the Governor to implement the following six goals for mental health system transformation recommended by the 2002 President's New Freedom Commission report:

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer and family driven.
- Disparities are eliminated.
- Early screening, assessment, and referral are common practice.
- Excellent care is delivered and research is accelerated.
- Technology is used to access care and information.

The Response

In September 2005, CMHS awarded seven MHTSIGs for each of 5 years. The awardees were Connecticut, Maryland, New Mexico, Ohio, Oklahoma, Texas, and Washington. In September 2006, two additional grants of for 5 years were awarded to Hawaii and Missouri. Grant funds are used for infrastructure change and are not used to provide services.

Each State forms a Transformation Working Group, appointed by the governor, consisting of the heads of all State agencies involved in mental health and related services and support, as well as consumers and family members and other key stakeholders. This group acts as a steering committee for all grant activities. In the first year of the program, each State completes a Needs Assessment and Inventory of Resources that includes data and input across State agencies that identifies both the available resources and current needs of the mental health system. This is the tool for States to identify the priorities and needs of its citizens. The Needs Assessment and Inventory of resources provides a foundation for the development and implementation of a Comprehensive Mental Health Plan for transforming the State's mental health system. The Comprehensive Mental Health Plan is the tool by which States will create a system that will respond to the priorities and needs of its citizens. It is also a tool for the States to be held accountable for how well it addresses those needs. Each State also participates in a national, cross-site evaluation and site-specific evaluation of the Transformation process and outcomes. The cross-site evaluation includes reporting of data in compliance with the Government Performance and Accountability Act as well as measures of recovery and cost efficiency.

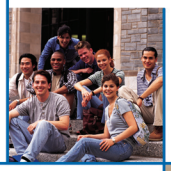
The Results

This program has increased the grantees' ability: to employ a public health approach to Transformation that promotes recovery and resiliency, is consumer- and family-driven, and that reflects true statewide collaboration; to engage a broad range of State agency and community stakeholders in the process of system transformation; to develop and implement innovative and resourceful approaches to information technologies, financing, and service improvements; and to understand and address the needs of the citizens across the lifespan and across cultural and ethnic groups.

[1] Budget Category—PRNS—Mental Health SIG for Transformation

Protection and Advocacy for Individuals with Mental Illness[1]

(CMHS)



The Challenge

In the early '80s, Congress found that adults with significant mental illness and children with significant emotional impairments were too frequently vulnerable to abuse, serious injury, and neglect within public or private care or treatment facilities. These individuals experienced inadequate or inappropriate treatment, nutrition, clothing, health care, and discharge planning. State systems for monitoring compliance with respect to the rights of these individuals varied widely in their effectiveness, were frequently inadequate and seldom independent of the institutions they monitored.

The Response

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act of 1986 created the State protection and advocacy (P&A) systems to monitor the care and treatment of these vulnerable individuals. The State P&A systems are congressionally authorized to investigate incidents of abuse, neglect and rights violations, to access the individual, his/her records and the facility, and to ensure that the individual's rights are protected under Federal and State laws. The Children's Health Act (CHA) of 2000 amended the PAIMI Act by creating a P&A system for the Navajo and Hopi Nations and allowing the systems to serve individuals living in the community, including their own homes. The CHA also addressed a national issue: the inappropriate use of seclusion and restraint in various care and treatment facilities that serve children, youth and adults with mental health disabilities. It authorized State P&A systems to receive and investigate reports of the inappropriate use of restraint and seclusion and related injuries and/or deaths in certain facilities.

SAMHSA currently funds 57 P&A systems in each State, the District of Columbia, and 6 jurisdictions through formula grants that support legal-based advocacy services. Each P&A system has a PAIMI Advisory Council (PAC), comprised of current and former mental health consumers, their family members (to represent minors), service providers and others interested and knowledgeable of mental health services. The PAC is chaired by a mental health recipient or a family member and advises the P&A governing authority (also known as the governing board) on the types of annual activities and services provided to State constituents. State P&A systems annual PAIMI Program activities and services are to ensure that persons with significant mental illness are treated with respect and dignity.

The Results

In fiscal year 2006, State P&A system activities include the following:

- Closed over 17,000 cases; over 4,500 were related to abuse, 3,700 to neglect, and 9,000 to violations of individual rights.
- Conducted investigations into the deaths of almost 3,000 individuals with mental illness in hospitals, institutions, and community settings.
- Resolved the majority of cases using short-term and technical assistance, investigations, and administrative remedies—only 3 percent of cases resulted in legal action.
- Served individuals with mental illness living in all settings, including public and private institutions and hospitals, prisons, foster care, provider-operated housing, and family's and individual's homes.
- Provided casework to over 4,000 children and young adults and almost 15,000 adults and elderly individuals with mental illness and provided information and referral services to over 46,000 individuals. In addition, the PAIMI Program provided training to over 210,000 individuals.
- Assisted hundreds of individuals with mental illness who were without supports, services, and medication in the aftermath of Hurricanes Katrina and Rita.

[1] Budget Category—PAIMI

Matrix Area—
Suicide Prevention

To provide national leadership for suicide prevention, consistent with the 11 goals and 68 objectives of the National Strategy for Suicide Prevention. In 2003, suicide was the 11th leading cause of death among persons of all ages, accounting for 31,484 deaths, a rate of 10.83 per 100,000 Americans. Among young people aged 15–24, suicide was the third leading cause of death.

Adolescents at Risk for Suicide[1]

(CMHS)

The Challenge

For young people aged 15 to 24, suicide is the third leading cause of death, following unintentional injury and homicide. In 1999, more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, and chronic lung disease combined. Many voluntary school-based suicide prevention programs have been developed and implemented for youth, but most have not been adequately evaluated to know if they are effective in "real world" settings. In particular, evaluations have not investigated whether these programs lead to successful referrals for treatment or other sources of help or to what extent families are engaged in and accept the programs. There is a clear need to further develop evidence-based programs to identify youth at risk for suicide and suicide attempts.

The Response

The Linking Adolescents at Risk for Suicide to Mental Health Services grant program provides funding to evaluate and document voluntary school-based suicide prevention programs that are already being implemented in high schools. Eligible applicants are local educational agencies, or local educational agencies in conjunction with nonprofit entities. Grantees perform a number of data collection and evaluation activities that are expected to generate the following information:

- Identification of new evidence regarding school-based suicide prevention practices.
- Knowledge of organizational and contextual factors of the school that impact the success or failure of the practices being evaluated.
- Knowledge of effective activities for engaging parents/legal guardians/other caregivers in school-based suicide prevention activities.
- Knowledge of the various factors that influence parents'/legal guardians'/other caregivers' engagement, or lack thereof.
- Knowledge of the processes by which at-risk students are referred for treatment services, and the outcomes of those processes.

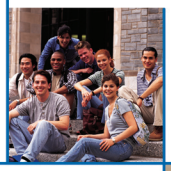
All activities undertaken in this grant program are developed with respect to the ages of the adolescents, their cultural background, and the cultural backgrounds of their parents, legal guardians, and other caregivers.

The Results

While the current projects are not complete and so results are not yet in, early indications are that more emphasis needs to be placed on engaging and educating parents prior to requesting permission for their child's participation. Current grantees also report the following "lessons learned":

- Maintaining a diverse network of pathways to service provision is key to reducing stigma about mental health services and suicide.
- It is important to build capacity for onsite mental health counseling simultaneously with increasing school staff awareness and ability to make referrals.
- School and community buy-in is critical to program acceptability and success.
- Reframing the benefits of services is important to gaining parental consent.
- It is essential to build collaboration between the school district and local mental health service providers to provide crisis evaluations for students.

[1] Budget Category—PRNS—Suicide Prevention Programs



Campus Suicide Prevention[1] Garrett Lee Smith (GLS) Memorial Suicide Prevention Act

(CMHS)

The Challenge

Approximately 12.5 million college students attend more than 3,400 schools in the United States (Brindis & Reyes, 1997). The American College Health Association found that 61 percent of college students reported feeling hopeless; 45 percent said they felt so depressed they could barely function; and 9 percent felt suicidal. Forty-four percent of students surveyed at 4-year colleges reported drinking heavily during the last 2 weeks (Wechsler, Lee, Kuo, & Lee, 2000). These problems have significant implications for students' lives, academic performance, and behavior. In addition to the increased need for mental health services on college campus, there is an increasing need to prevent suicides. An estimated 1,088 suicides occur among college students each year (National Mental Health Association [NMHA] & The Jed Foundation [JED], 2002). The complex problem of suicide and suicidal behaviors on campuses demands a multifaceted, collaborative, and coordinated response. It cannot rely solely on campus counselors or community mental health centers. Where campus resources alone are insufficient to provide prevention, intervention, and treatment services, the planning process needs to include agencies and helping institutions from the broader community.

The Response

In 2005, Congress passed the Garrett Lee Smith Suicide Prevention Act (GLS) in memory of Garrett Smith, son of Sen. Gordon Smith who died by suicide while at college. The purpose of the Campus Suicide Prevention Grants Program is to provide funding to support grants to institutions of higher education to enhance services for students with mental and behavioral health problems, such as depression, substance abuse, and suicide attempts which can lead to school failure. The other initiatives are the State/Tribal Youth Suicide Prevention Program and the National Suicide Prevention Resource Center:

- Develop training programs for students and campus personnel to respond effectively to students with mental health and behavioral health problems, such as depression, substance abuse, and suicide attempts.
- Create a networking infrastructure to link the institution with health care providers from the broader community who can treat mental and behavioral health problems.
- Develop and implement educational seminars including information on suicide prevention, identification, and reduction of risk factors.
- Create local college-based hotlines and/or promote linkage to the National Suicide Prevention Lifeline (1–800–273–TALK).
- Prepare informational materials that address warning signs of suicide, describe risk and protective factors, and identify appropriate actions to take when a student is in distress.
- Prepare educational materials for families of students to increase awareness of potential mental and behavioral health issues of students enrolled at the institution of higher education.

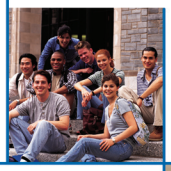
The Results

Since 2005, SAMHSA has awarded 55 Campus suicide prevention grants. Currently, a cross-site evaluation is underway and data collection has begun but it is too early for results to be reported.

[1] Budget Category—PRNS—GLS—Youth Suicide Prevention

National Suicide Prevention Lifeline[1]

(CMHS)



The Challenge

Suicide takes the lives of more than 30,000 Americans every year. Suicide was the 11th leading cause of death in the United States. Historically, hotlines have been either directly associated with a crisis center offering face-to-face client services or a hotline-only service that refers callers to crisis services or centers. This important work of telephone crisis intervention has been done almost exclusively by trained volunteers who need additional training in crisis intervention and clinical techniques to improve on the services of suicide prevention hotlines.

The Response

The National Suicide Prevention Lifeline initiative is designed to enhance training of crisis workers, increase the number of crisis centers certified in crisis intervention, improve referrals and follow through on referrals, and to encourage a consistent and clinically accepted approach to lethality assessments and rescue procedures for those assessed at imminent risk.

These certified crisis centers are networked through telephone technology that permits national access by someone in crisis or imminent risk of suicide to crisis workers through a single toll-free number. The technology will permit calls to be directed immediately to a crisis worker who is geographically convenient to the caller. Networking also entails development of systems to permit certification. In addition, networking at this scale will provide the opportunity to use response protocols and data collection standards to permit the evaluation of client- and community-centered outcomes that have not been previously pursued.

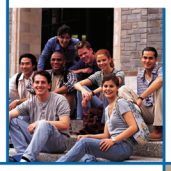
The Results

- Increased the number of certified crisis centers in the network to a current total of 120 covering all but three States.
- Assisted a rural, tribal community to establish a local network through creating collaborative relationships with nearby centers.
- Mobilized the network to respond to the needs of those impacted by Hurricane Katrina and provide alternate call support to the crisis center destroyed by Katrina.
- Increased monthly call volume by 60% through public education and marketing.
- Established a steering committee to guide the development and management of the network and two subcommittees focused on certification, training and consumer issues.

[1] Budget Category—PRNS—Suicide Prevention Programs

Suicide Prevention Resource Center[1]

(CMHS)



The Challenge

Suicide is the 11th leading cause of death in the United States, affecting families, children, and communities.

The Response

In 2005, Congress passed the Garrett Lee Smith Suicide Prevention Act (GLS) in memory of the son of Garrett Smith, who died by suicide while at college. The national effort for suicide prevention has led to a new initiative designed to promote outreach, education, and training through a Suicide Prevention Resource Center (SPRC). The SPRC promotes the implementation of the National Strategy for Suicide Prevention and enhances the Nation's mental health infrastructure by providing states, government agencies, private organizations, colleges and universities, and suicide survivor and mental health consumer groups with access to the science and experience that can support their efforts to develop programs, implement interventions, and promote policies to prevent suicide. The other initiatives are the Campus Suicide Prevention Program and the State/Tribal Youth Suicide Prevention Program. The overarching goals of the SPRC are 1) enhance the size and capacity of the suicide prevention workforce; 2) create a national network of communities of practice by connecting regional, State, and local networks, organizations, and practitioners engaged in suicide prevention; 3) create and disseminate resources; 4) support mechanisms for implementing the public health approach to suicide prevention; and 5) broaden participation in suicide prevention activities and integrate suicide prevention into existing activities and programs.

Specific tasks include—

- Provide Technical Assistance (TA) to grantees of the Garrett Lee Smith Suicide Prevention Program.
- Develop and implement training on suicide prevention products, materials services, and health promotion strategies to enhance and promote effective suicide prevention and early intervention.
- Assist States, Territories, and Tribes in their efforts to plan for the development, implementation, and evaluation of suicide prevention programs.
- Collect and disseminate information on best practices of suicide prevention.
- Support the field of suicide prevention by developing and providing access to needed resources for suicide prevention activities.

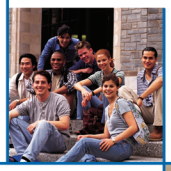
The Results

- Conducted regional planning meetings with all 50 States to promote comprehensive suicide prevention planning in State and local systems.
- Reviewed 14 suicide prevention programs for effectiveness and worked to establish entries for the National Registry of Evidence-based Programs and Practices.
- Developed and piloted a training curriculum for physicians on discharge planning for emergency room doctors following treatment of a suicide attempt.
- Prepared a white paper on the prevalence of suicide on college campuses.
- Provided technical assistance to 100 suicide prevention grantees.

[1] Budget Category—PRNS—GLS—Suicide Resource Center

State/Tribal Youth Suicide Prevention[1] Garrett Lee Smith (GLS) Memorial Suicide Prevention Act

(CMHS)



The Challenge

Suicide is the third leading cause of death for children and youth between the ages of 10 and 24. Over 4,500 children and young adults aged 10 to 24 took their lives in 2004. From 1952 to 1995, the rate of suicide among children and young adults tripled. From 1980 to 1997, the rate of suicide among youth age 10 to 14 increased 109 percent. More recent studies have found AI/AN youth to have suicide rates 2.4 times that of the U.S. population, with a suicide death rate among Alaska Natives 4.6 times higher than for all U.S. races. The *National Strategy for Suicide Prevention* states, "Suicide prevention is a complex problem. It intersects public health (especially injury prevention), mental health, and substance abuse. It requires commitment from education, justice, and social services, and it requires the commitment of various private sector groups…"

The Response

In 2005, Congress passed the Garrett Lee Smith Suicide Prevention Act (GLS) in memory of Garrett Smith, son of Sen. Gordon Smith who died by suicide while at college. The State/Tribal Youth Suicide Prevention Grant Program is designed to build on the foundation of prior suicide prevention efforts in order to support States and Tribes in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies. Such efforts must involve public/private collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations. Grantees must—

- Develop and implement statewide or tribal youth suicide early intervention and prevention strategies in schools, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems, and other child and youth support organizations.
- Support public and private nonprofit organizations actively involved in the development and continuation of statewide or tribal youth suicide early intervention and prevention strategies.
- Provide early intervention and assessment services to youth who are at risk for mental or emotional disorders that may lead to suicide or a suicide attempt.
- Provide timely referrals for appropriate community mental health care and treatment to youth who are at risk for suicide or suicide attempts.
- Provide immediate support and information resources to families of youth who are at risk for suicide, such as families of youth who have attempted suicide.
- Offer appropriate post-suicide intervention services, care, and information to families, friends, schools, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems, and other child and youth support organizations of youth who recently committed suicide.
- Participate in data collection and analysis activities and preparing an evaluation report.

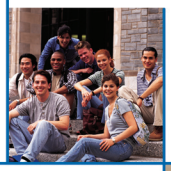
The Results

Since 2005, SAMHSA has awarded 36 grants to State and Tribal organizations to address youth suicide prevention. In 2006, two special awards were made to Louisiana and Mississippi in response to an apparent increase in suicides related to the gulf coast hurricanes. A cross-site evaluation is in its preliminary stage, thus no results are available to report at this time.

[1] Budget Category—PRNS—GLS—Youth Suicide Prevention—State

Native Aspirations[1]

(CMHS)



The Challenge

A decade ago, the Office of Technology Assessment noted that American Indian and Alaska Native (AI/AN) youth have more serious mental health problems than the general U.S. population, and limited access to mental health services in their home communities. More recent studies have found AI/AN youth to have suicide rates 2.4 times that of the U.S. population, with a suicide death rate among Alaska Natives 4.6 times higher than for all U.S. races. Suicide in Indian country too often affects entire communities, as young people may take their lives in clusters. For example, during a 12-week period from November 2004 to February 2005, eight young Native American youths died by suicide in separate events on the Standing Rock Sioux Reservation. Developing effective strategies for suicide and violence prevention in Indian country is an urgent public health need.

The Response

In 2005, SAMHSA funded Native Aspirations, a training and technical assistance project that provides resources for tribal communities to mobilize existing social and educational resources to implement comprehensive and collaborative community-driven prevention plans that will reduce violence, bullying, and suicide among American Indian/Alaska Native youth. The project enhances pro-social and help-seeking behaviors among Native youth and their families, increases protective factors, and decreases risk factors that contribute to youth violence, bullying, and suicide.

To select its communities, Native Aspirations develops a list of high-risk sites from statistics for poverty, suicide, homicide, and motor vehicle accidents among youth. From that list, behavioral health experts from the Indian Health Service, Bureau of Indian Affairs, and State programs identify communities with highest need. Since 2005, 15 communities have been selected and an additional 9 will be selected in FY 2007–08.

For each of its communities, Native Aspirations provides consultation and financial support and conducts facilitated events and trainings to implement the community's prevention plan. Activities can include site visits for project planning, passage of tribal resolutions or Executive Orders, and onsite Gathering of Native Americans (GONA). By providing a safe place to share, heal, and plan for action, the GONA offers hope and a positive start to communities; an onsite Youth Visioning event to garner youth input and involvement; an onsite Community Mobilization and Planning event (CMP) to engage as many stakeholders as possible, including Tribal leaders, elders, youth, key service providers, representatives of local schools, healthcare facilities, law enforcement, and social service agencies, and to enhance cross-collaboration with Indian Health Service, State, and National efforts; training and other activities supporting community members' implementation of evidence/practice/cultural-based interventions chosen during the CMP; and, technical assistance in evaluating the anticipated outcomes of the chosen interventions.

The Results

Although the cross-site evaluation is in its preliminary stages, lessons learned from Native Aspirations include a grassroots approach that promotes community ownership. The approach must be culturally tailored and community-specific, and community buy-in and ownership are essential.

[1] Budget Category—PRNS—AI/AN MH/Suicide Prevention Initiative

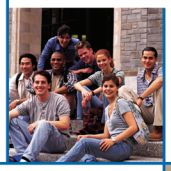
DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Matrix Area—Homelessness

To prevent or reduce homelessness among persons with mental illnesses and/or substance abuse disorders by providing outreach, mental health, substance abuse prevention and treatment, and other supportive services to individuals who are homeless or at risk of becoming homeless. It is estimated that up to 600,000 persons are homeless on any given night. Many homeless individuals, in particular those who experience chronic homelessness, tend to have disabling health and behavioral health problems. Half of homeless adults have histories of alcohol abuse or dependence, and one-third have histories of drug abuse. About 20 to 25 percent of homeless adults have lifetime histories of serious mental illness. Between 10 and 20 percent have a co-occurring substance abuse/mental health disorder.

Services in Supportive Housing[1]

(CMHS)



The Challenge

Persons experiencing chronic homelessness generally have multiple needs, including those for extreme poverty, serious mental illnesses (SMI), substance abuse disorders, physical health problems, and problems accessing affordable housing. Homeless families with children have become the fastest growing segment of the homeless population. The purpose of this grant program is to help end chronic and family homelessness by funding services for individuals and families experiencing homelessness in coordination with existing permanent supportive housing programs and resources.

The Response

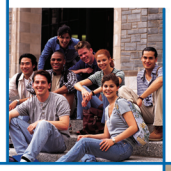
Supportive housing provides consumers with long-term, community-based housing options and combines housing assistance and intensive individualized support services to people with serious psychiatric conditions and those with co-occurring mental and substance abuse disorders. Under this program, the grants will help support direct services in coordination with existing permanent supportive housing, with services and supports responsive to the diverse populations of homeless individuals and families.

The Results

With SAMHSA funds, grantees have considerable flexibility to fund services to meet the specific needs of homeless individuals and families to support their stability in permanent housing and in their recovery.

[1] Budget Category—PRNS—Homelessness (Capacity)

Projects for Assistance in Transition from Homelessness[1] (CMHS)



The Challenge

At any point in time, approximately one-fifth of homeless individuals also have SMI. Established in 1991 as a formula grant program, the Projects for Assistance in Transition from Homelessness (PATH) program distributes Federal funds to each State, the District of Columbia, and certain U.S. territories to support an array of individualized services to the homeless.

The Response

The authorizing Statute (section 521–535 of the Public Health Service Act) specifies the range of services that may be supported by States under the program: outreach; screening and diagnostic services; habilitation and rehabilitation; community mental health services; alcohol or drug treatment (for those with co-occurring disorders); staff training; case management; supportive and supervisory services in residential settings; referrals for primary health care, job training, and education; and limited housing services.

The goal of the PATH program is to provide outreach services to persons who are homeless and have SMI through case management, linking them to housing, and referral to an array of needed services and resources available from community agencies.

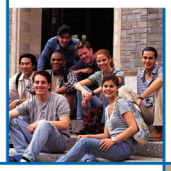
The Results

With Federal matching funds, States have considerable flexibility to design programs and fund services to meet the specific needs of people who are homeless and have SMI (States match funds with $1.00—in cash or in kind—for every $3.00 received in Federal funds). Beyond being award recipients, PATH program participants also serve as a source of knowledge for identifying best practices in the delivery of mental health services for homeless persons.

[1] Budget Category—PATH

Treatment for Homeless Program[1]

(CSAT & CMHS)



The Challenge

Up to 600,000 persons are homeless on any given night. Persons with substance abuse disorders have an elevated risk for homelessness and for being homeless for long periods. Persons who are homeless have an elevated risk of infectious diseases associated with substance abuse, such as HIV/AIDS and hepatitis. Half of homeless adults have histories of alcohol abuse or dependence, and one-third have histories of drug abuse. About 20 to 25 percent of homeless adults have lifetime histories of serious mental illness. Between 10 and 20 percent have a co-occurring substance abuse or mental health disorder.

The Response

The purpose of the cross-Center (CSAT and CMHS) Treatment for Homeless program is to enable communities to expand and strengthen their treatment services for persons who are homeless with substance use disorders, mental illness, or with co-occurring substance use disorders and mental illness. The "Treatment for Homeless" program, also known as "Grants to Benefit Homeless Individuals" (GBHI), began in FY 2001. SAMHSA issued 23 new awards on September 30, 2006, bringing the total number of grants awarded during the life of the program to 137. There were no new awards in 2007. Currently, there are 87 active Treatment for Homeless grants. Each funded project incorporates its own intervention using evidenced-based practices into an integrated, comprehensive, community-based service system for persons who are homeless and have substance use or mental disorders.

The Results

As of July 2007, the current GBHI grantees have served 12,586 persons. Persons served reported substantial benefits 6 months after beginning services:

- Abstinence increased by 51% from intake to 6 months.
- Employment increased by 130% from intake to 6 months.
- The percentage reporting being housed increased by 164% from intake to 6 months.

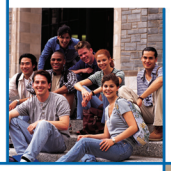
[1] Budget Category—CMHS—PRNS—Homelessness (Capacity); CSAT—PRNS—Treatment Systems for Homeless

Matrix Area—Older Adults

To promote adoption of evidence-based mental health and substance abuse programs for older adults and promote the integration of older adult issues into SAMHSA's other Matrix priority areas.

Targeted Capacity Expansion: Meeting the Mental Health Services Needs of Older Adults[1]

(CMHS)



The Challenge

One in four older adults has a significant mental disorder; over the next 25 years, the number of older adults with major mental illnesses will more than double. Yet the majority of older adults mental health problems do not receive the treatment they need. There is a need for disseminating and understanding evidence-based programs for older adult mental health treatment and health promotion.

In 2002, the President created the New Freedom Commission on Mental Health to study the mental health service delivery system and to make recommendations for improving the system. Attention to the prevention and appropriate treatment of substance abuse and mental health problems was identified as a major priority for older adults by the Commission. SAMHSA's Center for Mental Health Services (CMHS) is charged as the lead Government agency to implement the goals and recommendations of the New Freedom Commission Report. One of the strategies for achieving transformation of the mental health system is for CMHS to work closely with States and communities to carry out specific recommendations of the New Freedom Commission Report. The Older Adult Mental Health Targeted Capacity Expansion (TCE) program provides communities the opportunity to move research to practice through the implementation of evidence-based practices, and targeting critical infrastructure enhancements.

The Response

The purpose of the Older Adult Mental Health TCE Grant Program is to help communities provide direct services and to build the necessary infrastructure to support expanded services for meeting the diverse mental health needs of older persons. The target population of older adults, for the purpose of this program, is defined as persons 60 years and older who are at risk for or are experiencing mental health problems. SAMHSA recognizes that each applicant will start from a unique point in developing service and infrastructure building programs and will serve populations/communities with specific needs. Awardees may pursue diverse strategies and methods to achieve their capacity expansion goals. Awardees may target specific subpopulations of older persons with particularly high needs within their communities, such as racial/ethnic groups, persons in rural areas, or persons with high degrees of behavioral and physical health co morbidities.

In FY 2005, funding was awarded to 11 programs that serve the mental health needs of older adults. The grantee sites serve a broad and diverse array of populations and geographical areas. Applicants may request a project period of up to 3 years. Up to 20 percent of the total budget is used for a local evaluation of the services and infrastructure expansion program and to collect Government Performance and Results Act (GPRA) data. In June 2007, the Older Adults Targeted Capacity Expansion program was one of three CMHS grant programs to be chosen to pilot the Transformation Accountability (TRAC) online GPRA reporting system.

The Results

Evidence-based practices for serving the mental health needs of older adults have been implemented at 11 geographically and culturally diverse locations. Grantees have documented an increase in recruitment and retention rates for older adults as a result of enhanced outreach and education activities. Effective service delivery has been expanded for a diverse array of populations and geographical locations, including seniors living in rural areas; elder Latinos; Holocaust survivors and their families; lesbian, gay, bisexual, and transgender older adults; and Vietnamese elders with a history of trauma and refugee experiences. Among the individual-level outcomes that grantees are measuring are decreased depressive symptoms and improved cognitive functioning. Currently, grantees are also beginning to collect SAMHSA National Outcomes measures data that is being reported through the web-based Transformation Accountability (TRAC) system.

[1] Budget Category—PRNS—Older Adults

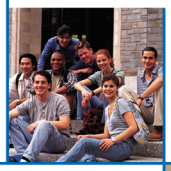
Matrix Area—
HIV/AIDS & Hepatitis

To provide access and increase use of mental health and substance abuse prevention and treatment services to prevent HIV and hepatitis transmission among high-risk populations, including minority populations.

Approximately 40,000 Americans annually become infected with HIV. Of these, about one-third of those persons are co-infected with viral hepatitis from similar modes of transmission. Only a small percentage of individuals at risk for transmission of these diseases resulting from a substance abuse and/or mental health disorders receive appropriate prevention and treatment services.

Substance Abuse Treatment and HIV/AIDS Services (Targeted Capacity Expansion)[1]

(CSAT)



The Challenge

The need for treatment services in the United States outstrips the availability of such services. In addition, because the Substance Abuse Prevention and Treatment Block Grant funds typically provide support to maintain baseline services nationwide, these funds are difficult to redirect rapidly to meet unanticipated or emerging demands for specific treatments in particular areas of the country. The historic under-representation of certain racial and ethnic groups among substance abuse providers and in client populations further compounds the difficulty. It has been difficult for African American, Hispanic/Latino, and other ethnic and racial minority populations to find treatment and other related HIV/AIDS services they need. Specific subpopulations particularly at risk include women and their children, adolescents (aged 12 to 19), men who inject drugs, men who both have sex with men and inject drugs, and individuals who have been released from prisons and jails within the past 2 years.

The Response

To redress this disparity and in response to a congressional directive, in FY 1999, the Center for Substance Abuse Treatment (CSAT) added a new specialized grant program within the Targeted Capacity Expansion (TCE) program. Designed to help Government entities in their efforts to address treatment gaps, it supports rapid, strategic responses for substance abuse treatment and related HIV/AIDS services (including sexually transmitted diseases, tuberculosis, and hepatitis B and C) specifically targeted toward racial and ethnic minority communities highly affected by the twin epidemics of substance abuse and HIV/AIDS. Currently, grantees are community-based organizations with 2 years or more of experience in the delivery of substance abuse treatment and related HIV/AIDS services and a demonstrated commitment to providing comprehensive, integrated services that effectively address substance abuse and HIV/AIDS in targeted communities. Services provided reflect state-of-the-art treatment practices to address gender, age, racial, ethnic, cultural, and sexual orientation issues as well as physical/cognitive disabilities, and geographic and economic climates.

The Results

Between FY 1999 and FY 2006, there have been an average 125 active grants each year. The current funding level is approximately $62 million per year. In FY 2007, 67 new 5-year grants, totaling $31 million, will be awarded. Since 2006, grantees have been authorized to purchase HIV rapid testing kits and to fund and train staff to conduct onsite HIV testing. As of the end of FY 2007, a total of 126 TCE-HIV grants will be receiving funding. Continuous data collection assesses the number of clients served, the number working, and the number living in permanent housing. In addition, the data collection assesses the number of clients having less involvement with the criminal justice system, with reduced substance abuse, and with reduced HIV risk behaviors.

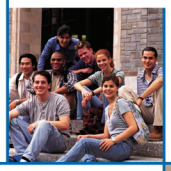
As of July 2007, 65,815 persons are served by the active TCE/HIV and HIV Outreach grantees. Since the inception of the Minority AIDS program, TCE/HIV and HIV Outreach grants have recorded the following outcomes:

- Abstinence increased by 63.2% from intake to 6 months.
- Employment increased by 41.7% from intake to 6 months.
- The number housed increased by 16.8% from intake to 6 months.

[1] Budget Category—PRNS—Minority AIDS

HIV/AIDS Related Mental Health Services in Minority Communities Mental Health Treatment Program [1]

(CMHS)



The Challenge

To date, HIV/AIDS services have not always addressed related mental health treatment needs, nor have mental health services always been accessible to individuals living with HIV/AIDS. These system deficiencies result in a lack of coordinated and integrated care for individuals with HIV/AIDS. Resources and community service infrastructures related to comprehensive care that include culturally appropriate and competent mental health services need to be identified and applied to meet the unmet needs of individuals of color with HIV/AIDS, both in traditional and nontraditional settings.

Recent data show that more than 944,000 AIDS cases have been reported in the United States; another 122,000 were reported with HIV. Each year, over 40,000 Americans are infected, though the numbers vary by gender, race, and ethnicity. African Americans and Hispanic/Latinos have higher prevalence rates than Caucasians do. As HIV/AIDS increases among people of color, the need for mental health treatment increases. Mental health issues are associated with increased morbidity and mortality, impaired quality of life, and numerous other psychosocial challenges when left untreated.

The Response

Twenty HIV/AIDS cooperative agreements to fund mental health treatment sites were funded for 5 years in FY 2001. In 2006, 16 new cooperative agreements were awarded. Each grantee creates a Consumer Advisory Board, representative of the target population to support consumer involvement in program design, implementation, and evaluation. An HIV/AIDS mental health training/education program has been implemented to enhance capacity to address neuropsychiatric and psychosocial aspects of HIV/AIDS as well as the integration of both mental health and substance abuse issues into the treatment program. A five-year cross-site evaluation of the program was also funded in 2006.

The Results

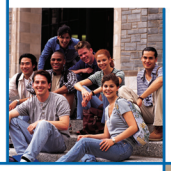
We have no evaluation results yet to demonstrate improved outcomes.

Substance Abuse/HIV/Hepatitis Strategic Prevention Framework for

[1] Budget Category—PRNS—Minority AIDS

Minority and Minority Reentry Populations[1]

(CSAP)



The Challenge

According to data from the National Institute of Justice's Arrestee Drug Abuse Monitoring (ADAM), about 66 percent of adult and more than 50 percent of juvenile arrestees tested positive for one or more illicit drugs in 1999. Each year since, approximately 600,000 inmates have been released back into their communities. An estimated 33 percent of these individuals have a substance abuse disorder and other medical and mental health problems. Of particular concern is that many of these individuals are unaware of their HIV and hepatitis sero-status and engage in substance abuse and other high-risk behaviors, putting themselves and others at risk for HIV and hepatitis transmission. Those who are aware of their sero-status often have few connections in the community to help them access local substance abuse, HIV, and/or hepatitis prevention, treatment, or other supportive care services.

The Response

SAMHSA is committed to reducing the rates of substance abuse, HIV/AIDS, and hepatitis among minority and minority reentry populations under the Minority AIDS Initiative (MAI). The MAI supports an array of activities to assist grantees in building a solid foundation for delivering and sustaining effective substance abuse prevention and related services. Specifically, the program aims to engage community-level domestic public and private nonprofit entities to prevent and reduce the onset of substance abuse and transmission of HIV and hepatitis among minority and minority reentry populations disproportionately affected by substance abuse, HIV/AIDS, and/or hepatitis. While grantees have substantial flexibility in designing their grant projects, all are required to base their projects on the five steps of SAMHSA's Strategic Prevention Framework (SPF) to build a service capacity specific to substance abuse, HIV, and hepatitis prevention services.

The following evidence-based prevention programs and infrastructure development activities are supported by this initiative: outreach to and training for at-risk minority populations; mobilization of key community stakeholders; screening and pre/post-HIV counseling; substance abuse, HIV/AIDS, and hepatitis education; prevention interventions for at-risk minority and minority reentry populations, their significant other(s), and family members; referrals to appropriate medical treatment; counseling and other supportive services for clients who are confirmed HIV positive; referrals to effective counseling services for persons who test negative for HIV in order to decrease their risk of acquiring HIV; referrals to hepatitis A and B immunization services; hepatitis screening and testing, but not immunizations; and the purchase of HIV rapid test kits.

The Results

In September 2005, SAMHSA's Center for Substance Abuse Prevention (CSAP) awarded 5-year grants to community-based organizations to implement the SPF and provide evidence-based interventions to prevent the onset and reduce the progression of substance abuse, the transmission of HIV, and hepatitis infections for minority and minority reentry populations. The projects are located in 26 States. For the first year of their projects, grantees conducted planning activities, using local epidemiological data and built community support for their projects. Grantees submitted needs assessments for the target populations in their identified communities and comprehensive Strategic Prevention Plans to deliver substance abuse, HIV, and hepatitis prevention services beginning in the second year after receiving CSAP approval.

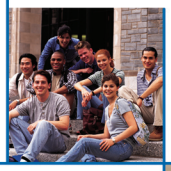
[1] Budget Category—PRNS—HIV/AIDS & Hepatitis

Matrix Area—Criminal & Juvenile Justice

To create a SAMHSA strategy to develop and manage mental health and substance abuse prevention, early intervention, clinical treatment, recovery support policies, programs, strategies, and practices for criminal and juvenile justice-involved populations.

Jail Diversion Programs (Targeted Capacity Expansion)[1]

(CMHS)



The Challenge

This program is tasked with improving policy and practice for addressing the needs of persons with a mental illness or co-occurring disorders who become involved with the criminal justice system. Too many people who need treatment for mental illness are being sent to correctional facilities instead. The challenge is to divert and support them so that they can enjoy a healthy and productive life in the community. In order for diversion to be effective, the program promotes the use of evidence-based community mental health services including case management, assertive community treatment, medications management, trauma recovery, integrated mental health, and co-occurring substance abuse treatment, and psychiatric rehabilitation.

The Response

SAMHSA designed a grant program to enable chief executives of States, political subdivisions of States, Indian tribes, and tribal organizations, to develop and implement programs to divert individuals with a mental illness from the criminal justice system. Since 2002, SAMHSA has awarded grants to help 32 States and communities build their capacity for diversion and the provision of community based treatment and supportive services, such as health care, housing, and job placement. SAMHSA also provides technical assistance to grantees to help them build integrated service networks and implement evidence based practices in their communities. This program awards 3-year grants to develop, implement and sustain diversion programs for people with mental illnesses.

Grantees of the Jail Diversion programs may plan programs for diversion at one or more points on the criminal justice processing spectrum. The goals of this grant program are to expand the capacity of sites to implement evidence-based programs; create service linkages between individuals and groups that serve the targeted population (e.g., mental health providers and criminal justice system personnel); communicate to the larger community the importance of mental health and the capacity of a well-run criminal justice diversion program to serve persons with a mental illness; and evaluate programs locally as well as participate in a national multisite effort with other program grantees to deepen our understanding of how best to divert and treat people with serious mental illness who become involved in the justice system.

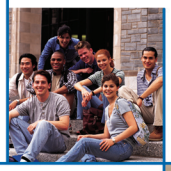
The Results

Grantees are using state-of the-art community-based mental health services, including housing and case management, assertive community treatment, medications management, integrated mental health and co-occurring substance abuse treatment, trauma treatment, and psychiatric rehabilitation to good effect. Programs have conducted over 75,000 screenings, referring over 5100 people to Courts and enrolling over 2700 in programs. Preliminary data indicates that diverted individuals have reduced symptoms of mental illness, reduced substance abuse, and improved daily living skills and role functioning. Sixteen of the 19 earliest SAMHSA grantees have continued their programs after SAMHSA funding ended.

[1] Budget Category—PRNS—Jail Diversion

Adult, Juvenile, and Family Treatment Drug Courts[1]

(CSAT)



The Challenge

Treatment Drug Courts are part of a larger group of "problem solving courts," which includes models such as Mental Health Courts, Co-Occurring Courts, and Gun Courts. Over 1,800 Treatment Drug Courts were in operation in mid-2007. Locating sufficient substance abuse treatment services for court referrals can be challenging. Three primary types of Treatment Drug Courts are Adult Treatment Drug Courts; Juvenile Treatment Drug Courts; and Family Treatment Drug Courts for parents who have abused and/or neglected their children. Treatment Drug Courts combine the sanctioning power of courts with treatment services to break the cycle of child abuse/neglect, criminal behavior, alcohol and/or drug use, and incarceration or other penalties. SAMHSA funds this program to help close treatment gaps by supporting the efforts of Treatment Drug Courts to expand and/or enhance treatment services.

The Response

Treatment Drug Courts require a sophisticated, multi-system approach. Adult and juvenile clients often enter as a partial or complete diversion from jail or detention. Family Treatment Drug Courts, when coupled with immediate access to substance abuse treatment, are an effective tool to enhance parents' ability to comply with the time limits created by the Adoption and Safe Families Act of 1997, which requires that permanency decisions for children be made on a 12-month timeline.

Drug Court clients take frequent drug tests and meet regularly with their judges. These meetings are usually held once per week initially, with the frequency decreasing, as the client succeeds in complying with the program. Treatment Drug Courts usually employ a case management model with a team monitoring the progress of individual clients and making recommendations to the judge about services, sanctions, or rewards a client should receive. On the basis of the recommendations, judges may order new or modified services, impose graduated sanctions, or provide rewards. Drug court treatment programs generally last from 6 months to 1 year. Clients are expected to stay in treatment as long as clinically appropriate and may be ordered to participate in educational, vocational, or community service activities.

The Results

The goals of this grant program are to 1) develop a multi-systems approach that enables collaboration in providing effective substance abuse treatment, while holding the offender accountable; 2) reduce criminal and delinquent activity; 3) reduce the abuse and neglect of children and adolescents, and promote the development of healthy, well-adjusted children and adolescents; 4) provide programming that results in adults and juveniles stopping their use of drugs and alcohol; 5) reduce the financial costs caused by repeated acts of criminality, delinquency, abuse, and neglect; and 6) reduce the financial costs caused by continued abuse of, or dependence on, drugs and alcohol.

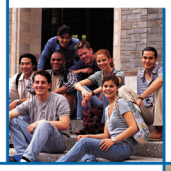
As of July 2007, SAMHSA National Outcomes Measures (NOMs) data indicate these initial results:

- There have been 2,006 persons served by the currently active grantees.
- Abstinence increased by 72.5% from intake to 6 months after intake.
- The percentage reporting no involvement in the criminal justice system increased by 9.7% from intake to 6 months.
- Employment increased by 28.0% from intake to 6 months.
- The percentage reporting social connectedness increased by 4.6% from intake to 6 months.
- The percentage reporting being housed increased by 2.8% from intake to 6 months.

[1] Budget Category—PRNS—Drug Courts (non-add)

Young Offender Reentry Program[1]

(CSAT)



The Challenge

Over the past decade, awareness of the need for a continuing care system for juvenile and young adult offenders has grown as States and local communities have struggled with the increasing number of these individuals returning to the community after release from correctional confinement. Often the juvenile or adult criminal justice system has services and structures in place for these offenders at entry into the system (i.e., at pretrial or adjudication, or during incarceration—detention, jail, or prison settings), but there are few and fragmented services in place for these young offenders as they are released from correctional settings. Reentry into the community and reintegration into the family are risky times for these offenders and their families. Substance abuse treatment for offenders in prison and in the community has been extensively studied and evaluated over the past several years, and the results are consistent and clear—treatment works, reducing crime and recidivism.

The Response

Grantees are expected to form stakeholder partnerships that plan, develop, and provide community-based substance abuse treatment and related reentry services for the target population. Because reentry transition must begin in the correctional or juvenile facility before the offender's release, funding may be used for limited screening, assessment, and release planning activities in institutional correctional settings in addition to the expected community-based services.

The Results

Grantees use a coordinated and comprehensive continuum of supervision, programs, and services to help members of the target population—

- Become productive, responsible, and law-abiding citizens.
- Obtain and retain long-term employment.
- Maintain a stable residence.
- Successfully address their substance abuse issues and mental health needs.

As of July 2007, SAMHSA National Outcomes Measures data indicate the following initial results:

- There have been 3,292 persons served by the currently active Young Offender Reentry Program grantees.
- The percentage reporting being employed increased 2.0% from intake to 6 months.
- The percentage reporting being housed increased by 109.2% from intake to 6 months.

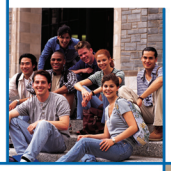
[1] Budget Category—PRNS—Criminal Justice Activities

Matrix Area — Workforce Development

Across the Nation, there is a high degree of concern about the current state and future direction of the workforce for preventing and treating mental health and substance use disorders. Despite these concerns, the many dedicated members of the current "behavioral health" workforce, and the pockets of innovative training, recruitment and retention activities that are beginning to emerge, are reasons for optimism that, together, we can build more comprehensive and systemic solutions to present workforce dilemmas.

Addiction Technology Transfer Centers[1]

(CSAT)



The Challenge

Utilizing state-of-the-art technology transfer strategies addressing all elements of addiction treatment and recovery, the Addiction Technology Transfer Centers (ATTCs) disseminate evidence-based and promising practices to addictions treatment/recovery and public health/mental health personnel, institutional and community corrections professionals, and other related disciplines.

The Response

SAMHSA's Center for Substance Abuse Treatment (CSAT) supports a network of 1 national and 14 geographically dispersed ATTCs covering all States, the District of Columbia, Puerto Rico, and the Virgin Islands. The ATTC Coordinating Center facilitates national initiatives and promotes cross-ATTC Regional Center communication and collaboration. The Regional Centers support national activities and initiate programs and initiatives in response to regional needs. This structure allows the ATTCs to respond to the needs of the addiction treatment/recovery field and form successful partnerships with key stakeholders. Key ATTC program dissemination models include a growing catalog of educational and training materials created to translate the latest science for adoption into practice by the substance use disorders treatment workforce; the National Institute on Drug Abuse (NIDA)/SAMHSA-ATTC Blending Initiative, an interagency agreement to disseminate NIDA research to the addiction treatment workforce; the Partners for Recovery/ATTC Network-wide Leadership Institute designed to develop new leaders in the addictions services field; an extensive array of Web-based resources (**www.nattc.org**) used to enhance all aspects of ATTC work; and regional and national multidisciplinary consortia designed to create opportunities for positive systems change and the development of key resources for the field.

The ATTC Curriculum Committee produced CSAT's Technical Assistance Publication, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, which describes educational outcomes and other attributes essential to the competent practice of addiction counselors. CSAT has recently published an updated and enhanced version of this publication, as well as a companion publication on core competencies for clinical supervisors in the addiction treatment field.

The Results

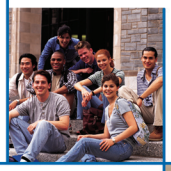
Drawing from current research from the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, as well as lessons learned from SAMHSA's programs, this program allows ATTCs to develop and disseminate curricula and state-of-the-art addiction treatment and recovery information, working toward preparing practitioners to deliver evidence-based treatment approaches and stimulating educational providers to address addiction in academic programs for relevant disciplines, thereby upgrading the standards of professional practice for addictions workers in multiple settings.

ATTCs trained 102,702 individuals through 5,132 training events during FY 2002–2007. Almost 93 percent (92.9%) of participants reported being satisfied with the training, and 86.1 percent reported sharing information from the training.

[1] Budget Category—PRNS—Addiction Technology Transfer Centers

Minority Fellowship Program[1]

(CMHS, CSAP, and CSAT)



The Challenge

The United States has approximately 329,000 mental health professionals, including psychiatrists, psychiatric nurses, psychologists, social workers, and other mental health workers with a bachelor's degree or higher. Although minorities make up approximately one-fourth of the population, only about 10 percent of mental health providers are ethnic minorities. The Minority Fellowship Program's (MFP's) objective is to increase the knowledge of issues related to ethnic minority mental health and substance use disorders and to improve the quality of mental health and substance abuse prevention and treatment delivered to ethnic minority populations. SAMHSA provides financial support and professional guidance to individuals pursuing doctoral degrees in psychology, neuroscience, and other disciplines.

The Response

Through this program, SAMHSA's Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), and CSAT provide grants to encourage and facilitate the doctoral and post-doctoral development of minority nurses, psychiatrists, psychologists, social workers, and others who maintain a professional focus on the provision of mental health and substance abuse prevention and treatment services. Implementation of this grant program is ongoing and funding is allocated based on 3-year fellowships.

The goals of this program are to support doctoral training in mental health and substance abuse services by—

- Promoting culturally competent mental health and substance abuse services provided to ethnic minority populations.
- Increasing the number of ethnic minority professionals delivering mental health and substance abuse services to ethnic minority populations.
- Increasing the general knowledge and research of issues related to ethnic minority and substance abuse treatment.

The Results

The SAMHSA Centers' MFP grants for doctoral-level and post-doctoral mental health provider training have been awarded over the past years to each of the following professional associations: the American Nurses Association, the American Psychiatric Association, the American Psychological Association, and the Council on Social Work Education. The American Association of Marriage and Family Therapy was added to the list of eligible applicants in 2007. Each entity uses different decision methods, strategies, and criteria that are specific to the discipline. However, the focus of each organization is to prepare fellowship recipients to address the most critical service provision needs in their respective fields.

This program expects to increase the pool of professionals qualified to provide leadership, consultation, training, and administration to government and public and private organizations concerned with the development and implementation of programs and services for under-served ethnic minority persons with mental and/or substance abuse disorders.

[1] Budget Category—jointly funded by all three Centers—PRNS—Minority Fellowship Program

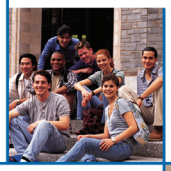
DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

National and Agency Data Systems

SAMHSA has dual responsibilities and needs in terms of data systems. First, SAMHSA serves in a stewardship role for national data sets, which are used not only by SAMHSA internally but also by external users from policymakers to researchers and members of the media. Second, SAMHSA is responsible to the Office of Management and Budget for agency-based data activities, which are responsive to the Government Performance and Results Act, as well as for the Program Assessment and Rating Tool.

National Survey on Drug Use and Health[1]

(OAS)



The Challenge

The National Survey on Drug Use and Health (NSDUH) is an ongoing national survey of the civilian, noninstitutionalized population, aged 12 years and older in the United States. It addresses the need for information on the nature and extent of substance use and abuse in the general population, including the number and characteristics of persons using alcohol, tobacco, and illicit drugs; changes over time in substance use incidence and prevalence; and the number of persons in need of substance abuse treatment. The design of the survey provides estimates at the national, regional, and State levels, with oversampling of people aged 12 through 25 to provide more detailed data for youth and young adults.

The Response

Since 1971, the survey has provided estimates of the incidence and prevalence of substance abuse in the United States. It measures trends and patterns of substance abuse, as well as the personal, family, and other factors associated with substance abuse. The NSDUH is the only continuous survey that provides both national and State measures of substance use in the general population. The expansion of the survey in 1999 made it possible to provide State-level estimates annually, as well as more precise national estimates than in the past, including estimates of rare and emerging patterns of substance abuse, such as methamphetamine use. Each year since that expansion, employing state-of-the-art computer-assisted interviewing techniques, the survey has collected comprehensive information from about 70,000 respondents on their demographic and socioeconomic characteristics, attitudes, and health status in conjunction with information on their substance use, abuse, and treatment.

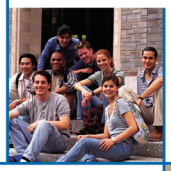
The Results

The NSDUH offers the opportunity for in-depth analysis on a wide variety of policy issues, such as treatment need and access to treatment services; patterns of substance use among special populations of interest, such as racial/ethnic minorities, pregnant women, welfare recipients, and the unemployed; and relationships of substance use with other problems, such as mental illness, school dropout, and criminal behavior. Such research will result in more efficient prevention interventions and treatment services. The NSDUH data facilitate the evaluation of SAMHSA programs and make it possible to direct Federal funds to areas with severe or unique problems. Because of its State-level capability, the data can be used to assess the impact of differing laws and policies across the States. Each year, national results are made available within 10 months following the close of data collection. State results are made available within 15 months following the close of data collection.

[1] Budget Category—SAPT Block Grant Set-Aside

Drug and Alcohol Services Information System[1]

(OAS)



The Challenge

The Drug and Alcohol Services Information System (DASIS) is the only source of comprehensive national data on the services available for substance abuse treatment, on the characteristics of the national treatment system, and on the numbers and general characteristics of people who are admitted to treatment.

The Response

DASIS contains three data sets, which are maintained with the cooperation and support of the States:

- **The Inventory of Substance Abuse Treatment (I-SATS)**—a master list of all specialty substance abuse treatment programs known to SAMHSA. It serves as the list frame for the annual National Survey of Substance Abuse Treatment Services and as a sampling frame for other special surveys of treatment providers and their clients.
- **The National Survey of Substance Abuse Treatment Services (N-SSATS)**—an annual census of all facilities listed on the I-SATS, which collects information on the location, organization, structure, services, and utilization of substance abuse treatment facilities in the United States. Data are used for program administration and policy analysis, and to compile and update the National Directory of Drug and Alcohol Abuse Treatment Programs and the online Substance Abuse Treatment Facility Locator.
- **The Treatment Episode Data Set (TEDS)**—a standard set of variables describing the demographic and drug use characteristics of individuals admitted to treatment, primarily by providers receiving public funding. TEDS consists of an admissions and a discharge data set, which can be linked to provide information on treatment episodes. In 2006, new data elements were added to the TEDS discharge data set so that comparisons of client status at admission and at discharge can be made on several critical dimensions, including substance use, living arrangements, employment status, and criminal justice involvement.

The goals of DASIS are to collect the most complete data possible on substance abuse treatment services and to make these data available to the public in a variety of useful formats.

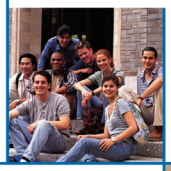
The Results

The DASIS data sets offer the opportunity to identify treatment programs, characterize services, enumerate persons in treatment, describe the general characteristics of people admitted to treatment, determine the proportion of those admitted that complete treatment and measure length of stay in treatment. The N-SSATS and its predecessors have been in place for nearly two decades, allowing analysis of change over time in the structure, composition, and use of treatment services. The TEDS has data on admissions since 1992, making it possible to monitor changing patterns in the drugs that lead people into treatment and to assess trends in age, gender, and race/ethnicity among admissions to treatment. The information has application for policymakers, program managers, academic researchers, and the public.

[1] Budget Category—SAPT Block Grant Set-Aside

Drug Abuse Warning Network[1]

(OAS)



The Challenge

The Drug Abuse Warning Network (DAWN) is a public health surveillance system that continuously monitors drug-related visits to hospital emergency departments and drug-related deaths reviewed by medical examiners and coroners. Annually, DAWN produces estimates of drug-related visits to hospital emergency departments for the Nation as a whole and for selected metropolitan areas. DAWN also publishes annual profiles of drug-related deaths submitted by medical examiners and coroners in selected metropolitan areas and selected States. DAWN is used to monitor trends in drug misuse and abuse; identify the emergence of new substances and drug combinations; assess health hazards associated with drug abuse; and estimate the impact of drug misuse and abuse on the Nation's healthcare system.

The Response

DAWN is the only data system providing estimates of the number of emergency department admissions associated with drug misuse and abuse and the particular drugs involved, not only for the United States as a whole but also for selected major metropolitan areas. These estimates are used to monitor trends in major substances of abuse (e.g., heroin, cocaine, marijuana), to assess alcohol use by minors that manifest in emergency department visits, to identify emerging new drugs of abuse (e.g., ecstasy, methamphetamine), to identify the abuse potential of prescription and over-the-counter drugs to better inform labeling and scheduling decisions, and to reveal changing patterns of drug abuse in local communities. Furthermore, DAWN is the only national data collection system on drug abuse today with the capacity to monitor specific and relatively infrequently used substances of abuse (such as club drugs, PCP, or medications used to treat attention-deficit/hyperactivity disorder) as they emerge and diffuse across population groups and geographic areas. Both the emergency department and mortality components of DAWN have been redesigned recently to improve their utility for a larger audience of users.

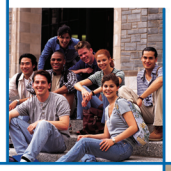
The Results

DAWN is a major component of the Nation's capacity to monitor trends in the morbidity and mortality associated with drug misuse and abuse. It is used by national, State, and local professionals to monitor trends in the health hazards associated with substance abuse and to identify emerging trends and changing patterns of drug abuse. DAWN offers data of value to policymakers, law enforcement, pharmacologists, and health professionals. The data are used by the White House Office of National Drug Control Policy to monitor national trends; the Drug Enforcement Administration for surveillance, diversion control, and intelligence; and the Food and Drug Administration and pharmaceutical industry for post-marketing surveillance of prescription and over-the-counter pharmaceuticals, for active monitoring of adverse events associated with medications that are new or old, and for assessing the abuse potential for labeling and scheduling decisions. State and local professionals, including law enforcement and the Community Epidemiology Work Group, use DAWN to assess changes in local trends and patterns of drug use. SAMHSA itself uses DAWN to target program resources to areas of greatest need and to monitor adverse events associated with buprenorphine treatment for opiate addiction. The redesign of DAWN began in 2003 and was fully in place in 2004.

[1] Budget Category—SAPT Block Grant Set-Aside

State Outcomes Measurement and Management Systems[1]

(OAS CSAT, CSAP, CMHS)



The Challenge

The challenge this program addresses is to develop common measures and methodologies to support performance management at local, State, and national levels to support continuous improvement of services.

The Response

SAMHSA, the States, and SAMHSA grantees initiated a partnership to define, implement, collect, and conduct analyses of National Outcome Measures. This partnership is supported by the State Outcomes Measurement and Management System (SOMMS) that is composed of several contracts supporting consensus development, State data collection, information technology (IT) technical assistance to States to improve data infrastructure for reporting National Outcome Measures (NOMs) and analysis of NOMs.

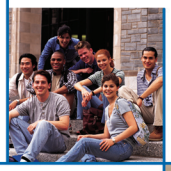
The Results

In 2006, the following "Five Next Steps for Data Quality Improvements" were identified for achievement by the spring of 2008: standardize operational definitions and outcome measures, and link records to support pre- and postservice comparisons; reduce the cycle time from data collection to data availability for performance management; achieve State reporting on currently defined NOMs; develop benchmarking strategies to determine acceptable levels of outcomes; and, produce management reports to direct efforts to improve outcomes.

[1] Budget Category—SAPT Block Grant Set-Aside and MH Block Grant Set-Aside

Center-Specific Data Systems

(CSAP, CSAT, & CMHS)



CSAP[1]: The Data Coordination and Consolidation Contract (DCCC) integrates and coordinates many of SAMHSA's Center for Substance Abuse Prevention's (CSAP's) data activities into one mechanism, reducing duplication, increasing efficiency of data processes, and enhancing data quality, timeliness and analysis. The DCCC will help to communicate and implement SAMHSA's data standards, data requirements, and ensure that available data reporting systems that are aligned with data requirements. Among the existing CSAP data activities that the DCCC will integrate are CSAP's Data Coordinating Center, the Prevention Platform, Minimum Data Set (MDS), Database Builder (DbB) and Services Accountability Improvement System (SAIS) data systems, and the proposed Data and Evaluation Unit Support. The overriding objective of the DCCC is to create and provide a centralized and comprehensive data resource with web-based access for SAMHSA, CSAP and the prevention field, for both block grant and discretionary grant programs.

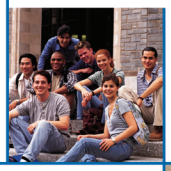
CSAT[2]: SAIS is a Web-based system which serves as the single repository for SAMHSA's Center for Substance Abuse Treatment's (CSAT's) discretionary grant Government Performance and Results Act (GPRA) measures. Grantees set targets for the number of persons to be served within established cost bands and submit real time client measures on uniform U.S. Office of Management and Budget (OMB)-approved questions, at baseline, 6 months post baseline, and discharge. Grantees are required to submit their information via the Web, 1 to 7 business days after seeing a client. Thus, client-level information is available on a "real time" basis for CSAT project officers. SAIS generates daily Web-based reports on Intake Coverage, Follow-up, and Outcomes which serve as tools to monitor program performance.

CMHS[3]: The Center for Mental Health Services (CMHS) Transformation Accountability System (TRAC) is a new Web-based platform for the receipt, storage, and analysis of GPRA data for the grants within the following key program areas: the Programs of Regional and National Significance (PRNS), the Children's Mental Health Initiative, Programs for Assistance in Transition from Homelessness (PATH), and Protection and Advocacy programs within CMHS. The TRAC system is designed to address data requirements related to the GPRA and is tied to the implementation of SAMHSA's NOMs, which create cross-cutting outcome and performance information across multiple CMHS programs and activities. The TRAC project includes training for grantees on how to enter data into this platform over multiple periods of time.

[1] Budget Category—SAPT Block Grant Set-Aside
[2] Budget Category—PRNS—Program Coordination and Evaluation
[3] Budget Category—RNS—Mental Health System Transformation Activities

State Mental Health Data Infrastructure Grants[1]

(CMHS)



The Challenge

The need to develop a mechanism to ensure accountability in the provision of mental health services at the State and community levels has grown markedly in the face of a rapidly changing healthcare system at the national, State, and local levels. Moreover, the flexibility of Federal mental health block grant funds—a significant source of public dollars to State mental health programs—allows States to fund the filling of gaps as well as new and innovative services. If Federal and State programs are to succeed in meeting the needs of people of all ages with mental illnesses and to identify and fill service gaps, they must be able to document that funds have been expended appropriately and that desired effects have been achieved. Uniform data in the public mental health field can improve planning and accountability for the Community Mental Health Services Block Grant and for oversight of community mental health services.

The Response

Through 5 percent set-aside funds from the Community Mental Health Services Block Grant, CMHS supports a broad range of national data collection and technical assistance activities on mental health issues of local and national importance. Significant portions of this effort focus on the State Mental Health Data Infrastructure Grant program.

Working with State mental health authorities, both within the context of these grants and in other information-driven activities, CMHS has developed a consensus-based information framework for mental health, which incorporates population data as well as services, outcome, and performance indicator information. This framework, which includes the Uniform Reporting System (URS) for recording and reporting on performance indicators, serves as an underpinning for the current 3-year grants awarded as part of the State Mental Health Data Infrastructure Grant program. The URS reporting incorporates the SMAHS NOMS. CMHS has awarded State Mental Health Data Infrastructure Grants to 49 States, the District of Columbia and 8 territories, and established a coordinating center to provide technical assistance to grantees and to ensure and infrastructure development and implementation.

The Results

The State Mental Health Data Infrastructure Grant program helps States improve data infrastructure and comparable reporting at the State and national levels. The program builds upon the work of a number of CMHS-funded projects, including the Mental Health Statistics Improvement Program (MHSIP) Consumer-Oriented Mental Health Report Card, the 5-State Feasibility Project, the 16-State Indicator Pilot Grant Project, the URS, and Decision Support 2000+. Linkages between MHSIP developments and the Community Mental Health Services Block Grant reporting needs are encouraged through these grants. This effort is designed to ensure State uniform data reporting for accountability and planning, utilizing an information framework that incorporates essential data standards, including quality tools and measures. States report uniform data as part of the block grant implementation reports using the URS. They also produce new methodologies and approaches that will benefit the entire mental health field.

[1] Budget Category—MH Block Grant Set-Aside

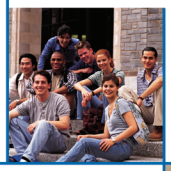
DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Disaster Readiness and Response

To integrate behavioral health into the public health emergency response, promote population resilience and prevent adverse substance abuse and mental health consequences through pre-event, event and post-event services and other activities.

FEMA/SAMHSA Crisis Counseling Program[1]

(CMHS)



The Challenge

Natural or human-caused disasters create a collective need that can overwhelm local resources and require additional assistance from outside sources. Typical reactions to a disaster include physical, emotional, cognitive, and behavioral responses that may be experienced by individuals and families. Many people may experience anxiety, loss of sleep or appetite, stress, grief, irritability, hopelessness, and family conflict. Each category of disaster response includes a diverse set of reactions that may change over time. For example, one might experience hyper-vigilance immediately after a disaster and then, over time, lapse into a state of chronic fatigue. Whether the reactions are adaptive or become distressing, people who are affected by a disaster may experience more than one type of reaction, and these reactions may change over time.

The Response

Funding for the Crisis Counseling Training and Assistance Program (CCP) is implemented as a supplemental assistance program available to the United States and its Territories, by the Federal Emergency Management Agency (FEMA). Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 1974 authorized FEMA to fund in States, territories, and localities in which Presidential declarations of disaster have been made. SAMHSA, under an Interagency Advisory Group (IAG) with FEMA, implements and monitors grants supporting mental health assistance and training activities.

For over 30 years, the Crisis Counseling Program has supported short-term, solutions-focused interventions with individuals and groups experiencing psychological and behavioral sequel to large-scale disasters. These interventions assist disaster survivors in understanding their current situation and reactions, mitigate additional stress, assist survivors in reviewing their options, promote using specific evidence-based coping strategies, provide emotional support, and encourage links with other individuals and agencies able to help survivors recover to their pre-disaster level of functioning.

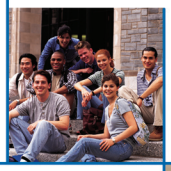
The Results

The Crisis Counseling Program uses an outreach model that includes, Individual Crisis Counseling, Group Crisis Counseling, Public Education, Community Networking and Assessment and Referral to reach those affected in a federally declared disaster area. There are currently seven active Individual Service Programs (ISP) in five states and eight Regular Service Programs (RSP) in eight States. Crisis Counseling Program grants provide efficient and effective services to disaster survivors. This is evident when examining the services provided to the Gulf Coast States in the aftermath of the 2005 hurricane season. Crisis Counseling Programs established in response to Hurricanes Katrina, Wilma and Rita provided 733,256 individual counseling sessions, 158,342 group sessions and 410,848 public education services over the first 18 months following the storms.

[1] Funded through an interagency agreement with FEMA

SAMHSA Disaster and Technical Assistance Training Center[1]

(CMHS, CSAT, CSAP)



The Challenge

When disaster strikes, State and Territory mental health/substance abuse agencies and local service providers are thrust onto the frontline for response and recovery efforts. Often local and regional supportive response systems are overwhelmed by the magnitude of the disaster. Systems and survivors are left to scramble to regain a foothold in their communities.

The Response

The SAMHSA Disaster and Technical Assistance Training Center (DTAC) assists States and Territories with behavioral health "all-hazards" disaster planning that allows them to prepare for and respond to both natural and man made disasters. SAMHSA DTAC provides consultation to review disaster plans and compiles research on "new" threats and planning methodologies. Through an interagency agreement with FEMA, SAMHSA administers CCP grants to help States provide ongoing support for the emotional recovery of disaster victims. This SAMHSA/FEMA collaboration allows the SAMHSA DTAC to train State mental health staff to perform outreach and education on stress reactions and stress reduction through the CCP model. The Center organizes training events and workshops and facilitates the sharing of information and best practices.

The Results

SAMHSA DTAC houses a library of print and electronic resource materials and continually identifies and develops new materials to address gaps and meet emerging disaster behavioral health needs. SAMHSA DTAC produces *The Dialogue*, an electronic quarterly informational bulletin highlighting Center activities and resources relevant to the field. The Center maintains a toll-free help line (1–800–308–3515), a comprehensive Web site, and an e-mail address (**dtac@esi-dc.com**).

SAMHSA DTAC has built upon existing partnerships and the field's knowledge and expertise to provide technical assistance and support to states and partnering Federal agencies. DTAC's achievements for 2007 were the creation of the Disaster Behavioral Health Information Series, refining support materials for the CCP, developing the State Behavioral Health All-Hazards Disaster Plan Review Report, and participating in the Federal Workgroup on Disaster which included the development of the Federal Resource Collection on Disaster Behavioral Health.

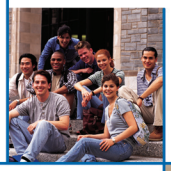
[1] Budget Category—PRNS—Disaster Response

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Cross-Cutting Programs of Interest

National Registry of Evidence-Based Programs and Practices[1]

(OPPB)



The Challenge

Recent reports (i.e., The Surgeon General's Report on Mental Health, the Institute of Medicine's Crossing the Quality Chasm, and the President's New Freedom Commission report Achieving the Promise) have documented the challenges that exist in closing the "research to practice gap," or promoting broader use in routine clinical and community-based settings those services that science has demonstrated to be effective in preventing and/or treating mental and substance use disorders. In addition, there are increasing expectations from purchasers that mental health and substance abuse providers be able to demonstrate the effectiveness (through scientific means) of the services that they provide. More attention is being paid to assessing and demonstrating the "evidence-base" for particular services, and in developing systems that will identify, evaluate and provide relevant information to assist both purchasers and the general public in making informed decisions about the selection and use of evidence-based services.

The Response

The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The purpose of this registry is to assist the public in identifying approaches to preventing and treating mental and/or substance use disorders that have been scientifically tested and that can be readily disseminated to the field. NREPP is one way that SAMHSA is working to improve access to information on tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field.

NREPP publishes a report called an intervention summary on its Web site (**www.nrepp.samhsa.gov**) for every intervention it reviews. Each intervention summary includes descriptive information about the intervention and its targeted outcomes; quality of research and readiness for dissemination ratings; a list of studies and materials submitted for review; and contact information for the intervention developer. SAMHSA believes that NREPP may promote informed decision-making by providing descriptive information and ratings that help stakeholders begin to determine whether a particular intervention may meet their unique needs. Nevertheless, NREPP should not be perceived or used as an exclusive or exhaustive list of "approved" or "endorsed" interventions, and service purchasers are discouraged from limiting contracted providers and/or potential grantees to selecting only among NREPP interventions.

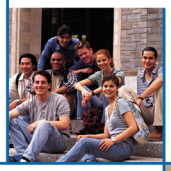
The Response

After an extensive period of redesign, the new NREPP system and Web site was launched in March 2007. Information on approximately 50 interventions is currently available, and new intervention summaries (approximately 5 to 10 per month) are continually being added as reviews are completed. The registry is expected to grow to a large number of interventions over the coming months and years. Moreover, new interventions to address service needs and gaps will be submitted for review each year in response to an annual Federal Register notice.

[1] Budget Category—Jointly funded by all three Centers

SAMHSA Conference Grants[1]

(CMHS, CSAP, CSAT)



The Challenge

The SAMHSA Knowledge Dissemination Conference Grant program promotes the advancement of treatment and prevention knowledge and the dissemination of that knowledge in the field. New knowledge derives from research, practice, and the experiences of providers, as well as from professional organizations, academia, and consumers and their families. The knowledge development process is incomplete until successful innovations are put into practice. Supporting conferences through grants is one way that SAMHSA can facilitate the transfer of knowledge from discovery to application.

The Response

Conferences funded under the program disseminate knowledge and allow advocates, providers, and consumers to showcase practices and develop strategies to improve mental health and substance abuse services. Conferences also serve to educate the general public through the publication of conference presentations, panel discussions, and recommendations. Conference grant awards are limited to 75 percent of the proposed conference's total direct costs of planned meetings and conferences. Grant awards range from $25,000 to a maximum of $50,000 for the project period. SAMHSA supports conferences through the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). SAMHSA is particularly interested in reviewing applications for conferences that address one or more of the following programmatic priorities and cross-cutting principles:

Programmatic Priorities: Co-occurring disorders; substance abuse treatment capacity; seclusion and restraint; strategic prevention framework; children and families; suicide prevention; mental health system transformation; disaster readiness and response; homelessness; older adults; HIV/AIDS and hepatitis; and criminal and juvenile justice.

Cross-cutting principles: Science to services/evidence-based practices; data for performance measurement and management; collaboration with public and private partners; recovery/reducing stigma and barriers to services; cultural competency/eliminating disparities; community and faith-based approaches; trauma and violence (e.g., physical and sexual abuse); financing strategies and cost-effectiveness; rural and other specific setting; and, workforce development.

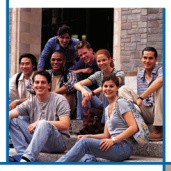
The Results

The SAMHSA Conference Grant program supports the convening of regionally and/or nationally significant conferences related to substance abuse and mental illness prevention, early intervention, and treatment innovations.

[1] Budget Category—Jointly funded by all three Centers

SAMHSA Health Information Network[1]

(OC, CSAT, CSAP, CMHS, OAS)



The Challenge

The American public needs substance abuse and mental health information that is accurate and grounded in science. Parents need information on how to talk to their children about drugs. Consumers seek treatment resources and support services that will allow them to live independently in their communities. Health professionals must stay informed of best practices in treatment.

The Response

SAMHSA's Health Information Network (SHIN) includes the National Clearinghouse for Alcohol and Drug Information (NCADI) and the National Mental Health Information Center (NMHIC). SHIN provides the public and professionals with one-stop, quick access to information, materials, and services for mental health and substance abuse prevention and addictions treatment. SHIN supports the Agency's vision of a life in the community for everyone. It also helps to position SAMHSA as the leading provider of reliable, evidence-based information about substance abuse and mental health prevention, treatment and recovery support services. Over the next 5 years, SHIN's strategic plan seeks to 1) focus on the end-user; 2) increase visibility and use of services offered by SHIN; 3) apply the latest technology and innovation to information management; and 4) implement and apply data related to project performance to achieve SAMHSA's vision and meet the needs of its customers.

The Results

Contact Center—responds to 45,000 public inquiries each month (in English and Spanish) by toll-free telephone, e-mail, and regular mail.

Warehouse and Distribution Center—receives, maintains, ships, and manages SAMHSA's publications and multimedia inventory and fills approximately 19,000 publication orders each month.

Web Site Operations—maintains and updates content of the NCADI, NMHIC, and other related SAMHSA web pages, which receive over 1 million visits per month; initiating redesign of clearinghouse web sites and associated systems development.

SAMHSA eNetwork—launched a new, Web-based marketing tool that allows subscribers to create profiles and select to receive materials on topics of interest to them. Subscribers can choose to receive e-mail updates on a wide range of SAMHSA information—from upcoming awareness campaigns and funding opportunities to downloadable e newsletters and new publications.

Health Communications Services—provides materials and resource development; graphic design; marketing and promotion of SAMHSA programs and products; forges strategic, collaborative partnerships to advance the Agency's mission; promotes SAMHSA programs, products, and new initiatives at national, regional, and local conferences.

Support ONDCP Media Campaign—maintains toll-free information lines; fulfills publication orders and mailings; manages content on Freevibe.com Web site; provides duplication of audiovisual media; and manages product inventory for Office of National Drug Control Policy.

[1] Budget Category—Jointly funded by all three Centers, OAS, and OC

Substance Abuse and Mental Health Data Archive[1]

(OAS)

The Challenge

The Substance Abuse and Mental Health Data Archive's (SAMHDA's) goal is to facilitate the use of data to assess, understand, and resolve substance abuse and mental health problems and related policy and treatment issues. SAMHDA's website is designed to provide ready access to substance abuse and mental health research data, to ensure the data are in user-friendly format, and to promote the sharing of these data. This data use and sharing among researchers, academics, policymakers, service providers, the public and others increases the effectiveness of substance abuse and mental health policies as well as prevention and treatment programs.

The Response

The SAMHDA provides quick, easy access to substance abuse and mental health data for research, policy studies, speeches, and media reports. The SAMHDA website offers a large electronic library of substance abuse and mental health data sets with the documentation required to use them. These SAMHDA data can be downloaded to personal computers or analyzed online. Staff are available to assist users through a toll-free helpline and e-mail support. SAMHDA's website was established in 1998, redesigned in 2005 in response to user feedback, and continues to add important substance abuse and mental health data sets annually. In 2006, several improvements were made to the computing hardware and software.

The Results

SAMHDA has become a major resource to the public, practitioners, researchers and policymakers at the Federal, State, and local levels. In the first 6 months of 2007, the SAMHDA convenient and easy-to-use web site averaged 111,000 hits each month. As a measure of the contribution to substance abuse and mental health research, over 400 citations were added to the bibliography of publications based on SAMHDA data in the last year.

[1] Budget Category—Jointly funded by all three Centers

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Appendix—
Budget Display

Center for Mental Health Services
Programs of Regional & National Significance
Summary Listing of Activities

(Dollars in Thousands)

Programs of Regional and National Significance	FY 2007 Present Budget	FY 2007 Continuing Resolution
CAPACITY:		
Co-Occurring State Incentive Grants (SIGs)	$7,633	$7,618
Seclusion and Restraint	2,331	2,449
Suicide Hotline	3,021	4,484
GLS—Youth Suicide Prevention—States	17,820	17,820
GLS—Youth Suicide Prevention—Campus	4,950	4,950
AI/AN Mental Health/Suicide Prevention Initiative	2,970	2,970
School Violence Prevention	75,710	93,156
Safe Schools/Healthy Students (non-add)	*65,546*	*80,868*
Post Traumatic Stress Disorder	29,462	29,418
Children's SIG	2,946	2,942
Children's Programs	6,485	8,171
Mental Health SIG for Transformation	19,796	26,012
Mental Health System Transformation Activities	1,017	2,702
Homelessness	4,439	8,492
Older Adults	4,910	4,903
Minority AIDS	9,283	9,283
Jail Diversion	6,875	6,863
Subtotal, CAPACITY	**$199,648**	**$232,233**
SCIENCE TO SERVICE:		
GLS—Suicide Resource Center	$3,960	$3,960
Adolescents at Risk	1,964	1,961
Mental Health System Transformation Activities	8,758	11,161
National Registry of Evidence-Based Programs and Practices	445	445
SAMHSA Health Information Network	3,739	2,970
Consumer Support TA Centers	1,964	1,961
Minority Fellowship Program	3,465	3,873
Disaster Response	1,066	1,119
Homelessness	2,118	2,606
HIV/AIDS Education	974	974
Subtotal, SCIENCE TO SERVICE	**$28,453**	**$31,030**
TOTAL	**$228,101**	**$263,263**

Center for Substance Abuse Prevention
Programs of Regional & National Significance
Summary Listing of Activities

(Dollars in Thousands)

Programs of Regional and National Significance	FY 2007 Present Budget	FY 2007 Continuing Resolution
CAPACITY:		
Strategic Prevention Framework State Incentive Grants (SIGs)	$95,389	$105,462
Workplace	5,459	5,147
Minority AIDS	39,385	39,385
Methamphetamine	3,960	3,960
Program Coordination/Data Coordination and Consolidation Center	5,500	5,500
Subtotal, CAPACITY	**$149,693**	**$159,454**
SCIENCE TO SERVICE:		
Evidence-Based Practices	--	$1,409
Fetal Alcohol Spectrum Disorder	9,821	9,821
Center for the Application of Prevention Technologies	9,430	9,430
Underage Drinking Ad Council	--	--
Dissemination/Training	1,656	2,114
Best Practices Program Coordination	6,007	7,315
National Registry of Evidence-Based Programs and Practices	350	550
SAMHSA Health Information Network	3,579	2,749
Minority Fellowship Program	62	60
Subtotal, SCIENCE TO SERVICE	**$30,905**	**$33,448**
TOTAL	**$180,598**	**$192,902**

Center for Substance Abuse Treatment
Programs of Regional & National Significance
Summary Listing of Activities

(Dollars in Thousands)

Programs of Regional and National Significance	FY 2007 Present Budget	FY 2007 Continuing Resolution
CAPACITY:		
Co-Occurring State Incentive Grants (SIGs)	$7,979	$6,645
Opioid Treatment Programs/Regulatory Activities	7,496	7,520
Screening, Brief Intervention, Referral, & Treatment	31,151	29,624
TCE—General	20,939	29,842
Pregnant and Postpartum Women	3,932	10,390
Strengthening Treatment Access and Retention	3,977	3,627
Recovery Community Services Program	9,400	9,116
Access to Recovery	98,208	98,208
Methamphetamine Treatment (non-add)	*25,000*	*25,000*
Children and Families	20,959	29,275
Treatment Systems for Homeless	34,077	34,517
Minority AIDS	63,129	62,853
Criminal Justice Activities	24,023	24,114
Drug Courts (non-add)	*10,283*	*10,117*
Disaster Technical Assistance Center	--	--
Program Coordination and Evaluation	16,195	22,694
Clinical Technical Assistance	3,145	1,234
Subtotal, CAPACITY	**$344,610**	**$369,659**
SCIENCE TO SERVICE:		
Addiction Technology Transfer	$8,060	$9,242
Seclusion and Restraint	--	20
Minority Fellowship Program	531	536
Special Initiatives/Outreach	3,243	5,241
State Service Improvement	3,294	1,739
Information Dissemination	3,471	3,616
National Registry of Evidence-Based Programs and Practices	743	500
SAMHSA Health Information Network	4,255	2,985
Program Coordination and Evaluation	5,984	4,543
Technical Assistance	1,188	868
Subtotal, SCIENCE TO SERVICE	**$30,769**	**$29,290**
TOTAL	**$375,379**	**$398,949**

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services