DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2013

Substance Abuse and Mental Health Services Administration

Justification of Estimates for Appropriations Committees

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SAMHSA

Substance Abuse and Mental Health Services Administration
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Letter from the Administrator

This letter presents the SAMHSA FY 2013 Budget Request. A total of $3,151,508,000 is requested from Budget Authority funds, which reflects an overall reduction of $195,512,000 below the FY 2012 Enacted Level. The FY 2013 Request reflects the four Appropriations: Mental Health ($902,856,000), Substance Abuse Prevention ($463,378,000), Substance Abuse Treatment ($1,711,045,000), and Health Surveillance and Program Support ($74,229,000). This request maintains the budget structure in the FY 2012 Consolidated Appropriations Act and program priorities reflected in the FY 2012 President's Budget. Prevention remains SAMHSA's top priority and funding is provided for three major prevention programs requested in the FY 2012 President's Budget. The proportion of funding for mental health and substance abuse for FY 2013 is generally comparable to the FY 2012 Enacted funding level (29.42 percent Mental Health; 70.58 percent Substance Abuse).

After careful review of SAMHSA's entire portfolio in FY 2012, strategic reductions are proposed in FY 2013 while maintaining support for the highest priority strategic initiative goals for Prevention and for Trauma and Justice. The SAMHSA FY 2013 Budget Request also maintains level funding for the States to support the infrastructure necessary to maintain and improve access to quality behavioral health services. As other programs are reduced, restructured, or eliminated, it will be necessary to rethink performance targets to reflect realistic expectations and viable management paradigms.

In addition, this budget includes a request of $105,000,000 from the Affordable Care Act (ACA) Prevention Fund reflecting an increase of $17,000,000 over FY 2012. This funding includes $28,000,000 for Primary and Behavioral Health Care Integration (PBHCI), $7,000,000 for the Sober Truths on Preventing (STOP) Under Age Drinking Act, $30,000,000 for Screening, Brief Intervention, Referral and Treatment, and $40,000,000 for the establishment of the Behavioral Health-Tribal Prevention Grant program.

The SAMHSA request maintains level funding in Budget Authority for both Block Grants, i.e., the Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG). These programs' contribution to the PHS evaluation tap will increase from 1.25 percent in FY 2012 to 3.2 percent in FY 2013.

This budget requests funding for the creation of three State and Tribal Prevention Grants. Consistent with the FY 2012 President's Budget and the FY 2012 Consolidated Appropriations Act budget structure, SAMHSA is requesting that these State and Tribal Prevention Grants be funded as separate lines within the new Mental Health, Substance Abuse Prevention, and Health Surveillance and Program Support appropriations. These important prevention programs will ensure that States and Tribes can implement and sustain evidence-based prevention practices in high need communities. The three programs will bring the successes realized in SAMHSA's discretionary

grant programs to a broader scale. Funding is requested to continue existing Project LAUNCH and Strategic Prevention Framework (SPF) program grants (consistent with the FY 2012 President's Budget). SAMHSA looks forward to working with Congress and stakeholders to discuss how best to strengthen our Nation's prevention capacity.

Consistent with the Trauma and Justice Strategic Initiative, funding is also requested for a new program, Grants for Adult Trauma Screening and Brief Intervention (GATSBI). The GATSBI program will advance the knowledge base to address trauma and interpersonal violence for women in common healthcare settings such as emergency departments, primary care, and OB/GYN offices. The concept and design for these grants is being developed by SAMHSA in consultation with its federal partners. Funding is continued for the National Child Traumatic Stress Network in FY 2013 at the 2012 Enacted Level.

In addition, funding is requested for a nationally available disaster distress crisis counseling telephone line. The need for this initiative has been documented through the Assistant Secretary for Preparedness and Response after various emergency conditions throughout the U.S. The request for FY 2013 will expand an existing SAMHSA pilot program to make this response line available for any disaster, anywhere in the U.S., through a connection to local crisis lines throughout the country.

Budget Authority funding in FY 2013 is reduced for selected discretionary programs such as PBHCI and Children's Mental Health Services. These reductions are largely from grants coming to a natural end. Funding for substance abuse technical assistance is maintained but at a lower level [Center for the Application of Prevention Technologies (CAPT) and the Addiction Technology Transfer Centers (ATTCs)], allowing SAMHSA to continue promulgating the adoption of evidence-based approaches in the Nation's behavioral health system. Total funding for the Minority AIDS Initiative is maintained with some rebalancing of funds across CSAT and CMHS to support ongoing collaboration with CDC. Statutory authority is requested to charge and collect fees for selected data and publication user requests beyond the normal requests from the general public. Through close management of operating costs and contracts, program support is also reduced.

This budget reflects the Administration's priorities in tight and difficult economic times, and it reflects a commitment to supporting states and communities in improving health and health care in all America’s communities.

Pamela S. Hyde, J.D.
Administrator

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

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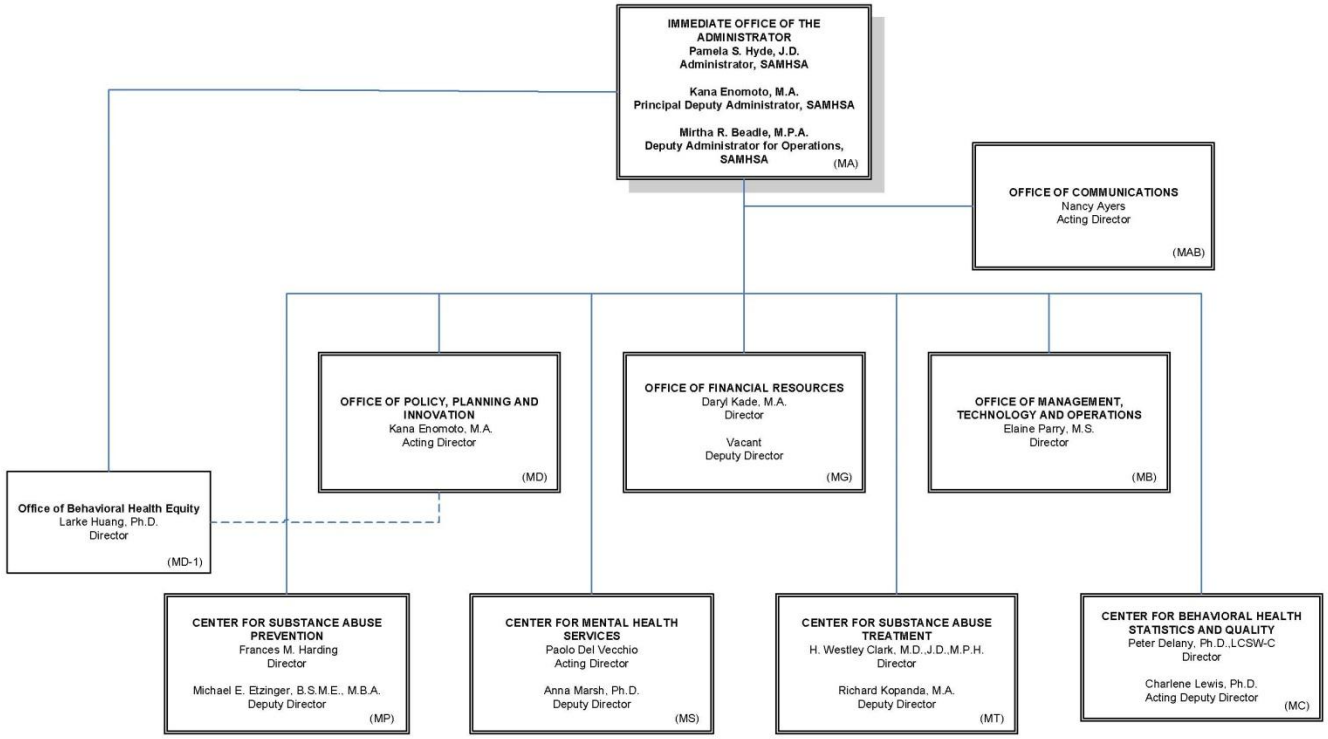
Fiscal Year 2013 Budget

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



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SAMHSA Overview

Individuals and families cannot be healthy without positive mental health and freedom from addictions and abuse of substances. Prevention, treatment, and recovery support services for behavioral health are important parts of health service systems and community-wide strategies that work to improve health status and lower costs for individuals, families, businesses, and governments. Substance abuse, addictions, poor emotional health, and mental illnesses take a toll on individuals, families, and communities. They cost money, and they cost lives, as do physical illnesses that are not prevented, are left untreated, or are poorly managed. Their presence exacerbates the cost of treating co-morbid physical diseases and results in some of the highest disability burdens in the world, compared with other causes of disability. SAMHSA has a unique responsibility to focus the Nation's health and social agendas on these preventable and treatable problems stemming from disease, trauma, inadequate access to appropriate care, and insufficient community and family supports.

Vision

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

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

Mission

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

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Eight Strategic Initiatives

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

1 Prevention of Substance Abuse and Mental Illness

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

2 Trauma and Justice

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

3 Military Families

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

4 Recovery Support

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

5 Health Reform

Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.

6 Health Information Technology

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

7 Data, Outcomes, and Quality

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

8 Public Awareness and Support

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

Across the eight strategic initiatives, SAMHSA identified a number of goals, objectives, and action steps to guide its work through 2014. Now that SAMHSA has moved past the planning stage to implementation, staff is refining management and communications plans for each initiative. In a continued effort to focus SAMHSA's resources on items of highest priority, senior leadership has worked with each initiative lead through this process to identify projects requiring action in the near term. This will enable SAMHSA to move forward on key issues, such as the prevention of substance abuse and mental illness, and prioritize declining resources in FY 2012 and FY 2013.

Discretionary All-Purpose Table
FY 2013 Budget Submission
(Dollars in Thousands)

Program Activities	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Mental Health:				
Mental Health Programs of Regional and National Significance	$358,571	$286,116	$247,550	-$38,566
ACA Prevention Fund (non-add)	*45,000*	*45,000*	*28,000*	*-17,000*
Mental Health - State Prevention Grant	24,706	34,640	55,000	+20,360
Project LAUNCH (non-add)	*24,706*	*34,640*	*24,750*	*-9,890*
Children's Mental Health Services	117,803	117,315	88,557	-28,758
PATH Homeless Formula Grant	64,917	64,917	64,794	---
PAIMI	36,307	36,238	36,238	---
Mental Health Block Grant	419,933	459,756	459,756	---
PHS Evaluation Funds (non-add)	*20,997*	*21,039*	*21,039*	---
Total, Mental Health	**1,022,237**	**998,859**	**951,895**	**-46,964**
Substance Abuse Prevention:				
Substance Abuse Prevention Programs of Regional and National Significance	75,956	76,202	65,877	-10,325
ACA Prevention Fund (non-add)	---	---	*7,000*	*+7,000*
Substance Abuse - State Prevention Grant	451,107	453,980	404,501	-49,479
Strategic Prevention Framework (non-add)	*110,417*	*109,754*	*60,275*	*-49,479*
Total, Substance Abuse Prevention	**527,063**	**530,182**	**470,378**	**-59,804**
Substance Abuse Treatment:				
Substance Abuse Treatment Programs of Regional and National Significance	431,389	425,243	364,139	-61,104
ACA Prevention Fund (non-add)	*25,000*	*25,000*	*30,000*	*+5,000*
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	---	*-2,000*
Substance Abuse Block Grant	1,441,962	1,456,106	1,448,630	-7,476
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*71,724*	*-7,476*
Total, Substance Abuse Treatment	**1,873,351**	**1,881,349**	**1,812,769**	**-68,580**
Health Surveillance and Program Support				
Health Surveillance and Program Support	119,789	124,319	121,157	-3,162
ACA Prevention Fund (non-add)	*18,000*	*18,000*	---	*-18,000*
Data Request and Publications User Fees (non-add)	---	---	*1,500*	*+1,500*
PHS Evaluation Funds (non-add)	*22,750*	*27,428*	*45,428*	+18,000
Public Awareness and Support	14,029	13,545	13,571	+26
Performance and Quality Information Systems	---	---	*13,571*	*+13,571*
PHS Evaluation Funds (non-add)	37,362	12,940	12,996	+56
Agency-Wide Initiatives	*6,596*	---	*12,996*	*+12,996*
ACA Prevention Fund (non-add)	---	---	*40,000*	*+40,000*
Total, Health Surveillance and Program Support	**176,430**	**154,297**	**187,724**	**+33,427**
TOTAL, SAMHSA Discretionary PL	**3,599,081**	**3,564,687**	**3,422,766**	-141,921
Less PHS Evaluation Funds	*131,543*	*129,667*	*164,758*	*+35,091*
Less ACA Prevention Funds	*88,000*	*88,000*	*105,000*	*+17,000*
Less Data Request and Publications User Fees	---	---	*1,500*	*+1,500*
TOTAL, SAMHSA Budget Authority	**$3,379,538**	**$3,347,020**	**$3,151,508**	**-195,512**
FTEs	**547**	**574**	**574**	---

Overview of the Budget Request

The SAMHSA FY 2013 President's Budget Request for Total Program Level is $3.4 billion, a $141.9 million decrease from the FY 2012 Enacted Level. This FY 2013 Total Program Level of $3.4 billion is comprised of $3.2 billion in Budget Authority (a decrease of $195.5 million from the FY 2012 Enacted Level), $164.8 million in PHS Evaluation funds (an increase of $35.1 million from FY 2012), $105.0 million in ACA Prevention Funds (an increase of $17.0 million from FY 2012), and $1.5 million for User Fees for data and publications requests beyond the normal requests from the general public (which is new for FY 2013).

Prevention is SAMHSA's top priority and funding is provided for each of three major prevention programs to focus resources, enhance collaboration, identify strategic problems, and develop plans for addressing the health and well-being of whole communities. The promotion of positive mental health and prevention of mental and substance use disorders are key parts of SAMHSA's mission to reduce the impact of substance abuse and mental illnesses on America's communities. SAMHSA plans to promote behavioral health by placing a national priority on healthy mental, emotional, and behavioral development, especially in children, youth, and young adults. SAMHSA will assist States, Territories, Tribal governments, and communities in adopting evidence-based practices, deliver prevention focused health education, and establish effective policies, programs, and infrastructure to build resilience and prevent mental and substance use disorders.

Additionally, with the passage of the Affordable Care Act, there is increasing commitment to prevention across government and in States, Territories, Tribes, and communities. This commitment to foster physical and behavioral health and well-being presents a perfect opportunity to engage stakeholders and partners—including AI/AN Tribes—to embrace prevention as the top strategic initiative in the behavioral health field.

This request reflects the budget structure in the FY 2012 Consolidated Appropriations Act with new program priorities. The proportion of funding for mental health and substance abuse for FY 2013 is generally comparable to the FY 2012 Enacted funding level (29.42 percent Mental Health; 70.58 percent Substance Abuse).

After careful review of SAMHSA's entire portfolio in FY 2012, strategic reductions are proposed in FY 2013 while maintaining support for the highest priority strategic initiative goals for Prevention and for Trauma and Justice. The SAMHSA FY 2013 Budget Request also largely maintains funding for States to support the infrastructure necessary to maintain and improve access to quality behavioral health services. As other programs are reduced, restructured, or eliminated, it will be necessary to rethink performance targets to reflect realistic expectations and viable management paradigms.

The FY 2013 President's Budget Request for SAMHSA is divided among four appropriations consistent with the FY 2012 Consolidated Appropriations Act. The four appropriations are Mental Health, Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support. The following is a summary of changes for each of the four appropriations in the FY 2013 President's Budget Request for SAMHSA.

Mental Health Appropriation

The FY 2013 President's Budget Request for the Total Program Level of the SAMHSA Mental Health appropriation is $951.9 million, a decrease of $47.0 million from the FY 2012 Enacted Level. The request includes $247.6 million for Programs of Regional and National Significance, a decrease of $38.6 million from the FY 2012 Enacted Level, and maintains key programs such as National Traumatic Stress Network, Primary and Behavioral Health Integration, Suicide Prevention Activities, Minority AIDS and Homelessness Prevention Programs. The Mental Health appropriation request includes $55.0 million for the Mental Health – State Prevention Grant, an increase of $20.4 million from a comparable level in FY 2012, which will provide consistent and sustainable support for States and Territories to implement State-wide comprehensive prevention strategies to address the prevention of mental illnesses and reduce the impact of mental illness on America's communities. The Request also includes $88.6 million for Children's Mental Health Services to provide comprehensive services to children and their families, as well as technical assistance to the field. The PATH Homelessness Formula Grant and the Protection and Advocacy for Individuals with Mental Illness (PAIMI) are maintained at the same level as FY 2012. Finally, the request includes $459.8 million for the Mental Health Block Grant, the same as FY 2012 which provides support to States for provision of key mental health services to the Nation's most vulnerable populations and support critical service infrastructure.

Substance Abuse Prevention Appropriation

The FY 2013 President's Budget Request for the Total Program Level of the SAMHSA Substance Abuse Prevention appropriation is $470.4 million, a decrease of $59.8 million from the FY 2012 Enacted Level. The request includes $65.9 million for Programs of Regional and National Significance, a decrease of $10.3 million from the FY 2012 Enacted Level, and maintains key programs such as Mandatory Drug Testing, Minority AIDS and Centers for the Application of Prevention Technologies. These programs provide flexible support to State and local substance abuse prevention service providers and can rapidly address emerging needs. It also includes $404.5 million for the Substance Abuse – State Prevention Grant, a decrease of $49.5 million from a comparable level in FY 2012, which will bring substance abuse prevention to a National scale by providing consistent and sustainable support for States and Territories to implement State-wide comprehensive substance abuse prevention strategies and reduce the impact of substance abuse on America's communities.

Substance Abuse Treatment Appropriation

The FY 2013 President's Budget Request for the Total Program Level of the SAMHSA Substance Abuse Treatment appropriation is $1.8 billion, a decrease of $68.6 million from the FY 2012 Enacted Level. The request includes $364.1 million for Programs of Regional and National Significance, a decrease of $59.1 million from the FY 2012 Enacted Level and maintains key programs such as Screening, Brief Intervention and Referral to Treatment, Pregnant and Postpartum Women, Access to Recovery, Treatment Systems for Homeless, Minority AIDS, Criminal Justice and Addiction Technology Transfer Centers. These programs provide flexible support to State and local substance abuse treatment service providers and can rapidly address emerging needs. The request also includes $1.4 billion for the Substance Abuse Block Grant. This includes $1.4 billion in Budget Authority and $71.7 million in PHS

Evaluation Funds which provides support to States for provision of key substance treatment services to the Nation's most vulnerable populations and support critical service infrastructure.

Health Surveillance and Program Support Appropriation

The FY 2013 President's Budget Request for the Total Program Level of the SAMHSA Health Surveillance and Program Support appropriation is $187.7 million, an increase of $33.4 million from the FY 2012 Enacted Level. The FY 2013 request includes $121.2 million for Health Surveillance and Program Support activities within this appropriation, a decrease of $3.2 million from FY 2012. $1.5 million is requested to be collected from user fees for extraordinary data and publications user requests not currently able to be fulfilled. Regular requests from the general public will continue to be met without cost. The request for Public Awareness and Support is $13.6 million, an increase of $26 thousand from the FY 2012 Enacted Level, but is requested through PHS Evaluation Funds. The request for Performance and Quality Information Systems is $13.0 million, an increase of $56 thousand from the FY 2012 Enacted Level, but is requested through PHS Evaluation Funds. Finally, $40.0 million is requested for the Behavioral Health – Tribal Prevention Grant, to be funded from the ACA Prevention Fund which will provide consistent and sustainable support for Tribes to implement comprehensive substance abuse and mental illness prevention strategies, including preventing underage drinking and suicides, to reduce the impact of substance abuse and mental illness on Tribal populations.

It should be noted that all grant and contract numbers in the budget for FY 2012 and FY 2013 should be considered approximate and the best estimate at this point in the planning process. The grant and contract numbers could be affected by the amount of available funding, number of applicants, timing of funding, potential partners, and best approaches to implementing best practices and Congressional intent.

Overview of Performance

FY 2013 Performance Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA) is charged with reducing the suffering associated with substance abuse and mental illness within America's communities. Addressing the needs of vulnerable citizens during this time of significant change within the US health care system creates both opportunities and challenges. As SAMHSA pursues its mission as an active partner in the delivery of mental health and substance abuse services, improvements are measured in how care is delivered, how care is paid for, how performance is monitored and tracked, and how feedback about effectiveness is used to support sound decision-making.

The knowledge base associated with both substance abuse and mental health continues to expand in ways that help patients, providers, policymakers, family members, spiritual advisors and others understand which prevention, treatment, and recovery services/interventions work (or do not work), with which populations, and under what conditions. With growing options for dissemination, collaboration, promotion of sustainability, and other avenues of communication, SAMHSA is finding new ways to facilitate ongoing improvements in structures, processes, and outcomes.

During FY 2011, SAMHSA identified eight Strategic Initiatives (SIs) that focus on areas of particular opportunity (http://www.samhsa.gov/about/strategy.aspx). Each SI has an overarching purpose, specific goals, action steps, and measures for monitoring progress. In addition, three issues cut across all SI's: behavioral health disparities, health reform, and workforce development. SI's are central at SAMHSA:

- Sets budget and policy priorities;
- Manages grants, contracts, technical assistance, Agency staff, and interagency efforts;
- Engages partners at every level and across stakeholders; and
- Measures and communicates progress.

SAMHSA sets priorities within the context of limited resources and fiscal restraint. In conjunction with SAMHSA's eight SIs, decisions stemming from the decrease in SAMHSA's FY 2013 Budget Request are influenced by many factors. While reductions will result in few terminations of grants or contracts, performance may be negatively influenced.

Internal Performance Management Processes

As required by the Government Performance and Results Modernization Act of 2010 (GPRA Modernization Act), performance measures are monitored and reported. SAMHSA has achieved or surpassed a majority of FY 2011 goals and significant progress was made when goals were not achieved. In recent years, SAMHSA maintained between 58-70 percent target achievements across GPRA Modernization Act measures. For FY 2011, SAMHSA currently documents that 60 percent of the targets are either met or exceeded. Although this number will change as more FY 2011 data are reported, SAMHSA is optimistic that the collective achievements for FY 2011 represent promising benefit to many Americans. Considering that many of SAMHSA's performance measures are outcomes (e.g., substance use, housing, and employment) which have been greatly impacted by the economic downturn, SAMHSA's programs are seen as highly successful.

SAMHSA's GPRA Modernization Act reporting portfolio is designed to generate feedback useful to decision-makers across stakeholder groups. Measures are continuously evaluated and refined in ways that optimize responsiveness. An example of specific importance is growing agreement across public and private groups about how to accurately measure and report recovery from mental illness or substance use disorders.

Each of SAMHSA's program Centers currently operate their own performance management system and use output to monitor their programs and report results. As this occurs, SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) is leading the development of a common data platform to track all performance and oversee evaluation and overall performance within available resources. Three separate existing systems, (TRAC, PMART, and SAIS) will be replaced over the next couple of years by the new SAMHSA-wide system. The future common data platform will be critical in generating information for quarterly performance data reports and for supporting the development of internal review processes in compliance with the GPRA Modernization Act of 2010.

All four of SAMHSA's Centers are currently working together to develop a behavioral health framework designed to monitor the performance of SAMHSA programs. This framework will facilitate performance management and inform SAMSHA about how to most effectively influence outcomes. The resulting data and information will expand collective understanding of how SAMHSA can influence change by collaborating with other operating divisions, States, networks, and non-governmental groups. Finally, SAMHSA's National Behavioral Health Quality Framework (NBHQF) will be of value as SAMHSA tracks population-based indicators which can be used to monitor trends and prioritize activities.

Support for the HHS Strategic Plan and Federal Priorities

SAMHSA contributes to HHS priorities and works across traditional agency and program boundaries in pursuit of optimal processes and outcomes. SAMHSA contributes to implementation of the Affordable Care Act (ACA) as well as active participation in the Department of Health and Human Services (HHS) Strategic Plan. Within this context, SAMHSA is committed to optimal program performance that emphasizes strong data analysis as a key part of performance management. SAMHSA uses performance goals as tools designed to advance performance management through effective, efficient, and productive government efforts. SAMHSA data efforts, including GPRA Modernization Act, support many of the priorities of the Secretary and the President. SAMHSA has ongoing activities that relate to each of the Secretarial priorities:

• Transforming Health Care – SAMHSA is monitoring the percentage of persons with a mental health or substance use disorder service need and who have health insurance through the National Survey on Drug Use and Health (NSDUH).

• Advance Scientific Knowledge and Innovation – SAMHSA has consolidated staff efforts in the new Office of Policy, Planning and Innovation to lead cutting edge efforts across SAMHSA and across government.

• Advance the Health, Safety, and Well-Being of the American People – SAMHSA is monitoring trends in mental health and substance abuse disorders.

• Increase Efficiency, Transparency, and Accountability of HHS programs – SAMHSA is working directly with the HHS Chief Technology Officer to make more SAMHSA data publicly available.

• Strengthen the Nation's Health and Human Services Infrastructure and Workforce – SAMHSA is working with HRSA to examine ongoing technical assistance and training activities and incentives to see if there are more effective and efficient ways of expanding, supporting, and reaching the behavioral health workforce.

FY 2013 Budget by HHS Strategic Goal
Substance Abuse and Mental Health Services Administration
(Dollars in Millions)

HHS Strategic Goals	FY 2011	FY 2012	FY 2013
1.Strengthen Health Care	**$757,585**	**$760,599**	**$643,793**
1.A Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured	---	---	---
1.B Improve health care quality and patient safety	47,309	47,568	46,273
1.C Emphasize primary & preventative care linked with community prevention services	116,452	120,932	58,000
1.D Reduce growth of health care costs while promoting high-value, effective care	104,191	100,714	96,221
1.E Ensure access to quality, culturally competent care for vulnerable	489,633	491,385	443,299
1.F Promote the adoption and meaningful use of health information	---	---	---
2. Advance Scientific Knowledge and Innovation	**28,113**	**21,617**	**18,102**
2.A Accelerate the process of scientific discovery to improve patient care	---	---	---
2.B Foster innovation at HHS to create shared solutions	---	---	---
2.C Invest in the regulatory sciences to improve food & medical product	---	---	---
2.D Increase our understanding of what works in public health and human service practice	28,113	21,617	18,102
3. Advance the Health, Safety and Well-Being of the American	**2,757,892**	**2,751,635**	**2,731,510**
3.A Promote the safety, well-being, resilience, and health development of children and youth	223,034	170,996	159,651
3.B Promote economic & social well-being for individuals, families and	18,018	13,343	11,795
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults	---	---	---
3.D Promote prevention and wellness	2,515,936	2,566,244	2,557,114
3.E Reduce the occurrence of infectious diseases	---	---	---
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies	904	1,052	2,950
4. Increase Efficiency, Transparency and Accountability of HHS	**37,362**	**12,940**	**12,996**
4.A Ensure program integrity and responsible stewardship of resources	---	---	---
4.B Fight fraud and work to eliminate improper payments	---	---	---
4.C Use HHS data to improve American health and well-being of the American people	37,362	12,940	12,996
4.D Improve HHS environmental energy, and economic performance to promote sustainability	---	---	---
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**18,129**	**17,896**	**16,365**
5.A Invest in HHS workforce to meet America's health and human service needs today & tomorrow	---	---	---
5. B Ensure that the Nation's health care workforce meets increased	18,129	17,896	16,365
5. C Enhance the ability of the public health workforce to improve health at home and abroad	---	---	---
5.D Strengthen the Nation's human service workforce	---	---	---
5.E Improve national State & local surveillance and epidemiology capacity	---	---	---
TOTAL	**$3,599,081**	**$3,564 ,687**	**$3,422,766**

Summary of Changes
SAMHSA
(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY2012
Mental Health	$1,022,237	$998,859	$951,895	-$46,964
Substance Abuse Prevention	527,063	530,182	470,378	-59,804
Substance Abuse Treatment	1,873,351	1,881,349	1,812,769	-68,580
Health Surveillance and Program Support	176,430	154,297	187,724	+33,427
Total, SAMHSA	**$3,599,081**	**$3,564,687**	**$3,422,766**	**-$141,921**
FTEs[1]	**547**	**574**	**574**	---

[1] In 2012, SAMHSA will continue to in source positions for activities that are central to SAMHSA's mission, represent critical skills for the agency, and result in overall savings consistent with Office of Federal Procurement Policy guidelines. A total of 98 positions will be added and fully staffed by the end of FY 2012. These positions are allocated across SAMHSA's four appropriations to reflect the provision of direct program support or to reflect the proration of overhead and indirect costs. An additional 13 positions have been added to provide support to the ten HHS regions. These positions are allocated across three appropriations to reflect the provision of technical assistance to the states as well as linking SAMHSA with its sister operating divisions in the regions. The additional positions are fiscally neutral.

Summary of the FY 2013 Budget:

The SAMHSA FY 2013 President's Budget Request for its Total Program Level is $3.4 billion, a $141.9 million decrease from the FY 2012 Enacted Level. This FY 2013 Total Program Level of $3.4 billion includes $3.2 billion in Budget Authority (a decrease of $195.5 million from the FY 2012 Enacted Level), $164.8 million in PHS Evaluation funds (an increase of $35.1 million from FY 2012), $105.0 million in ACA Prevention Funds (an increase of $17.0 million from FY 2012), and $1.5 million for user fees (new for FY 2013) for extraordinary data and publications requests not currently able to be fulfilled. The FY 2013 President's Budget Request for SAMHSA is divided among the four appropriations consistent with the FY 2012 Consolidated Appropriations Act: Mental Health, Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support.

The Mental Health appropriation is $951.9 million, a decrease of $47.0 million from the FY 2012 Enacted Level. The Request includes $902.9 million in Budget Authority (a decrease of $30.0 million from FY 2012), $21.0 million in PHS Evaluation funds (the same as FY 2012), and $28.0 million in ACA Prevention Funds (a decrease of $17.0 million from FY 2012). The reductions are primarily due to targeted reductions in select Programs of Regional and National Significance and the Children's Mental Health Services program as the concepts and strategies are brought to scale in the Mental Health – State Prevention Grant which builds on the successes of the Project LAUNCH model to expand the program nationally.

The Substance Abuse Prevention appropriation is $470.4 million, a decrease of $59.8 million from the FY 2012 Enacted Level. The Request includes $463.4 million in Budget Authority (a decrease of $66.8 million from FY 2012), and $7.0 million in ACA Prevention Funds (an increase of $7.0 million from FY 2012). The reductions are primarily due to targeted reductions in select Programs of Regional and National Significance and the Strategic Prevention Framework program as the concepts and strategies are brought to scale in the Substance Abuse – State Prevention Grant which will provide a stable source of funding to implement prevention activities for substance use disorders among the most vulnerable and impoverished in States, Territories, and Tribes and communities.

The Substance Abuse Treatment appropriation is $1.8 billion, a decrease of $68.6 million from the FY 2012 Enacted Level. The Request includes $1.7 billion in Budget Authority (a decrease of $64.1 million from FY 2012), $71.7 million in PHS Evaluation funds (a decrease of $9.5 million from FY 2012), and $30.0 million in ACA Prevention Funds (an increase of $5.0 million from FY 2012). The reductions are is primarily due to targeted reductions in select Programs of Regional and National Significance as the concepts and strategies are brought to scale within the Substance Abuse Block Grant.

The Health Surveillance and Program Support appropriation is $187.7 million, an increase of $33.4 million from the FY 2012 Enacted Level. The Request includes $74.2 million in Budget Authority (a decrease of $4.7 million from FY 2012), $72.0 million in PHS Evaluation funds (an increase of $44.6 million from FY 2012), and $40.0 million in ACA Prevention Funds (an increase of $22.0 million from FY 2012). By making targeted realignments in staffing and overhead costs, as well as consolidations of data collection and public outreach activities, the funding for Health Surveillance and Program Support is reduced. Also included in the FY 2013 Request is $1.5 million from user fees to be collected for extraordinary data and publications user requests not currently able to be fulfilled. Regular requests from the general public will continue to be met without cost. Additionally, within this appropriation, $40.0 million is requested from the ACA Prevention Fund to provide a formula-based grant program to deliver behavioral health services specifically to Tribal populations.

Appropriation Language

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

ADMINISTRATION

MENTAL HEALTH

For carrying out titles III, V, and XIX of the PHS Act with respect to mental health, and the Protection and Advocacy for Individuals with Mental Illness Act, **[**$934,853,000**]** *$902,856,000:* Provided, That notwithstanding section 520A(f)(2) of the PHS Act, no funds appropriated for carrying out section 520A shall be available for carrying out section 1971 of the PHS Act: Provided further, That in addition to amounts provided herein, **[**$21,039,000**]** *$21,039,000* shall be available under section 241 of the PHS Act to carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1920(b) activities shall not exceed 5 percent of the amounts appropriated for subpart I of part B of title XIX: Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated under this Act for fiscal year **[**2012: Provided further, That of the amount appropriated under this heading, $45,800,000 shall be for the National Child Traumatic Stress Initiative as described in section 582 of the PHS Act**]** *2013.*

SUBSTANCE ABUSE TREATMENT

For carrying out titles III, V, and XIX of the PHS Act with respect to substance abuse treatment **[**and section 1922(a) of the PHS Act with respect to substance abuse prevention, $2,123,993,000**]**, *$1,711,045,000*: Provided, That in addition to amounts provided herein, **[**the following amounts shall be available under section 241 of the PHS Act: (1) $79,200,000**]** *$71,724,000 shall be available under section 241 of the PHS Act* to carry out subpart II of part B

of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX **[**; and (2) $2,000,000 to evaluate substance abuse treatment programs**]**: Provided further, That **[**no funds shall be available for the National All Schedules Prescription Reporting system**]** *section 1922(a)(1) of the PHS Act shall not apply to amounts provided herein*.

SUBSTANCE ABUSE PREVENTION

For carrying out titles III and V of the PHS Act with respect to substance abuse prevention, **[**$186,361,000**]** *$463,378,000.*

HEALTH SURVEILLANCE AND PROGRAM SUPPORT

For program support and cross-cutting activities that supplement activities funded under the headings ``Mental Health'', ``Substance Abuse Treatment'', and ``Substance Abuse Prevention'' in carrying out titles III, V, and XIX of the PHS Act and the Protection and Advocacy for Individuals with Mental Illness Act in the Substance Abuse and Mental Health Services Administration, **[**$109,106,000**]** *$74,229,000*: Provided, That in addition to amounts provided herein, **[**$27,428,000**]** *$71,995,000* shall be available under section 241 of the PHS Act to supplement funds available to carry out national surveys on drug abuse and mental health, to collect and analyze program data, and to conduct public awareness and technical assistance activities: *Provided further, That, in addition, fees may be collected for the costs associated with additional publications, data, data tabulations, and data analysis completed under title V of the PHS Act and provided to a public or private entity upon request, which shall be credited to this appropriation and shall remain available until expended for such purposes:* Provided further, That funds made available under this heading may be used to supplement program support

funding provided under the headings “Mental Health”, “Substance Abuse Treatment”, and “Substance Abuse Prevention”*: Provided further, That the Administrator may transfer funds between any of the accounts of SAMHSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer. (Department of Health and Human Services Appropriations Act, 2012.)*

Language Analysis

Language Provision	Explanation
Provided, That notwithstanding section 520A(f)(2) of the PHS Act, no funds appropriated for carrying out section 520A are available for carrying out section 1971 of the PHS Act: Provided further…	No funds from the CMHS PRNS can be used to fund data infrastructure support.
Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated under this Act for fiscal year 2013.	Allows States to receive more than one grant under the Garrett Lee Smith Youth Suicide State-sponsored statewide program.
Provided further, That section 1922(a)(1) of the PHS Act shall not apply to amounts provided herein.	Waives the 20% of the Substance Abuse Prevention and Treatment Block Grant minimum expenditure requirement for prevention services; prevention activities will be funded under the new Substance Abuse State Prevention Grants under the new SAMHSA budget structure
…conduct public awareness and technical assistance activities:	Provides PHS evaluation funds to finance public awareness and support which constitutes technical assistance in the new SAMHSA budget structure.
Provided further, That, in addition, fees may be collected for the costs associated with additional publications, data, data tabulations, and data analysis completed under title V of the PHS Act and provided to a public or private entity upon request, which shall be credited to this appropriation and shall remain available until expended for such purposes.	Allow user fees to be collected for data and publications and for those fees to be available to SAMHSA until expended.

Amounts Available for Obligation

	FY 2011 Actual	FY 2012 Appropriation	FY 2013 President's Budget
Appropriation:			
Labor/HHS/Ed-Annual Appropriation	3,386,311,000	3,354,313,000	3,151,508,000
Subtotal, adjusted appropriation	3,379,538,000	3,347,973,000	3,151,508,000
Subtotal, adjusted budget authority	3,379,538,000	3,347,973,000	3,151,508,000
Real Transfer to: Office of the Secretary	---	(953,809)	---
Offsetting Collections from:			
Federal Sources	131,543,000	129,667,000	164,758,000
ARRA	---	---	---
Data Request and Publications User Fees	---	---	1,500,000
Unobligated balance start of year	187,000	2,991,000	2,963,064
Unobligated balance end of year	2,991,000	2,963,064	2,789,186
Unobligated balance expiring	---	---	---
Total obligations	$3,514,259,000	$3,482,640,255	$3,323,518,250

Summary of Changes

(*Dollars in Thousands*)

2012

Total budget authority	$ 3,347,020,000
(Obligation)	$ 3,347,020,000

2013

Total estimated budget authority	$ 3,151,508,000
(Obligation)	$ 3,151,508,000
Net Change	**-$ 195,512,000**

	FY2012 Enacted Level FTE	FY 2012 Enacted Level Budget Authority	Change from base FTE	Change from base Budget Authority
Increases:				
A. Built-in:	---	$ 72,280,000	---	+$ 25,000
1. Annualization of 2012 Commissioned Corps pay costs	---	7,228,000	---	+323,000
2. Increase for January 2013 pay raise	---	6,500,000	---	+65,000
3. Increase in rental payments to GSA	---	278,000	---	+278,000
4. One additional compensable day	---	---	---	+691,000
Subtotal, Built-in Increases				
B. Program				
1. Mental Health State Prevention Grant	---	34,640,000	---	+20,360,000
Subtotal, Program Increases	---	---	---	+20,360,000
Total Increases	---	---	---	**+21,051,000**
Decreases:				
A. Built-in:				
Subtotal, Built-in Decreases	---	---	---	---
B. Program:				
1. Mental Health PRNS	---	241,116,000	---	-22,272,000
2. Children's Mental Health Services	---	117,315,000	---	-28,758,000
3. Substance Abuse Prevention PRNS	---	58,877,000	---	-17,274,000
4. Substance Abuse-State Prevention Grant	---	454,033,000	---	-49,532,000
5. Substance Abuse Treatment PRNS	---	398,243,000	---	-65,285,000
6. Health Surveillance and Program Support	---	78,891,000	---	-3,464,000
7. PAS	---	13,545,000	---	-13,545,000
8. PQIS	---	12,940,000	---	-12,940,000
9. Military Families	---	-3,493,000	---	-3,493,000
Subtotal, Program Decreases	---	---	---	-216,563,000
Total Decreases	---	---	---	**-216,563,000**
Net Change, Discretionary Budget Authority	**574**	**3,347,020,000**	---	**-$195,512,000**

Budget Authority by Activity

(Dollars in Thousands)

Program Activities	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget
Mental Health:			
Mental Health Programs of Regional & National Significance	$358,571	$286,116	$247,550
ACA Prevention Fund (non-add)	45,000	45,000	28,000
Mental Health - State Prevention Grant	24,706	34,640	55,000
Children's Mental Health Services	117,803	117,315	88,557
PATH Homeless Formula Grant	64,917	64,794	64,794
PAIMI	36,307	36,238	36,238
Mental Health Block Grant	419,933	459,756	459,756
PHS Evaluation Funds (non-add)	20,997	21,039	21,039
Total, Mental Health	**1,022,237**	**998,859**	**951,895**
Substance Abuse Prevention:			
Substance Abuse Prevention Programs of Regional & National Significance	75,956	76,149	65,877
ACA Prevention Fund (non-add)	---	---	7,000
Substance Abuse - State Prevention Grant	451,107	454,033	404,501
Strategic Prevention Framework (non-add)	110,417	109,807	60,275
Total, Substance Abuse Prevention	**527,063**	**530,182**	**470,378**
Substance Abuse Treatment:			
Substance Abuse Treatment Programs of Regional & National Significance	431,389	425,243	364,139
ACA Prevention Fund (non-add)	25,000	25,000	30,000
PHS Evaluation Funds (non-add)	2,000	2,000	---
Substance Abuse Block Grant	1,441,962	1,456,106	1,448,630
PHS Evaluation Funds (non-add)	79,200	79,200	71,724
Total, Substance Abuse Treatment	**1,873,351**	**1,881,349**	**1,812,769**
Health Surveillance and Program Support			
Health Surveillance and Program Support	119,789	124,319	121,157
ACA Prevention Fund (non-add)	18,000	18,000	---
Data Request and Publications User Fees (non-add)	---	---	1,500
PHS Evaluation Funds (non-add)	22,750	27,428	45,428
Public Awareness and Support	14,029	13,545	13,571
PHS Evaluation Funds (non-add)	---	---	13,571
Performance and Quality Information Systems	37,362	12,940	12,996
PHS Evaluation Funds (non-add)	6,596	---	12,996
Agency-Wide Initiatives	5,250	3,493	40,000
ACA Prevention Fund (non-add)	---	---	40,000
Total, Health Surveillance and Program Support	**176,430**	**154,297**	**187,724**
TOTAL, SAMHSA Discretionary PL	**3,599,081**	**3,564,687**	**3,422,766**
Less PHS Evaluation Funds	131,543	129,667	164,758
Less ACA Prevention Funds	88,000	88,000	105,000
Less Data Request and Publications User Fees	---	---	1,500
TOTAL, SAMHSA Budget Authority	**$3,379,538**	**$3,347,020**	**$3,151,508**
FTEs	**547**	**574**	**574**

Authorizing Legislation

Program Description/PHS Act:	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2013 Amount Authorized	FY 2013 President's Budget
NASPER Sec. 399O	Expired	$0	Expired	$0
Emergency Response Sec. 501	0	0	0	0
Grants for the Benefit of Homeless Individuals Sec. 506	Expired	$41,571,000	Expired	$41,571,000
Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans Sec. 506A*	0	0	0	0
Grants for Ecstasy and Other Club Drugs Abuse Prevention Sec. 506B*	0	0	0	0
Residential Treatment Programs for Pregnant and Postpartum Women Sec. 508	Expired	$15,970,000	Expired	$15,970,000
Priority Substance Abuse Treatment Needs of Regional and National Significance Sec. 509*	Expired	$310,082,000	Expired	$246,920,000
Substance Abuse Treatment Services for Children and Adolescents Sec. 514*	Expired	$30,620,000	Expired	$29,678,000
Early Intervention Services for Children and Adolescents Sec. 514A*	0	0	0	0
Methamphetamine and Amphetamine Treatment Initiative Sec. 514(d)*	0	0	0	0
Priority Substance Abuse Prevention Needs of Regional and National Significance Sec. 516*	Expired	$513,393,000	Expired	$462,378,000
Prevention, Treatment and Rehabilitation Model Projects for High Risk Youth Sec. 517	0	0	0	0
Services for Children of Substance Abusers Sec. 519*	0	0	0	0
Grants for Strengthening Families Sec. 519A*	0	0	0	0
Programs to Reduce Underage Drinking Sec. 519B*	Expired	$ 6,987,000	Expired	---

SSAN = Such Sums as Necessary

Authorizing Legislation

Program Description/PHS Act:	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2013 Amount Authorized	FY 2013 President's Budget
Services for Individuals with Fetal Alcohol Syndrome (FAS) Sec. 519C*	0	0	0	0
Centers of Excellence on Services for Individuals with FAS and Alcohol-related Birth Defects and Treatment for Individuals with Such Conditions and Their Families Sec. 519D*	Expired	$9,802,000	Expired	$1,000,000
Prevention of Methamphetamine and Inhalant Abuse and Addiction Sec. 519E*	Expired	0	Expired	0
Priority Mental Health Needs of Regional and National Significance Sec. 520A*	Expired	$160,619,000	Expired	$162,220,000
National Centers of Excellence for Depression Sec. 520B*	Expired	0	Expired	0
Youth Interagency Research, Training, and Technical Assistance Centers Sec. 520C*	Expired	$4,948,000	Expired	$4,948,000
Services for Youth Offenders Sec. 520D*	0	0	0	0
Suicide Prevention for Children and Youth Sec. 520E1*	Expired	$29,682,000	Expired	$29,374,000
Suicide Prevention for Children and Youth Sec. 520E2*	Expired	$4,966,000	Expired	$4,858,000
Grants for Emergency Mental Health Centers Sec. 520F*	0	0	0	0
Grants for Jail Diversion Programs Sec. 520G*	Expired	$6,672,000	Expired	$4,281,000
Improving Outcomes for Children and Adolescents through Services Integration between Child Welfare and MH Services Sec. 520H*	0	0	0	0
Grants for Integrated Treatment of Serious Mental Illness and Co-occurring Substance Abuse Sec. 520I*	0	0	0	0
Mental Health Training Grants Sec. 520J*	0	0	0	0
Awards for Co-locating Primary and Specialty Care in Community-based Mental Health Settings Sec. 520K*	$50,000,000	$30,749,000	$50,000,000	0
PATH Grants to States Sec. 535(a)	Expired	$64,794,000	Expired	$64,794,000

SSAN = Such Sums as Necessary

Authorizing Legislation

Program Description/PHS Act:	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2013 Amount Authorized	FY 2013 President's Budget
Community Mental Health Services for Children with Serious Emotional Disturbances Sec. 565 (f)	Expired	$117,315,000	Expired	$88,557,000
Children and Violence Program Sec. 581*	Expired	$23,156,000	Expired	$23,156,000
Grants for Persons who Experience Violence Related Stress Sec. 582 **	Expired	$45,713,000	Expired	$45,713,000
Community Mental Health Services Block Grants Sec. 1920(a)	Expired	$438,717,000	Expired	$438,717,000
Substance Abuse Prevention and Treatment Block Grants Sec. 1935(a)	Expired	$1,376,906,000	Expired	$1,376,906,000
Data Infrastructure Development Sec. 1971*	Expired	0	Expired	0
Other Legislation/Program Description				
Protection and Advocacy for Individuals with Mental Illness Act P.L. 99-319, Sec. 117	Expired	$36,238,000	Expired	$36,238,000
Program Management: Program Management, Sec. 501	Indefinite	$107,709,000	Indefinite	$73,069,000
SEH Workers' Compensation Fund P.L. 98-621	Indefinite	$1,160,000	Indefinite	$1,160,000
Total, Program Management	0	$108,869,000	0	$74,229,000
St. Elizabeths Hospital Building & Facilities Sec. 501	0	0	0	0
Data Evaluation Sec. 505	0	0	0	0
Indian Health Care Improvement Reauthorization and Extension Act of 2009				
Substance Abuse and Mental Health Services Administration Grants Sec. 724	SSAN	0	SSAN	0
Indian Youth Life Skills Development Demonstration Program Sec. 726	$1,000,000	0	$1,000,000	0
TOTAL, SAMHSA Budget Authority	$51,000,000	$3,377,769,000	$50,000,000	$3,151,508,000

SSAN = Such Sums as Necessary

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

Appropriation History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
2002	$3,058,456,000	$3,131,558,000	$3,073,456,000	$3,138,279,000	1/
2002 Res. H.R. 3061	0	0	0	-$589,000	2/
2002 Res. P.L. 107-216	0	0	0	-$1,681,000	3/
2003 P.L. 108-5	$3,193,086,000	$3,167,897,000	$3,129,717,000	$3,158,068,000	
2003 P.L. 108-7	0	0	0	-$20,521,235	4/
2004 P.L. 108-84	$3,393,315,000	$3,329,000,000	$3,157,540,000	$3,253,763,000	
2004 P.L. 108-199	0	0	0	-$19,856,290	5/
2005 P.L. 108-447 & P.L. 108-309 as mended	$3,428,939,000	$3,270,360,000	$3,361,426,000	$3,295,361,000	6/
2005 H.R. 4818	0	0	0	-$26,895,592	
2006 P.L. 109-149	$3,336,023,000	$3,352,047,000	$3,398,086,000	$3,237,813,000	
2006 Res. P.L. 109-359	0	0	0	-$1,681,000	7/
2006 Section 202	0	0	0	-$2,201,000	
2007 P.L. 109-383	$3,260,001,000	$3,326,341,772	$3,326,341,772	$1,211,654,381	8/
2007 Continuing Resolution	0	0	0	$3,326,341,772	9/
2008 H.R. 2764/P.L. 110-161	$3,167,589,000	$3,393,841,000	$3,404,798,000	$3,291,543,000	
2008 Res. P.L. 110-161	0	0	0	-$57,503,000	10/
2009 H.R. 1105/P.L. 111-8	$3,024,967,000	$3,303,265,000	$3,257,647,000	$3,334,906,000	
2010 H.R. 3288/P.L. 111-117	$ 3,393,882,000	$ 3,429,782,000	$3,419,438,000	$3,431,116,000	11/
2011 H.R. 1473/P.L. 112-10	$ 3,541,362,000	$ 3,565,360,000	$ 3,576,184,000	$3,386,311,000	
2012 H.R. 2055/P.L. 112-74	$ 3,386,903,000	$ 3,096,914,000	$ 3,354,637,000	$3,347,020,000	12/
2013	$ 3,151,508,000				

1/ Reflects Administrative reduction in Section 516 of the Appropriations Bill (H.R. 3061).

2/ Reflects Administrative reduction in P.L. 107-216.

3/ Reflects a Rescission mandated by P.L.108-7.

4/ Reflects SAMHSA's share of the Division E, section 515 reduction on administrative and related expenses and the Division H, section 168(b) rescission of P.L. 108-199.

5/ Reflects SAMHSA's share of the Division F, section 519(a) reduction on administrative and related expenses and the Division J, section 122(a) rescission of H.R. 4818.

6/ Reflects SAMHSA's share of the rescission mandated by P.L. 109-359.

7/ Reflects Section 202 transfer to CMS.

8/ Reflects Continuing Resolution through February 15, 2007.

9/ Reflects the whole year appropriation

10/ Reflects a 1.7 percent across-the-board Rescission from the H.R. 2764/P.L. 110-161.

11/ Reflects a $508 thousand transfer to HHS

12/ Reflects a 0.189 percent across-the-board Rescission from the H.R. 2055/P.L. 112-74. and $953.809 thousand Ryan White transfer to HRSA

Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in the Last Year of Authorization	Appropriations in FY 2013
Emergency Response Sec. 501O	2003	$ 25,000,000	2.5% all disc grants	$0
Grants for the Benefit of Homeless Individuals Sec. 506	2003	$ 50,000,000	$ 16,700,000	$ 41,571,000
Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans Sec. 506A*	2003	$ 15,000,000	$0	$0
Grants for Ecstasy and Other Club Drugs Abuse Prevention Sec. 506B*	2001	$ 10,000,000	$0	$0
Residential Treatment Programs for Pregnant and Postpartum Women Sec. 508	2003	SSAN	$0	$ 15,970,000
Priority Substance Abuse Treatment Needs of Regional and National Significance Sec. 509*	2003	$ 300,000,000	$ 322,994,000	$ 246,920,000
Substance Abuse Treatment Services for Children and Adolescents Sec. 514*	2003	$ 40,000,000	$ 20,000,000	$ 29,678,000
Early Intervention Services for Children and Adolescents Sec. 514A*	2003	$ 20,000,000	$0	$0
Methamphetamine and Amphetamine Treatment Initiative Sec. 514**	2003	$ 10,000,000	$0	$0
Priority Substance Abuse Prevention Needs of Regional and National Significance Sec. 516*	2003	$ 300,000,000	$ 138,399,000	$ 462,378,000
Prevention, Treatment and Rehabilitation Model Projects for High Risk Youth Sec. 517	2003	SSAN	$ 7,000,000	$0
Services for Children of Substance Abusers Sec. 519*	2003	$ 50,000,000	$0	$0
Grants for Strengthening Families Sec. 519A*	2003	$ 3,000,000	$0	$0
Services for Individuals with Fetal Alcohol Syndrome (FAS) Sec. 519C*	2003	$ 25,000,000	$0	$0
Centers of Excellence on Services for Individuals with FAS and Alcohol-related Birth Defects and Treatment for Individuals with Such Conditions and Their Families Sec. 519D*	2003	$ 5,000,000	$ 2,416,000	$ 1,000,000
Prevention of Methamphetamine and Inhalant Abuse and Addiction Sec. 519E*	2003	$ 10,000,000	$ 5,000,000	$0
Priority Mental Health Needs of Regional and National Significance Sec. 520A*	2003	$ 300,000,000	$ 94,289,000	$ 162,220,000
Youth Interagency Research, Training, and Technical Assistance Centers Sec. 520C*	2007	$ 5,000,000	$ 3,960,000	$ 4,948,000
Services for Youth Offenders Sec. 520D*	2003	$ 40,000,000	$0	$0

Suicide Prevention for Children and Youth Sec. 520E (GLS - State Grants)	2007	$ 30,000,000	$ 17,829,000	$ 29,374,000
Sec. 520E1 (Suicide Prevention for Youth)	2003	$ 75,000,000	$0	$0
Sec. 520E2 (GLS-Campus Grants)	2007	$ 5,000,000	$ 4,950,000	$ 4,858,000
Grants for Emergency Mental Health Centers Sec. 520F*	2003	$ 25,000,000	$0	$0
Grants for Jail Diversion Programs Sec. 520G*	2003	$ 10,000,000	$ 6,043,000	$ 4,281,000
Improving Outcomes for Children and Adolescents through Services Integration between Child Welfare and MH Services Sec. 520H*	2003	$ 10,000,000	$0	$0
Grants for Integrated Treatment of Serious Mental Illness and Co-occurring Substance Abuse Sec. 520I*	2003	$ 40,000,000	$0	$0
Mental Health Training Grants Sec. 520J*	2003	$ 25,000,000	$0	$0
PATH Grants to States Sec. 535(a)	2003	$ 75,000,000	$ 46,855,000	$ 64,794,000
Community Mental Health Services for Children with Serious Emotional Disturbances Sec. 565 (f)	2003	$ 100,000,000	$ 96,694,000	$ 88,557,000
Children and Violence Program Sec. 581*	2003	$ 100,000,000	$ 83,035,000	$ 23,156,000
Grants for Persons who Experience Violence Related Stress Sec. 582 *	2003	$ 50,000,000	$ 20,000,000	$ 45,713,000
Community Mental Health Services Block Grants Sec. 1920(a)	2003	$ 450,000,000	$ 433,000,000	$ 438,717,000
Substance Abuse Prevention and Treatment Block Grants Sec. 1935(a)	2003	$ 2,000,000,000	$ 1,785,000,000	$ 1,376,906,000
Data Infrastructure Development Sec. 1971*	2003	SSAN	$ 6,000,000	$0
Other Legislation/Program Description				
Protection and Advocacy for Individuals with Mental Illness Act P.L. 99-319, Sec. 117	2003	$ 19,500,000	$ 32,500,000	$ 36,238,000
TOTAL, SAMHSA Budget Authority	---	$ 4,222,500,000	$ 3,142,664,000	$ 3,077,279,000

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

**Congress authorized two provisions as section 514.

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SAMHSA
Mental Health
Summary of Changes
(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Mental Health Programs of Regional and National Significance	$358,571	$286,116	$247,550	-$38,566
ACA Prevention Fund (non-add)	*45,000*	45,000	28,000	-17,000
Mental Health-State Prevention Grant	24,706	34,640	55,000	+20,360
Project LAUNCH (non-add)	24,706	34,640	24,750	-9,890
Children's Mental Health Services	117,803	117,315	88,557	-28,758
PATH Homeless Formula Grant	64,917	64,794	64,794	---
PAIMI	36,307	36,238	36,238	---
Mental Health Block Grant	419,933	459,756	459,756	---
PHS Evaluation Funds (non-add)	*20,997*	21,039	21,039	---
Total, Mental Health	**$1,022,237**	**$998,859**	**$951,895**	**-$46,964**
FTEs [1]	**15**	**29**	**35**	**+6**

[1] In 2012, SAMHSA will continue to in source positions for activities that are central to SAMHSA's mission, represent critical skills for the agency, and result in overall savings consistent with Office of Federal Procurement Policy guidelines. A total of 98 positions will be added and fully staffed by the end of FY 2012. These positions are allocated across SAMHSA's four appropriations to reflect the provision of direct program support or to reflect the proration of overhead and indirect costs. An additional 13 positions have been added to provide support to the ten HHS regions. These positions are allocated across three appropriations to reflect the provision of technical assistance to the states as well as linking SAMHSA with its sister operating divisions in the regions. The additional positions are fiscally neutral.

The FY 2013 President's Budget Request for the SAMHSA Mental Health appropriation is $951.9 million, a decrease of $47.0 million from the FY 2012 Enacted Level. This FY 2013 Total Program Level budget request of $951.9 million includes $902.9 million in Budget Authority (a decrease of $30.0 million from FY 2012), $21.0 million in PHS Evaluation funds (the same as FY 2012), and $28.0 million in ACA Prevention Fund (a decrease of $17.0 million from FY 2012). The request includes $247.6 million for Programs of Regional and National Significance, a decrease of $38.6 million from the FY 2012 Enacted Level. The Mental Health appropriation request includes $55.0 million for the Mental Health – State Prevention Grant, an increase of $20.4 million from a comparable level in FY 2012. It also includes $88.6 million for Children's Mental Health Services, a decrease of $28.8 million from FY 2012. Also requested is $64.8 million for PATH Homelessness Formula Grant, the same as FY 2012. The request includes $36.2 million for the Protection and Advocacy for Individuals with Mental Illness (PAIMI), the same as FY 2012. Finally, the request includes $459.8 million for the Mental Health Block Grant, the same as FY 2012. This includes $438.7 million in Budget Authority and $21.0 million in PHS Funds.

The FY 2013 Budget Request for Mental Health includes the following increases: Grants for Adult

Trauma Screening and Brief Intervention: (+$2.9 million)

A new program for Grants for Adult Trauma Screening and Brief Intervention (GATSBI) is requested for FY 2013 to advance the knowledge base to address trauma in common health care settings, such as emergency departments, primary care, and OB/GYN. The concept and design for these grants will be developed by SAMHSA in consultation with its Federal partners: CDC; NIAAA; NIDA; NIMH; and the VA.

Mental Health Minority AIDS: (+$13.5 million)
In the Mental Health appropriation, PRNS Minority AIDS is increased by $13.5 million from FY 2012 enacted to expand behavioral health services to individuals who are at risk for or have mental and/or co-occurring substance use disorders and are at risk for or living with HIV/AIDS. While SAMHSA is requesting the same total amount for Minority AIDS programs in FY 2013 as in FY 2012, the Budget Request realigns resources within SAMHSA to balance the overall minority AIDS portfolio in order to enhance the capacity to collaborate on HIV/AIDS prevention and treatment efforts across HHS. CMHS, in collaboration with CSAP and CSAT, will support an integrated program to develop and expand culturally competent and effective behavioral health and primary care network in order to reduce the impact of behavioral health problems, HIV risk, and HIV-related health disparities.

Disaster Response: (+$1.9 million)
This increase is for a nationally available disaster distress crisis counseling telephone line, the need for this initiative has been documented through the Assistant Secretary for Preparedness and Response after various emergency conditions throughout the world and after U.S. disasters that did not rise to the level of presidentially declared emergencies and therefore did not qualify for Stafford Act funding.

Mental Health – State Prevention Grant: (+$20.4 million)
The FY 2013 request for the Mental Health – State Prevention Grant is $55.0 million. This is a $20.4 million increase over a comparable level in the FY 2012 Enacted Level. Funding includes recycled funding from discretionary mental health programs to provide consistent and sustainable support for States and Territories to implement State-wide comprehensive prevention strategies to address the prevention of mental illnesses and reduce the impact of mental illness on America's communities. Continuation grants under Project LAUNCH will be fully funded.

The FY 2013 Budget Request for Mental Health includes the following decreases:

Primary and Behavioral Health Care Integration: (-$39.7 million)
The FY 2013 request for Primary and Behavioral Health Care Integration (PBHCI) is $28.0 million, funded totally from the Prevention and Public Health Fund of the ACA. This is a decrease of $39.7 million from the FY 2012 Enacted Level that included funding for PBHCI Technical Assistance. The FY 2012 funding from the ACA Prevention Fund allowed SAMHSA to strategically fully fund multi-year grants and monitor them in FY 2013.

Suicide Programs: (-$10.4 million)
The FY 2013 request for Suicide Programs in the Mental Health appropriation is $47.6 million. This is a decrease of $10.4 million from the FY 2012 Enacted Level and is attributed mostly to

the end of $10.0 million in funding from the Prevention and Public Health Fund of the ACA. These reductions include -$1.7 million for Suicide Lifeline, -$6.1 million for Garrett Lee Smith – Youth Suicide Prevention – States, -$1.6 million for Garrett Lee Smith – Youth Suicide Prevention – Campus, and -$1.0 million for the Garrett Lee Smith – Suicide Prevention Resource Center.

Children's Mental Health Services: (-$28.8 million)

The FY 2013 request for Children's Mental Health Services is $88.6 million. This is a decrease of $28.8 million from the FY 2012 Enacted Level reflecting savings from grants coming to a natural end. As the Systems of Care have become a proven strategy, SAMHSA intends to bring the Systems of Care to scale through the Mental Health Block Grant. No grants will be terminated and the reduction will not affect current grants.

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SAMHSA/Programs of Regional and National Significance
Mental Health services
(Dollars in Thousands)

Programs of Regional & National Significance	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
CAPACITY				
Co-Occurring State Incentive Grant	$2,168	---	---	---
Seclusion & Restraint	2,449	2,444	1,149	-1,295
Youth Violence Prevention	77,675	23,156	23,156	---
National Traumatic Stress Network	40,715	45,713	45,713	---
Children and Family Programs	9,194	6,474	6,474	---
Consumer and Family Network Grants	6,236	6,224	4,966	-1,258
MH System Transformation and Health Reform	26,515	10,603	10,603	---
Primary and Behavioral Health Care Integration	62,790	65,749	26,004	-39,745
ACA Prevention Funds (non-add)	35,000	35,000	26,004	-8,996
Community Resilience and Recovery Initiative	5,000	---	---	---
Suicide Lifeline	7,227	7,217	5,512	-1,705
ACA Prevention Funds (non-add)	1,705	1,705	---	-1,705
GLS - Youth Suicide Prevention - States	35,239	35,442	29,374	-6,068
ACA Prevention Funds (non-add)	5,760	5,760	---	-5,760
GLS - Youth Suicide Prevention - Campus	6,399	6,496	4,858	-1,638
ACA Prevention Funds (non-add)	1,530	1,530	---	-1,530
AI/AN Suicide Prevention Initiative	2,944	2,938	2,938	---
Homelessness Prevention Programs	30,830	30,772	30,772	---
Older Adult Programs	2,815	---	---	---
Minority AIDS	9,283 o	9,265	22,770	+13,505
Grants for Adult Trauma Screening & Brief Intervention	---	---	2,896	+2,896
Criminal and Juvenile Justice Programs	6,683	6,672	4,281	-2,391
Subtotal, Capacity	**334,162**	**259,165**	**221,466**	**-37,699**
SCIENCE AND SERVICE				
GLS - Suicide Prevention Resource Center	5,962	5,953	4,948	-1,005
ACA Prevention Funds (non-add)	*1,005*	*1,005*	---	*-1,005*
Practice Improvement and Training	8,057	7,863	7,437	-426
Consumer and Consumer Support Technical Assistance Centers	1,927	1,923	1,923	---
Primary and Behavioral Health Care Integration TA	---	1,996	1,996	
ACA Prevention Funds (non-add)	---	---	*1,996*	---
Minority Fellowship Program	4,279	5,089	3,755	*+1,996*
Disaster Response	904	1,052	2,950	-1,334
Homelessness	2,306	2,302	2,302	+1,898
HIV/AIDS Education	974	773	773	---
Subtotal, Capacity	**24,409**	**26,951**	**26,084**	**-867**
TOTAL, MH PRNS/ 1	**$358,571**	**$286,116**	**$247,550**	**-$38,566**

1/The FY 2011 & FY 2012 totals includes $35.0 million for the PBHCI program, and $10.0 million for the Garrett Lee Smith (GLS) Suicide Prevention & the Suicide Lifeline programs funded by the ACA Prevention Fund. The FY 2013 total includes $28.0 million for the PBHCI program funded by the ACA Prevention Fund.

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

FY 2013 Authorization .....Expired

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

Program Description and Accomplishments

Seclusion & Restraint

This program area supports States/Tribes and communities in their efforts to implement best practices to reduce and ultimately eliminate the use of restraints and seclusion in institutional and community-based settings that provide services for individuals with mental health and co-occurring substance abuse disorders. While this initiative includes a focus on the mental health system, it also includes other service sectors, such as criminal justice, schools, and child welfare, that similarly use coercive practices with people with mental health and co-occurring substance use disorders. In all of these settings, coercive practices impede recovery and well-being.
Each year approximately 150 people die as a result of seclusion and restraint practices; countless others are injured and many are secondarily traumatized by coercive practices. Children with emotional and behavioral problems are more frequently subjected to restraints in schools than students with other disabilities, often leading to serious physical injuries and emotional trauma for the students and the staff.

SAMHSA's vision for this initiative is to promulgate its evidence-supported strategies for reducing the use of seclusion and restraint and implementing trauma-informed care, an approach that mitigates the use and harmful effects of coercive practices.

In 2010, SAMHSA awarded a contract to establish the National Technical Assistance Center: Promoting Alternatives to Seclusion and Restraint Through Trauma-Informed Practices. The purpose of this Center is to disseminate, train, and implement trauma informed care with the goal of reducing and, ultimately, preventing the use of seclusion and restraint and other traumatizing practices in service systems and treatment agencies that serve children, youth and adults with mental and co-occurring substance use disorders. SAMHSA will continue these activities in FY 2012. SAMHSA will be developing a standard definition and culturally competent measures of individual and community trauma and develop criteria and measures for trauma-informed care that can be used with a range of health and human service programs.

Youth Violence Prevention

The Safe Schools/Healthy Students Initiative is a discretionary grant program that seeks to create healthy learning environments which help students thrive, succeed in school, and build healthy relationships by providing students, schools, and communities with Federal funding to implement an enhanced, coordinated, comprehensive plan of activities, programs, and services that promote healthy childhood development and prevent violence and alcohol and other drug

abuse. This grant program supports 89 school districts across the country, spanning rural, tribal, suburban and urban areas as well as diverse racial, ethnic and economic sectors. Grantees are required to develop local strategic plans that addresses five required elements across the three sectors: 1) safe school environments and violence prevention activities; 2) alcohol, tobacco, and other drug prevention activities; 3) student behavioral, social, and emotional supports; 4) mental health services; and, 5) early childhood social and emotional learning programs. Grantees have developed organizational, informational, and programmatic systems that bring together many diverse sectors of the community, creating the capacity for comprehensive system reform so that all agencies concerned with the welfare of children and families could collaborate on an ongoing basis. One exciting example of the impact of this program are the results of activities in Element 3 that show the initiative has been successful in reducing alcohol consumption among students at participating SS/HS school districts. Between Year 1 and Year 3 of the grant, the percentage of students who reported drinking declined from 25.4 percent to 22.4 percent. More than 80 percent of school staff reported the SS/HS grant helped reduce alcohol and other drug use among students. Reduction in reported alcohol use might yield significant cost savings for Safe School/Healthy Students communities. Based on the average estimated 30-day societal cost per juvenile drinker of $457, the reduced alcohol use across cohorts results in cost savings of $1,471,121 over a 30-day period. In FY 2011, SAMHSA/ED provided support for all continuation grants.

In FY 2012, SAMHSA will support current Safe Schools/Healthy Students grants in collaboration with ED. SAMHSA will utilize the funding in FY 2012 to realign technical assistance activities to meet the needs of grantees and the field, and evaluate the performance of the existing program. With these savings, SAMHSA plans to transfer $2.0 million to ED to help finance technical assistance to improve the school climate for learning, including but not limited to technical assistance on bullying prevention.

National Child Traumatic Stress Network

In FY 2001, Congress authorized the National Child Traumatic Stress Initiative (NCTSI) to improve treatment, services and interventions for children and adolescents exposed to traumatic events. The NCTSI funds a national network of grantees that collaborates broadly to develop and promote effective community practices for children and adolescents exposed to a wide array of traumatic events. Domestic public and private nonprofit entities are eligible to apply for grants. Centers are located in or associated with a diverse group of organizations, such as State government agencies, community mental health centers, children's advocacy centers, universities, children's hospitals, schools, and refugee programs.

NCTSI experts provide training and technical support on intervention approaches to reduce the mental, emotional and behavioral effects of traumatic events on children/adolescents and their families. Through SAMHSA's grant making, the NCTSI has built the National Child Traumatic Stress Network(NCTSN), which is comprised of nationally recognized experts in child and adolescent trauma who have developed evidence-based interventions to treat children who have experienced a range of traumas from neglect, physical abuse, sexual abuse, medical trauma, school violence, war, refugee and disasters, etc.; community service providers across multiple child-serving systems; and a National Coordinating Center to promote further product

development, learning collaborative and system changes efforts in systems across the country. Since its inception, NCTSN has expanded its reach across the country, with current grantees in twenty-nine States. It has provided training and/or education on child trauma to over 1 million individuals; more than 73,000 people were trained in 2011 in nearly 3,000 annual training/education events. In FY 2011, 34 percent of children receiving trauma informed services had improved outcomes (percentage showing clinically significant improvement). The unduplicated count of the number of children and adolescents receiving trauma-informed services was 3,052 in FY 2011.

In FY 2011, SAMHSA issued a one year combined RFA with a limited competition for the FY 2007 cohort of Category 2 and 3 grantees. The purpose was to continue the current program and to enhance trauma treatment and services, and expand grantees activities to the child welfare system and juvenile justice/dependency court systems and/or publicly funded child mental health system providing services to targeted populations.

For FY 2012, SAMHSA will continue to support the NCTSI model and mission of the NCTSN with an increased focus on effective implementation strategies for maximizing the uptake of trauma interventions, enhanced learning networks, and prioritization of child trauma in the child welfare and juvenile justice systems. The NCTSI will build on the strong work of the Network and will improve and enhance the capacity of the NCTSI to deliver core practices developed by the NCTSN to children and youth in need.

Children and Family Programs

The Children and Family's Healthy Transitions Program uses a system of care approach to promote a seamless transition to independence and the successful adaptation of adult roles and responsibilities for youth and young adults with serious mental health conditions and their families. Young people with serious mental health conditions (often with co-occurring substance abuse) face a difficult transition to adulthood compared to their peers. Moreover, youth who age out of child-serving systems may have difficulty obtaining developmentally appropriate, culturally-competent and appealing services and support services as they move into adulthood. These at-risk youth are better able to navigate the transition to adulthood by creating supportive State-level policies and making available evidence-based, age-appropriate services and supports.

The Circles of Care program provides Tribal and urban Indian communities with tools and resources to build systems of care to promote mental health for children, youth and their families in American Indian and Alaska Native (AI/AN) communities by developing the infrastructure necessary to plan and implement these systems. For the first time, in FY 2011, Circles of Care V Grantees can also use grant funds for the provision of direct services. As a result of the Circles of Care program, 13 of 23 Phase I-IV grantees secured larger federal grants (e.g., Children's Mental Health Initiative (CMHI) funds), either directly or indirectly to implement the grantee's model.

In FY 2012, SAMHSA anticipates providing continuation support for the Circles of Care and Healthy Transitions services grants.

Consumer & Family Network Grant

The Consumer and Family Network grant promotes consumer, family, and youth participation in the development of policies, programs, and quality assurance activities related to the mental health systems reform in States across America.

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

The Statewide Family Network provides education and training to increase family organization capacity for policy and service development by: 1) strengthening organizational relationships; 2) fostering leadership and business management skills among families of children and adolescents with serious emotional disturbance; and 3) identifying and addressing the technical assistance needs of children and adolescents with serious emotional disturbances and their families. The Statewide Family Network focuses on families: parents, primary caregivers of children, youth and young adults. In this case, young adults refer to individuals up to age 18, up to age 21 if they have an Individualized Education Plan, or up to age 26 if transitioning to the adult system. In FY 2011, SAMHSA provided 42 continuation grants to support the Statewide Family Network program.

In FY 2012, SAMHSA will continue to support 19 Statewide Consumer Network and 37 Statewide Family Network continuation grants as well as Technical Assistance continuation contract. In addition, SAMHSA plans to award new Statewide Consumer Network and new Statewide Family Network grants.

Mental Health System Transformation and Health Reform

SAMHSA supports the President's efforts to reform health care by engaging in activities that support the transformation of the mental health system. These include the Mental Health Transformation Grants.

In FY 2010, SAMHSA awarded 20 Mental Health Transformation Grants (MHTGs - formerly Mental Health State Incentive Grants) to promote the adoption and implementation of permanent transformative changes in how communities manage and deliver mental health services. Grantees are currently implementing evidence-based or best practices that will create or expand capacity to address prevention of mental illness; trauma-informed care; screening, treatment, and support services for military personnel; and housing and employment support. Necessary changes to policies and organizational structures to support improved mental health services will also be

supported along with workforce training, implementation of evidence-based practices, and improving access to quality mental health services.

In FY 2011, SAMHSA awarded 11 grants for Grants to Develop and Expand Behavioral Health Treatment Court Collaboratives. SAMHSA's vision of a Behavioral Health Treatment Court Collaborative in the justice system is one that supports treatment and recovery support for people with behavioral health conditions and that improves public health and public safety by transforming the behavioral health system at the community level. The purpose of the Behavioral Health Treatment Court Collaborative grant program is to allow State and local criminal and dependency courts serving adults more flexibility to collaborate with the other judicial components and the local community treatment and recovery providers to better address the behavioral health needs of adults who are involved with the criminal court system.

In FY 2012, SAMHSA will provide continuation support for all the MHT grants at a reduced amount and related contracts will not be continued. SAMHSA will continue to provide technical assistance and support States and communities in implementing flexible solutions to address substance abuse, mental illnesses, and co-occurring disorders in the criminal justice system through collaboration between the Center for Substance Abuse Treatment and the Center for Mental Health Services. This approach helps local courts find the model that best meets their needs and capacities. It also encourages partnership with the behavioral health system to allocate treatment and recovery support services effectively and efficiently.

Primary & Behavioral Health Care Integration (PBHCI)

Physical health problems among people with mental illnesses impact quality of life and contribute to premature deaths, where these individuals die much earlier than the general population. While several factors contribute to this disparity, empirical findings indicate that early mortality among people with serious mental illnesses (SMI) is clearly linked to the lack of access to primary care services.

The PBHCI program supports the coordination and integration of primary care services into publicly-funded community behavioral health settings. The expected outcome of improved health status for people with serious mental illness will be achieved by encouraging grantees to engage in necessary partnerships, expand infrastructure, and increase the availability of primary health care and wellness services to individuals with mental illness. Partnerships between primary care and behavioral health organizations as well as information technology are deemed crucial to the success of this program**.** The population of focus for this grant program is individuals with serious mental illness and/or persons with co-occurring disorders served in the public mental health system.

In FY 2010, SAMHSA awarded 43 additional grants, mostly funded with the Affordable Care Act's Prevention Fund and awarded another 8 grants in FY 2011 (also with funds from the ACA Prevention Fund). In FY 2011, SAMHSA utilized $35.0 million in Affordable Care Act Prevention Fund for PBHCI to promote more integrated services between primary care services and mental health services. These funds were used to facilitate screening and referral for

necessary primary care prevention and treatment needs. In total, SAMHSA has awarded 64 PBHCI grants to date.

In FY 2012, SAMHSA plans to continue support to 56 existing grants, and may fully fund a number of new grants from both Budget Authority and the ACA Prevention Fund under Section 520K. SAMHSA will continue to support the PBHCI-TTA center at a reduced level.

National Suicide Prevention Lifeline

The National Suicide Prevention Lifeline, 1-800-273-TALK, coordinates a network of 152 crisis centers across the U.S. providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night. The importance of suicide prevention measures during difficult economic times cannot be overstated. Researchers have shown a relationship between sustained high rates of unemployment and increased risk for and incidence of suicide.

The National Suicide Prevention Lifeline routes calls from anywhere in the U.S. to a network of certified local crisis centers that can link callers to local emergency, mental health, and social services resources, averaging nearly 64,000 calls per month answered. Since July 2007, SAMHSA has partnered with the Department of Veterans Affairs to provide and ensure 24/7 access to a veterans suicide prevention hotline. This hotline has answered an average of more than 6,000 calls from veterans per month and nearly 800 calls per month from veterans' families. The National Suicide Prevention Lifeline is also responding to calls from active duty military and their families. In addition, the Lifeline has been increasingly responding to letters and emails sent to the White House from people in crisis for a variety of reasons, including the impact of the economic downturn. SAMHSA is in the process of developing a suicide hotline outcome measure to determine the number of people who contacted the Lifeline who believe the call prevented them from taking their lives. This new data collection will help inform SAMHSA and HHS on the vital impact the Lifeline is having across the Nation.

In fiscal year 2011, the Lifeline answered 765,638 calls, an average of 2,097 calls per day from people at risk for suicide, more than 68,000 in the last month of fiscal year 2011 alone. Between 30-40 percent of the calls are linked to economic distress or concerns about unemployment. National Suicide Prevention Lifeline crisis centers across the nation are responding to people in suicidal crises. At the same time, these centers are threatened with significant cutbacks in funding from State and local governments and other sources of support.

In September 2008, SAMHSA awarded six grants to National Suicide Prevention Lifeline crisis centers to provide follow up to suicidal callers. Evaluation and research findings indicate that the immediate aftermath of suicidal crises is a time of heightened risk for suicide but has great potential for suicide prevention. Preliminary data from this program indicate that when asked by an independent evaluator "To what extent did the counselor's calling you stop you from killing yourself," more than 50 percent of those receiving follow up phone contact responded "a lot." Urgent supplemental funding was provided to the crisis centers in 2009 as well. In FY 2010, SAMHSA added six more crisis center grants to continue to help address the need for critical

follow up services and supports for people contacting the Lifeline. FY 2011 continued the existing crisis center grants as well as awarded 6 more crisis center grants.

In FY 2011, SAMHSA also received $10.0 million in ACA Prevention Fund, which supported the GLS grants, the National Suicide Prevention Lifeline, and the SPRC. The National Suicide Prevention Lifeline received $1.7 million in supplemental funds to provide additional capacity for the Lifeline to handle increased volume.

In FY 2012, SAMHSA will continue the existing 12 crisis center grants and plans to award a new Suicide Lifeline grant. Funds from the ACA Prevention Fund will also be awarded for one-time activities.

GLS Youth Suicide Prevention

The Garrett Lee Smith (GLS) Memorial Act authorizes SAMHSA to manage two significant youth suicide prevention programs and a resource center. The GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program currently supports 27 States, 26 Tribes or Tribal organizations, the District of Columbia, and one Territory in developing and implementing youth suicide prevention and early intervention strategies involving public-private collaborations among youth serving institutions. The GLS Campus Suicide Prevention program currently provides funding to 45 institutions of higher education to prevent suicide and suicide attempts. The Suicide Prevention Resource Center (SPRC) develops effective strategies and best practices to ensure the field has access to the most crucial information.

In FY 2011, SAMHSA received $10 million in ACA Prevention Fund, which supported the GLS grants, the National Suicide Prevention Lifeline, and the SPRC. The GLS State and Campus programs funded four State/Tribal GLS grants ($5.8 million) and five Campus GLS grants ($1.5 million). SAMHSA also funded one supplement to the SPRC of $1.0 million to support the work of the National Action Alliance for Suicide Prevention, a public/private partnership established to update and implement the Surgeon General's National Strategy on Suicide Prevention.

When reviewing the performance for this program, you will notice that the number of individuals trained in youth suicide prevention (Measure 2.3.59) is an important indicator of program penetration as well as increased suicidal awareness. All targets for which data were available were exceeded for this program in FY 2011. The FY 2014 target for Measure 2.3.60, total number of youth screened, reflects proposed flat program funding in FY 2013. There are plans to expand data collection for this program to capture client outcomes in the future.

In FY 2012, SAMHSA anticipates providing support for 34 GLS State/Tribal continuation grants and 17 new grants. In addition, SAMHSA provided support for 16 GLS Campus continuation grants and 23 new grants. SAMHSA anticipates receiving $10.0 million from the ACA Prevention Fund and will support one-time Suicide Prevention activities consistent with the approach in FY 2011 with a priority on support for the GLS Campus program.

AI/AN Suicide Prevention

SAMHSA supports an innovative training and technical assistance project that helps tribal communities mobilize existing social and educational resources by facilitating the development and implementation of comprehensive and collaborative community based prevention plans to reduce violence, bullying, and suicide among American Indian/Alaska Native youth. To date, nearly 200,000 Tribal members in 20 communities and 2,100 Alaska Natives in five villages have been provided specialized technical assistance and support in suicide prevention and related topic areas for these communities. In addition, over 750 community members were trained in prevention and mental health promotion in these communities.

In FY 2012, SAMHSA will continue to support the existing AI/AN Suicide Prevention efforts and continue evaluation efforts.

Homelessness Prevention and Housing Program

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

The Grants for the Benefit of Homeless Individuals (GBHI) program enables communities to expand and strengthen their treatment services for homeless individuals with substance use disorders, or with co-occurring substance use and mental disorders. SAMHSA supports GBHI programs that demonstrate treatment effectiveness in serving homeless, runaways, street youth, and homeless veterans and moving them to transition into permanent supportive housing. Funds are also used to expand and strengthen substance abuse treatment services for homeless, alcohol-dependent persons who have histories of public inebriation, frequent emergency room visits, and arrests. Services include outreach, screening and assessment, referral, direct treatment, and wrap-around services, all directed to permanent and stable housing. The Services in Supportive Housing (SSH) program was implemented to help end chronic homelessness by funding treatment and support services to individuals and families in coordination with permanent supportive housing programs and resources. The SSH program provides comprehensive services that focus on outreach, engagement, intensive case management, mental health services, substance abuse treatment, benefits support, and linkage to permanent housing. The population of focus is individuals with severe mental illness and/or a co-occurring mental and substance use disorder and their families who have been continuously homeless for at least one year or have had at least four episodes of homelessness in the past three years.

As of January 2012, the SSH grantees, in CMHS, have provided cumulatively 9,951 persons with comprehensive and coordinated mental health and related services. Nearly two-thirds (63.1 percent) of the people served have demonstrated improvement in behavioral functioning. Five new SSH grants were awarded in FY 2010 bringing the grant portfolio to 62 grants. With the expansion of the SSH program, SAMHSA expects to triple the number of individuals provided supportive services in conjunction with permanent housing.

In FY 2011 SAMHSA awarded 23 grants for Cooperative Agreements to Benefit Homeless Individuals (CABHI). The major goal of this joint Center for Mental Health Services and Center for Substance Abuse Treatment CABHI program is to ensure that the most vulnerable individuals who are chronically homeless receive access to sustainable permanent housing, treatment, and recovery supports through mainstream funding sources. This grant program builds on the success of the previous SAMHSA Services in Supportive Housing (SSH) program and SAMHSA Grants to Benefit Homeless Individuals (GBHI) program. In FY 2012, SAMHSA is considering awarding 7 new CABHI grants, as well as maintain the 23 CABHI grant continuations.

Minority AIDS

The purpose of the Minority AIDS program is to enhance and expand the provision of effective, culturally competent HIV/AIDS-related mental health services in minority communities for persons living with HIV/AIDS and having a mental health need. The Centers for Disease Control and Prevention (CDC) reports significantly higher rates of HIV/AIDS among people of color. Blacks accounted for 44 percent and Hispanics accounted for 20 percent of all HIV/AIDS cases diagnosed in 2009, the most recent data available (CDC, 2011). 2009 data also shows a significant increase of 48% in HIV incidence among black/African American Men who have Sex with Men (MSM) aged 13-29, even as overall rates remained stable. Reasons for this increase are not fully known, although the high HIV prevalence rate in black MSM and factors such as stigma of HIV and homosexuality, limited healthcare access, and poverty may create an enabling environment for HIV (CDC 2011). Psychiatric and psychosocial complications frequently are not diagnosed or addressed either at the time of diagnosis or through the course of the HIV/AIDS disease process. When untreated, these complications are associated with increased morbidity and mortality, impaired quality of life, and numerous medical and/or behavioral challenges, such as non-adherence with the treatment regimen.

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

Criminal & Juvenile Justice Programs

Data from the 2010 National Survey on Drug Use and Health show that there were 11.1 million adults aged 18 and older who reported an unmet need for mental health care in the past year. This included 5.2 million adults who did not receive any mental health services in the past year. The data also show that of the 2.9 million Americans with co-occurring serious mental illness (SMI) and substance abuse disorder, over one third (36 percent) of these adults received no

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

Since 2002, SAMHSA has administered the Jail Diversion Program for Adults involved in the criminal justice system and has awarded grants to 40 States and communities. Over the past 30 years, the criminal justice system has become a repository for a large number of individuals with SMI who are arrested for a wide range of crimes[2]. The purpose of this initiative is to divert individuals with mental illness from the criminal justice system to more appropriate, community-based treatment and recovery support services including primary health care, housing, and job counseling/placement. The Jail Diversion Program's focus includes individuals with trauma-related mental disorders and co-occurring substance use disorders involved in the criminal justice system, with a priority for veterans. The program supports to States to pilot local diversion programs and replicate them State-wide. To date, grantees have conducted over 82,000 screenings and diverted over 3,500 persons with mental illness from jail to community treatment services. Of the 34 programs that were initially funded for the TCE Jail Diversion Program, 25 (75 percent) continued after SAMHSA funding ended.

In FY 2012, SAMHSA will continue to support 13 continuation grants and all evaluation and TA contracts.

Suicide Prevention Resource Center

In addition to programs that build suicide prevention capacity, SAMHSA also supports the Suicide Prevention Resource Center. This initiative 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 Suicide Prevention Resource Center works with and supports prevention networks to reduce suicides, community by community. Prevention networks are coalitions of organizations and individuals working together to promote suicide prevention including State-wide or tribal coalitions, community task forces, regional alliances, and professional groups.

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

[1] Serious Mental Illness and Arrest, Swartz and Lurigio, 2007

[2] Serious Mental Illness and Arrest, Swartz and Lurigio, 2007

In FY 2011, SAMHSA received $10.0 million in ACA Prevention Fund, which supported the GLS grants, the National Suicide Prevention Lifeline, and the SPRC. SAMHSA funded one supplement to the SPRC of $1.0 million to expand and enhance the level of support provided to the National Action Alliance for Suicide Prevention. This supplement expanded future organizational development, partnerships, and collaborations to support the implementation of the Surgeon General's *National Strategy for Suicide Prevention* (NSSP).

In FY 2012 SAMHSA is considering continuing support to the SPRC and the goals and objectives of the Action Alliance by providing the infrastructure supports to update and advance the NSSP. This will further support national investment in prevention and public health.

Practice Improvement/Training

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

The purpose of the HBCU - Center of Excellence is to network the 103 HBCUs throughout the U.S. and promote workforce development through expanding knowledge of best practices, leadership development and encouraging community partnerships that enhance the participation of African-Americans in the substance abuse treatment and mental health professions. The comprehensive focus of the HBCU – Center for Excellence will simultaneously expand service capacity on campuses and in other treatment venues. The goals of the HBCU-Center for Excellence are to: expand and enhance the existing national network of HBCUs to foster the development of programs, and to facilitate collaboration and the exchange of information related to substance abuse and mental health; provide culturally appropriate substance abuse and mental health disorder resources to HBCUs; and to promote workforce development in substance abuse and mental health by exposing HBCU students to a wide range of opportunities in the field, including, but not limited to internships, mentoring and leadership trainings.

In FY 2012, SAMHSA will provide support to all continuation grants.

Consumer & Consumer Support TA Centers

Consumer and Consumer Supported TA Centers foster a recovery-oriented, consumer-driven system of care to enhance consumer self-determination and recovery by helping people decrease their dependence on expensive social services and avoid inappropriate use of inpatient hospitalization through the use of alternative interventions. The program helps improve collaboration among consumers, families, advocates, providers and administrators which facilitates transforming community mental health services to be more consumer driven and family focused. In FY 2012, SAMHSA will provide support to all continuation grants.

Minority Fellowship Program (MFP)

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

Disaster Response

SAMHSA's Coordinated Technical Assistance Project on Emergencies and Disasters "Disaster Technical Assistance Center (DTAC)" supports individuals and communities faced with the behavioral health impact of natural and human made disasters. DTAC provides the field a wide range of technical assistance activities, resources and products to advance State and local government capacity to deliver effective behavioral health services that are well integrated with traditional public health and disaster recovery efforts. In addition, DTAC supports the Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program (CCP). The FEMA CCP is an inter-agency agreement between SAMHSA and FEMA that supplies supplemental financial assistance to provide crisis counseling services for disaster survivors to promote recovery and mitigate the need for traditional behavioral health services. These crisis counseling services assist individuals and communities in recovering from the challenging effects of natural and human caused disasters through the provision of community-based outreach and psycho-educational services. In October 2009, the CCP Online Data Collection and Evaluation System was released and is a significant advancement for the CCP's data collection. For FY 2011, CCP provided over 1.4 million primary and secondary services to consumers. These services included face-to-face encounters, community networking, telephone and email contacts, and material distributions.

In FY 2011, SAMHSA expanded and enhanced the National Suicide Prevention Lifeline to include the Disaster Distress Helpline pilot. This expansion supports services that connect residents who are experiencing distress as a result of a disaster with local crisis center responders.

Funding History

FY	Amount
2008 a/	$257,599,000
2009 a/	$330,263,000
2010 a/	$324,349,000
2011 a/	$358,677,000
2012 a/	$286,116,000

a/ The funding history is based on a comparable basis to previous funding levels to reflect the revised budget restructure and includes ACA Prevention Fund.

Mental Health PRNS Budget Request

The FY 2013 Budget Request is comprised of $247.6 million at the program level with $219.6 million from Budget Authority (BA) and $28.0 million provided by ACA Prevention Fund. This includes a decrease of $21.6 million in BA and $17.0 million in ACA Prevention Fund below the comparable FY 2012 Enacted Level. This level of funding enables the continuation of most programmatic activities. The request will support 380 grant and 30 contract continuations, as well as 86 new grants and 6 new contracts.

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

The effects of trauma place a heavy burden on individuals, families, and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationship among traumatic events, impaired neurodevelopment and immune system responses, and subsequent health risk behaviors resulting in chronic physical and behavioral disorders. In fact, the chronic stress that often accompanies repeated or unresolved trauma has even been linked to physically observable negative changes in brain development, including a reduction in the size of the hippocampus, the portion of the brain associated with long-term memory and spatial reasoning. With appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders, chronic physical diseases, and early death.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice systems reveal high rates

of mental and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Preventing exposure to traumatic events and responding with early interventions and treatment for those experiencing traumatic stress may improve outcomes for these individuals and prevent prolonged involvement with the justice and child welfare systems.

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

The Grants for Adult Trauma Screening and Brief Intervention (GATSBI) program will advance the knowledge base to address trauma in common health care settings, such as emergency departments, primary care, and OB/GYN. The concept and design for these grants will be developed by SAMSHA in consultation with its Federal partners: CDC, NIAAA, NIDA, NIMH, and VA. Grants will be up to $0.600 million per year for five years.

The FY 2013 Budget Request also includes increases for the following (+$15.4 million):

- Minority AIDS: $22.8 million, +$13.5 million increase from FY 2012 enacted to expand behavioral health services to individuals who are at risk for or have mental and/or co-occurring substance use disorders and are at risk for or living with HIV/AIDS. While SAMHSA is requesting the same total amount for Minority AIDS programs in FY 2013 as in FY 2012, the Budget Request realigns resources within SAMHSA in order to enhance the capacity to collaborate on HIV/AIDS prevention and treatment efforts across HHS. CMHS, in collaboration with CSAP and CSAT, will support an integrated program to develop and expand culturally competent and effective behavioral health and primary care network in order to reduce the impact of behavioral health problems, HIV risk, and HIV-related health disparities.
- Disaster Response: $3.0 million, +$1.9 million above the FY 2012 enacted level to support a nationally available disaster distress crisis counseling telephone line through a connection to local crisis lines throughout the country. The need for this initiative has been documented through the Assistant Secretary for Preparedness and Response after various emergency conditions throughout the world and after U.S. disasters that did not rise to the level of presidentially declared emergencies and therefore did not qualify for Stafford Act Funding.

The FY 2013 Budget Request also includes level funding, the same as FY 2012, for the following:

- Youth Violence Prevention: $23.2 million,
- National Child Traumatic Stress Network: $45.4 million,
- Children and Family Programs: $6.5 million,

- MH State Transformation and Health Reform: $10.6 million,
- AI/AN Suicide Prevention Initiative: $2.9 million, the same as FY 2012 and is proposing to align the AI/AN Suicide Prevention activities with the Center for Substance Abuse Prevention efforts with the Native American Center of Excellence.
- Homelessness Prevention Programs: $30.8 million,
- Consumer and Consumer Support TA Centers: $1.9 million,
- Homelessness: $2.3 million,
- HIV/AIDS Education: $0.8 million,

The FY 2013 Budget Request also includes decreases for the following (-$56.9):

- Seclusion and Restraint: $1.1 million, -$1.3 million below the FY 2012 enacted level. Reduction was a result of a contract coming to a natural end. SAMHSA intends to integrate much of the Seclusion and Restraint strategies into current programs.
- Consumer and Family Network Grants: $5.0 million, -$1.3 million below the FY 2012 enacted level. Reduction was a result of grants coming to a natural end. 38 new grants will also be awarded.
- Primary and Behavioral Health Care Integration: $28.0 million, -$39.7 million below the FY 2012 enacted level. In FY 2012, PBHCI was supported by both Direct Budget Authority and the ACA Prevention Fund. In FY 2013, PBHCI is requested to be funded by the ACA Prevention Fund and will continue to support 9 continuation grants originally awarded from direct Budget Authority and 34 continuation grants originally awarded from the ACA Prevention Fund as well as the PBHCI-TA center at a reduced funding level.
- Suicide Lifeline: $5.5, -$1.7 million below the FY2012 enacted level. Reduction was a result of one-time activities supported the ACA Prevention Fund in FY 2012.
- GLS-Youth Suicide Prevention-States: $29.4 million, -$6.1 million below the FY 2012 enacted level. Reduction was a result of fully funding grants in FY 2012 by the ACA Prevention Fund. The existing 51 grants and 2 contracts from FY 2012 will be maintained.
- GLS-Youth Suicide Prevention-Campus: $4.9 million, -$1.6 million below the FY 2012 enacted level. Reduction was a result of fully funding grants in FY 2012 with the ACA Prevention Fund. 37 grants and 1 contract will be maintained.
- Criminal and Juvenile Justice Programs: $4.3 million, -$2.4 million below the FY 2012 enacted level. 7 grants and 1 contract will be maintained.
- GLS-Suicide Prevention Resource Center: $4.9 million, -$-1.0 million below the FY 2012 enacted level. Reduction was a result of not renewing supplemental funds that were received as part of the ACA Prevention Fund in FY 2012.
- Practice Improvement and Training: $7.4 million, -$0.4 million below the FY 2012 enacted level. Existing grant amount will be continued.
- Minority Fellowship Program: $3.8 million, -$1.3 million below the FY 2012 enacted level. All 6 grants will be continued at a reduced amount.

A detailed table for all grant and contract continuations and new activities can be found on page 227.

SAMHSA/ Mental Health

PRNS Mechanism Table by APT

(Dollars in *Thousands)*

Programs of Regional & National Significance	FY 2011 Enacted Number	FY 2011 Enacted Amount	FY 2012 Enacted Number	FY 2012 Enacted Amount	FY 2013 President's Budget Number	FY 2013 President's Budget Amount
Grant s/Cooperative Agreements:						
Continuations	357	$143,406	364	$124,381	378	$152,621
New/Competing	137	58,929	166	99,061	98	40,897
Supplements	73	24,491	2	2,705	---	---
Subtotal	**567**	**226,826**	**532**	**226,147**	**476**	**193,518**
Contracts:						
Continuations	37	119,263	36	56,531	32	48,045
New/Competing	15	11,990	3	3,409	6	5,987
Supplements	---	492	---	29	---	---
Subtotal	**52**	**131,745**	**39**	**59,969**	**38**	**54,032**
Total, PRNS MH 1/	**619**	**$358,571**	**571**	**$286,116**	**514**	**$247,550**

1/ This total inc1udes PRNS items funded with both BA and ACA Prevention Funds. ACA finding amounts to $45 million in FY 2011 and FY 2012, and $28 million in FY 2013.

Outcomes and Outputs

Youth Violence Prevention

Table 1: Key Performance Indicators for Youth Violence Prevention

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target [3] (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.2.04 Number of children served (Outcome)	FY 2011: 3,223,075 Target: 2,328,500 (Target Exceeded)	2,328,500	2,328,500	524,931	-1,803,569
3.2.10 Percentage of students who receive mental health services (Outcome)	FY 2011: 69.2% Target: 66% (Target Exceeded)	66%	66%	66%	Maintain
3.2.29 Percentage of middle and high school students who have been in a physical fight on school property (Outcome)	FY 2011: 18.8 % Target: 27.0 % (Target Exceeded)	27%	27%	27%	Maintain
3.2.30 Decrease the percentage of middle and high school students who report current substance abuse (Outcome)	FY 2011: 21.5 % Target: 20.0 % (Target Not Met but Improved)	20%	20%	20%	Maintain

[3] Target has been reduced to reflect the reduced program funding in FY 2013

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target [3] (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.2.31 Number of children (ages 0-5) screened for mental health or related interventions (Outcome)	N/A	N/A	N/A	Baseline December, 2014	N/A
3.2.32 Number of organizations collaborating and sharing resources with other organizations as a result of the grant (Outcome)	N/A	N/A	N/A	Baseline December, 2014	N/A

National Child Traumatic Stress Initiative (NCTSI)

Table 2: Key Performance Indicators for National Child Traumatic Stress Network

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.2.02 Increase the percentage of children receiving trauma informed services showing clinically significant improvement (Outcome)	FY 2011: 34%[4] Target: 43% (Target Not Met)	43%	43%	43%	Maintain
3.2.23 Unduplicated count of the number of children and adolescents receiving trauma-informed services (Outcome)	FY 2011: 3,052 Target: 3,217 (Target Not Met but Improved)	1,922[5]	3,052	3,052	Maintain
3.2.24 Number of child-serving professionals trained in providing trauma-informed services (Outcome)	FY 2011: 92,975[6] Target: 100,800 (Target Not Met)	95,186	73,992	95,186	+21,194

[4] Analysis of the FY2011 GPRA result revealed that one of three measures that contributes to the overall result was used at a significantly lower level in FY 2012. The measure had the highest percentage of youth demonstrating improvement in previous years and was unavailable for a significant portion of FY 2011 due to license issues which are now resolved. We anticipate that the result for this GPRA measure will increase as grantee use of the measure with lower utilization in FY2011 moves closer to historic levels in FY 2012.

[5] Target adjusted reflect 2009 actual.

[6] Data for this measure is now being collected by the TRAC system and data is collected in real time with no data lag. Thus, result dates have been changed accordingly.

Mental Health System Transformation Grants

Table 3: Key Performance Indicators for Mental Health System Transformation Grants

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.11 Number of persons in the mental health and related workforce trained in specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2011: 3,720 Target: 746 (Target Exceeded)	4,095	1,488[7]	1,488	Maintain

[7] Target has been reduced to reflect the reduced program funding in FY 2012.

Suicide Prevention

Table 4: Key Performance Indicators for Suicide Prevention Activities

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
2.3.59 Total number of individuals trained in youth suicide prevention (Outcome)	FY 2011: 106,835 Target: 35,371 (Target Exceeded)	35,371	35,371	36,078	+707
2.3.60 Total number of youth screened (Output)	FY 2011: 15,352 Target: 3,360 (Target Exceeded)	3,360	3,360	3,427	+67
2.3.61 Increase the number of calls answered by the suicide hotline (Output)	FY 2011: 765,638 Target: 555,132 (Target Exceeded)	555,132	555,132	555,132	Maintain

Mental Health Services – Homelessness Programs

Table 5: Key Performance Indicators for Mental Health Homelessness Prevention Programs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.4.01 Number of clients served (Output)	FY 2011: 5,034 Target: 2,262 (Target Exceeded)	2,223	5,034	5,034	Maintain
3.4.02 Increase the percentage of adults receiving services receiving homeless support services who report improved functioning (Outcome)	FY 2011: 63.1 % Target: 68.4 % (Target Not Met)	68.4%	63.1 %	63.1 %	Maintain
3.4.03 Percentage of adults receiving services who were currently employed (Outcome)	FY 2011: 24.7 % Target: 15.6 % (Target Exceeded)	15.6%	15.6 %	15.6 %	Maintain
3.4.05 Percentage of adults receiving services who had a permanent place to live in the community (Outcome)	FY 2011: 79.5 % Target: 60.6 % (Target Exceeded)	60.6%	74.2 %	60.6 %	-13.6%
3.4.06 Percentage of adults receiving services who had improved social support (Outcome)	FY 2011: 71 % Target: 78 % (Target Not Met)	78%	71 %	71 %	Maintain

Table 6: Key Performance Indicators for Mental Health – Other Capacity [16]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.05 Percentage of clients receiving services who report improved functioning (Outcome)	FY 2011: 52.1% Target: 54% (Target Not Met)	54%	54%	54%	Maintain
1.2.82 Percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2011: 69.4 % Target: 67.7 % (Target Exceeded)	67.7%	67.7 %	67.7 %	Maintain
1.2.83 Percentage of clients receiving services who are currently employed (Outcome)	FY 2011: 24.4 % Target: 14.0 % (Target Exceeded)	14%	14%	14%	Maintain
1.2.88 Number of individuals screened for mental health or related interventions (Outcome)	FY 2011: 32,763 Target: 32,763 (Baseline)	32,763	32,763	32,763	Maintain

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

Table 7: Key Performance Indicators for Mental Health – Science and Service Activities

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.4.06 Number of people trained by CMHS Science and Service Programs (Output)	FY 2011: 10,910 Target: 4,237 (Target Exceeded)	4,237	3,390	5,568	+2,178
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2010: 51,415[9] (Historical Actual)	37,896	37,049	31,473	-5,576

Grant Award Table

(Whole Dollars)	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	567	530	476
Average Award	$400,046	$426,692	$406,550
Range of Awards	$15,000-$6,000,000	$15,000-$6,000,000	$15,000-$6,000,000

[9] All component programs have now reported; therefore, data are revised from previously reported.

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Mental Health - State Prevention Grants

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Mental Health State Prevention Grant	$24,706	$34,640	$55,000	+$20,360
Project LAUNCH (non-add)	*$24,706*	*$34,640*	*$24,750*	*-$9,890*

Authorizing Legislation ..... Section 520A of the PHS Act

FY 2013 Authorization .....N/A

Allocation Method ..... Discretionary Grants

Mental Health Promotion and Mental Illness Prevention at a National Scale

The new MH-SPG program brings the success realized in Project LAUNCH to a broader scale. States and Territories will be required to use data to identify communities at highest risk and select proven mental health promotion and mental illness prevention programs and practices based on community needs. A statewide approach to comprehensive prevention planning will help bring these proven practices to an operational and implementation scale. By providing a stable and predictable source of funding through the MH-SPG, SAMHSA will support the development of a mental health promotion/mental illness prevention infrastructure in every State and Territory.

Program Description and Accomplishments - Project LAUNCH

In FY 2008, Congress provided funding to implement the Linking Actions for Unmet Needs in Children's Health (Project LAUNCH) Wellness Initiative. Project LAUNCH implements evidence-based practices that promote and enhance the wellness of young children by increasing grantees' capacity to develop infrastructure and implement prevention/promotion strategies necessary to promote wellness for young children. LAUNCH has been focused on children birth through age eight.

Project LAUNCH defines wellness as optimal functioning across all developmental domains, including physical, social, emotional, cognitive and behavioral health. Project LAUNCH is unique at SAMHSA with regard to its exclusive focus on prevention of mental illness beginning in early childhood, a time that is so critically important to the developing brain, and as a determinant of later physical and behavioral health. For this program behavioral health includes mental and emotional health and positive development free from substance abuse and other negative behavior. The goal of Project LAUNCH is to create a shared vision for the wellness of young children that drives the development of Federal, State, Territorial, Tribal and locally-based networks for the coordination of key child-serving systems and the integration of behavioral and physical health services. The expected result is for children to be thriving in safe, supportive environments and entering school ready to learn and able to succeed.

In FY 2011 SAMHSA continued 24 Project LAUNCH grants. To date, 49,000 children and parents have been screened and assessed in diverse settings and over 7,000 families have been served in LAUNCH-supported home visiting and family strengthening programs. Over 11,000 community providers have been trained on social-emotional and behavioral health for young children. Mental health consultation has been provided to 1,100 child care and education staff, as well as 700 primary care providers. Project LAUNCH data also indicates that nearly 900 organizations are collaborating, coordinating, and sharing resources to implement prevention/promotion strategies for young children.

In FY 2012, SAMHSA will continue to support continuation grants and contracts and plans to award grants to a new cohort as well as additional funding to TA and evaluation contracts to support the new cohort.

Funding History

FY	Amount
2008 a/	$7,369,000
2009 a/	$20,000,000
2010 a/	$24,993,000
2011 a/	$24,706,000
2012 a/	$34,640,000

a/ This funding history is representative of Project LAUNCH's funding which is the precursor to the MH State Prevention Grant.

Mental Health State Prevention Grant Budget Request

The FY 2013 President's Budget, proposes to expand the use of evidence-based prevention strategies from Project LAUNCH into Mental Health - State Prevention Grants (MH-SPG). The overall purpose of this program is to provide consistent and sustainable support for States and Territories to implement State-wide comprehensive prevention strategies to address the prevention of mental illnesses and reduce the impact of mental illness on America's communities. These grants will promote the wellness of children and youth by building on the findings and recommendations of the 2009 Institute of Medicine (IOM) report on *Preventing Mental, Emotional, and Behavioral Disorders Among Youth People*. The IOM Report recommends building partnerships across Federal, State, and local agencies, and research institutions to address risk factors that can lead to mental illness. Since research has shown that birth to age eight is a critical developmental phase for the prevention of substance abuse and mental illness, the MH-SPG state formula grants will continue to focus on young children and may provide States with the option to expand their focus to include older youth (e.g, birth to age 14) to continue efforts as young children enter middle school and transition to adolescence, if the State can demonstrate need and the capacity to provide additional prevention services. Any expansion in age range would extend the Project LAUNCH model of evidence-based programs and system coordination with an age-appropriate approach for the populations served. Consistent with the Project LAUNCH program, the MH-SPG will ensure that there is non-

duplication of effort across other State and Federal programs, and the non-supplantation of State and Federal funds.

The MH-SPG program will provide funding for all interested States and U.S. Territories in order to:

- Use evidence-based practices to promote known protective factors for mental health in young children and to reduce risk factors for mental illness and substance abuse;
- Prevent or delay the onset of mental illnesses and prevent suicide; and
- Build mental health promotion and mental illness prevention capacity and infrastructure at the State, local, and community levels.

The FY 2013 Budget request is $55.0 million, a $20.4 million increase over the comparable FY 2012 Enacted Level. This amount includes $24.8 million to continue grants funded under the current Project LAUNCH and $30.3 million available to support the MH-SPG. Since the State grants will build on the LAUNCH approach, as the current Project LAUNCH grants reach their natural end in future years, available funds will be folded into the MH-SPG program so that Project LAUNCH-like formula-based awards can be expanded to all States and Territories. The final distribution of $30.3 million will be determined by a formula that will be developed in consultation with stakeholders and Congress.

Background

The 2009 IOM Report provides evidence that a set of risk and protective factors affects the development of mental and substance use disorders in youth. For example, children with strong coping skills who live in safe, stable families and communities tend to develop certain mental illnesses and abuse substances less often than those who have not had these advantages. Although many mental illnesses have a biological basis, improvements in these personal, family, and community factors can help prevent, delay, and/or reduce the severity of these illnesses. Evidence also demonstrates that community risk and protective factors, such as poverty, violence, gangs, etc. can have a negative impact on the healthy development of young people in neighborhoods. Community norms, values, and beliefs are powerful factors in fostering positive community and youth development. Collectively, improvements in these areas can reduce the impact of mental illness on America's communities.

The MH-SPG state formula grants will require States and Territories to address mental health promotion and mental illness prevention at three levels of prevention practice: universal, which addresses populations at large; selective, which targets individuals or subgroups of the population whose risk of developing mental, emotional, or behavioral disorders is significantly higher than average (such as children with a family history of abuse or schools in high poverty areas); and indicated, which addresses individuals with early symptoms or behaviors that are precursors for a disorder, but are not yet diagnosable. SAMHSA will require States and Territories to consider and use environmental and policy approaches as well as individual approaches in developing the application for these funds. This coordinated approach supports SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, which aims to support communities where individuals, families, schools, workplaces, communities, and

States and Territories take action to promote emotional health and to prevent mental illness, substance abuse (including tobacco), and suicide.

Moving Mental Health Promotion and Mental Illness Prevention to a National Scale

The new MH-SPG program brings the success realized in Project LAUNCH to a broader scale. States and Territories will be required to use data to identify communities at highest risk and select proven mental health promotion and mental illness prevention programs and practices based on community needs. A statewide approach to comprehensive prevention planning will help bring these proven practices to an operational and implementation scale.

By providing a stable and predictable source of funding through the MH-SPG, SAMHSA will support the development of a mental health promotion/mental illness prevention infrastructure in every State and Territory. This formula-based grant program will provide funding to each State's and Territory's Mental Health Authorities (MHA) that are responsible for managing the MHBG. SAMHSA will require States and Territories to work across early childhood and other child serving systems (e.g., State and local education authorities, maternal and child health, public health, primary care, juvenile justice, child welfare, Medicaid, substance abuse, and faith communities) to engage and leverage existing Federal, State, and local resources already dedicated to or aligned with the prevention of mental, emotional, and behavioral disorders.

Following a comprehensive needs assessment process, grantees will develop statewide plans for enhancing the prevention infrastructure, training, and service systems at the State and local levels. Ultimately, States and Territories will assist and support high-risk/high-need communities to promote mental, emotional, and behavioral (MEB) health and reduce the risk for MEB disorders in young children.

SAMHSA will develop general criteria for selection of high-risk, high-need communities in order to focus limited dollars Nationwide. However, the actual selection of these communities will be responsibility of the designated MHA that receives and administers the grant funds.

Structure and Required Activities

The MH-SPG program will be a formula-based discretionary grant program available to all States and Territories. States and Territories will continue to be eligible for these funds beyond the initial grant award so long as they meet the requirements of each renewal application, provide the necessary annual reports, and show continued movement toward implementing their approved plans.

Each State/Territory will be required to develop a strategic plan based on national, State/Territory, and local epidemiological data sources and should describe a system with appropriate monitoring, funding and workforce resources. The plan must address, at a minimum, coordinated health and mental health promotion, mental illness prevention, and suicide prevention services for young children (and older youth if need and capacity are demonstrated). States and Territories will be required to partner with State Maternal and Child Health programs and will be expected to work across child and family serving systems (including working with

schools). This may address priorities such as school readiness, violence/trauma prevention, suicide prevention, depression, conduct/oppositional defiant disorder, Attention Deficit Hyperactivity Disorder, eating disorders, anxiety disorders, and prevention or reduction of high risk behaviors (e.g., substance abuse, unprotected sex, etc.) States and Territories will be expected to indicate the evidence-base, utilizing the 2009 IOM Report or other relevant scientific evidence, of the programs, services and activities they plan to fund. Data tracking the outcome of these expenditures, specifically decreasing disorders and risk factors, and increasing protective factors and/or emotional health in the communities funded.

States and Territories will be required to allocate most of the funds (at least 80 percent) to local communities to organize and carry out the promotion and prevention activities identified in the State plan while addressing the particular needs of communities. States and Territories will be allowed to retain up to 15 percent of the funds for State-level activities to achieve positive outcomes, such as the operation of a State or Territory prevention advisory group, epidemiological work group, training and technical assistance to communities, data collection and evaluation, development and dissemination of State or Territory-wide messages and resources, and oversight and monitoring of funded communities. States and Territories will be able to use funds for coordinated workforce development, training in evidence-based practices, and the development of coordinated infrastructure and service delivery systems in high need communities. Up to an additional five percent of the grant funds may be used for administrative costs.

A detailed table for Project LAUNCH grant and contract continuations can be found on page 232.

Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Most Recent Result/(Summary of Results)	FY 2011 Actual/ Associated Target/ (FY 2012)	FY 2012 Enacted/ Associated Target/ (FY 2013)	FY 2013 PB/ Associated Target/ (FY 2014)	FY 2013 PB/ Associated Target/ (FY 2014) +/- FY 2012 Enacted/ Associated Target/ (FY 2013)
2.3.94 Numbers of persons served (Output)	N/A	N/A	N/A	Baseline December 2013	Maintain
2.3.95 Number of persons trained in mental illness prevention or mental health promotion (Outcome)	N/A	N/A	N/A	Baseline December 2013	Maintain
2.3.99 Percentage of youth age 12-25 who experience a Major Depression Episode in the past 12 months (Outcome)	N/A	N/A	N/A	Baseline December 2013	Maintain

Children's Mental Health Services Program

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$117,803	$117,315	$88,557	-$28,758

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

FY 2013 Authorization ..... Expired

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

Program Description and Accomplishments

The Children's Mental Health Services Program was first authorized in 1992. The program supports the development of comprehensive, community-based systems of care for children and adolescents with serious emotional disorders and their families. Systems of care is an approach to the delivery of services that recognizes the importance of family, school and community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural, and social needs. Accordingly, a system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families.

Since 1993, the program has funded 173 grantees across the country; serving more than 100,000 children, and adolescents and their families. Through FY 2010 grants were funded for a total of six years, with an increasing non-Federal match requirement over the term of the award. The match requirement is intended to promote sustainability of the local systems of care beyond the grant period. Sixty-four percent of system of care communities sustained five years post-Federal funding.

National program evaluation data collected for more than a decade indicate that systems of care are successful, resulting in many favorable outcomes for children, youth and their families, including:

- Sustained mental health improvements, including improvements for participating children and youth in clinical outcomes after six months of program participation;
- Improvements in school attendance and achievement;
- Reductions in suicide-related behaviors;
- Decreases in utilization of inpatient care and reduced costs due to fewer days in inpatient care;
- Significant reductions in contacts with law enforcement agencies.

A hallmark of this program is that youth and families partner with providers and policy makers in service delivery and system reform planning and decision-making. In addition to the

substantial roles children, youth, and families play in the care they receive, services are delivered in the least restrictive environment with evidence-based treatments and interventions. Care management ensures that planned services and supports are delivered appropriately and effectively.

In FY 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) funded System of Care Expansion Planning Grants. The purpose of these one-year planning grants are to develop a comprehensive strategic plan for improving and expanding services provided by systems of care and to expand the number of jurisdictions and locations within a state, political subdivision, territory or tribal entity that have adopted a system of care approach.

SAMHSA will be issuing implementation grants in FY 2012 to assist states in acting on the strategic plans developed in the one-year planning grants funded in FY 2011. This approach will expand and sustain system of care values and principles, infrastructure and services throughout the funded states, territories or tribes. A central focus of these efforts will be linking systems of care with other child serving systems, block grant activities, and coordinating funding streams to support the systems of care approach.

Funding History

FY	Amount
2008	$102,260,000
2009	$108,373,000
2010	$121,316,000
2011	$117,803,000
2012	$117,315,000

Budget Request

The FY 2013 Budget Request is $88.6 million, a net budget decrease of $28.8 million below the FY 2012 Enacted Level, and reflects savings from grants coming to a natural end. Over a decade of national program evaluation data indicate that the Systems of Care model developed and promoted by the program on a community-by-community basis are successful at achieving a variety of outcomes including: mental health improvements, reductions in suicidal behavior, juvenile justice involvement and lower medical costs. In FY 2011, SAMHSA awarded grants to 24 states and the District of Columbia to develop strategic plans for expanding the systems of care model statewide. As the Systems of Care have become a proven strategy, SAMHSA intends to bring the Systems of Care to scale through the Mental Health Block Grant. SAMHSA plans to continue working with states to move these models to scale through the use of their Mental Health Block Grant dollars. No grants will be terminated and the reduction will not affect current grants. The request will support 65 grant and 4 contract continuations.

A detailed table for all grant and contract continuations and new activities can be found on page 232.

Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Most Recent Result/(Summary of Results)	FY 2011 Actual/ Associated Target/ (FY 2012)	FY 2012 Enacted/ Associated Target/ (FY 2013)	FY 2013 PB/ Associated Target/ (FY 2014)	FY 2013 PB/ Associated Target/ (FY 2014) +/- FY 2012 Enacted/ Associated Target/ (FY 2013)
3.2.16 Number of children receiving services [3] (Output)	FY 2011: 6,639 Target: 13,051 (Target Not Met but Improved)	4,930	6,457	4,141	-2,316
3.2.25 Percentage of children receiving services who report social support (Outcome)	FY 2011: 86.9% Target: 87.6% (Target Not Met but Improved)	87.6%	87.6%	87.6%	Maintain
3.2.26 Increase the percentage of children receiving System of Care mental health services who improved functioning (Outcome)	FY 2011: 53.0% Target: 50.2% (Target Not Met but Improved)	50.2%	50.2%	50.2%	Maintain

[3] FY 2010 source for this measure has been transferred from the cross-site evaluation to the TRAC data collection system. The lower actual and subsequent targets are due to the fact that grantee use of the TRAC system is slower than expected.

Measure	Year and Most Recent Result/ Target for Most Recent Result/(Summary of Results)	FY 2011 Actual/ Associated Target/ (FY 2012)	FY 2012 Enacted/ Associated Target/ (FY 2013)	FY 2013 PB/ Associated Target/ (FY 2014)	FY 2013 PB/ Associated Target/ (FY 2014) +/- FY 2012 Enacted/ Associated Target/ (FY 2013)
3.2.27 Number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the program (Output)	FY 2011: 4,818 Target: 4,571 (Baseline)	4,571	4,571	4,571	Maintain
3.2.28 Number of organizations that entered into formal written inter/intra-organizational agreements (e.g. MOUs/MOAs) to improve mental health-related practices/activities as a result of the grant (Output)	FY 2011: 984 Target: 928 (Baseline)	928	928	928	Maintain
3.2.26 Increase the percentage of children receiving System of Care mental health services who improved functioning (Outcome)	FY 2011: 53.0% Target: 50.2% (Target Not Met but Improved)	50.2%	50.2%	50.2%	Maintain

Grant Awards Table

(Whole Dollars)	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	77	80	65
Average Award	$1,295,078	$1,224,075	$1,217,015
Range of Award	$330,000-$2,000,000	$330,000-$2,000,000	$300,000-$2,000,000

Projects for Assistance in Transition from Homelessness

(Dollars in thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$64,917	$64,794	$64,794	$---

Authorizing Legislation	Section 521 of the Public Health Service Act
FY 2013 Authorization	Expired
Allocation Method	Formula grant

Program Description and Accomplishments

In 1990, the Stewart B. McKinney Homeless Assistance Amendments Act authorized the Projects for Assistance in Transition from Homelessness (PATH) program. PATH is unique in that it alone is authorized to address the needs of individuals with serious mental illness (SMI) and/or SMI with a co-occurring substance use disorder who are experiencing homelessness or are at risk of homelessness. PATH connects this largely un-served population to critical services and resources to assist them on the road of recovery. PATH funds community-based outreach, mental health, substance abuse, case management and other supportive services, and a limited set of housing services in 483 communities from all 50 States, the District of Columbia, Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, and the Northern Mariana Islands.

The PATH formula calculates State allotments based on the population living in urbanized areas. This population data is updated after each census. This program requires matching funds of $1 to every $3 of Federal funds. In the past several years, State and local matching funds exceeded the required amount. The PATH program has been highly successful in targeting assistance to individuals with SMI who are homeless or are at-risk for homelessness or experiencing a co-occurring mental and substance use disorder. The PATH budget supports 57 grants to States and Territories, as well as centralized activities like technical assistance and evaluation.

In 2010, the PATH program contacted 177,966 homeless persons. PATH has implemented several activities to improve data collection and reporting. A partnership has been established with the Department of Housing and Urban Development (HUD) to determine the feasibility of having all PATH grantees collect and report PATH data in the Homeless Management Information System (HMIS).

Involving consumers in the PATH program is essential. The program established a PATH consumer-provider network that developed a consumer involvement curriculum to assist in the planning, design, and delivery of PATH at the local, State, and national levels. Located at http://pathprogram.samhsa.gov, the recently re-designed PATH website provides tools and information for consumers, PATH providers, other homeless service providers, policy makers

and the general public. It also presents opportunities for providers working with individuals who are homeless to connect with each other.

SAMHSA changed the way PATH grantees report on persons served/enrolled for the PATH annual report. Grantees now report on all persons served with Federal and State match funds and not just persons served with Federal PATH funds only (as was done in the past). This change was made in order to better align PATH data collection efforts with the U.S. Department of Housing and Urban Development's (HUD) Homeless Management Information System (HMIS), an outcome-based reporting system. All PATH programs will be expected to be using the Homeless Management Information System (HMIS) within the next 2-4 years for tracking PATH data used for GPRA reporting. This will enable SAMHSA to report reliable and consistent client- and aggregate-level data on the performance of the PATH program.

Performance for the number of homeless persons contacted and the number enrolled in mental health services exceeded targets in FY 2010. Performance for percentage of contacted homeless persons with serious mental illness who become enrolled in services, an indicator of the rate of enrollment for PATH-eligible individuals, was not met in FY 2010. To ensure that low performing providers have the opportunity to improve, SAMHSA plans on focusing its technical assistance in 2012 on clarifying definitions and best practices around enrollment and engagement. The states with low performing providers will receive more intense technical assistance and be encouraged to monitor their PATH providers more closely. Being pro-active and assertive in identifying and addressing the issues that contribute to low performance is expected to significantly improve this performance measure in the coming year.

Performance for the number of PATH providers trained on Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR)was not met in FY 2010. It is important to note, however, that nearly 24,000PATH providers have been trained since the initiative began. This output is important in that once trained, PATH providers are better able to assist PATH clients in applying for and getting the income benefits for which they are eligible.[1]

Funding History

FY	Amount
2008	$53,313,000
2009	$59,687,000
2010	$65,047,000
2011	$64,917,000
2012	$64,794,000

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

Budget Request

The FY 2013 Budget Request is $64.8 million, the same as the FY 2012 Enacted Level. This level of funding enables the continuation of all programmatic activities. The request will support 57 grant continuations.

Data Elements Used to Calculate FY 2013 Allotments

Population: For the States, District of Columbia, and Puerto Rico, April 1, 2000 population of urbanized areas from the 2000 Decennial Census, Summary File 1, from the U.S. Department of Commerce, Bureau of the Census. For the territories other than Puerto Rico, no data for the population of urbanized areas were available from the 2000 Decennial Census and so were not used in the allotment calculations (territories receive the statutory minimum territory allotment).

Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Most Recent Result/(Summary of Results)	FY 2011 Actual/ Associated Target/ (FY 2012)	FY 2012 Enacted/ Associated Target/ (FY 2013)	FY 2013 PB/ Associated Target/ (FY 2014)	FY 2013 PB/ Associated Target/ (FY 2014) +/- FY 2012 Enacted/ Associated Target/ (FY 2013)
3.4.15 Percentage of enrolled homeless persons who receive community mental health services (Outcome)	FY 2011: 60% Target: 47% (Target Exceeded)	47%	50%	47%	-3%
3.4.16 Numbers of homeless persons contacted (Outcome)	FY 2011: 177,966 Target: 160,000 (Target Exceeded)	182,000	182,000	182,130	+130
3.4.17 Percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome)	FY 2011: 47% Target: 55% (Target Not Met)	55%	55%	55%	Maintain
3.4.20 Increase the number of PATH providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits. (Output)	FY 2011: 4,459 Target: 5,420 (Target Not Met)	5,420	5,420	5,431	+11

DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration

FY 2013 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH) CFDA #93.150

State/Territory	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Alabama	$587,000	$586,000	$586,000	$---
Alaska	300,000	300,000	300,000	---
Arizona	1,181,000	1,179,000	1,179,000	---
Arkansas	300,000	300,000	300,000	---
California	9,053,000	9,034,000	9,034,000	---
Colorado	971,000	969,000	969,000	---
Connecticut	861,000	859,000	859,000	---
Delaware	300,000	300,000	300,000	---
District Of Columbia	300,000	300,000	300,000	---
Florida	4,072,000	4,063,000	4,063,000	---
Georgia	1,514,000	1,511,000	1,511,000	---
Hawaii	300,000	300,000	300,000	---
Idaho	300,000	300,000	300,000	---
Illinois	2,943,000	2,937,000	2,937,000	---
Indiana	1,031,000	1,029,000	1,029,000	---
Iowa	337,000	336,000	336,000	---
Kansas	365,000	364,000	364,000	---
Kentucky	474,000	473,000	473,000	---
Louisiana	766,000	765,000	765,000	---
Maine	300,000	300,000	300,000	---
Maryland	1,284,000	1,281,000	1,281,000	---
Massachusetts	1,703,000	1,700,000	1,700,000	---
Michigan	1,988,000	1,984,000	1,984,000	---
Minnesota	820,000	818,000	818,000	---
Mississippi	300,000	300,000	300,000	---
Missouri	934,000	932,000	932,000	---
Montana	300,000	300,000	300,000	---
Nebraska	300,000	300,000	300,000	---
Nevada	507,000	506,000	506,000	---
New Hampshire	300,000	300,000	300,000	---

DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration

FY 2013 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH) CFDA #93.150

State/Territory	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
New Jersey	$2,344,000	$2,339,000	$2,339,000	
New Mexico	300,000	300,000	300,000	
New York	4,687,000	4,677,000	4,677,000	
North Carolina	1,137,000	1,134,000	1,134,000	
North Dakota	300,000	300,000	300,000	
Ohio	2,210,000	2,205,000	2,205,000	
Oklahoma	448,000	448,000	448,000	
Oregon	597,000	596,000	596,000	
Pennsylvania	2,482,000	2,477,000	2,477,000	
Rhode Island	300,000	300,000	300,000	
South Carolina	566,000	565,000	565,000	
South Dakota	300,000	300,000	300,000	
Tennessee	896,000	894,000	894,000	
Texas	4,472,000	4,463,000	4,463,000	
Utah	528,000	527,000	527,000	
Vermont	300,000	300,000	300,000	
Virginia	1,425,000	1,422,000	1,422,000	
Washington	1,301,000	1,298,000	1,298,000	
West Virginia	300,000	300,000	300,000	
Wisconsin	859,000	857,000	857,000	
Wyoming	300,000	300,000	300,000	
State Sub-total	**60,743,000**	**60,628,000**	**60,628,000**	
Puerto Rico	1,051,000	1,049,000	1,049,000	
Guam	50,000	50,000	50,000	
Virgin Islands	50,000	50,000	50,000	
American Samoa	50,000	50,000	50,000	
Northern Marianas	50,000	50,000	50,000	
Territory Sub total	**1,251,000**	**1,249,000**	**1,249,000**	
Total, States/Territories	**61,994,000**	**61,877,000**	**61,877,000**	
SAMSHA Set-Aside 1/	**2,922,906**	**2,917,307**	**2,917,000**	**-307**
Total, PATH	**$64,916,906**	**$64,794,307**	**$64,794,000**	**-$307**

1/ FY 2012: 4.5% Set-Aside, plus $1,563 to compensate from rounding allotments. FY 2013: 4.5% Set-Aside, plus $1,270 to compensate from rounding allotments.

Protection and Advocacy for Individuals with Mental Illness

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$36,307	$36,238	$36,238	$---

Authorizing Legislation	Section 102 of the PAIMI Act
FY 2013 Authorization	Expired
Allocation Method	Competitive Grants/Cooperative Agreements/Contracts

Program Description and Accomplishments

The Protection and Advocacy for Individuals with Mental Illness Program (PAIMI) provides formula grant awards to support protection and advocacy systems designated by the Governor of each State and the Territories, and the Mayor of the District of Columbia. State protection and advocacy systems monitor facility compliance with respect to the rights of individuals through activities that ensure the enforcement of the Constitution and Federal and State laws. State protection and advocacy systems monitor public and private residential care and treatment facilities and non-medical community-based facilities for children and youth. The Budget Request will support 57 grants to States and Territories. An independent evaluation of the program was completed in FY 2009 which confirmed that PAIMI programs provide those with psychiatric disability a voice in the exercise of their rights and are highly successful in achieving client and system goals and objectives.

In 2010, the PAIMI program:

- Provided casework to 3,974 children and adolescents and 12,525 adults and elderly individuals with mental illness;
- Closed 13,422 cases, of which 3,216 were related to abuse, 2,673 to neglect, and 7,533 to a violation of individual rights;
- Resolved 84 percent of alleged abuse cases, 88 percent of alleged neglect cases, and 92 percent of alleged rights violations cases that resulted in positive change for the client in her/his environment, community, or facility.

The FY 2012 funding will resolve over 11,000 complaints in FY 2012, drawing upon a marginal cost analysis conducted for this program (which estimated an average cost per complaint resolved successfully in FY 2009 of $3,164). For complaints of alleged abuse that resulted in positive change for the client in her or his environment, community, or facility as a result of PAIMI involvement, the outcome has improved each year from 83% in FY 2007 to 84% in FY 2010.

This program is one of eight protection and advocacy (P&A) programs housed in three Federal departments. The different reporting and evaluation requirements translate into a significant

paperwork burden for recipients. To help remedy this problem, HHS, along with the Department of Education and the Social Security Administration, is committed to improving federal program coordination related to the monitoring and evaluating of these programs.

Twenty percent of grantees sampled report that they met or partially met all projected goals and objectives, which may include increasing the percentage of complaints of alleged abuse, neglect and rights violations not withdrawn by the client that resulted in positive change for the client. Overall, grantees reported having met 93 percent of targeted goals and objectives. However, only four of 20 P&A executive directors reported no cutbacks in goals due to insufficient resources.

Measure 3.3.12 is the number of people served by the PAIMI program. The FY 2010 target was again not met and has not been met over the previous five years. The PAIMI Program includes both an individual case and systemic focus. This balance appears to have shifted over time from a more individual case emphasis to a more systemic emphasis not only within individual program but nationally across all programs as well. Also, the case mix can impact this outcome, as individuals with more complex and extensive needs will require more time and resources which will reduce the total number of persons that can be served. Finally, although the program provides education and outreach, the number of persons served is ultimately determined by the number of persons who seek services which may vary over time. Because of all of these factors, the target for FY 2013 was adjusted downward and the 2014 target will remain flat. What appears to be happening is that with little additional funding and increasing demands, PAIMI program are focusing more on systemic activities which impact a much broader population than the individual case work.

Steps are being taken to improve the program performance for the PAIMI Program. A PAIMI Program Peer Review process is in place for the Annual Program Performance Report which assesses and provides specific feedback regarding strengths and weaknesses of the program as well as specific recommendations for ongoing quality improvement. Also, the PAIMI Programs within each State Protection & Advocacy (P&A) agency are monitored via on-site reviews on a regular schedule. These on-site monitoring reviews are conducted by independent consultants and provide SAMHSA with an assessment of key areas: governance, legal, fiscal and consumer/constituent services/activities of the State's PAIMI Program. Following these site visits, the consultants issue a report that summarizes its program findings and when appropriate, may include recommendations for technical assistance and/or corrective action. These steps are expected to improve performance so that annual and long-term targets can be met.

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

Funding History

FY	Amount
2008	$34,880,000
2009	$35,880,000
2010	$36,380,000
2011	$36,307,000
2012	$36,238,000

Budget Request

The FY 2013 Budget Request is $36.2 million, the same as the FY 2012 Enacted Level. This level of funding enables the continuation of programmatic activities. The request will support 57 grant continuations.

Data Elements Used to Calculate FY 2013 Allotments

Population: For the States, District of Columbia, and Puerto Rico, July 1, 2010 population estimates from the U.S. Department of Commerce, Bureau of the Census, Population Estimates Division. For the territories other than Puerto Rico, April 1, 2010 population counts from the 2010 Decennial Census from the U.S. Department of Commerce, Bureau of the Census.

Per Capita Income (PCI): For the States, District of Columbia, and Puerto Rico, 2010 Per Capita Income estimates from the U.S. Department of Commerce, Bureau of Economic Analysis. PCI data are not required for the calculation of allotments for territories other than Puerto Rico.

American Indian Consortium: Populations of relevant Indian tribes and geographic areas, from the 2010 Decennial Census, 2010 Census Redistricting Data Summary File, U.S. Department of Commerce, Bureau of the Census.

Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.4.12 Number of people served by the PAIMI program (Outcome)	FY 2010: 16,499 Target: 22,325 (Target Not Met)	22,325	16,499[1]	16,499	Maintain
3.4.19 Number attending public education/ constituency training and public awareness activities (Output)	FY 2010: 98,681 Target: 120,000 (Target Not Met but Improved)	92,953[2]	92,953	93,139	+186
3.4.21 Increase percentage of complaints of alleged abuse, neglect, and rights violations substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making,elimination of other barriers to personal decision-making,as a result of PAIMI involvement (Outcome)	FY 2010: 90% Target: 87% (Target Exceeded)	87%	87%	87%	Maintain

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

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

Department of Health and Human Services Substance Abuse and Mental Health Services Administration
FY 2013 Discretionary State/Formula Grants Protection and Advocacy for Individuals with Mental Illness (PAIMI) CFDA #93.138

State/Territory	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Alabama	$452,242	$451,372	$457,463	+$6,091
Alaska	429,900	429,100	429,100	---
Arizona	634,663	633,443	603,295	-30,148
Arkansas	429,900	429,100	429,100	---
California	3,140,608	3,134,571	3,164,025	+29,454
Colorado	430,374	429,546	429,422	-124
Connecticut	429,900	429,100	429,100	---
Delaware	429,900	429,100	429,100	---
District of Columbia	429,900	429,100	429,100	---
Florida	1,645,271	1,642,108	1,682,740	+40,632
Georgia	934,836	933,039	910,176	-22,863
Hawaii	429,900	429,100	429,100	---
Idaho	429,900	429,100	429,100	---
Illinois	1,104,968	1,102,843	1,094,403	-8,440
Indiana	611,538	610,362	615,360	+4,998
Iowa	429,900	429,100	429,100	---
Kansas	429,900	429,100	429,100	---
Kentucky	429,900	429,100	429,100	---
Louisiana	429,900	429,100	429,100	---
Maine	429,900	429,100	429,100	---
Maryland	457,094	456,215	459,342	+3,127
Massachusetts	522,362	521,358	510,608	-10,750
Michigan	943,025	941,212	927,165	-14,047
Minnesota	450,952	450,085	448,540	-1,545
Mississippi	429,900	429,100	429,100	---
Missouri	553,042	551,979	544,616	-7,363
Montana	429,900	429,100	429,100	---
Nebraska	429,900	429,100	429,100	---
Nevada	429,900	429,100	429,100	---
New Hampshire	429,900	429,100	429,100	---

Abuse and Mental Health Services Administration

FY 2013 Discretionary State/Formula Grants Protection and Advocacy for Individuals with Mental Illness (PAIMI) CFDA #93.138

State/Territory	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
New Jersey	$687,655	$686,332	$686,151	-181
New Mexico	429,900	429,100	429,100	---
New York	1,594,281	1,591,215	1,548,197	---
North Carolina	882,144	880,448	893,640	+13,192
North Dakota	429,900	429,100	429,100	---
Ohio	1,071,508	1,069,448	1,059,396	
Oklahoma	429,900	429,100	429,100	---
Oregon	429,900	429,100	429,100	---
Pennsylvania	1,101,143	1,099,025	1,101,624	+2,599
Rhode Island	429,900	429,100	429,100	---
South Carolina	445,471	444,614	450,934	+6,320
South Dakota	429,900	429,100	429,100	---
Tennessee	596,371	595,224	594,323	-901
Texas	2,209,194	2,204,946	2,271,001	+66,055
Utah	429,900	429,100	429,100	---
Vermont	429,900	429,100	429,100	---
Virginia	658,424	657,158	667,622	+10,464
Washington	563,850	562,766	571,406	+8,640
West Virginia	429,900	429,100	429,100	---
Wisconsin	511,794	510,809	508,521	-2,288
Wyoming	429,900	429,100	429,100	---
State Sub-total	**33,810,110**	**33,745,818**	**33,785,670**	**+39,852**
Puerto Rico	619,485	618,294	578,070	-40,224
American Samoa	230,300	229,900	229,900	---
Guam	230,300	229,900	229,900	---
American Indian	230,300	229,900	229,900	---
Northern Marianas	230,300	229,900	229,900	---
Virgin Islands	230,300	229,900	229,900	---
Territory Sub-total	**1,770,985**	**1,767,794**	**1,727,570**	**-40,224**
Total, States/Territories	**35,581,095**	**35,513,612**	**35,513,240**	**-372**
SAMSHA Set-Aside	**726,145**	**724,768**	**724,760**	**-8**
Total, PAIMI	**$36,307,240**	**$36,238,380**	**$36,238,000**	**-$380**

Community Mental Health Services Block Grant

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Mental Health Block Grant	$419,932	$459,756	$459,756	$---
PHS Evaluations Fund (non-add)	$20,996	$21,039	$21,039	$---

Authorizing Legislation	Section 1911 of the Public Health Service Act
FY 2013 Authorization	Expired
Allocation Method	Formula Grant

Program Description and Accomplishments

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

A major provision of the MHBG authorization includes a Maintenance of Effort (MOE) requirement wherein States are required to maintain expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the year for which the State is applying for a grant. In FY 2010, due to significant fiscal reductions among many State budgets, approximately one-third of States and Territories had MHBG MOE expenditure shortfalls. The MHBG continues to represent a significant "safety net" source of funding for mental health services for some of the most vulnerable populations across the country. Despite these state reductions, funding for the MHBG has not been increased in many years. The increased FY 2012 enacted amount ensures that States and Territories as a whole will receive a modest increase in funding over FY 2011.

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

and services carried out under the plan, and for planning, administration, and educational activities related to providing services under the plan. States also rely on the MHBG for an array of non-clinical activities and services in support of their respective systems of care, e.g., planning, coordination, needs assessment, quality assurance, program development, and evaluation.

The legislation provides a five percent set-aside, which is retained by SAMHSA, to assist the States and Territories in the development of their mental health systems through the support of technical assistance, data collection and evaluation activities.

The Mental Health State Data Infrastructure Grants are funded under the MHBG five percent set-aside. This grant program meets the goal of developing State capacity to collect and report data on 21 Uniform Reporting System measures, which include the National Outcome Measures (NOMS). With support of the Data Infrastructure Grants and through the Uniform Reporting System, State Mental Health Authorities provide annual State mental health system data reports to the MHBG program to assure efficiency and effectiveness and to report on program performance. Over the past six years, 59 States and Territories have consistently increased in their ability to provide data, focusing on use of common measures across States. The Data Infrastructure Grant also supports mental health data system development and use of data for policy and program decision making. States must match grant awards at a 100 percent level. SAMHSA is working to initiate and expand common client-level data collection for both the MHBG and the Substance Abuse Prevention and Treatment Block Grant (SABG).

Most States are currently reporting on NOMS for public mental health services within their State. The first compilation of State National Outcome Measures data was submitted to Congress in the spring of 2005. State level outcome data for mental health are currently reported by State Mental Health Authorities through the Uniform Reporting System. The following outcomes for services provided during 2010 show that:

- For the 58 States and Territories that reported data in the Employment Domain, 19 percent of the mental health consumers were in competitive employment;
- For the 57 States and Territories that reported data in the Housing Domain, 82.7 percent of the mental health consumers were living in private residences;
- For the 59 States and Territories that reported data in the Access/Capacity Domain, State mental health agencies provided mental health services for 21.94 people per 1,000 population.
- For the 52 States and Territories that reported data in the Retention Domain, only 9.2 percent of the mental health patients returned to a State hospital within 30 days of State hospital discharge;
- For the 54 States and Territories that reported data in the Perception of Care Domain, 72 percent of adult mental health consumers improved functioning as a direct result of the mental health services they received;

The independent evaluation of the MHBG demonstrates that funds allow States to explore new innovations and strategies, target emerging needs with special programs; pay services not covered by commercial insurance, Medicaid, or Medicare, that are recovery-focused and

consumer-centered; and create the administrative, organizational, or service delivery linkages that foster community-based, transformed system of mental health services. The study of the program has been completed and the final report has been placed on the SAMHSA website (http://store.samhsa.gov/products/SMA10-4610).

Funding History

FY	Amount
2008 a/	$420,774,000
2009 a/	$420,774,000
2010 a/	$420,774,000
2011 a/	$419,933,000
2012 a/	$459,756,000

a/ Includes PHS Evaluation funds of $21 million

MHBG Budget Request

The FY 2013 Budget Request for the Mental Health Block Grant (MHBG) is $459.8 million, the same as the FY 2012 Enacted Level. This budget will support 59 grants to States and Territories. In FY 2012, 1.25 percent of the Budget Authority appropriated for the MHBG will be set aside pursuant to section 241 of the Public Health Service Act. In FY 2013, 3.2 percent of the Budget Authority appropriated for the MHBG will be set aside pursuant to section 241 of the Public Health Service Act. SAMHSA will work to ensure conformance with Section 1920 of the Public Health Service Act. These resources will be used to support activities such as evaluation, data collection, and technical assistance. State allotments in FY 2013 have been adjusted to reflect this change. It is important to maintain the MHBG funding level as it supports and preserves vital mental health service infrastructure, which, if lost now, may never be rebuilt. Additionally, the MHBG strongly supports the Nation's behavioral health infrastructure in preparation for ACA implementation.

In FY 2011, SAMHSA revised the MHBG and the SABG applications to make them uniform where appropriate, to allow States and Territories to submit a plan every two years instead of annually, and to allow States and Territories to submit one combined application for both Block Grants if they so chose. Twenty-two of the 58 eligible States and two Territories chose to submit a combined application for FYs 2012 and 2013. Other States have indicated a desire to do so in future years.

Other changes to the MHBG application for FYs 2012 and 2013 included updated requests and guidance to address good and modern behavioral health services and priority populations. The Uniform Block Grant application for FYs 2014 and 2015 will be released for public comment in the Spring or early Summer of 2012 with completion expected by Fall or early Winter of 2012/2013. Applications will be due in the Spring of 2013, in advance of most States/Territories 2014 fiscal year beginning in July of 2013.

CBHSQ, working with CMHS, plans to use PHS Evaluation Funds for a modification to the Drug and Alcohol Services Information System (DASIS) contract in FY 2012 to collect both substance abuse and mental health facilities information and client level data. A new DASIS-type contract will be awarded in FY 2013 to capture client level data collection and reporting capability for both Block Grants. Support for MHBG grantees to support data collection efforts is being considered through a new cohort of Data Infrastructure Grants (DIG) or through a mechanism related to the new data collection contract. This effort will enhance data reporting for the MHBG in the future.

Data Elements Used to Calculate FY 2013 Allotments

Population: For the States and the District of Columbia, July 1, 2010 population estimates from the U.S. Department of Commerce, Bureau of the Census, Population Estimates Division. For American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, i.e., the current territories, April 1, 2010 population counts from the 2010 Decennial Census from the U.S. Department of Commerce, Bureau of the Census. For the Federated States of Micronesia, the Marshall Islands, and Palau, i.e., the former territories, July 1, 2010 population estimates from the U.S. Department of Commerce, Bureau of the Census, International Data Base.

Total Taxable Resources (TTR): For the States and the District of Columbia, 2007, 2008, and 2009 Total Taxable Resources estimates from the U.S. Department of the Treasury, Office of Economic Policy.

Total Personal Income (TPI): For the States and the District of Columbia, 2008, 2009, and 2010 Total Personal Income estimates from the U.S. Department of Commerce, Bureau of Economic Analysis.

Cost of Services Index (CSI): For the States and the District of Columbia. This index is determined triennially (i.e., it is revised every third fiscal year rather than annually), and the FY2013 allotment calculations use the CSI determined for FY2013-FY2015. For the Wage Index of the CSI, wage rates were calculated using earnings and hours worked by place-of-work-state from 2010 American Community Survey (ACS) 1-Year Data for specific occupation-industry categories, as determined by the U.S. Department of Commerce, Bureau of the Census, in a special tabulation performed for SAMHSA. For the Rental Index of the CSI, FY2012 Median Fair Market Rent (FMR) estimates from U.S. Department of Housing and Urban Development were used, as well as July 1, 2009 population estimates at the county and subcounty levels from the U.S. Department of Commerce, Bureau of the Census, Population Estimates Division.

Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Most Recent Result/(Summary of Results)	FY 2011 Actual/ Associated Target/ (FY 2012)	FY 2012 Enacted/ Associated Target/ (FY 2013)	FY 2013 PB/ Associated Target/ (FY 2014)	FY 2013 PB/ Associated Target/ (FY 2014) +/- FY 2012 Enacted/ Associated Target/ (FY 2013)
2.3.14 Number of people served by the public mental health system (Output)	FY 2010: 6,835,040 Target: 6,300,000 (Target Exceeded)	6,300,000	6,340,320	6,340,320	Maintain
2.3.11 Number of evidence based practices (EBPs) implemented [1] (Output)	FY 2010:4.5 per State Target: 4.1 per State (Target Exceeded)	4.2 per State	4.2 per State	4.2 per State	Maintain
2.3.16 Rate of family members (children/adolescents) reporting positively about outcomes (Outcome)	FY 2010: 62.1% Target: 73% (Target Not Met)	73%	67%	67%	Maintain
2.3.15 Rate of consumers (adults) reporting positively about outcomes (Outcome)	FY 2010: 71.1% Target: 72% (Target Not Met)	72%	72%	72%	Maintain

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

Measure	Year and Most Recent Result/ Target for Most Recent Result/(Summary of Results)	FY 2011 Actual/ Associated Target/ (FY 2012)	FY 2012 Enacted/ Associated Target/ (FY 2013)	FY 2013 PB/ Associated Target/ (FY 2014)	FY 2013 PB/ Associated Target/ (FY 2014) +/- FY 2012 Enacted/ Associated Target/ (FY 2013)
2.3.81 Percentage of service population receiving any evidence based practice (Outcome)	FY 2010: 7.2% Target: 7.2% (Target Met)	7.2%	7.2%	7.2%	Maintain

Department of Health and Human Services Substance Abuse and Mental Health Services Administration FY 2013 Discretionary State/Formula Grants Community Mental Health Services Block Grant Program CFDA #93.958

State/Territory	FY 2011 Actual	FY 2012 Enacted	FY 2013 Estimate	+/- FY 2012
Alabama	$6,056,643	$6,551,928	$6,276,657	-$275,271
Alaska	707,289	765,128	729,005	-36,123
Arizona	9,597,122	10,381,931	9,617,887	-764,044
Arkansas	3,694,496	3,996,615	3,998,377	+1,762
California	53,096,425	57,438,409	57,015,240	-423,169
Colorado	6,633,747	7,176,225	6,235,472	-940,753
Connecticut	4,127,256	4,464,764	4,364,681	-100,083
Delaware	751,221	812,652	986,793	+174,141
District Of Columbia	752,010	813,506	829,485	+15,979
Florida	26,455,887	28,619,330	28,302,042	-317,288
Georgia	13,336,060	14,426,622	13,136,258	-1,290,364
Hawaii	1,952,865	2,112,561	2,171,042	+58,481
Idaho	1,820,039	1,968,874	2,359,440	+390,566
Illinois	15,461,971	16,726,381	16,137,013	-589,368
Indiana	7,899,482	8,545,466	7,926,963	-618,503
Iowa	3,317,318	3,588,593	3,494,088	-94,505
Kansas	3,091,154	3,343,934	3,264,415	-79,519
Kentucky	5,405,058	5,847,060	6,034,376	+187,316
Louisiana	5,528,359	5,980,444	5,333,770	-646,674
Maine	1,625,856	1,758,811	1,717,995	-40,816
Maryland	7,336,336	7,936,269	8,481,148	+544,879
Massachusetts	8,144,191	8,810,187	9,342,486	+532,299
Michigan	12,532,381	13,557,223	13,471,657	-85,566
Minnesota	6,822,149	7,380,034	6,671,095	-708,939
Mississippi	3,943,410	4,265,884	3,933,345	-332,539
Missouri	7,018,889	7,592,862	7,368,338	-224,524
Montana	1,182,935	1,279,671	1,263,590	-16,081
Nebraska	1,922,173	2,079,360	2,034,115	-45,245
Nevada	3,704,316	4,007,238	4,161,472	+154,234
New Hampshire	1,491,079	1,613,013	1,751,223	+138,210

State/Territory	FY 2011 Actual	FY 2012 Enacted	FY 2013 Estimate	+/- FY 2012
New Jersey	$11,324,910	$12,251,010	$12,095,028	-155,982
New Mexico	2,371,503	2,565,434	2,599,168	+33,734
New York	23,126,557	25,017,742	26,377,936	+1,360,194
North Carolina	11,381,944	12,312,708	12,043,997	-268,711
North Dakota	734,840	794,932	792,558	-2,374
Ohio	$13,735,192	$14,858,394	$14,194,612	-663,782
Oklahoma	4,359,258	4,715,738	4,643,466	-72,272
Oregon	4,973,982	5,380,731	5,629,200	+248,469
Pennsylvania	14,510,113	15,696,685	15,395,567	-301,118
Rhode Island	1,366,928	1,478,709	1,663,216	+184,507
South Carolina	5,882,807	6,363,877	6,166,766	-197,111
South Dakota	866,033	936,853	883,279	-53,574
Tennessee	7,779,137	8,415,280	8,268,909	-146,371
Texas	32,443,238	35,096,299	33,809,945	-1,286,354
Utah	3,124,776	3,380,306	3,239,831	-140,475
Vermont	729,303	788,942	782,599	-6,343
Virginia	10,042,428	10,863,652	10,624,842	-238,810
Washington	8,558,257	9,258,112	9,558,568	+300,456
West Virginia	2,368,354	2,562,028	2,560,752	-1,276
Wisconsin	7,409,959	8,015,911	6,877,044	-1,138,867
Wyoming	453,861	490,976	463,214	-27,762
State Sub-total	**392,951,497**	**425,085,294**	**417,079,965**	**-8,005,329**
American Samoa	86,505	93,638	81,856	-11,782
Guam	235,515	254,936	234,955	-19,981
Northern Marianas	62,916	68,105	79,444	+11,339
Puerto Rico	5,180,895	5,608,135	5,493,247	-114,888
Palau	50,000	50,000	50,000	---
Marshall Islands	85,759	92,831	97,102	+4,271
Micronesia	139,531	151,038	157,986	+6,948
Virgin Islands	142,912	154,697	156,882	+2,185
Territory Sub-total	**5,984,033**	**6,473,380**	**6,351,472**	**-121,908**
Total States/Territories	**398,935,530**	**431,558,674**	**423,431,437**	**-8,127,237**
SAMHSA Set-Aside	**20,996,607**	**22,713,614**	**22,285,865**	**-427,749**
Transfer	---	5,483,966	14,038,952	+8,554,986
Total, MHBG	**$419,932,137**	**$459,756,254**	**$459,756,254**	**$---**

SAMHSA Substance Abuse
Prevention Table of Contents

SAMHSA/Substance Abuse Prevention

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SAMHSA Substance Abuse Prevention
Summary of Changes
(Dollars in Thousands)

	FY2011 Actual	FY 2012 Enacted	FY 2012 President's Budget	FY 2013 +/- FY 2012
Substance Abuse Prevention Programs of Regional and National Significance	$75,956	$76,202	$65,877	-$10,325
ACA Prevention Fund (non-add)	---	---	7,000	+7,000
Substance Abuse - State Prevention Grant	451,107	453,980	404,501	-49,479
Total, Substance Abuse Prevention	**$527,063**	**$530,182**	**$470,378**	**-$59,804**
FTEs[1]	---	1	1	---

[1] In 2012, SAMHSA will continue to in source positions for activities that are central to SAMHSA's mission, represent critical skills for the agency, and result in overall savings consistent with Office of Federal Procurement Policy guidelines. A total of 98 positions will be added and fully staffed by the end of FY 2012. These positions are allocated across SAMHSA's four appropriations to reflect the provision of direct program support or to reflect the proration of overhead and indirect costs. The additional positions are fiscally neutral.

Substance Abuse Prevention:

The FY 2013 President's Budget Request for the SAMHSA Substance Abuse Prevention appropriation is $470.4 million, a decrease of $59.8 million from the FY 2012 Enacted Level. This FY 2013 Total Program Level budget request of $470.4 million includes $463.4 million in Budget Authority (a decrease of $66.8 million from FY 2012), and $7.0 million in ACA Prevention Funds (an increase of $7.0 million from FY 2012). This is due to funding for STOP Act being requested from ACA Prevention Funds in FY 2013 in place of Budget Authority in FY 2012. The request includes $65.9 million for Programs of Regional and National Significance, a decrease of $10.3 million from the FY 2012 Enacted Level. It also includes $404.5 million for the Substance Abuse – State Prevention Grant, a decrease of $49.5 million from a comparable level in FY 2012.

The FY 2013 Budget Request for Substance Abuse Prevention includes the following

decreases: Mandatory Drug Testing (-$0.3 million)
The FY 2013 request for Mandatory Drug Testing is $4.9 million. This is a decrease of $0.3 million from the FY 2012 Enacted Level. This minor decrease does not affect this program activity overall, and this level of funding will support 3 continuation contracts, as well as 2 new contracts.

Fetal Alcohol Spectrum Disorder (FASD) (-$8.8 million)
The FY 2013 request for FASD is $1.0 million. This is a decrease of $8.0 million from the FY 2012 Enacted Level. This level of funding will enable continued support for related technical assistance to the field and collaborative prevention strategies to prevent alcohol use among women of childbearing age.

Center for the Application of Prevention Technologies (CAPT) (-$0.5)
The FY 2013 request for CAPT is $7.5 million. This is a decrease of $0.5 million from the FY 2012 Enacted Level. This level of funding will enable provisional continuation of technical assistance to the field in support of delivery of effective prevention programs and practices.

Science and Service Program Coordination (-$0.7 million)
The FY 2013 request for Science and Service Program Coordination is $4.1 million. This is a decrease of $0.7 million from the FY 2012 Enacted Level. This level of funding primarily supports two key technical assistance contracts that enable SAMHSA to focus on two critical issues: assisting Tribes in obtaining support and implementing outreach to complement the Tribal Prevention Grant, and development and implementation of policy changes to prevent underage drinking.

Substance Abuse - State Prevention Grant (-$49.5 million)
The FY 2013 request for the Substance Abuse – State Prevention Grant is $404.5 million. This is a decrease of $49.5 million from the comparable FY 2012 Enacted Level. The funding will bring substance abuse prevention to a National scale by providing consistent and sustainable support for States and Territories to implement State-wide comprehensive substance abuse prevention strategies and reduce the impact of substance abuse on America's communities. The reduction is primarily from SPF grants coming to a natural end; no grants will be terminated. Thirty-five SPF State Incentive Grants and five Partnerships for Success (PFS) grants will be continued in FY 2013.

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

Programs of Regional & National Significance	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
CAPACITY:				
Mandatory Drug Testing	4,855	5,196	4,906	-290
Minority AIDS	41,391	41,307	41,307	---
Sober Truth on Preventing Underage Drinking (STOP Act) 1	7,009	6,987	7,000	13
ACA Prevention Fund (non-add)	---	---	7,000	7,000
Subtotal, Capacity	**53,255**	**53,490**	**53,213**	**277**
SCIENCE AND SERVICE:				
Fetal Alcohol Spectrum Disorder	9,830	9,802	1,000	-8,802
Center for the Application of Prevention Technologies	8,074	8,059	7,511	-548
Science and Service Program Coordination	4,726	4,780	4,082	-698
Minority Fellowship Program	71	71	71	---
Subtotal, Science and Service	**22,701**	**22,712**	**12,664**	**10,048**
Total, CSAP PRNS	**$75,956**	**$76,202**	**$65,877**	**-10,325**

1/The FY 2013 President's Budget request total of $7.0 million for the STOP Act program is funded by the ACA Prevention Fund.

Authorizing Legislation	Section 516, 519B, 519E of the PHS Act
FY 2013 Authorization	Expired
Allocation Method	Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

Mandatory Drug Testing

The Federal Drug-Free Workplace Mandatory Drug Testing program, initiated in 1986 by Executive Order #12564 and Public Law 100-71 in 1987, provides funding for accreditation and ongoing quality assurance of laboratories that perform mandatory drug testing for Federal and non-Federal employees across the nation. SAMHSA's Drug Testing mission focuses on the elimination of illicit drug use in the Federal workforce through the administration of the National Laboratory Certification Program (NLCP) that certifies laboratories for forensic drug testing for Federal agencies and some Federally-regulated industries including pre-hire and periodic testing for over 400,000 of the approximately 2.2 million non-uniformed service Federal employees, such as the Federal Bureau of Investigation, the Drug Enforcement Administration, and many others in the Department of Defense and the intelligence agencies. These laboratories provide for regulation of workplace testing for the presence of 5 illicit drugs: opiates, PCP, cocaine, marijuana, amphetamines. The mandatory drug testing program is further supported by the CSAP Workplace Helpline, a toll-free telephone service for business and industry that answers

questions about drug abuse in the workplace. The Workplace Helpline receives requests for assistance from small business owners who represent the vast majority of enterprise in the American economy, and from individuals regarding prescription drugs, illicit drugs, and alcohol use.

The FY 2012 funds for Federal Workplace Drug Testing will be used to include oral fluid as an alternative specimen to urine, and also to include additional Schedule II prescription medications (e.g., oxycodone, oxymorphone, hydrocodone and hydromorphone) in the drug testing protocol. These changes are based on recommendations from the Drug Testing National Advisory Council on July 13, 2011. SAMHSA continues to partner with NIH/NIDA to ascertain the scientific evidence needed to set standards for the Guidelines, and with FDA and DOT on implementation of the Guidelines.

Minority AIDS Initiative (MAI)

Implemented in FY 1999, SAMHSA/CSAP's Minority AIDS Initiative (MAI) supports efforts to increase access to substance abuse and HIV prevention services for the highest risk and hardest-to-serve racial and ethnic minority populations. Grantees of the MAI must implement integrated, evidence-based substance abuse and HIV prevention interventions, including HIV testing, that target one or more high-risk populations such as African American women, adolescents, individuals who have been released from prisons and jails within the past two years, or MSM. In addition, the MAI supports efforts around developing partnerships between public and private nonprofit entities as a way to prevent and reduce the onset of substance abuse and transmission of HIV among high-risk populations. All grantees are required to use SAMHSA's Strategic Prevention Framework for assessing their community needs; developing their long-range and annual strategic plans; implementing their evidence-based interventions; and evaluating intervention outcomes and performance. The MAI has funded a total of ten cohorts; currently, there are 122 active grants funded from cohorts seven through ten.

The two most recent cohorts are the Ready-To-Respond Initiative and the Capacity Building Initiative (CBI) programs, both initially funded in FY 2010. The Ready-To-Respond Initiative (RTR) provides substance abuse and HIV prevention services to at-risk minority populations in communities disproportionately affected by HIV/AIDS. The RTR program builds on previous accomplishments of MAI grantees by providing evidence-based prevention services and by expanding knowledge and experience in developing blended substance abuse and HIV prevention practices for these populations. In the CBI, grantees focus on using evidence-based prevention strategies and media technology to reach college students. College students comprise one-third of the 18-24 year old population in the United States and are particularly at risk for substance use and HIV infection. According to data from SAMHSA's National Survey on Drug Use and Health, college students in America are more likely to have used alcohol in the past month, binge drink, and drink more heavily than their peers not enrolled in school. SAMHSA will continue to support the RTR and CBI initiatives in FY 2012.

In FY 2011, SAMHSA awarded grants for the Minority AIDS Initiative Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements, jointly funded with CMHS and CSAT. This grant program facilitates the development and expansion of

culturally competent and effective integrated behavioral health and primary care networks, which include HIV services and medical treatment, within racial and ethnic minority communities in the 11 Metropolitan Statistical Areas and Metropolitan Divisions most impacted by HIV/AIDS. Expected outcomes include: reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas. SAMHSA will continue to support these grants in 2012.

During FY 2010, data from the cross-site evaluation of the MAI showed that grantees were successful in reaching and serving racial/ethnic minorities. Specifically, data showed that MAI grantees served larger proportions of Hispanics and African Americans (28.6 percent and 66.4 percent, respectively) than are represented in the general population (14.6 percent and 12.6 percent, respectively). In addition, grantees were also successful in serving hard-to-reach minority populations such as lesbian, gay, bisexual, and transgender youth and adults; homeless adults; and individuals who lacked health coverage at program entry.

Performance data showed a number of significant accomplishments in FY 2010. For example, MAI Grantees provided direct services to a total of 13,833 individuals in FY 2010. Of these, 4,552 were provided with substance abuse prevention education services—exceeding the annual performance target for the third consecutive year. Data also showed that 63.1 percent of adults decreased levels of alcohol use between pretest and posttest—marking the third consecutive year that the MAI has been able to exceed this specific performance target. Performance data also showed a number of opportunities to improve in the areas of nonuser stability for alcohol and illicit drug use among program participants. As a result, the two most recent cohorts of the MAI—which include the Capacity Building Initiative and the Ready to Respond Initiative—are specifically focused on increasing grantees' capacity to implement integrated, evidence-based substance abuse and HIV prevention interventions with high-risk populations. This change in focus will ultimately increase program performance in these areas.

Sober Truth on Preventing Underage Drinking Act (STOP Act)

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 is the nation's first comprehensive legislation on underage drinking. The Act recognizes underage drinking prevention as a public health priority and, as a result, authorizes a number of efforts that all aim to reduce the national prevalence of underage drinking. One of the primary components of the Act is the STOP Act grant program that provides additional funds to organizations that receive or have received grant funds under the Drug Free Communities Act of 1997. Through the STOP Act grant program, organizations are able to supplement their current prevention efforts, as well as strengthen collaboration and coordination among stakeholders in order to achieve a reduction in underage drinking in their communities. The initial program, funded in FY 2008, provided 79 four year grants to local communities with up to $50,000 per community per year. In FY 2011, a total of 99 grants received funding under this initiative. The FY 2012 level of funding supports 78 new grants for up to $50,000 per grant per year for up to four years.

Another component of the STOP Act is the National Adult-Oriented Media Public Service Campaign, with funding up to $1.0 million in FY 2012. The Underage Drinking Prevention campaign educates and urges parents to speak with their children, age 11-15, about underage

drinking in order to delay the onset of, and ultimately reduce, underage drinking. Nationwide, 38.9 percent of the estimated 10 million underage drinkers were provided free alcohol by adults 21 or older—representing a slight increase from 2009 (2010 NSDUH). Further, research continues to show that parents of teens generally underestimate the extent of alcohol used by youth and its negative consequences--with the vast majority viewing underage drinking as "inevitable." Many parents also find it difficult to know how or when to start a conversation with their children about underage drinking. Through TV, radio, print, and outdoor activities, SAMHSA's multicultural campaign seeks to overcome parents' misperceptions about underage drinking by creating a greater urgency around the issue and encourages them to communicate with their children at an early age about alcohol. Parents and viewers are encouraged to visit www.stopalcoholabuse.gov, funded through the media campaign, to get information about teens and alcohol, as well as tips on how to initiate conversations with their children about underage drinking.

The third important component of the STOP Act is the Federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), which includes representatives from 15 Federal agencies and is funded at $1.0 million in FY 2012. The ICCPUD provides ongoing, high-level leadership on the issue of underage drinking and serves as a mechanism for coordinating Federal efforts aimed at preventing and reducing underage drinking. The ICCPUD also produces an Annual Report summarizing all programs and policies of Federal agencies designed to prevent and reduce underage drinking as well as the State-level activities pertaining to underage drinking prevention programs, policies, enforcement efforts, and expenditures. In FY 2012, the ICCPUD will work with the Surgeon General's office to draft a new National Strategy for Preventing Underage Drinking, updating and expanding the 2007 Surgeon General's Call to Action to Prevent Underage Drinking.

Performance data show that, for two consecutive fiscal years, the STOP Act grant program has exceeded targets of increasing the percentage of grantees that show a 5 percent or more reduction in past 30-day use of alcohol in at least two grade levels. This accomplishment is significant as reducing the prevalence of underage drinking is the primary legislative goal of the STOP Act. Additional performance data suggest that the program has demonstrated improvement in the percentage of grantees that report increases in levels of parental disapproval of substance use—showing a nearly 6 percentage point increase from FY 2009. However, the program has not met or improved on increasing youth perception of risk of harm—a key predictor to substance use. Likewise, the number of deaths as a result of underage drinking remains unchanged at approximately 5,000 annually. As part of SAMHSA's Strategic Initiative around Data, Outcomes, and Quality, Government Project Officers (GPOs) of all prevention programs have been working closely with analysts to identify and discuss challenges and barriers reported by grantees. Using a combination of qualitative and quantitative data, GPOs are gaining better insight into the needs of grantees and are providing the necessary technical assistance and guidance to improve program performance in these areas.

Fetal Alcohol Spectrum Disorder (FASD)

SAMHSA's Fetal Alcohol Spectrum Disorder programming has focused on identifying and disseminating information about innovative techniques and effective evidence-based strategies for preventing Fetal Alcohol Spectrum Disorder and increasing functioning and quality of life for individuals and their families impacted by these disorders. In FY 2012, SAMSHA's will emphasize and expand prevention strategies to prevent alcohol use among women of childbearing age.

Center for the Application of Prevention Technologies (CAPT)

In existence for more than a decade, the Center for the Application of Prevention Technologies (CAPT) promotes state-of-the-art behavioral health promotion technologies through three core strategies: 1) establishment of technical assistance networks using local experts; 2) development of training activities; and 3) innovative use of communication media such as teleconference and video conferencing, online events, and Web-based support. These training and technical assistance activities are designed to build the capacity of SAMHSA grantees and develop the skills, knowledge, and expertise of their prevention workforce. These activities help support the delivery of effective prevention programs and practices and the development of accountability systems for performance measurement and management.

During FY 2012, the CAPT expects to deliver approximately 1,400 capacity-building technical assistance services to more than 7,000 people and orchestrate 400 events for 10,000 people. Topics include the use of evidence-based environmental strategies to reduce underage drinking, the application of behavioral health indicators for substance abuse prevention planning, the use of traditional and cultural practices as prevention strategies within indigenous populations, and the diffusion of state-of-the-art methods to guide intra-State training and technical assistance (T/TA) prevention systems. In addition, the CAPT will develop workforce development products, including skills training, fact sheets, and a web-based toolkit; and will provide evaluation capacity-building technical assistance to 53 community-based prevention programs and to 24 Science-to-Service programs. They also will plan and facilitate a program for special populations including Pacific Islanders and Tribal grantees. Finally, the CAPT will develop training and materials for SAMHSA special issues, including webinars on best practices, epidemiological data, evidence- programs, and evaluation techniques.

Performance data for the CAPT are captured using common measures with other technical assistance activities in the Science and Service Program Coordination category. Footnotes are used to identify measures that include CAPT performance data.

Science and Service Program Coordination

The Science and Service Program Coordination category primarily encompasses contracts that provide technical assistance and training to States, Tribes, communities, and grantees around substance abuse prevention. Included in the performance measurement section for this category is the Native American Center for Excellence (NACE), and the Underage Drinking Prevention Education Initiative (UADPEI).

The NACE supports behavioral health outreach activities to Tribal nations and organizations and assists them with applying for SAMHSA and other Federal agency grants. In addition, the NACE helps Tribes have a clear understanding of the need for coordinating prevention funding, establishing and implementing prevention policies and evidence-based programs, utilizing strategic planning, and developing the necessary infrastructure to prevent and reduce substance use. NACE has developed training and technical assistance to build learning communities of tribal members, content experts, and other stakeholders. NACE continues to build content expertise and knowledge dissemination in five prevention domains (youth, community, family, schools, and Tribal leaders/policy) through routine literature reviews, focused peer-to-peer discussion groups, and development of technical papers and abstracts. SAMHSA will continue these activities in FY 2012.

The UADPEI engages parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences. The UADPEI supports States and their communities by providing training to improve community organization and mobilization; build capacity to prevent and reduce underage drinking in the community; and increase sustainability of programs. Through this initiative, more than 50 million families, their children, and other youth-serving organizations have been reached through Town Hall Meetings, technical assistance, trainings, and a variety of tools and materials.

During FY 2010, NACE conducted a total of 49 training events and served over 1,000 individuals. Among activities funded through the UADPEI, over 200,000 individuals were reached through Town Hall Meetings, while over 900,000 individuals were reached through underage drinking prevention websites. Performance data show that, collectively, the CAPT and Science and Service Program Coordination have exceeded their targets around customer satisfaction, as well as the proportion of participants who report implementing recommendations. Although the programs appear to be providing technical assistance and/or prevention information directly to fewer individuals than anticipated, this result reflects efficiencies from the growing focus on train-the-trainer models rather than training of individuals. In addition, since the Town Hall Meetings under the UADPEI contract occur biannually, numbers served expand in the years the meetings occur and contract in alternate years. Targets for FY 2012 and beyond have been adjusted to better account for these factors.

Funding History

FY	Amount
2008/a	$ 81,543,000
2009/a	$ 80,917,000
2010/a	$ 80,733,000
2011/a	$ 75,956,000
2012/a	$ 76,202,000

a/ The funding history is based on a comparable basis to previous funding levels to reflect the revised budget restructure; the FY 2012 amount is the FY 2012 Enacted Level.

Substance Abuse Prevention Budget Request

The FY 2013 Budget Request is comprised of $65.9 million at program level with $58.9 million from Budget Authority and $7.0 million provided by ACA Prevention Funds. This is a $10.3 million decrease in Budget Authority, and includes a $7.0 million decrease in Budget Authority for the STOP Act. STOP Act funding is being requested from ACA Prevention Funds in FY 2013 in place of Budget Authority in FY 2012. This level of funding enables the continuation of most programmatic activities. The request will support 157 grant and 9 contract continuations, as well as 38 new grants and 5 new contracts.

The FY 2013 Budget Request includes level funding for the following:

- Minority AIDS Initiative request is $41.3 million, the same as the FY 2012 Enacted Level, which will support 78 continuation grants, 16 new grants, 2 continuation contracts and 1 new contract. This request will support a new cohort of grantees using recycled funds that will become available in FY 2013. While SAMHSA is requesting the same total amount for Minority AIDS programs in FY 2013 as in FY 2012, the Budget Request realigns resources within SAMHSA. CSAP, in collaboration with CMHS and CSAT, will support an integrated program to develop and expand culturally competent and effective behavioral health and primary care network in order to reduce the impact of behavioral health problems, HIV risk, and HIV-related health disparities.
- The STOP Act program request is $7.0 million in the ACA Prevention Fund. This reflects a $7.0 million decrease in Budget Authority due to additional STOP Act funding being requested from ACA Prevention Funds in FY 2013. This level of funding will support 78 continuation grants, 22 new grants, 1 continuation contract, and 1 new contract.
- The Minority Fellowship Program request is $0.1 million, the same as the FY 2012 Enacted Level. These funds will support 1 continuation grant.

The FY 2013 Budget Request includes decreases for the following (-$10.3 million):

- Mandatory Drug Testing request is $4.9 million, reduced by $0.3 million. These funds will support 3 continuation contracts and 2 new contracts.
- The FASD Center of Excellence program request is $1.0 million, reduced by $8.8 million, for technical support activities. These funds will continue to support prevention strategies, in partnership with other activities and mechanisms, to prevent alcohol use among women of childbearing age, but will not fund new grants.
- The CAPT program request is $7.5 million, reduced by $0.5 million. These funds will enable provisional continuation of technical assistance to the field in support of delivery of effective prevention programs and practices.
- Science and Services Program Coordination request is $4.1 million, reduced by $0.7 million. In FY 2013, SAMHSA is considering aligning the AI/AN Suicide Prevention activities with the CSAP efforts in the NACE contract to respond to Tribes' request for more simplified assistance and for a more holistic approach to Tribal prevention efforts.

A detailed table for all grant and contract continuations and new activities can be found on page 233.

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

(Dollars in Thousands)

Programs of Regional & National Significance	FY 2011 Actual Number	FY 2011 Actual Amount	FY 2012 Enacted Number	FY 2012 Enacted Amount	FY 2013 President's Budget Number	FY 2013 President's Budget Amount
Grants:						
Continuations	222	$43,545	156	$40,744	157	$25,019
New/Competing	11	1,112	78	3,887	38	17,760
Subtotal	**233**	**44,657**	**234**	**44,631**	**195**	**42,779**
Contracts:						
Continuation	14	28,216	22	21,408	9	10,809
New	3	3,083	1	10,163	5	12,289
Subtotal	**17**	**31,299**	**23**	**31,571**	**14**	**23,098**
Total, CSAP PRNS/1	**250**	**$75,956**	**257**	**$76,202**	**209**	**$65,877**

1/The FY 2013 President's Budget request number and amount totals for CSAP PRNS grants and contracts include $7.0 million for the STOP Act program, which is funded by the ACA Prevention Fund.

Outcomes and Outputs

Program: Minority AIDS Initiative[1]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
2.3.56 Number of program participants exposed to substance abuse prevention education services (Output)	FY 2010: 4,552 Target: 2,327 (Target Exceeded)	1,535	5,734[2]	3,891[3]	-1,843
2.3.82 Percent of program participants that rate the risk of harm from substance abuse as great (all ages) (Outcome)	FY 2010: 86.9 %[4] Target: 86.9 % (Baseline)	88%	88%	88%	Maintain
2.3.83 Percent of program participants who report no use of alcohol at pre-test who remain non-users at post-test (all ages) (Outcome)	FY 2010: 91.2 % Target: 91.2 % (Target Met)	91.2%	91.2 %	91.2 %	Maintain
2.3.84 Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (all ages) (Outcome)	FY 2010: 93.8 % Target: 92.6 % (Target Exceeded)	92.6%	92.6 %	92.6 %	Maintain

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

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

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

[4] Actual has been revised from previously reported in FY13 HHS–J.

Program: Sober Truth on Preventing Underage Drinking (STOP Act)[5]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.3.01 Increase the percentage of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades (Outcome)	FY 2010: 67.3% Target: 41% (Target Exceeded)	46.7%	40%[6]	40%[7]	Maintain
3.3.02 Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades (Outcome)	FY 2010: 45.5% Target: 63.4% (Target Not Met)	63.4%	60.9%[8]	60.9%[9]	Maintain
3.3.03 Percentage of coalitions that report improvement in youth perception of parental disapproval on the use of alcohol in at least two grades (Outcome)	FY 2010: 48.8% Target: 56.7% (Target Not Met but Improved)	56.7%	54.5%[10]	54.5%[11]	Maintain

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

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

[7] Target reflects close–out of Cohort II and the start up of future cohorts.

[8] Target has been changed from previously reported. Target has been decreased due to cohort effect. This target now reflects the close–out of Cohort I and start of Cohort III.

[9] Target reflects close–out of Chort II and start up of future cohorts.

[10] Target has been changed from previously reported. Target has been decreased due to cohort effect. Now, the target reflects close–out of Cohort I and start of Cohort III.

[11] Target reflects the close–out of Cohort II and the start up of future cohorts.

Program: Prevention - Science and Service Activities[12]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
2.3.71 Number of people provided technical assistance (TA) services (Output)[13]	FY 2010: 22,568 Target: 21,117 (Target Exceeded)	13,143	13,143	Retiring Measure	N/A
2.3.74 Percentage of TA recipients who reported that the TA recommendations have been fully implemented (Outcome)[14]	FY 2010: 57.4% Target: 54% (Target Exceeded)	60.2%	60.2%	Retiring Measure	N/A
2.3.75 Number of persons receiving prevention information directly (Output)[15]	FY 2010: 205,289 Target: 120,223 (Target Exceeded)	73,768	368[16]	Retiring Measure	N/A
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2010: 51,415[17] Target: N/A (Historical Actual)	37,896	37,049	31,473	-5,576
2.3.36 Percent of participants that	N/A	N/A	N/A	Baseline December	N/A

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

[13] Updated to include CAPT, NACE, Fetal Alcohol Spectrum Disorders (FASD) Center of Excellence, MEI and Prevention Fellowships

[14] Includes only CAPT.

[15] Includes THM and FASD Center of Excellence. Town Hall Meetings occur in even-numbered years.

[16] Again, the Town Hall Meetings are conducted only in even–numbered years, so the targets in odd–numbered years reflect only the direct TA activities of FASD Center of Excellence.

[17] All component programs have now reported; therefore, data are revised from previously reported.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
agree or strongly agree that the training or TA provided increased their capacity to do prevention work (Outcome)	---	---	---	2014	---
2.3.37 Percent of participants that agree or strongly agree that the training or TA provided increased their organization's capacity to do prevention work (Outcome)	N/A	N/A	N/A	Baseline December 2014	N/A

Grant Award Table

(whole dollars)	FY 2011	FY 2012	FY 2013
Number of Awards	225	222	200
Average Award	$197,427	$197,833	$174,355
Range of Awards	$25,000-$500,000	$25,000-$500,000	$25,000-$500,000

Substance Abuse – State Prevention Grants

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Substance Abuse - State Prevention Grants	$451,107	$453,980	$404,501	-$49,479
Strategic Prevention Framework (non-add)	110,417	109,754	60,275	-49,479

Authorizing Legislation	Section 516 of the PHS Act
FY 2013 Authorization	N/A
Allocation Method	Discretionary Grants

Substance Abuse Prevention at a National Scale

The new Substance Abuse – State Prevention Grant program will bring the success realized in SAMHSA's discretionary grant programs and evidence-based programs described in the IOM report to a broader scale. The SA-SPGs draw upon the strengths of both Block Grant and discretionary approaches. Through the funding realigned from the 20 percent prevention set-aside of the current formula-based Substance Abuse Prevention and Treatment Block Grant (SABG) program, SAMHSA will ensure funding availability and decision-making authority for prevention at the State level. The SA-SPG program will build on the success of the planning approach promoted through the SPF-SIG, bringing it to scale nationwide and shepherding successes into the next step of development

Program Description and Accomplishments

The 2009 Institute of Medicine report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People,* defined "public health" as what society must do to keep people healthy and further defined it as involving the collection of data, assessment of problems, and assurance of health protection. Established in 2004, the Strategic Prevention Framework embodies this public health approach and provides grantees with a targeted framework to implement a comprehensive approach to substance abuse prevention in communities across our Nation.

Strategic Prevention Framework State Incentive Grants (SPF SIG)

Through the Strategic Prevention Framework (SPF), SAMHSA provides vital resources to States, Federally recognized Tribes and U.S. Territories to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; reduce substance abuse-related problems; and build prevention capacity and infrastructure at the State, Tribal, Territorial and Community levels. The unique aspect of the SPF program is that it requires grantees to follow a five-step framework to select, implement, and evaluate prevention efforts. Specifically, SPF grantees conduct a community needs assessment; mobilize and/or build capacity to implement prevention efforts; develop a comprehensive strategic plan; implement

evidence-based prevention programs and infrastructure development activities; and monitor implementation and evaluate outcomes. These series of implementation principles can be operationalized at the Federal, State and community levels. The grants use the SPF five-step strategic planning process to achieve their goals. By the end of FY 2011, a total of 49 states, Washington, D.C., 8 territories, and 19 Native American Tribes and tribal organizations have received this award. In FY 2012, SAMHSA will continue to support these efforts by awarding 35 continuation grants.

Performance Analysis

Performance data has shown a number of significant accomplishments for the SPF SIG program. For example, at the state-level, grantees of the SPF SIG program have been able to meet or exceed targets related to decreasing past 30-day alcohol use among minors and adults for three consecutive years. In addition, performance data have also shown that 28 percent of grantees showed improvement in levels of perceived risk of harm from substance use among adults; 54 percent showed improvement in rates of peer disapproval; and roughly half the grantees demonstrated improvement in rates of past 30-day illicit drug use (excluding marijuana) among youth and adults. At the community-level, data have shown that over 50 percent of funded communities with outcome data showed reductions in underage alcohol use, binge drinking, and DUI-related arrests.

Available performance data have also shown areas of opportunity within the SPF SIG program. Through its technical assistance capacity SAMHSA continues to actively work with States, Tribes, and their sub-recipients to maintain the program's significant accomplishments while also improving performance in areas where targets were not met.

Partnerships for Success (PFS)

In FY 2009, SAMHSA initiated a new five-year grant program under the Strategic Prevention Framework that builds on the success of the SPF-SIG program. In FY 2009, 4 grants were awarded, and in FY 2010, one additional award was made. The Partnerships for Success program is designed to provide eligible States, Tribes and U.S. Territories with grants to achieve a quantifiable decline in State-wide substance use disorders rates and incorporates an incentive award to grantees that have reached or exceeded their prevention performance targets. Eligible applicants are the immediate Office of the Chief Executive (e.g., Governor) in those States and U.S. Territories that have previously received a cohort one or cohort two SPF-SIG from SAMHSA. Applicants were strongly encouraged to leverage and coordinate other Federal and State-generated funding to ensure sufficient impact to meet their performance targets. Grantees have demonstrated that their State has the infrastructure and capacity to reduce substance abuse problems in a three-year period. In FY 2012, SAMHSA will continue to support these efforts by awarding 5 continuation grants.

Performance Analysis

To date, available data shows that grantees of the PFS program have funded a total of 55 sub recipient communities. Given that performance measures for this program focus on determining improvement in a number of areas (such as leveraging of funds), these data will not be available until later in FY 2012 as two data points are needed to determine baseline improvement rates.

State Prevention Enhancement Grants (SPE)

In FY 2011, SAMHSA designed the State Prevention Enhancement (SPE) grant program to strengthen and extend SAMHSA's national implementation of the Strategic Prevention Framework (SPF) in order to bring the SPF to scale and support communities of high need nationwide. These one-year grants required Single State Agency Directors and Tribal leaders to assess their current prevention infrastructure, identify gaps and develop a long-term, data-driven plan to restructure, enhance, and further strengthen their State and Tribal systems to better meet the needs of their communities. Grantees were required to ensure that their SPE projects were closely aligned with the four goals listed in SAMHSA Initiative #1: Prevention of Substance Abuse and Mental Illness. In FY 2011, 46 grants were awarded for a total of $22.5 million. Eligible applicants were States, Territories, the District of Columbia, and Federally-recognized American Indian/Alaska Native Tribes or Tribal organizations. In FY 2012, this one-year program came to a natural end.

Prevention Achievement Grants (PAG)

In FY 2012, SAMHSA plans to institute the $31.0 million Prevention Achievement Grants (PAG) program, which is intended to bring the successful SPF SIG program to scale, build on States' prevention systems and plans, and support community level substance abuse prevention programming to address national needs. It is expected that the PAG will fund SAPT Block Grant recipients to support data-driven, evidence-based prevention programming at the community level to prevent underage drinking, prescription drug misuse and abuse, and other illicit drug use among youth as demonstrated by state and community needs. Grantees will be required to use at least 85 percent of PAG funds, and any other leveraged resources, such as Block Grant funds, to fund and support communities that demonstrate a need for prevention programming in these areas—thereby creating a direct alignment between priorities at the Federal, State, and Community levels.

Funding History

FY	Amount
2008	$0
2009	$0
2010	$0
2011	$451,107,000
2012/a	$453,980,000

a/ The FY 2012 amount is the FY 2012 Enacted Level.

Substance Abuse Prevention Budget Request

The FY 2013 Budget request is $404.5 million, a $49.5 million decrease from the comparable FY 2012 Enacted Level. The amount includes funding from the 20 percent prevention set-aside requirement of the SABG, and fully funding the $60.3 million of FY 2013 continuation grants under the current Strategic Prevention Framework program. The final allocation for the Substance Abuse – State Prevention Grant will be determined by a formula that will be developed after discussion with State and Territory representatives and based on amounts appropriated by Congress.

In 2004, Congress provided funding to implement the Strategic Prevention Framework (SPF), a comprehensive public health approach that provides grantees with a targeted methodology to implement substance abuse prevention in communities across our Nation. The FY 2013 President's Budget proposes the Substance Abuse – State Prevention Grant (SA-SPG), a new grant program building on the construct of the SPF and focusing exclusively on preventing substance abuse. The SA-SPG program represents a significant advance in the Nation's approach to prevention in several ways.

The SA-SPG program will provide funding for all interested States, Territories, and the District of Columbia in order to:

- Use a comprehensive, data-driven planning process to identify and address problems in communities.
- Create a sustainable and predictable source of prevention funding that will focus on high risk communities and youth.
- Move the Strategic Prevention Framework State Incentive Grant (SPF-SIG) approach to scale across the Nation.
- Hold States and the Territories accountable for achieving measurable outcomes for their residents.

Background

The 2009 IOM report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People* provides evidence that a set of risk and protective factors affects the development of substance use and mental disorders in youth. For example, children with strong coping skills who live in safe, stable families and communities tend to abuse substances and develop certain mental illnesses less often than those who have not had these advantages. Evidence also demonstrates that community risk and protective factors, such as poverty, violence, gangs, etc. can have a negative impact on the healthy development of young people in neighborhoods. Community norms, values, and beliefs are powerful factors in fostering positive community and youth development. Collectively, improvements in these areas can prevent/reduce the impact of substance abuse on America's communities.

Moving Substance Abuse Prevention to a National Scale

The new Substance Abuse – State Prevention Grant program will bring the success realized in SAMHSA's discretionary grant programs and evidence-based programs described in the IOM report to a broader scale. The SA-SPGs draw upon the strengths of both Block Grant and discretionary approaches. First, through the funding realigned from the 20 percent prevention set-aside of the current formula-based Substance Abuse Prevention and Treatment Block Grant (SABG) program, SAMHSA will ensure funding availability and decision-making authority for prevention at the State level, as these funds have been expended historically. At the same time, SAMHSA has guided the development of data-driven, needs-based, evidence-proven methods for facilitating substance abuse prevention through its discretionary programs, including the SPF-SIG and the Partnerships for Success. The new SA-SPG program integrates key aspects of both approaches in a systematic and logical approach designed to avoid duplication, improve coordination, increase accountability, prioritize high-need communities, and focus exclusively on substance abuse prevention, and it will require States and Territories to support and fund communities in achieving outcomes, thereby helping to address that part of SAMHSA's mission that aims to reduce impact of substance abuse on America's communities. The SA-SPG program will build on the success of the planning approach promoted through the SPF-SIG, bringing it to scale nationwide and shepherding successes into the next step of development.

The SA-SPG will provide formula-based prevention funding to ensure that every State and Territory is able to make prevention of substance abuse a priority. The SA-SPG will allow States and Territories to address substance abuse prevention at three levels: universal prevention, which addresses populations at large; selected prevention, which targets subgroups of the population that share common risks of developing substance use disorders (such as children with a family history of substance abuse or schools in high poverty areas); and indicated prevention, which addresses individuals with multiple risk factors, early symptoms, or behaviors that are precursors for substance abuse, but who do not require treatment for substance abuse. States/Territories and communities will be able to utilize environmental and individual prevention approaches – as well as approaches to change the culture and community beliefs about substance use, including alcohol and/or tobacco – in order to achieve measurable results. This new program supports SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, which aims to support individuals, families, schools, workplaces,

communities and States and Territories take action to strengthen protective factors and reduce risk factors for substance abuse (including tobacco) and to create environmental changes that support community living without the use of substances of abuse.

Structure and Required Activities:

The SA-SPG program will consist of formula-based discretionary grants available to all States and Territories. States and Territories will continue to be eligible for these funds beyond the initial award so long as they meet the requirements of renewal applications, provide the necessary annual reports, and show continued movement toward implementing their approved plans.

Each State and Territory will be required to develop a data-driven strategic plan based on national, State/Territory, and local epidemiological data sources. The plan, which must be approved by SAMHSA, must utilize proven Strategic Prevention Framework (SPF) processes that reflects the results of an assessment of need, a review of the resources and capacity within the State or Territory and in local communities, a plan for carrying out the strategy, monitoring the strategy as it is implemented, and an evaluation to identify strengths and weaknesses. It must address, at a minimum: substance abuse, underage drinking (including adults' providing alcohol to minors) and binge drinking; prescription drug misuse and abuse; and tobacco use; and it should provide for coordinated services for children, youth, and young adults from birth through age 25 (including working with schools). While the focus will be on youth, additional age groups, conditions, and services may be addressed if supported by the State or Territory needs assessment.

States and Territories will be required to allocate a minimum of 80 percent of the funds to local communities to organize and carry out the prevention activities identified in the State plan while addressing the particular needs of high risk communities. Each community selected for funding will be responsible for aligning its programming with the plan. In carrying out these activities, the State or Territory, and communities receiving these funds will be required to establish a comprehensive community plan that utilizes evidence-based and/or proven successful programs, policies or practices. In addition, separate funding directly to communities will continue to be available through STOP Act grants and through grants to Drug Free Community (DFC) coalitions through funds appropriated to the White House Office of National Drug Control Policy (ONDCP) and administered by SAMHSA.

States and Territories will be allowed to retain up to 15 percent of the funds for State-level activities to achieve positive outcomes, including the operation of a State or Territory prevention advisory group, epidemiological work group, training and technical assistance to communities, data collection and evaluation, development and dissemination of State or Territory-wide messages and resources, and oversight and monitoring of funded communities. States and Territories will be able to use funds for coordinated workforce development, training in evidence-based practices, and the development of coordinated infrastructure and service delivery systems in high need communities. Up to an additional five percent of the grant funds may be used for administrative costs.

Other Considerations:

Using the CSAP discretionary authority, the new SA-SPG can increase accountability for Federal funds. It will require States and Territories to monitor and report on specific program outcomes; while continuing to allow States and Territories to use SABG funds for additional prevention services should they so choose and plan to do so.

The SA–SPG maintains funding to continue the activities under the remaining Strategic Prevention Framework State Incentive Grants (SPF-SIG) and Partnerships for Success (PFS) grants at the FY 2010 level. As these grants reach their natural conclusion, the funds that supported them will be added to the SA-SPG and distributed to all interested States and Territories by a formula. All current SPF-SIG and PFS grants will end by FY 2015.

Outcomes and Outputs

Strategic Prevention Framework (SPF) State Incentive Grants

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
2.3.21 Decrease underage drinking as measured by an increase in the percent of SPF SIG states that show a decrease in 30-day use of alcohol for individuals 12 – 20 years old (Outcome)	FY 2010: 56% Target: 50.4% (Target Exceeded)	55.9%	50%	50%	Maintain
2.3.23 Percent of SPF SIG states showing a decrease in state level estimates of survey respondents (age 12-17) who report 30-day use of other	FY 2010: 48% Target: 59.8% (Target Not Met)	67.6%	52%	52%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result /(Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
illicit drugs (Outcome)					
2.3.25 Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who rate the risk of substance abuse as moderate or great (Outcome)	FY 2010: 18% Target:78.7% (Target Not Met)	50%	50%	50%	Maintain
2.3.28 Number of evidence-based policies, practices, and strategies implemented (Output)	FY 2010: 2,161 Target:234 (Target Exceeded)	274	250[18]	250	Maintain

Partnerships for Success

Measure	Year and Most Recent Result / Target for Recent Result /(Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)

[18] Target decreased due to cohort effect. Reflects close–out of Cohort III and IV.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
2.3.78 Number of communities who report an increase in prevention activities that are supported by collaboration and leveraging of funding streams (Output)	N/A[19]	75	50[20]	50	Maintain
2.3.79 Number of EBPs implemented by sub-recipient communities (Output)	FY 2010: 946 Target: 946 (Baseline)	300	950	950	Maintain
2.3.80 Number of sub-recipient communities that improved on one or more targeted NOMs indicators (Outcome)	N/A[21]	30	50[22]	50[23]	Maintain

[19] Baseline for this measure has been changed from FY 2010 TO FY 2011 so that two years of reporting can be compared to show if there has been an increase in prevention activities.

[20] Target has been revised from previously reported. Target was decreased from previous fiscal year to reflect the funding status of this program (i.e. continuation only).

[21] Baseline for this measure has been changed from FY 2010 to FY 2011 so that two years of reporting can be compared to show if there has been an improvement in one or more of the NOMs indicators.

[22] Target has been revised from previously reported.

[23] Target has been revised from previously reported.

Substance Abuse-State Prevention Grants

Measure	Year and Most Recent Result/ Target for Most Recent Result/(Summary of Results)	FY 2011 Actual/ Associated Target/ (FY 2012)	FY 2012 Enacted/ Associated Target/ (FY 2013)	FY 2013 PB/ Associated Target/ (FY 2014)	FY 2013 PB/ Associated Target/ (FY 2014) +/- FY 2012 Enacted/ Associated Target/ (FY 2013)
2.3.85 Number of persons served (Output)	N/A	N/A	N/A	TBD	N/A
2.3.90 Increase the percentage of grantees that report a decrease in the number of youth ages 12-20 who reported drinking alcohol in the past 30 days (HHS Strategic Plan Measure) (Outcome)	N/A	N/A	N/A	TBD	N/A
2.3.97 Percent of grantees that report a decrease in the number of youth ages 12-25 who reported nonmedical use of prescription-type drugs in the past 30 days (Outcome)	N/A	N/A	N/A	TBD	N/A

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SAMHSA Substance Abuse Treatment Summary of Changes

(Dollars in thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Substance Abuse Treatment Programs of Regional and National Significance	$431,389	$425,243	$364,139	-$61,104
ACA Prevention Fund (non-add)	25,000	25,000	30,000	+5,000
PHS Evaluation Funds	2,000	2,000	---	-2,000
Substance Abuse Block Grant	1,441,962	1,456,106	1,448,630	-7,476
PHS Evaluation Funds (non-add)	79,200	79,200	71,724	-7,476
Total, Substance Abuse Treatment	**$1,873,351**	**$1,881,349**	**$1,812,769**	**-$68,580**

[1] In 2012, SAMHSA will continue to in source positions for activities that are central to SAMHSA's mission, represent critical skills for the agency, and result in overall savings consistent with Office of Federal Procurement Policy guidelines. A total of 98 positions will be added and fully staffed by the end of FY 2012. These positions are allocated across SAMHSA's four appropriations to reflect the provision of direct program support or to reflect the proration of overhead and indirect costs. An additional 13 positions have been added to provide support to the ten HHS regions. These positions are allocated across three appropriations to reflect the provision of technical assistance to the states as well as linking SAMHSA with its sister operating divisions in the regions. The additional positions are fiscally neutral.

The FY 2013 President's Budget Request for the Substance Abuse Treatment appropriation is $1.8 billion, a decrease of $68.6 million from the FY 2012 Enacted Level. This FY 2013 Total Program Level budget request of $1.8 billion includes $1.7 billion in Budget Authority (a decrease of $64.1 million from FY 2012), $71.7 million in PHS Evaluation funds (a decrease of $9.5 million from FY 2012), and $30.0 million in ACA Prevention Funds (an increase of $5.0 million from FY 2012). The request includes $364.1 million for Programs of Regional and National Significance, a decrease of $59.1 million from the FY 2012 Enacted Level. The request also includes $1.4 billion for the Substance Abuse Block Grant. This includes $1.4 billion in Budget Authority and $71.7 million in PHS Evaluation Funds. This is a decrease of $7.5 million in PHS Evaluation Funds from FY 2012.

The FY 2013 Budget Request for Substance Abuse Treatment includes the following

decreases: Screening, Brief Intervention and Referral to Treatment: (-$23.2 million)
The FY 2013 request for Screening, Brief Intervention and Referral to Treatment is $30.0 million, all funded from the Prevention and Public Health Fund of the ACA. This reflects a decrease of $23.2 million in Budget Authority from the FY 2012 Enacted level, partially offset by the $5.0million increase in ACA Prevention Funds. While the overall funding for this program is reduced in FY 2013, it will allow for the continuation of all grant programs and the funding of several new cohorts of grants enabling the program to continue to serve individuals at the same levels as in past years. These services will be brought to scale by the SAPT block grant moving forward.

Targeted Capacity Expansion – General: (-$14.7 million)

The FY 2013 request for Targeted Capacity Expansion – General is $13.3 million. This is a decrease of $14.7 million from the FY 2012 Enacted Level. While the overall funding for this program is reduced in FY 2013, it will allow for the continuation of all grant programs enabling the program to continue to serve individuals and provide much needed services. These services will be brought to scale by the SAPT block grant moving forward.

Access to Recovery: (-$4.5 million)

The FY 2013 request for Access to Recovery is $93.8 million. This is a decrease of $4.5 million from the FY 2012 Enacted level. While the overall funding for this program is reduced in FY 2013, it will allow for the continuation of all grant programs enabling the program to continue to serve individuals and provide much needed services. These services will be brought to scale by the SAPT block grant moving forward.

Minority AIDS: (-$13.5 million)

The FY 2013 request for Minority AIDS is $52.4 million. This is a decrease of $13.5 million and offset by the increase of $13.5 million in Mental Health Minority AIDS. While SAMHSA is requesting the same total amount for Minority AIDS programs in FY 2013 compared FY 2012, the Budget Request realigns resources within SAMHSA to enhance the capacity to collaborate on HIV/AIDS prevention and treatment efforts across HHS. CSAT, in collaboration with CMHS and CSAP, will support an integrated program to develop and expand culturally competent and effective behavioral health and primary care network in order to reduce the impact of behavioral health problems, HIV risk, and HIV-related health disparities.

Substance Abuse Block Grant: (-$7.5 million)

The FY 2013 request for the Substance Abuse Block Grant is $1.5 billion. This is a decrease of $7.5 million in PHS Funding from the FY 2012 Enacted Level.

SAMHSA/Programs of Regional and National Significance
Substance Abuse Treatment

(Dollars in Thousands)

Programs of Regional & National Significance	FY 2011 Actual	FY 2012 Enacted	FY 2013 President Budget	FY 2013 +/- FY 2012
CAPACITY:				
Co-occurring State Incentive Grants (SIGs)	$4,173	$---	$---	$---
Opioid Treatment Programs/Regulatory Activities	8,553	8,886	8,886	---
Screening, Brief Intervention and Referral to Treatment	53,662	53,187	30,000	-23,187
a/ACA Prevention Fund (non-add)	25,000	25,000	30,000	+5,000
TCE-General	28,033	27,980	13,256	-14,724
Pregnant & Postpartum Women	15,878	15,970	15,970	---
Strengthening Treatment Access and Retention	1,775	1,672	1,000	-672
Recovery Community Services Program	5,236	2,445	2,445	---
Access to Recovery	98,954	98,268	93,776	-4,492
Children and Family	30,670	30,620	29,678	-942
Treatment System for Homeless	41,650	41,571	41,571	---
Minority AIDS	65,988	65,863	52,359	-13,504
Criminal Justice Activities	65,188	66,903	65,135	-1,768
Sub Total, Capacity	**419,760**	**413,365**	**354,076**	**-59,289**
SCIENCE AND SERVICE:				
Addition Technology Transfer Centers	9,081	9,064	8,081	-983
Minority Fellowship Program	547	546	546	---
Special Initiative/Outreach	2,000	2,267	1,436	-831
Sub Total, Science and Service	**11,628**	**11,877**	**10,063**	**-1,814**
TOTAL, PRNS	**$431,389**	**$425,243**	**$364,139**	**-$61,104**

a/ Includes $25.0 million in ACA Prevention Funds in FY11 and FY12 and $30.0 million in ACA Prevention Funds in FY13.

Authorizing Legislation	Section 506, 508, 509, 514 of the PHS Act
FY 2013 Authorization	Expired
Allocation Method	Competitive Grants/Cooperative Agreements/Contracts

Program Description and Accomplishments

Opioid Drug Treatment/Regulatory Activities

SAMHSA/CSAT funds a number of contracts that support its regulatory efforts and monitoring activities of opioid treatment programs. In FY 2012, SAMHSA will fund the continuation of 2 grants and 12 contracts. The contracts include:

SAMHSA certifies Opioid Treatment Programs (OTPs) that use Methadone, Subutex, or Suboxone to treat patients with opioid dependence. SAMHSA carries out this responsibility by enforcing the regulations that established the accreditation-based system, and it is accomplished in coordination with the Drug Enforcement Administration (DEA), States, Territories, and the District of Columbia. An OTP must comply with applicable State licensing requirements to operate as an OTP and must meet regulatory requirements set forth in Title 42 Code of Federal Regulations Part 8 (42 CFR Part 8). Within the regulations there is also a requirement for each OTP to achieve formal accreditation by a SAMHSA/CSAT recognized accreditation body.

SAMHSA will also continue supporting the Physician Clinical Support System-Methadone, a national mentoring network offering support (clinical updates, evidence-based outcomes, and training) to physicians and other medical professionals in the appropriate use of methadone for the treatment of chronic pain and opioid addiction. This program also addresses the nation's rise in methadone-associated deaths that has been spurred by misuse/abuse, and fatal drug interactions involving methadone and other prescription medications, over the counter medications, and illicit drugs

SAMHSA will also continue funding the Physician Clinical Support System-Buprenorphine, a program designed to assist practicing physicians that wish to incorporate into their practices the treatment of prescription opioid and heroin dependent patients using the medication buprenorphine. The goal of this program is to expand access to office-based buprenorphine treatment by first providing expert education and training to physicians on the appropriate use of buprenorphine, and certify their eligibility to treat opioid dependent patients.

SAMHSA will also continue funding the Opioid Treatment Technical Assistance Program (OTTAP), of which the primary objective is to educate and prepare OTPs to achieve accreditation by SAMHSA's approved accreditation bodies. Accreditation has been shown to improve treatment and access to treatment for patients and provides the opportunity for OTPs to incorporate best practices in their treatment programs. Other goals include improving OTP administration and management, increasing staff retention, providing more OTP staff training, increasing availability of comprehensive services and emergency services, and improving patient outcomes. Even though most OTPs have been able to achieve initial accreditation (approximately 97 percent of over 1,160 active OTPs are accredited), continuing technical assistance is considered necessary to assist OTPs in maintaining accreditation, as they are subject to re-survey, occurring at least triennially.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Screening, Brief Intervention and Referral to Treatment (SBIRT) was initiated in SAMHSA/CSAT in FY 2003, using cooperative agreements to expand and enhance the State or Tribal organization's continuum of care. The purpose of the program is to integrate screening, brief intervention, referral, and treatment services within general medical and primary care settings. According to SAMHSA's National Survey on Drug Use and Health (NSDUH), in 2009 approximately 21 million people who needed treatment for a substance use disorder did not receive it. Of those people, 95 percent did not feel they needed treatment. Therefore, most people with or at risk for a substance use disorder are unlikely to seek help from the specialty treatment system.

The SBIRT cooperative agreements require grant recipients to effect practice change throughout the spectrum of medical practice. This is achieved through implementation of SBIRT programs in all levels of primary care, including hospitals, trauma centers, health clinics, nursing home, employee assistance programs, and school systems. Practice change is also envisioned as altering the educational structure of medical schools by developing and implementing SBIRT curriculum as standard and permanent practice.

Substance abuse is one of our Nation's most significant public health challenges, and the SBIRT approach can intervene early in the disease process before individuals achieve dependency, and can motivate the addicted client to engage in substance abuse treatment. Research and clinical experience supports the use of the SBIRT approach to provide effective early identification and interventions in primary care and general medical settings. Early identification can decrease total healthcare costs by arresting progression toward addiction. SBIRT also can identify persons with more serious problems and encourage them to obtain appropriate specialty treatment services.

Since the beginning of this program, more than 1.4 million individuals have been screened. Of those, 19 percent required a brief intervention, brief treatment, or referral to specialty treatment programs. In 2008, in an effort to incorporate SBIRT into general health care practice, 11 grants were awarded to embed SBIRT training and practice in medical residency programs. In 2009, an additional six grants were awarded, increasing the number of medical residency programs to 17. In FY 2010, SAMHSA/CSAT supported continuation of eight State SBIRT grants and seventeen Medical Residency SBIRT Training grants. In 2011, over 213,000 clients were served by the SBIRT Program. The percentage of clients reporting abstinence at follow-up tripled compared to the percentage reporting abstinence at baseline.

SBIRT has great future potential for promoting changes to the entire primary care medical service delivery system. In FY 2012, SAMHSA will continue to diversify settings in which the SBIRT program would be expected to make an impact on health outcomes to include dentistry, pediatrics and adolescent care organizations, community health and mental health agencies, and other locations where primary care services are offered. As funding for new grants is reduced, efforts are underway to identify other funding streams to take this practice to scale. For example, new diagnostic codes have been adopted by 16 U.S. States, making it easier for doctors to get reimbursed for screening Medicaid patients. Likewise, alcohol screening is now available to

Medicare beneficiaries as a preventive service without cost. In FY 2012, SAMHSA will fund the continuation of 27 SBIRT grants and two contracts as well as three new multi-year grants funded out of the ACA Prevention Fund and will continue to monitor the progress of the three FY 2011 multi-year ACA Prevention Fund grants.

Targeted Capacity Expansion-General (TCE-General)

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

In FY 2011, SAHMSA funded Grants to Expand Care Coordination through the Use of Health Information Technology (HIT) in Targeted Areas of Need. The purpose of this program is to leverage technology to enhance and/or expand the capacity of substance abuse treatment providers to serve persons in treatment who have been underserved because of lack of access to treatment in their immediate community due to transportation concerns, an inadequate number of substance abuse treatment providers in their community, and/or financial constraints. The use of HIT, including web-based services, smart phones, and behavioral health electronic applications (e-apps), and Telehealth will expand and/or enhance the ability of providers to effectively communicate with persons in treatment and to track and manage their health to ensure treatment and services are available where and when needed. Grantees will use technology that will support recovery and resiliency efforts and promote wellness. In FY 2012, SAMHSA will fund the continuation of 46 grants and 6 contracts as well as up to 3 new multi-year funded Health IT grants.

Pregnant & Postpartum Women (PPW)

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

The national treatment infrastructure has not kept pace with the demand or complexity of needs experienced by this population, such as access to primary health care, mental health care, social and recovery support services. Services are also often lacking for their minor children impacted by the perinatal and environmental effects of maternal substance use and abuse. SAMHSA/CSAT's Pregnant and Postpartum Women (PPW) program has supported gender and

culturally specific treatment service grants for pregnant, postpartum, and other parenting women. Using a family-centered trauma informed treatment approach in residential and community settings, with women and their minor children at the center, the program has focused on the strengths and resources of the entire family, supporting sustained recovery for individual family members, coordinating with services in the community, and improving overall family functioning. In FY 2011, the PPW program funded a new cohort of grantees and in FY 2012 another cohort of grantees will be funded. Data shows that the percentage of women reporting abstinence at six month follow-up doubled compared to those reporting abstinence at intake. Employment also showed large increases with the percentage tripling from intake to follow-up. In FY 2012, SAMHSA will fund the continuation of 20 grants and 1 contract as well as up to 6 new grants.

Strengthening Treatment Access & Retention (STAR)

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

Based on the NIATx program success, CSAT funded a follow-on effort in 2006, the STAR – State Implementation (STAR-SI) program, an infrastructure initiative that promotes State-level implementation of process improvement methods to improve access to and retention in outpatient treatment. Under STAR-SI, program grantees have: (1) used process improvement methods to improve both State and treatment agency level organizational processes that impact client access to and retention in outpatient substance abuse treatment services; (2) developed provider and payer capacity to implement process improvement methods through the operation of peer-to-peer learning networks; (3) partnered with outpatient treatment providers, including, when applicable, the State treatment provider association and key fiscal intermediaries, in program design and implementation; and (4) implemented performance management systems to track progress and provide feedback to participating treatment providers on performance outcomes.

In FY 2010 and FY 2011, STAR initiative provided technical assistance and support to six SAMHSA/CSAT discretionary grant programs and over 50 treatment organizations to improve client access, retention and handoffs to other levels of care. STAR also conducted a learning collaborative with over 300 treatment providers on how to improve third party billing practices

in anticipation of the transition to increasing Medicaid clients under health care reform. In FY 2011, STAR initiative participated in the National Quality Improvement SAAS Conference and NIATx Leadership. In FY 2012, SAMHSA will fund the continuation of 1 contract to continue to provide technical assistance to the field.

Recovery Community Services Program (RCSP)

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

The RCSP program has targeted a variety of underserved groups including women; gay, lesbian, and transgender populations; African-American; Latino; rural populations; persons recently released from incarceration; the homeless; and adolescents. In addition, the RCSP program serves family members and allies of individuals in recovery. The primary targets for the RCSP initiative are people with a history of alcohol and/or drug problems who are in or are seeking recovery. RCSP grants provide a wide range of services such as peer coaching, peer support groups, life skills workshops, peer-led resource connector programs for housing, employment, educational assistance, vocational rehabilitation and training, leadership development, alcohol and drug free events, and recovery drop-in centers. In FY 2011 the RCSP program provided funding to new grantees; 80 percent of clients served reporting being abstinent at follow-up; 35 percent reported being employed; 57 percent reported being housed and 99 percent reported not being involved in the CJ system. In FY 2012, SAMHSA will fund the continuation of 6 grants and 1 contract.

Access to Recovery (ATR)

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

Since 2004, ATR has funded a total of 69 grants in a total of 3 cohorts: 15 three-year grants were awarded in FY 2004, 24 three-year grants were awarded in FY 2007, and 30 four-year grants were awarded in FY 2010. ATR is designed to: (1) allow recovery to be pursued through

personal choice and many pathways; (2) require grantees to manage performance based outcomes that demonstrate client successes; and, (3) expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services. The recommended target is 225,000 clients for this third cohort, which began in FY 2010, with approximately 33,500 to be served in the first year, 70,750 clients to be served in the two subsequent years, and 50,000 to be served in the final year. In its first year of operation, this cohort of ATR has exceeded its target of 33,500 having served over 47,000 clients. In FY 2012, SAMHSA will fund the continuation of 30 grants and 1 contract.

Children & Family Programs

SAMHSA/CSAT's Adolescent Treatment grants are designed to address the gaps in substance abuse services by providing services to adolescents and their families/primary caregivers using previously proven effective practices that are family centered.

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

The Family Centered Treatment grantees are receiving training and ongoing coaching for their clinical supervisors and clinicians that will lead to certification in the ACRA/ACC intervention model. In addition, each site has received training and certification to conduct a standardized bio-psychosocial clinical assessment that identifies substance use disorders, co-occurring mental health disorders, and family support and functioning. Utilizing this intensive process ensures that a standardized implementation of the intervention is completed. Important lessons to be learned from these grantee sites include how to effectively implement and sustain best and proven practices in community based agencies. SAMSHA will fund new adolescent treatment grants in FY 2012 to further the use of effective family-centered treatment approaches while supporting connections between locally based treatment systems and their state, tribal, or territorial infrastructure.

In addition to the Adolescent Treatment grant programs, SAMHSA/CSAT has been collaborating with the Administration for Children and Families (ACF) through an inter-agency agreement to fund a National Center on Substance Abuse and Child Welfare. The vast majority of children, particularly infants, who are placed in protective custody, have a parent with a substance use disorder. Thus, it is imperative that child welfare, substance abuse treatment providers, and the courts work efficiently together. Activities of this National Center include in-depth technical assistance to States, working more closely with legislators and Governors' offices, forging more extensive partnerships with family drug courts, and planning greater emphasis on work with Tribes. ACF grantees will be able to draw upon SAMHSA Technical Assistance provided to the Child Welfare and Substance Abuse Treatment fields, including grantees awarded under an ACF grant program entitled "Targeted Grants to Increase the Well

Being of and to Improve the Permanency Outcomes for Children Affected by Methamphetamine and Other Substance Abuse", referred to as Regional Partnership grants. In FY 2012, funding will support the Women, Youth and Families Task Force contract in addition to funding the continuation of 34 grants and 2 contracts as well as 12 new grants.

Treatment Systems for Homelessness

CSAT manages two grant portfolios under its Grants for the Benefit of Homeless Individuals (GBHI) program funded solely by CSAT, both of which provide focused services to individuals with a substance use disorder or who have co-occurring substance use and mental health disorders.

The GBHI program enables communities to expand and strengthen their substance abuse treatment services for homeless (including chronically homeless) individuals with substance abuse disorders, or with co-occurring substance abuse disorders and mental illness and move them to permanent supportive housing. In addition, CSAT provides funds for expansion and strengthening substance abuse treatment services for homeless, alcohol-dependent persons who have histories of public inebriation, frequent emergency room visits, arrests, mental illness, or co-occurring substance use and mental health disorders.

Through this grant program, grantees link substance abuse treatment services with housing programs and other services (e.g. mental health treatment, primary care). Funds support direct services, including the following types of activities: conducting outreach and pre-service strategies to expand access to treatment services to underserved populations; purchasing or providing direct treatment (including screening, assessment, and care management) services for populations at risk; purchasing or providing "wrap-around" services; and collecting data using specified tools and standards to measure and monitor substance abuse treatment services and costs. More specifically, programs are encouraged to implement evidence-based practices that result in treatment outcomes such as abstinence from alcohol and substance use, reduced criminal justice system involvement, employment, and stable housing.

In FY 2008, consistent with congressional intent, CSAT began allocating part of its GBHI funds for grants that address services in supportive housing (SSH), funded jointly with CMHS. Like CSAT's GBHI grants for the homeless population, the SSH grants seek to expand and strengthen treatment services for persons who are homeless by providing linkages to appropriate treatment for substance use or other support services. CSAT defines services in supportive housing for the purposes of the SSH grants as housing that is permanent, affordable, and linked to health, mental health, employment, and other support services. This approach combines long-term, community-based housing assistance and intensive individualized treatment and recovery support services to chronically homeless individuals with substance use disorders. It is a cost-effective combination of affordable housing with substance abuse treatment services that helps people live more stable, productive lives and leads to reductions in substance use.

The GBHI and SSH grants are complementary approaches that provide a comprehensive response to homeless persons living with substance use. Both support the implementation of effective, evidence-based practices, and the combination of the two approaches allows CSAT to

support communities in reaching their homeless populations in need of treatment wherever they are found, whether in supportive housing or other community-based settings.

Since the inception of the GBHI program, CSAT homeless grants have served over 49,300 individuals. The currently active portfolio has served over 13,500 individuals. Each grantee collects information on the clients that are served through the grant funds. The information is entered into a Web-based data system that allows for tracking and accountability of grantee performance on the goals outlined in the grant proposal. Outcome data available for a subset of clients served by the program through the active GBHI grantees show that individuals demonstrate:

- 78.3 percent increase in employment or engaging in productive activities;
- 138 percent increase in persons with a permanent place to live in the community;
- 46 percent increase in no past months substance use;

In 2011 SAMHSA/CSAT in collaboration with CMHS awarded grants for Cooperative Agreements to Benefit Homeless Individuals. The major goal of the program is to ensure that the most vulnerable individuals who are chronically homeless receive access to sustainable permanent housing, treatment, and recovery supports through mainstream funding sources. This grant program builds on the success of the previous SAMHSA SSH program and SAMHSA GBHI program. In FY 2012, SAMHSA will fund the continuation of 95 grants and 2 contracts.

Minority AIDS

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

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

In FY 2011, SAMHSA/CSAT's TCE/HIV program served approximately 6,200 individuals. Of these individuals, approximately 70 percent were between the ages of 25 and 54 years. Approximately 31 percent identified themselves as Hispanic/Latino in ethnicity; 46 percent as African American; 22 percent white; 1 percent Asian, Native Hawaiian, or Pacific Islander; and 4 percent as American Indian/Alaska Native.

In FY 2011, SAMHSA awarded grants for the Minority AIDS Initiative Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements, jointly funded with CMHS and CSAP. This grant program facilitates the development and expansion of culturally competent and effective integrated behavioral health and primary care networks, which

include HIV services and medical treatment, within racial and ethnic minority communities in the 11 Metropolitan Statistical Areas and Metropolitan Divisions most impacted by HIV/AIDS. Expected outcomes include: reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas. SAMHSA will continue to support these grants in 2012.

In FY 2012, SAMHSA will fund the continuation of 74 grants and 5 contracts as well as a new cohort of 64 grants to target areas of highest need based on the most recently available HIV epidemiological data.

Criminal Justice Activities

Criminal justice activities include grant programs which focus on diversion, alternatives to incarceration, and re-entry from incarceration for adolescents and adults with substance use disorders, and/or co-occurring substance use and mental disorders. Criminal justice program grantees are tasked with providing a coordinated and comprehensive continuum of programs and services to help members of the target population become productive, responsible and law abiding citizens. Data show positive improvements in outcomes of clients served by the CJ portfolio. For example, in 2011, abstinence increased by over 62 percent from intake to follow-up; CJ involvement decreased by 11.7 percent; employment and housing increased by 37 percent and 30 percent respectively.

Drug Courts

Problem solving courts are designed to combine the sanctioning power of courts with effective treatment services for a range of populations and problems such as alcohol and/or drug use, child abuse/neglect or criminal behavior, mental illness, and veterans issues. In 2007, the criminal justice system was the largest single source of referrals to substance abuse treatment. As treatment drug courts and other problem solving courts addressing drug and other behavioral health-related issues are being established at a high rate, communities are challenged to find sufficient substance abuse treatment and recovery support resources for people referred by the courts.

The number of such courts in the nation with a focus on drug treatment has increased, from 1,200 in 2005 to over 2,400 in 2011. Even with the increase in the availability of these courts, there is a limited amount of treatment, mental health, and recovery support services available. Approximately 10 percent of individuals in need of substance abuse treatment within the criminal justice system actually receive treatment as part of their justice system supervision.

In FY 2010, SAMHSA/CSAT funded 8 new Juvenile Treatment Drug Court grants for three years at an average cost of $325,000 per year. There were also three new Juvenile Treatment Drug Court grants that were funded in collaboration with the Department of Justice (DOJ)/Office of Juvenile Justice and Delinquency Prevention (OJJDP) and in partnership with Robert Wood Johnson for four years at an average cost of $200,000 per year. This collaborative program was initiated in FY 2009, with the award of three grants. These funds will provide services to support substance abuse treatment, assessment, case management, and program coordination for

those in need of treatment drug court services. Priority for the use of funding will be given to address gaps in the continuum of treatment.

In FY 2010, SAMHSA/CSAT funded 17 new Adult Treatment Drug Court grants for three years at an average cost of $325,000 per year. Also in FY 2010, SAMHSA and DOJ/Office of Justice Programs /Bureau of Justice Affairs (BJA) developed a joint program to enhance court services, coordination, and substance abuse treatment capacity of adult drug courts. The purpose of this joint initiative is for applicants to submit one application that outlines a comprehensive strategy for enhancing drug court capacity. SAMHSA and BJA jointly funded 28 new Adult Treatment Drug Court grants. Each grantee was awarded one separate grant from each agency, representing an innovative braided funding opportunity. This collaboration was modeled after the successful SAMHSA and DOJ/OJJDP collaborative Juvenile Treatment Drug Court grant program.

In 2010 SAMHSA started the Children Affected by Methamphetamine/Family Treatment Drug Court program. These grants provide a Child Case Coordinator to link available community-based social services resources that will focus on the trauma to the youngest victims caused by substance abuse/methamphetamine use in the family and concurrent criminal justice involvement. This program will provide a collaborative approach to child case coordination of services for these children of methamphetamine-addicted parents by including judges, treatment providers, child welfare specialists, and attorneys. In FY 2010, SAMHSA/CSAT funded 12 grants at $370,000 per year for up to four years.

In FY 2011, SAMHSA awarded grants to Develop and Expand Behavioral Health Treatment Court Collaboratives through collaboration with the Center for Mental Health Services. SAMHSA's vision of a Behavioral Health Treatment Court Collaborative (BHTCC) in the justice system is one that supports treatment and recovery support for people with behavioral health conditions and that improves public health and public safety by transforming the behavioral health system at the community level. The purpose of the BHCC grant program is to allow State and local criminal and dependency courts serving adults more flexibility to collaborate with the other judicial components and the local community treatment and recovery providers to better address the behavioral health needs of adults who are involved with the criminal court system.

In FY 2012, SAMHSA will continue to provide technical assistance and support States and communities in implementing flexible solutions to address substance abuse, mental illnesses, and co-occurring disorders in the criminal justice system through collaboration between the Center for Substance Abuse Treatment and the Center for Mental Health Services. SAMHSA will continue its partnership with DOJ in FY 2012 to award additional Adult Treatment Drug Court grants which braid support for substance abuse treatment services from SAMHSA with support for court operations from DOJ. SAMHSA will also award new grants to support drug courts with a special focus on high priority populations and systems. SAMHSA will also award new grants to support drug courts with a special focus on high priority populations and systems. A cohort of these new grants will include a focus on teen courts which will serve the substance abuse treatment needs of youth. In FY 2012, SAMHSA will fund the continuation of 53 grants and 3 contracts as well as 81 new grants.

Offender Re-entry Program

Research shows that the most positive gains made as the result of prison-based treatment rapidly dissipate if the individual is not linked to effective community-based services upon return to the community. In FY 2002, with the number of reentering offenders totaling over 625,000 persons, Federal agencies began to respond to the accompanying public safety and public health issues by funding new programs such as the Serious and Violent Offender Re-entry Initiative and the Prisoner Re-entry Initiative. SAMHSA participated as a Federal partner in both of these initiatives. In FY 2004, SAMHSA's Young Offender Re-entry Program (YORP) was initiated with the awarding of 12 grants to expand and enhance treatment capacity for juveniles and young offenders returning to their communities from correctional or detention facilities. This offender re-entry initiative was designed to facilitate reintegration into the community by providing pre-release screening, assessment, and transition planning in institutional corrections settings and linking clients to community-based treatment and recovery services upon release. In FY 2005, a second cohort of 13 grants was funded as part of an $11 million effort to respond to the escalating number of alcohol and drug involved offenders returning to the community.

The Offender Re-entry Program (ORP) grants provide screening, assessment and comprehensive treatment and recovery support services to offenders reentering the community, as well as offenders who are currently on or being released from probation or parole. In FY 2009, SAMHSA/CSAT funded 24 new ORP grants and 18 in FY 2010. These grants are funded for three years at an average cost of $400,000 per year.

SAMHSA and DOJ/Bureau of Justice Assistance share a mutual interest in supporting and shaping offender re-entry-treatment services, as both agencies fund "offender re-entry" programs. These two Agencies have a longstanding partnership regarding criminal justice-substance abuse treatment issues. SAMHSA and DOJ/Bureau of Justice Assistance have developed formal agreements to further encourage and engage in mutual interests and activities related to criminal justice-treatment issues. SAMHSA and DOJ/Bureau of Justice Assistance will continue to plan and coordinate relevant activities. Offender Re-entry Program grantees are expected to seek out and coordinate with local Federally-funded offender re-entry initiatives, including DOJ/Bureau of Justice Assistance's Prisoner Re-entry Initiative or "Second Chance Act" offender re-entry programs, as appropriate. In FY 2012, SAMHSA will fund the continuation of 29 grants and 3 contracts as well as 9 new grants.

Addiction Technology Transfer Centers (ATTCs)

The Addiction Technology Transfer Center (ATTC) Network is comprised of one national coordinating center and fourteen geographically dispersed regional ATTCs covering all States, the District of Columbia, Puerto Rico, the Virgin Islands, and U.S. Territories in the Pacific. The Regional Centers support national activities and implement programs and initiatives in response to regional needs, decreasing the gap in time between the release of new scientific findings and evidence-based practices and the implementation of these interventions by front-line clinicians. ATTCs disseminate evidence-based and promising practices to addictions treatment/recovery professionals, public health/mental health personnel, institutional and community corrections professionals, and other related disciplines. The ATTC program dissemination models include

technical assistance; training events; a growing catalog of educational and training materials; and an extensive array of Web-based resources created to translate the latest science for adoption into practice by the substance use disorders treatment workforce. The ATTCs are highly responsive to emerging challenges in the field. Data show that over 25,000 people were trained in 2011, exceeding the target of 20,516. In FY 2012, SAMHSA will fund the continuation of 1 contract as well as a new cohort of up to 15 new grants geographically consistent with HHS' 10 regional offices in order to coordinate SAMHSA services, technical assistance and workforce training and development with other HHS Operating Divisions such as HRSA, CMS, ACF, and the Regional Public Health Administrators.

Minority Fellowship Program (MFP)

In a partnership among CMHS, CSAP and CSAT, this program increases the knowledge of issues related to ethnic minority mental health and substance use disorders, as well as improves the quality of mental health and substance abuse prevention and treatment delivered to ethnic minorities by providing stipends to graduate students to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental health/substance abuse services to underserved minority populations. 125 individuals were trained in FY 2009. Since its start in 1973, the MFP has helped to support doctoral-level training of ethnic minority psychiatrists, psychologists, psychiatric nurses, and social workers. These individuals often serve in key leadership positions in mental health and substance abuse direct services, including supervision, direct services, services research, training, and administration. In FY 2012, SAMHSA will fund the continuation of the Minority Fellowship grant.

Special Initiatives/Outreach

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

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

In FY 2010, SAMHSA/CSAT entered into an inter-agency agreement with the Agency for Healthcare Research and Quality (AHRQ) to examine and graphically display selected trends in hospital-based stays for mental health and substance abuse treatment. This work was used to write a chapter in the annual AHRQ publication, "Healthcare Cost and Utilization Project (HCUP) Facts and Figures: Statistics on Hospital Based Care in the US 2008." This report drew attention to the extensive hospital resources devoted to people with mental and substance use disorders, some of which may be more effectively and efficiently served in community-based settings with a recovery-based system of care approach. In FY 2012, SAMHSA will fund the continuation of 1 grant and 1 contract.

Funding History a/

FY	Amount
2008 a/	$362,171,000
2009 a/	$376,359,000
2010 a/	$452,459,000
2011 a/	$431,389,000
2012 a/	$425,243,000

a/ The funding history is based on a comparable basis to previous funding levels to reflect the revised budget restructure and includes ACA Prevention Funds.

Substance Abuse Treatment Budget Request

The FY 2013 Budget Request is comprised of $364.1 million at the program level with $334.1 million from Budget Authority and $30.0 million provided by ACA Prevention Funds. This reflects a decrease of $59.1 million in Budget Authority partially offset by the $5.0 million increase in ACA Prevention Funds. This level of funding enables the continuation of most programmatic activities. The Request will support 419 grant and 27 contract continuations, as well as 142 new grants and 8 new contracts. The Request includes:

Decreases ($61.104 million):

The SBIRT program request is $30.0 million from the ACA Prevention Fund. This level of funding will support the continuation of 12 grants and 2 contracts as well as 22 new grants.

The Targeted Capacity Expansion program request is $13.3 million. This reflects a decrease of $14.7 million below FY 2012. This level of funding will support the continuation of 30 grants and 2 contracts and will continue to monitor the progress of the 3 FY 2012 multi-year funded HIT Grants.

The Strengthening Treatment Access and Retention program request is $1.0 million. This reflects a decrease of $0.7 million below FY 2012. This level of funding will support 1 new contract.

The Access to Recovery program request is $93.8 million. This reflects a decrease of $4.5 million below FY 2012. This level of funding will support the continuation of 30 grants and 1 contract.

The Children and Families program request is $29.7 million. This reflects a decrease of $0.9 million below FY 2012. This level of funding will support the continuation of 12 grants and 3 contracts as well as 38 new grants and 2 new contracts.

The Criminal Justice Activities program request is $65.1 million. This reflects a decrease of $1.8 million below FY 2012. This level of funding will support the continuation of 123 grants and 3 contracts as well as 40 new grants and 1 new contract.

The Minority HIV/AIDS program request is $52.4 million. This reflects a decrease of $13.5 million below FY 2012. This level of funding will support the continuation of 91 grants and 5 contracts as well as 16 new grants.

The Addiction Technology Transfer Centers program request is $8.1 million. This reflects a decrease of $1.0 million below FY 2012. This level of funding will support the continuation of 15 grants and 1 contract.

The Special Initiatives/Outreach program request is $1.436 million. This reflects a decrease of $0.831 million below FY 2012. This level of funding will support the continuation of 1 grant and 1 contract.

Level Funding:

The Opioid Treatment Programs request is $8.9 million, the same as FY 2012. This level of funding will support the continuation of 1 grant and 6 contracts as well as 1 new grant and 3 new contracts.

The Pregnant and Postpartum Women request is $16.0 million, the same as FY 2012. This level of funding will support the continuation of 26 grants and 1 contract.

The Recovery Community Services Program request is $2.5 million, the same as FY 2012. This level of funding will support the continuation of 6 grants as well as 2 new grants and 1 new contract.

The Treatment Systems for Homeless program request is $41.6 million, the same as FY 2012. This level of funding will support the continuation of 72 grants and 2 contracts as well as 23 new grants.

The Minority Fellowship Program request is $0.5 million, the same as FY 2012. This level of funding will support the continuation of 1 grant.

A detailed table for all grant and contract continuations and new activities can be found on page 235.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism by APT Table
(Dollars in Thousands)

PRNS- Treatment	FY 2011 Actual No.	FY 2011 Actual Amount	FY 2012 Enacted No.	FY 2012 Enacted Amount	FY 2013 Pres. Budget No.	FY 2013 Pres. Budget Amount
Grants/Cooperative Agreements:						
Continuations	520	$285,166	417	$251,677	419	$246,790
New/Competing	122	72,417	193	105,560	142	57,766
Supplements	(7)	850	0	0	0	0
Subtotal	**642**	**358,433**	**610**	**357,237**	**561**	**304,556**
Contracts:						
Continuations	32	53,644	42	68,005	27	53,654
New/Competing	10	19,311	0	0	8	5,929
Supplements	0	0	0	0	0	0
Subtotal	**42**	**72,955**	**42**	**68,005**	**35**	**59,583**
Subtotal, PRNS- Treatment	**684**	**$431,389**	**652**	**$425,243**	**596**	**$364,139**

Outcomes and Outputs

Program: Screening, Brief Intervention and Referral to Treatment

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.40 Number of clients served (Output)	FY 2011: 213,250 Target: 139,650 (Target Exceeded)	139,650	139,650	75,015	-64,635
1.2.41 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2011: 36% Target: 50% (Target Not Met but Improved)	36%	36%	36%	Maintain

Program: Access to Recovery

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.32 Number of clients gaining access to treatment (Output)	FY 2011: 47,036 Target: 33,500 (Target Exceeded)	70,750[1]	70,750	50,000	-20,750
1.2.33 Increase the percentage of adults receiving services who had no past month substance use (Outcome)	FY 2011: 82.1% Target: 82% (Target Exceeded)	83%	83%	81%	-2%
1.2.35 Percentage of adults receiving services who had no/reduced involvement with the criminal justice system (Outcome)	FY 2011: 96.7% Target: 96% (Target Exceeded)	96%	96%	94%	-2%
1.2.36 Percentage of adults receiving services who had improved social support (Outcome)	FY 2011: 90% Target: 91% (Target Not Met)	91%	91%	89%	-2%

[1] The targets for numbers served for ATR were determined based on previous funding information for the third cohort of this program. They have been published in the most recent RFA. As a result, FY 2012 targets have remained as published and not been adjusted based on funding levels in FY 2011.

Program: Treatment System for Homelessness (GBHI)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.4.22 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2011: 66 % Target: 67.4 % (Target Not Met)	67.4%	67.4 %	66.4 %	-1%
3.4.23 Number of clients served (Output)	FY 2011: 5,767 Target: 7,005 (Target Not Met but Improved)	5,800	5,800	5,800	Maintain
3.4.24 Percentage of clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2011: 32 % Target: 32.7 % (Target Not Met)	32.7%	32.7 %	31.7 %	-1%
3.4.25 Increase the percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2011: 33 % Target: 25.6 % (Target Exceeded)	25.6%	25.6 %	24.6 %	-1%

Program: Criminal Justice - Juvenile and Adult Problem Solving Drug Courts

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.63 Percentage of juvenile clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2011: 87% Target: 88% (Target Not Met)	88%	88%	86%	-2%
1.2.64 Percentage of juvenile clients receiving services who had a permanent place to live in the community (Outcome)	FY 2011: 79% Target: 82% (Target Not Met)	82%	82%	80%	-2%
1.2.65 Percentage of juvenile clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2011: 90.1% Target: 95% (Target Not Met)	95%	95%	93%	-2%
1.2.67 Percentage of juvenile clients receiving services who had no past month substance use (Outcome)	FY 2011: 68% Target: 73% (Target Not Met)	73%	73%	71%	-2%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.70 Number of juvenile clients served (Output)	FY 2011: 550 Target: 1463 (Target Not Met)	1,463	1,463	1000	-463
1.2.72 Percentage of adult clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2011: 58.3% Target: 57% (Target Exceeded)	57%	57%	55%	-2%
1.2.73 Percentage of adult clients receiving services who had a permanent place to live in the community (Outcome)	FY 2011: 42.3% Target: 42% (Target Exceeded)	43%	43%	41%	-2%
1.2.74 Percentage of adult clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2011: 93% Target: 93% (Target Met)	93%	93%	91%	-2%
1.2.76 Percentage of adult clients receiving services who had no past month substance use (Outcome)	FY 2011: 86.5% Target: 73% (Target Exceeded)	73%	73%	71%	-2%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.79 Number of adult clients served (Output)	FY 2011: 4,413 Target: 5,265 (Target Not Met but Improved)	5,265	5,265	4,413	-852

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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.80 Number of clients served (Outcome)	FY 2011: 3,740 Target: 2,912 (Target Exceeded)	2,912	2,912	3,552	+640
1.2.81 Percentage of clients who had no past month substance use (Outcome)	FY 2011: 80.9% Target: 70% (Target Exceeded)	80%	80%	80%	Maintain
1.2.84 Percentage of clients receiving services who had no involvement with the	FY 2011: 95.2 %	95%	96 %	94.9 %	-1.1%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
criminal justice system (Outcome)	Target: 95 % (Target Exceeded)				

Program: Treatment - Other Capacity[2]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.25 Percentage of adults receiving services who had no past month substance use (Outcome)	FY 2011: 70.2% Target: 62% (Target Exceeded)	62%	66%	60%	-6%
1.2.26 Number of clients served (Output)	FY 2011: 40,381 Target: 34,784 (Target Exceeded)	34,784	34,784	30,849	-3,935
1.2.27 Percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2011: 44% Target: 47% (Target Not Met)	47%	47%	45%	-2%
1.2.28 Percentage of adults receiving services who had a permanent place to live in the community (Outcome)	FY 2011: 48% Target: 49% (Target Not Met)	49%	49%	47%	-2%

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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.29 Percentage of adults receiving services who had no involvement with the criminal justice system (Outcome)	FY 2011: 96% Target: 95% (Target Exceeded)	95%	96%	93%	-3%

Program: Treatment - Science and Service Activities[3]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.4.01 Percentage of participants who report implementing improvements in treatment methods on the basis of information and training provided by the program (Outcome)	FY 2011: 95% Target: 90% (Target Exceeded)	90%	90%	90%	Maintain

[3] Includes Addiction Technology Transfer Centers

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.4.02 Number of individuals trained per year (Output)	FY 2011: 25,345 Target: 20,516 (Target Exceeded)	20,516	20,516	20,516	Maintain
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program (Output)	FY 2010: 51,415[4] Target: N/A (Historical Actual)	37,896	37,049	31,473	-5,576

Size of Awards

(whole dollars)	FY 2011 Actual	FY 2012 Enacted	FY 2013 Pres. Budget
Number of Awards	642	610	561
Average Award	$558,307	$585,634	$542,881
Range of Awards	$300,000-$600,000	$300,000-$600,000	$300,000-$600,000

[4] All component programs have now reported; therefore, data are revised from previously reported.

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Substance Abuse Block Grant
(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget
Substance Abuse Block Grant	$1,441,962	$1,456,106	$1,448,630
PHS Evaluation Fund (non-add)	*79,200*	*79,200*	*71,724*
FTEs	40	40	40

Authorizing Legislation .....Section 1921 of the Public Health Services Act[5]

FY 2013 Authorization ..... Expired

Allocation Method ..... Formula Grants

Program Description and Accomplishments

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

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

The program's overall goal is to support and expand substance abuse prevention and treatment services while providing maximum flexibility. States and Territories may expend Block Grant funds only for the purpose of planning, carrying out, and evaluating activities related to these services. Targeted technical assistance is available for the States and Territories through CSAT's State Systems Technical Assistance Project. The SABG requires States to maintain expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the two-year period preceding the year for which the State is

[5] Appropriation language is requested to not withstand the 20% prevention set-aside and allow for the movement of these funds into a separate State Prevention Grants for behavioral health; State will still be able to spend SAPTBG funds for prevention services

applying for a grant. Given the current economic situation, SAMHSA is aware that a number of States are experiencing challenges meeting the maintenance of effort requirement in the Federal FY 2011 grant cycle, and is monitoring the situation closely.

Of the amounts appropriated for the SABG program, 95 percent are distributed to States and other eligible applicants through a formula prescribed by the authorizing legislation. Factors used to calculate the allotments include total personal income; State population data by age groups (total population data for territories); total taxable resources; and a cost of services index factor.

The SABG is critically important to the States because it provides them the flexibility to respond to local and/or regional emergent issues impacting health, public health, and public safety through a consistent Federal funding stream. Individuals who are currently in need of such services may fall into several categories, such as no insurance or limited health insurance coverage for substance use disorder treatment and recovery support services, or may have been mandated to enter SUD treatment through public safety and/or public welfare systems. As previously indicated, there will continue to be individuals and families without health coverage or whose health insurance benefit will not cover certain services, e.g. recovery supports. Such individuals rely on services funded by the SABG. States also rely on the SABG funding for an array of non-clinical activities and services in support of their respective service systems, e.g. planning, coordination, needs assessment, quality assurance, program development, and evaluation.

In FY 2011, SAMHSA revised the SABG and the Mental Health Block Grant (MHBG) applications to make them uniform where appropriate, to allow States and Territories to submit a plan every two years instead of annually, and to allow States and Territories to submit one combined application for both Block Grants if they so chose. Twenty-two eligible States and two Territories chose to submit a combined application for FYs 2012 and 2013. Other States have indicated a desire to do so in future years.

Other changes to the SABG application for FY's 2012 and 2013 included updated requests and guidance to address good and modern behavioral health services and priority populations. The Uniform Block Grant application for FYs 2014 and 2015 will be released for public comment in the Spring or early Summer of 2012 with completion expected by Fall or early Winter of 2012/2013. Applications will be due in the Spring of 2013, in advance of most States/Territories 2014 fiscal year beginning in July of 2013.

The independent evaluation of the original Substance Abuse Prevention and Treatment Block Grant program (http://tie.samhsa.gov/SAPT2010.html#Evaluation) demonstrated how States have leveraged the statutory requirements of this Block Grant to expand existing or establish new treatment capacity in underserved areas of States and Territories and to improve coordination of services with other State systems.

As seen in the following table, the SABG Program has been successful in expanding treatment capacity in the latest year for which actual data are available (FY 2008) by supporting almost 2.3 million admissions to treatment programs receiving public funding. Outcomes data for the Block

Grant Program also show positive results. In FY 2009, at discharge, clients have demonstrated high abstinence rates from both illegal drug (75.7 percent) and alcohol (81.5 percent) use.

State Substance Abuse Authorities reported the following outcomes for services provided during 2007, the most recent year data is available:

For the 51 States that reported data in the Abstinence from Drug/Alcohol Use Domain for alcohol, 50 of 51 identified improvements in client abstinence. Forty-three of these States reported improvements based on information submitted to the Treatment Episode Data Set (TEDS) and seven reported improvements based on their own data collection systems.

Similarly, for the 51 States that reported data in the Abstinence from Drug/Alcohol Use Domain for drug use, 50 of 51 identified improvements in client abstinence. Forty-three of these States reported improvements based on information submitted to TEDS and seven reported improvements based on their own data collection systems.

For the 51 States that reported data in the Employment Domain, 46 of 51 identified improvements in client employment. Forty of these States reported improvements based on information submitted to TEDS and six reported improvements based on their own data collection systems.

For the 51 States that reported in the Criminal Justice Domain, 35 of 40 reported an increase in clients with no arrests based on data reported to TEDS.

For the 51 States that reported data in the Housing Domain, 35 of 47 identified improvements in stable housing for clients based on data reported to TEDS.

CBHSQ, working with CSAP and CSAT, plans to fund a modification to the Drug and Alcohol Services Information System (DASIS) contract in FY 2012 to collect both substance abuse and mental health facilities information and client level data. A new DASIS-type contract will be awarded in FY 2013 to capture client level data collection and reporting capability for both Block Grants. Support for SAPT BG grantees to support data collection efforts is being considered through a mechanism related to the new data collection contract. This effort will enhance data reporting for the SAPT BG in the future.

Funding History

FY	Funding[1/]	FTEs
2003	$1,418,986,000	
2004 [2/]	$1,439,157,000	
2005 [2/]	$1,436,284,000	
2006 [2/]	$1,421,780,000	40
2007 [2/]	$1,422,713,000	40
2008 [2/]	$1,422,822,000	40
2009 [2/]	$1,438,713,000	40
2010 [2/]	$1,454,713,000	40
2011 [2/]	$1,441,962,000	40
2012 [2/]	$1,448,630,000	40

1/ Reflects comparability adjustments to show total less the 20% Prevention Set-Aside
2/ Includes $79.2 million in FY 2003 through FY 2012 from PHS Evaluation Funds.

Budget Request

The FY 2013 Request for the Substance Abuse Block Grant is $1.449 billion, a decrease of $7.476 million in PHS Evaluation Funds from the comparable FY 2012 Enacted Level. In FY 2012, 1.25 percent of the Budget Authority appropriated for the MHBG will be set aside pursuant to section 241 of the Public Health Service Act. In FY 2013, 3.2 percent of the Budget Authority appropriated for the MHBG will be set aside pursuant to section 241 of the Public Health Service Act. SAMHSA will work to ensure conformance with Section 1935 of the Public Health Service Act. These resources will be used to support activities such as evaluation, data collection, and technical assistance. As a result, the state allotments in FY 2013 have been adjusted to reflect this change. The reduction of $7.476 million in PHS Evaluation Funds for the SABG relates to a comparable adjustment to reflect the transfer of the 20 percent prevention set aside to the Substance Abuse – State Prevention Grant. In FY 2013, States and Territories will also be allowed to utilize a portion of the SABG funds to augment the Substance Abuse-State Prevention Grant funding for additional prevention services if the submitted application indicates a desire to do so in the plan for expenditure of these dollars. This will allow States and Territories that currently expend more than 20 percent of the SABG funds for prevention to continue to do so if they so choose. It is important to maintain the SABG funding level as it supports and preserves vital substance abuse service infrastructure, which, if lost now, may never be rebuilt.

Data Elements Used to Calculate FY 2013 Allotments

Population: For the States and the District of Columbia, July 1, 2010 population estimates from the U.S. Department of Commerce, Bureau of the Census, Population Estimates Division; and population of urbanized areas ages 18-24, and population ages 18-24, for April 1, 2000 from the 2000 Decennial Census, Summary File 1, from the U.S. Department of Commerce, Bureau of the Census. For American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, i.e., the current territories, April 1, 2010 population counts from the 2010 Decennial Census from the U.S. Department of Commerce, Bureau of the Census. For the Federated States of Micronesia, the Marshall Islands, and Palau, i.e., the former territories, July 1, 2010 population estimates from the U.S. Department of Commerce, Bureau of the Census, International Data Base.

Total Taxable Resources (TTR): For the States and the District of Columbia, 2007, 2008, and 2009 Total Taxable Resources estimates from the U.S. Department of Treasury, Office of Economic Policy.

Total Personal Income (TPI): For the States and the District of Columbia, 2008, 2009, and 2010 Total Personal Income estimates from the U.S. Department of Commerce, Bureau of Economic Analysis.

Cost of Services Index (CSI): For the States and the District of Columbia. This index is determined triennially (i.e., it is revised every third fiscal year rather than annually), and the FY2013 allotment calculations use the CSI determined for FY2013-FY2015. For the Wage Index of the CSI, wage rates were calculated using earnings and hours worked by place-of-work-state from 2010 American Community Survey (ACS) 1-Year Data for specific occupation-industry categories, as determined by the U.S. Department of Commerce, Bureau of the Census,

in a special tabulation performed for SAMHSA. For the Rental Index of the CSI, FY2012 Median Fair Market Rent (FMR) estimates from U.S. Department of Housing and Urban Development were used, as well as July 1, 2009 population estimates at the county and sub county levels from the U.S. Department of Commerce, Bureau of the Census, Population Estimates Division.

Outcomes and Outputs

Substance Abuse Prevention and Treatment Block Grant
Program: Treatment Activities

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2011 Actual Associated Target (FY 2012)**	**FY 2012 Enacted Associated Target (FY 2013)**	**FY 2013 PB Associated Target (FY 2014)**	**FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)**
1.2.43 Number of admissions to substance abuse treatment programs receiving public funding (Output)	FY 2009: 1,674,295 Target: 1,881,515 (Target Not Met)	1,881,515	1,937,960	1,937,960	Maintain
1.2.48 Percentage of clients reporting no drug use in the past month at discharge (Outcome)	FY 2010: 76.8% Target: 70.3% (Target Exceeded)	70%	74%	74%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.49 Percentage of clients reporting no alcohol use in the past month at discharge (Outcome)	FY 2010: 83.7% Target: 74.7% (Target Exceeded)	75%	78%	78%	Maintain
1.2.50 Percentage of clients reporting being employed/in school at discharge (Outcome)	FY 2010: 37.9% Target: 43.9% (Target Not Met)	43%	43%	43%	Maintain
1.2.51 Percentage of clients reporting no involvement with the Criminal Justice System (Outcome)	FY 2010: 94.3% Target: 88.9% (Target Exceeded)	89%	92%	92%	Maintain
1.2.85 Percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2010: 93.9% Target: 92% (Target Exceeded)	92%	92%	92%	Maintain

Program: Synar Amendment

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
2.3.49 Number of States (including Puerto Rico) whose retail sales violations is at or below 20% (Outcome)	FY 2010: 52 Target: 52 (Target Met)	52	52	52	Maintain
2.3.62 Number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% (Outcome)	FY 2010: 34 Target: 25 (Target Exceeded)	34[6]	34	34	Maintain

[6] Although States continue to face funding cute to their youth tobacco access enforcement programs, SAMHSA anticipates that funding made available to States through the Tobacco Control Act will help to offset budget cuts to these programs. As a result, targets for FY 2012 and beyond have been increased.

Department of Health and Human Services Substance Abuse and Mental Health Services Administration FY 2013
Discretionary State/Formula Grants
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

State!ferritorv	FY2011 Actual	FY2012 Enacted	FY2013 Estimate	+/- FY2012
Alabama	$23,720,126	$23,669,104	$18,668,370	-$5,000,734
Alaska	4,914,342	4,903,771	3,867,718	-1,036,053
ArizDna	37,089,725	37,009,944	29,190,600	-7,819,344
Arkansas	13,262,590	13,234,062	10,438,011	-2,796,051
California	249,428,956	248,892,428	196,307,218	-52,585,210
Colorado	26,159,532	26,103,262	20,588,247	-5,515,015
Connecticut	16,919,808	16,883,413	13,316,339	-3,567,074
Delaware	6,684,946	6,670,567	5,261,231	-1,409,336
District Of Columbia	6,684,946	6,670,567	5,261,231	-1,409,336
Florida	99,796,302	99,581,639	78,542,344	-21,039,295
Georgia	50,248,875	50,140,789	39,547,201	-10,593,588
Hawaii	7,592,561	7,576,229	5,975,547	-1,600,682
Idaho	6,869,850	6,855,073	5,406,755	-1,448,318
Illinois	69,493,373	69,343,892	54,693,133	-14,650,759
Indiam	33,126,817	33,055,561	26,071,686	-6,983,875
Iowa	13,450,964	13,422,031	10,586,267	-2,835,764
Kansas	12,224,677	12,198,382	9,621,146	-2,577,236
Kentucky	20,552,530	20,508,321	16,175,388	-4,332,933
Louisiana	25,709,974	25,654,671	20,234,433	-5,420,238
Maine	6,684,946	6,670,567	5,261,231	-1,409,336
Maryland	31,805,845	31,737,430	25,032,046	-6,705,384
Massachusetts	34,146,666	34,073,216	26,874,334	-7,198,882
Michigan	57,583,816	57,459,952	45,319,994	-12,139,958
Minnesota	24,760,335	24,707,075	19,487,042	-5,220,033
Red Lake Indians	610,252	608,939	480,284	-128,655
Mississippi	14,180,578	14,150,075	11,160,492	-2,989,583
Missouri	26,016,004	25,960,043	20,475,287	-5,484,756
Montana	6,684,946	6,670,567	5,261,231	-1,409,336
Nebraska	7,849,944	7,833,059	6,178,115	-1,654,944
Nevada	13,774,658	13,745,028	10,841,022	-2,904,006
New Hampshire	$6,684,946	$6,670,567	$5,261,231	-1,409,336
New Jersey	46,685,830	46,585,408	36,742,990	-9,842,418
New Mexico	8,929,188	8,909,981	7,027,508	-1,882,473
New York	114,884,455	114,637,337	90,417,122	-24,220,215
North Carolina	39,686,878	39,601,511	31,234,629	-8,366,882

State!ferritory	FY2011	FY2012 Enacted	FY2013 Estimate	+/- FY2012
North Dakota	5,452,146	5,440,418	4,290,984	-1,149,434
Ohio	66,298,390	66,155,781	52,178,596	-13,977,185
Oklahoma	17,617,738	17,579,842	13,865,628	-3,714,214
Oregon	17,839,432	17,801,059	14,040,107	-3,760,952
Pennsylvania	58,766,078	58,639,671	46,250,466	-12,389,205
Rhode Island	6,684,946	6,670,567	5,261,231	-1,409,336
South Carolina	20,501,941	20,457,841	16,135,573	-4,322,268
South Dakota	5,041,716	5,030,871	3,967,964	-1,062,907
Tennessee	29,586,413	29,522,772	23,285,294	-6,237,478
Texas	135,246,934	134,956,016	106,442,934	-28,513,082
Utah	17,041,663	17,005,006	13,412,242	-3,592,764
Vel1llJnt	5,390,666	5,379,071	4,242,598	-1,136,473
Virginia	42,854,160	42,761,980	33,727,364	-9,034,616
Washington	34,787,819	34,712,990	27,378,939	-7,334,051
West Virginia	8,663,000	8,644,366	6,818,012	-1,826,354
Wisconsin	27,940,837	27,880,736	21,990,182	-5,890,554
Wyoming	3,502,800	3,495,265	2,756,796	-738,469
State Sub-total	**1,668,116,860**	**1,664,528,713**	**1,312,852,333**	**-351,676,380**
American Samoa	368,627	367,834	258,443	-109,391
Guam	1,003,608	1,001,449	741,818	-259,631
Northem Marianas	268,108	267,531	250,827	-16,704
Puerto Rico	22,077,562	22,030,073	17,343,693	-4,686,380
Palau	115,856	115,607	97,193	-18,414
Marshall Islands	365,447	364,661	306,576	-58,085
Micronesia	594,591	593,312	498,806	-94,506
Virgin Islands	608,996	607,686	495,319	-112,367
Territory Sub-Total	**25,402,795**	**25,348,153**	**19,992,675**	**-5,355,478**
Total States!fenitories	**1,693,519,655**	**1,689,876,866**	**1,332,845,008**	**-357,031,858**
SAMHSA Set-Aside	**89,132,613**	**88,940,888**	**70,149,737**	**-18,791,151**
Transfer		21,514,147	44,060,992	+22,546,845
Unavailable PHS Funds			1,574,263	
Total, SABG	**$1,782,652,268**	**$1,800,331,901**	**$1,448,630,000** [1]	**-$351,701,901**

[1]/ Funding in FY 2013 reflects an adjusted base without funding for the 20% prevention set-aside. Notwithstanding any other provision of law, section 1922(a) of the Public Health Service Act shall not apply in FY 2013.

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SAMHSA Health Surveillance and Program Support
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SAMHSA
Health Surveillance and Program Support

Summary of Changes

(Dollars in thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Health Surveillance and Program Support	$119,789	$124,319	$121,157	-$3,162
ACA Prevention Fund (non-add)	*18,000*	*18,000*	---	*-18,000*
Data Request and Publications User Fees (non-add)	---	---	*1,500*	*+1,500*
PHS Evaluation Funds (non-add)	*22,750*	*27,428*	*45,428*	*+18,000*
Public Awareness and Support	14,029	13,545	13,571	+26
PHS Evaluation Funds (non-add)	---	---	*13,571*	*+13,571*
Performance and Quality Information Systems	37,362	12,940	12,996	+56
PHS Evaluation Funds (non-add)	*6,596*	---	*12,996*	*+12,996*
Agency-Wide Initiatives	5,250	3,493	40,000	+36,507
ACA Prevention Fund (non-add)	---	---	*40,000*	*+40,000*
Total, Health Surveillance and Program Support	**$176,430**	**$154,297**	**$187,724**	**+$33,427**
FTEs[1]	**492**	**488**	**474**	**-14**

[1] In 2012, SAMHSA will continue to in source positions for activities that are central to SAMHSA's mission, represent critical skills for the agency, and result in overall savings consistent with Office of Federal Procurement Policy guidelines. A total of 98 positions will be added and fully staffed by the end of FY 2012. These positions are allocated across SAMHSA's four appropriations to reflect the provision of direct program support or to reflect the proration of overhead and indirect costs. An additional 13 positions have been added to provide support to the ten HHS regions. These positions are allocated across three appropriations to reflect the provision of technical assistance to the states as well as linking SAMHSA with its sister operating divisions in the regions. The additional positions are fiscally neutral.

The Health Surveillance and Program Support budget supports four activities consistent with the 2012 enacted budget: Health Surveillance and Program Support funds activities formerly funded by program management; Performance and Quality Information Systems, and Public Awareness and Support, both fund activities formerly funded by CMHS, CSAP and CSAT; and Agency-Wide Initiatives fund new programs that support cross-Center collaborative efforts. The FY 2013 President's Budget Request for the SAMHSA Health Surveillance and Program Support appropriation for its Total Program Level is $187.7 million, an increase of $33.4 million from the FY 2012 Enacted Level. This FY 2013 Total Program Level budget request of $187.7 million includes $74.2 million in Budget Authority (a decrease of $4.7 million from FY 2012), $72.0 million in PHS Evaluation funds (an increase of $44.6 million from FY 2012), and $40.0 million in ACA Prevention Funds (an increase of $22.0 million from FY 2012). Also included in the FY 2013 Total Program Level is $1.5 million from user fees to be collected for extraordinary data and publications user requests not otherwise able to be fulfilled within existing resources. The FY 2013 Budget Request includes the following:

Health Surveillance and Program Support: (-$3.2 million)

The FY 2013 request for Health Surveillance and Program Support activities is $121.2 million. This is a decrease of $3.2 million from the FY 2012 Enacted Level. This net decrease includes a

reduction of $4.7 million and an increase of $1.5 million for new user fees supporting new costs . This funding supports personnel costs, building and facilities, equipment, supplies, administrative costs and associated overhead to support SAMHSA programmatic activities (collectively called Program Support) as well as providing funding for SAMHSA national data collection, reporting, and survey systems, funding to help support the behavioral health portions of the CDC NHIS Survey, and the SAMHSA data archive (collectively called Health Surveillance).

Agency-Wide Initiatives: (+$36.5 million)

The FY 2013 request for Agency-Wide Initiatives is $40.0 million. This is an increase of $36.5 million from the FY 2012 Enacted Level. This request is for the Behavioral Health – Tribal Prevention Grant, requested from ACA Prevention Fund to provide a formula-based grant program for Tribes to plan and deliver substance abuse and suicide prevention services for Tribal communities.

Health Surveillance and Program Support

(Dollars in thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
Program Level	**$119,789**	**$124,319**	**$121,157**
Budget Authority (non-add)	*79,039*	*78,891*	*74,229*
PHS Evaluation Funds (non-add)	*22,750*	*27,428*	*45,428*
ACA Prevention Fund (non-add)	*18,000*	*18,000*	---
Data Request & Publications User Fees (non-add)	---	---	*1,500*
Total FTEs	**547**	**574**	**574**

Authorizing Legislation .....Section 501 of the Public Health Service Act

FY 2013 Authorization ..... Indefinite

Allocation Method ..... Direct Federal/Intramural, Contracts, Other

Program Description and Accomplishments

The Health Surveillance budget supports many of the critical behavioral health data systems, national surveys, and surveillance activities for DHHS undertaken by SAMHSA/CBHSQ to support SAMHSA grantees, the field, and the public. The National Survey on Drug Use and Health (NSDUH) serves as the nation's primary source for information on the incidence and prevalence of substance use and mental disorders and related health conditions. The Drug Abuse Warning Network (DAWN) is a national public health surveillance system that monitors emergency room visits for drug and mental illness-related problems. This activity represents a partnership with the National Center for Health Statistics/CDC which is expected both to increase response rates and improve the quality of behavioral health data available to help inform public policy and prevention and treatment initiatives. The Drug Abuse Services Information System (DASIS) is the primary source for data on treatment and treatment admissions. Other data collection efforts in SAMHSA collect similar data with a focus on mental disorders.

In 2012, SAMHSA Center for Behavioral Health Statistics and Quality (CBHSQ), working with CSAP, plans to fund a transition data collection system (with ACA funding) in preparation for the full implementation of the Common Data Platform (see PQIS narrative). CBHSQ, working with CMHS, also plans to fund a modification to the DASIS contract. This modification provides for the continued expansion and maintenance of the mental health portion of the Inventory of Behavioral Health Services (I-BHS, formerly the Inventory of Substance Abuse Treatment Services), as well as to put into full operation a Mental Health Treatment Facility Locator on par and in conjunction with the existing Substance Abuse Treatment Facility Locator. This modification will allow for collection of both substance abuse and mental health facilities information and client level data. In addition, CBHSQ will continue to insource positions for analytic work and will be fully staffed by the end of FY 2012.

CBHSQ, working with CMHS, CSAP and CSAT, plans to fund a modification to the Drug and Alcohol Services Information System (DASIS) contract in FY 2012 to collect both substance abuse and mental health facilities information and client level data. A new DASIS-type contract will be awarded in FY 2013 to capture client level data collection and reporting capability for both Block Grants. Support for MHBG and SAPT BG grantees to support data collection efforts is being considered through a new cohort of Data Infrastructure Grants (DIG) or through a mechanism related to the new data collection contract. This effort will enhance data reporting for the MHBG and SAPT BG in the future.

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

In 2012, SAMHSA will continue to in source positions for activities that are central to SAMHSA's mission, represent critical skills for the agency, and result in overall savings consistent with Office of Federal Procurement Policy guidelines. A total of 98 positions will be added and fully staffed by the end of FY 2012. These positions are allocated across SAMHSA's four appropriations to reflect the provision of direct program support or to reflect the proration of overhead and indirect costs. An additional 13 positions have been added to provide support and presence in the ten HHS regions and at central headquarters. These positions are allocated across three appropriations to reflect the provision of technical assistance to the states as well as linking SAMHSA with its sister operating divisions in the regions. The additional positions are fiscally neutral.

Health Surveillance

(Dollars in Thousands)

PHS Evaluation Funds	**FY 2011 Actual**	**FY 2012 Enacted**	**FY 2013 Request**
CBHSQ Data Collection Activities	$21,750	$25,779	$43,779
NSDUH Mental Health	1,000	1,000	1,000
Data Archive – Restricted Use	0	649	649
Total, PHS Evaluation Funds	**22,750**	**27,428**	**45,428**
Budget Authority			
CDC National Health Interview Survey	2,000	2,000	2,000
Total, Budget Authority	**2,000**	**2,000**	**2,000**

Funding History

FY	Amount	FTEs
2008	$93,131,000	544
2009	$100,131,000	528
2010	$101,947,000	537
2011	$119,789,000	547
2012	$124,319,000	574

Health Surveillance and Program Support Budget Request

The FY 2013 Budget Request is $121.2 million, a net budget decrease of $3.2 million from the FY 2012 Enacted Level. Funding for PHS evaluation increases by $18.0 million and funding for ACA decreases by $18.0 million.

A total of $47.4 million is requested for Health Surveillance, the same as the FY 2012 Enacted Level. This includes an increase of $18.0 million in PHS Evaluation Funds and a decrease of $18 million from the ACA Prevention Fund. The increase in PHS evaluation funds will help to maintain Center legacy data systems as the Common Data Platform is phased in during FY 2013. The decrease in ACA funding reflects completion of one-year surveillance activities completed in FY 2012.

A total of $73.7 million is requested for Program Support, which reflects a decrease of $4.7 million from the FY 2012 Enacted Level. This decrease reflects targeted reductions in overhead and administrative activities in areas such as travel, training, supplies and other costs, as well as efficiencies from consolidated contract activities and the implementation of controls for more efficient spending. This amount should provide sufficient funding to maintain staff at slightly higher attrition levels. The request includes an estimated $1.5 million for User Fees, which will be collected to offset increased costs for data request special analysis and materials publication requested by the field. SAMHSA has been carrying out special data runs and analyses, and materials publication and distribution for outside interests that are not critical to the accomplishment of SAMHSA's mission but do assist various members of the field or the public understand behavioral health needs. Regulations would be developed clearly delineating what are considered services non-critical to SAMHSA's mission and what the costs would be for those services before any user fee were established for such special data analyses or materials publication. By collecting these fees SAMHSA will be able to expand the service it provides to the general public.

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Public Awareness and Support

(Dollars in thousands)

	FY 2011 Actual	FY 2012 Enacted	**FY 2013 Request**
Program Level……	$14,029	$13,545	$13,571
PHS Evaluation Funds (non-add)……..	---	---	*13,571*

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

FY 2013 Authorization ..... Expired

Allocation Method ..... Contracts

Program Description and Accomplishments

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

The unmet need for prevention, treatment and recovery support services provides a vast untapped market for SAMHSA products and services. Today in America opportunities to prevent or intervene early to reduce disability and death associated with mental and substance use disorders are often missed. Over 60 percent of people who experience mental health problems and 90 percent of people who need substance abuse treatment do not receive care.

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

By confronting fear and misunderstanding with facts, raising awareness about the effectiveness of prevention and treatment, and improving knowledge about when and where to seek help, SAMHSA can help the Nation achieve the full potential of prevention and treat mental illness and substance abuse with the same urgency as any other health condition, and make recovery the expectation.

The SAMHSA Office of Communications, through the Communications Governance Council (CGC) is charged with setting the strategic direction and policy for SAMHSA's public communication activities. The CGC is working to assure research based approaches are used to influence behavior change for the sake of improving health, preventing injuries, protecting the environment, or contributing to the community. Individual behavior change involves 5 basic steps - changes in knowledge, approval, intention, practice, and advocacy.

To employ best-in-class communication practices and technologies that focus on creating and sustaining behavior change, SAMHSA is putting into place a new science based life cycle approach for public education communication efforts. The lifecycle provides a 5 step process for

planning, creating, disseminating, promoting and evaluating educational information produced and disseminated by SAMHSA.

SAMHSA's Public Engagement Platform and Web program are funded through the Public Awareness and Support budget line. These two programs provide the SAMHSA wide infrastructure required to advance SAMHSA's Strategic Initiatives by engaging audiences in a meaningful way.

The Web is the primary way people engage with the government. SAMHSA has prioritized the Web as a strategic business and communications asset and launched project Evolve. Evolve is an employee driven solution to multiple uncoordinated and undermanaged websites at SAMHSA. Consistent with the Federal Web Strategy, the project is working to support the development of quality content, effective communications governance and the use of modern communications platforms and to reduce redundancy in SAMHSA's web based communication efforts with the long term goals of improving customer satisfaction and achieving cost savings to the agency.

SAMHSA's Public Engagement Platform provides the agency's programs a customer oriented fulfillment system. SAMHSA's on-line store (http://store.samhsa.gov) is SAMHSA's most highly visible customer interface and works in concert with a call-in contact center, warehouse, email updates, exhibit program and strategic partnerships to fulfill public and health services provider publication needs. These multiple communications channels managed by the Office of Communications generated 25 million customer interactions last year and enables SAMHSA to gather data that illuminate the "voice" of SAMHSA customers and how well they are being served by the Agency.

SAMHSA integrates through its Knowledge Management System content, operations, and data collection and analytics on 430,000 inquiries to the contact center per year, 161,000 publication orders per year, 13,300,000 publications shipped each year, 1,700,000 SAMHSA Store visitors per year, email updates read by 8.2 million readers each year, 134,000 email update subscribers, more than 40,000 print subscribers and more than 337,000 online visits per year of the quarterly newsletter *SAMHSA News*, and 55,000 exhibit booth visitors per year. A new customer service launched in 2012 is SAMHSA Headlines. SAMHSA Headlines provides the behavioral health field with a sustained, systematic and predictable source of new information from SAMHSA.

Just as Americans are aware of the connection between hypertension, stroke and heart disease and take action to monitor their blood pressure, they can become aware of the connection between mental and substance use disorders and health and take action to prevent and treat these conditions. SAMHSA's Public Engagement Platform and new Web Program provides prevention, treatment and recovery support programs the communication channels needed to reach public and professional audiences with critical behavioral health information.
The Public Awareness and Support Initiative continues to be driven by research with SAMHSA stakeholders, including web-based public engagement strategies/platforms, and applies the communications and marketing principles of customer research and audience segmentation, message development and evaluation. Because it is based on customer needs and input, the

Public Awareness and Support Initiative is dynamic and evolving based on the shifting landscape of communications technologies and government involvement with the public.

Budget Request

The FY 2013 Budget request is $13.6 million, slightly less than the comparable FY 2012 Enacted Level. This funding level reflects the continued consolidation of funding sources for product development and dissemination contracts from across SAMHSA to support SAMHSA-wide professional training and public education activities. It also reflects ongoing efforts to consolidate multiple web sites resulting in more streamlined operations with improved capabilities.

Outcomes and Outputs
Program: Public Awareness Activities[1]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Target	FY 2012 Enacted Target	FY 2013 PB Target	FY 2013 PB Target +/- FY 2012 Enacted Target
2.3.76 Number of persons receiving prevention information indirectly from advertising, broadcast, or website (Output)	FY 2010: 1,136,172 Target: 906,707 (Target Exceeded)	1,250,000[2]	1,250,000[3]	250,000[4]	-1,000,000[5]
4.4.06 Percentage of persons reporting knowledge of how to find treatment services for mental and substance use disorders (Outcome)	N/A	N/A	N/A	N/A	N/A
4.4.07 Percentage of persons indicating they were screened by a health care provider for mental and substance use disorder (Outcome)	N/A	N/A	N/A	N/A	N/A

[1] There is no delay between fiscal year funding and the performance year.
[2] This is the FY 2012 target that is associated with the FY 2011 actual budget because there is a delay between fiscal year funding and the performance year.
[3] This is the FY 2013 target that is associated with the FY 2012 enacted budget because there is a delay between fiscal year funding and the performance year.
[4] This is the FY 2014 target that is associated with the FY 2013 President's Budget because there is a delay between fiscal year funding and the performance year.
[5] This is the difference between the FY 2013 PB Associated Target (FY 2014) and the FY 2012 Enacted Associated Target (FY 2013).

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Target	FY 2012 Enacted Target	FY 2013 PB Target	FY 2013 PB Target +/- FY 2012 Enacted Target
4.4.09 Percentage of children reporting their parents have talked to them about alcohol and drugs (Outcome)	FY 2010: 58.2% Target: 58.2% (Baseline)	N/A	58.2%	58.2%	Maintain

Performance & Quality Information Systems

(Dollars in thousands)

	FY 2011 Actual	FY 2012 Enacted	**FY 2013 Request**
Program Level……	$37,362	$12,940	$12,996
PHS Evaluation Funds (non-add).……			12,996

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

FY 2013 Authorization..... Expired

Allocation Method .....Contract

Program Description and Accomplishments

In January 2010, SAMHSA launched a new initiative focusing on data, outcomes, and quality. The goal of this initiative is to strengthen the integration of data begun with the previous data strategy. This new initiative will allow SAMHSA to meet the Administration's expectations for high quality and accessible data and create new opportunities to meet the information needs of individuals, families, and communities. A guiding principle of this new data strategy is that the data be meaningful and useful for decision-making and policy development. Central to this strategy is improving the balance in the collection of prevention and treatment data for substance use and mental disorders, providing clarity in how performance measures are collected and used, developing new mechanisms for coordinating across systems, and then disseminating quality information in a readily accessible format.

Integrating both performance data and information on the quality and effectiveness of interventions better serves State and community needs and promotes quality improvement efforts consistent with the President's health care reform goals. The Common Data Platform (CDP) initiative will coordinate the performance measurement efforts with quality improvement activities and promote greater efficiencies in the collection, analysis, and reporting of data and other information. It will also facilitate accountability and improve the quality and accessibility of data and other information for use by program staff, grantees, and the public. An important function of these activities will be its capacity to collect and disseminate data across prevention and mental health and substance abuse programs that share goals and funding lines; something extremely difficult to accomplish with the current idiosyncratic systems.

In FY 2011, SAMHSA began a process to modify the Substance Abuse Information System (SAIS), Prevention Management Reporting and Training Tool (PMRT) and the Transformation Accountability System (TRAC). SAMHSA also began the process of consolidating the data from the discretionary grants supported throughout SAMHSA into a CDP while maintaining the data currently available in the three systems for future analysis. The platform and warehouse were to be implemented in FY 2013. As the specifications and deliverables were developed for the new system, it became evident that further work on the contract was necessary to ensure that the system would meet the needs and expectations of SAMHSA and of each of the four Centers.

As a result, CBHSQ, working with CSAP, CSAT and CMHS, plans to fund a transitional data collection system in FY 2013 from a combination of funding from HSPS and PQIS in preparation for the full implementation of the Common Data Platform.

Concurrent with this effort, SAMHSA has taken steps to improve the activities of the National Registry of Evidence-based Programs and Practices (NREPP). Information on effective interventions will be more readily available to agency staff and stakeholders to inform decisions that can lead to improved service activities and outcomes for individuals who suffer from or who are at risk for mental and substance use disorders. Dissemination activities under this initiative will be further guided by the results of the ARRA-CER funded study on effective dissemination practices to be completed by 2012.

Funding History

FY	Amount
2008	$0
2009	$0
2010	$0
2011	$37,362,000
2012	$12,996,000

Budget Request

The FY 2013 Budget request is $13.0 million, a slight increase from the FY 2012 Enacted Level. Of the $13.0 million, $10.9 million is projected for the new Common Data Platform and $2.1 million is projected for the NREPP program. SAMHSA will be finalizing an acquisition proposal for an integrated performance measurement and management platform and anticipates an early FY 2013 contract award. CBHSQ, working with CSAP, CSAT and CMHS, will fund a transitional data collection system in FY 2013 from HSPS and PQIS as the Common Data Platform becomes fully operational.

Outcomes and Outputs

Program: Performance and Quality Information Systems

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Target	FY 2012 Enacted Target	FY 2013 PB Target	FY 2013 PB Target +/- FY 2012 Enacted Target
4.4.10 Combined count of webpage hits, hits to the locator, and hits to SAMHDA for SAMHSA-supported data sets (Output)	FY 2011: 3,864,940 Target: 5,585,000 (Target Not Met)	5,585,000	6,000,300	3,981,414	-2,018,886
4.4.11 Number of evidence-based programs or practices in review (Output)	FY 2011: 52 Target: 42 (Target Exceeded)	42	44	46	N/A

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Agency-Wide Initiatives

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
Agency-Wide Initiatives……	**$5,250**	**$3,493**	**$40,000**
Behavioral Health Information Technology (non-add).	*5,250*	---	---
Military Families Initiative (non-add)……	---	*3,493*	---
Behavioral Health – Tribal Prevention Grant (non-add)	---	---	*40,000*
ACA Prevention Fund (non-add)……	---	---	*40,000*

Authorizing Legislation .....Section 516 and 520A of the PHS Act

FY 2013 Authorization .....N/A

Allocation Method ..... Discretionary Grants

Program Descriptions and Accomplishments

Military Families

In FY 2012, SAMHSA will conduct at least two Service Members, Veterans, and their Families (SMVF) Policy Academies for the remaining 27 states that have not yet participated, as well as for the Virgin Islands and Guam. SAMHSA's Policy Academies help states and territories strengthen their behavioral health care systems and services for SMVF through the development of interagency strategic plans and the provision of technical assistance to facilitate implementation of those plans. The strategic plans developed by the Policy Academies will be able to be implemented immediately; thereby assuring the maximum impact will be felt in a short time. SAMHSA will also provide intensive technical assistance to those states and territories to ensure implementation of evidence-based behavioral health prevention, treatment, and recovery support services that advance and sustain the interagency approach to their strategic plan, and that meet the behavioral health needs of service members (especially National Guard and Reserves), veterans, and their families. The intensive technical assistance provided will greatly assist in the building of linkages between evidence-based services and recovery support services. As the Policy Academies are designed to be stand-alone programs that will be tailored to each State and Territory, the program can be quickly brought to scale in additional states without the need for annual support.

Behavioral Health – Tribal Prevention Grant Budget Request

The FY 2013 Budget Request is $40.0 million, a $36.507 million increase over the comparable FY 2012 Enacted Level. This funding is requested through the Prevention and Public Health Fund of the ACA. The final distribution of $40.0 million will be determined by a formula that will be developed in consultation with Tribes.

SAMHSA recognizes that Tribes currently receive different levels of mental health and substance abuse prevention services. Through the Behavioral Health - Tribal Prevention Grant (BH-TPG), all Tribes would be eligible for a base funding amount, with the remaining funds distributed to best serve the Tribal populations. SAMHSA has held consultations consistent with SAMHSA's Tribal Consultation Policy and will utilize the outcome of these consultations to determine how these funds would be best distributed to address as many of the needs of the Tribes as possible. The BH-TPG provides enhanced substance abuse (including alcohol) and suicide prevention funding to the Tribes to assure that their pressing needs are being met. This effort follows the lead of the President and Congress who have emphasized the importance of emotional health, prevention, and health promotion, and who have shown a commitment to the trust relationship of the Federal government with and for Federally-recognized Tribes.

The program will provide formula-based funds to Tribes who choose to apply. This will enable Tribes to develop a comprehensive plan to address the most pressing need based on treatment data as well as in consultation with SAMHSA. The plan would address the prevention of substance abuse and suicide, and will provide for coordinated services. This planning activity is one of the basic components of the Tribal Law and Order Act (TLOA) and the Indian Alcohol and Substance Abuse Act, which SAMHSA is charged by statute to coordinate. Tribes will continue to be eligible for these funds beyond the three-year time frame so long as they meet the requirements of renewal applications, provide the necessary annual reports, and show continued movement toward implementing their approved plans.

The plan will reflect the results of an assessment of need, a review of the resources and capacity within the Tribal communities, a plan for carrying out the strategy, a monitoring of the strategy as implemented, and an evaluation of the strategy to identify strengths and weaknesses. SAMHSA will review and approve the plans.

Tribes will be allowed to use a set percentage (determined based on consultations with the Tribes) of the funds for a combination of service and service-related activities, development and dissemination of prevention messages, and provider development and linkage building to support the Tribes in achieving outcomes. Funding for infrastructure activities will enable the Tribe to build service capacity. The Tribe will present data to support how the allocation will support infrastructure and/or provision of services. In carrying out these activities, the Tribe will be required to use comprehensive, evidence-based programming, and/or proven successful programming, based on either mainstream science or proven Tribal traditions. Up to 20 percent of the grant funds may be used to fund key support and development activities, such as operation of a Tribal prevention advisory group, support for a Tribal community coalition, access to an epidemiological work group, training and technical assistance to communities, data collection and evaluation, and oversight and monitoring of activities.

Approximately 75 percent of Federally-recognized tribes have a total enrollment of 2,000 or fewer persons and a greater percentage of these tribes have limited internal capacity or infrastructure in place to implement and support needed behavioral health services. Smaller Tribes will have the opportunity to work in collaboration with other small Tribes to maximize the impact of the resources. SAMHSA will continue to consult with the smaller Tribes to ensure that their needs are being met while reducing service overlap.

To ensure that providers in both the mental health and substance abuse fields are trained in both substance abuse and mental illness prevention and emotional health concepts and practices, Tribes will be able to use funds for coordinated workforce development, training in evidence-based practices, and the development of coordinated infrastructure and service delivery systems.

Outcomes and Outputs

Program: Military Families Initiative

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.4.26 The number of behavioral health outcomes for military personnel and their families served through SAMHSA supported programs (Outcome)	N/A	N/A	N/A	N/A	N/A
3.4.27 Percentage of adults receiving services who report improved functioning (Outcome)	N/A	N/A	N/A	N/A	N/A
3.4.28 Percentage of children receiving services who report improved functioning (Outcome)	N/A	N/A	N/A	N/A	N/A
3.4.29 Percentage of adults receiving services who had a permanent place to live in the community (Outcome)	N/A	N/A	N/A	N/A	N/A

Program: Behavioral Health-Tribal Prevention Grants

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
2.3.92 Number of persons served (Output)	N/A	N/A	N/A	Baseline August 2014	N/A
2.3.93 Percentage of youth age 12-20 who report drinking in the past month (Outcome)	N/A	N/A	N/A	Baseline August 2014	N/A
2.3.98 Percentage of persons aged 12 and older who report suicide ideation (Outcome)	N/A	N/A	N/A	Baseline August 2014	N/A

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

RESOURCE SUMMARY

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Pres. Budget
Drug Resources by Function			
Prevention	562,349	561,041	539,923
Treatment	2,014,495	2,004,787	1,930,948
Total, Drug Resources by Function	**2,576,844**	**2,565,828**	**2,470,871**
Drug Resources by Decision Unit			
Substance Abuse Prevention [1/]			
Programs of Regional and National Significance	75,956	76,202	65,877
Substance Abuse- State Prevention Grant	451,107	453,980	404,501
Total, Substance Abuse Prevention	**527,063**	**530,182**	**470,378**
Substance Abuse Treatment [1/]			
Programs of Regional and National Significance	431,389	425,243	364,139
Substance Abuse Block Grant	1,441,962	1,456,106	1,448,630
Total, Substance Abuse Treatment	**1,873,351**	**1,881,349**	**1,812,769**
Health Surveillance and Program Support			
Prevention	35,286	30,859	69,545
Treatment	141,144	123,438	118,179
Total, Health Surveillance and Program Support	**176,430**	**154,297**	**187,724**
Total, Drug Resources by Decision Unit	**2,576,844**	**2,565,828**	**2,470,871**
Drug Resources Personnel Summary			
Total FTEs (direct only)	**547**	**574**	**574**
Drug Resources as a Percent of Budget			
Total Agency Budget	**$3,599,081**	**$3,564,687**	**$3,422,766**
Drug Resources Percentage	**71.6%**	**72.0%**	**72.2%**

Footnotes

[1] A detailed breakout of programs within the Programs of Regional and National Significances can be found on the following page; does not include Mental Health Programs.

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Drug Budget Split between Prevention and Treatment FY 2011-FY 2013

(Dollars in Thousands)

Substance Abuse Prevention	FY 2011 Actual	FY 2012 Enacted	FY 2013 Pres. Budget
Substance Abuse Prevention PRNS			
Manadatory Drug Testing	$4,906	$5,196	$4,906
Minority AIDS Initiative	41,385	41,307	41,307
STOP Act	7,000	6,987	7,000
ACA Prevention Fund (non-add)	---	---	*7,000*
Fetal Acohol Syndrome	9,821	9,802	1,000
Center for the Application of Prevention Technologies	8,074	8,059	7,511
Science and Service Program Coordination	4,789	4,780	4,082
Minority Fellowship Program	71	71	71
Total, Substance Abuse Prevention PRNS	**75,956**	**76,202**	**65,877**
Substance Abuse - State Prevention Grant	451,107	453,980	404,501
Strategic Prevention Framework (non-add)	*110,417*	*109,754*	*60,275*
Total, Substance Abuse -State Prevention Grant	**451,107**	**453,980**	**404,501**
Total, Substance Abuse Prevention	**527,063**	**530,182**	**470,378**
Health Surveillance and Program Support			
Health Surveillance and Program Support	23,958	24,864	24,231
Public Awareness and Support	2,806	2,709	2,714
PHS Evaluation Funds (non-add)	---	---	*1,900*
Performance and Quality Information Systems	7,472	2,588	2,599
PHS Evaluation Funds (non-add)	---	---	*2,599*
Behavioral Health IT	1,050	---	---
Military Families	---	699	---
Tribal Prevention Grants	---	---	40,000
ACA Prevention Fund (non-add)	---	---	*40,000*
Total, Substance Abuse Prevention HSPS	**35,286**	**30,859**	**69,545**
Total, Substance Abuse Prevention	**$562,349**	**$561,041**	**$539,923**

Drug Budget Split between Prevention and Treatment FY 2011-FY 2013

(Dollars in Thousands)

Substance Abuse Treatment	FY2011 Actual	FY2012 Enacted	FY2013 Pres. Budget
Substance Abuse Treatment PRNS			
Co-occurring State Incentive Grants (S!Gs)	4,173	---	---
Opioid Treatment Programs/Regulatory Activities	8,553	8,886	8,886
Screening, Brief Intervention and Referral to Treatment	51,662	51,187	30,000
ACA Prevention Fund (non-add)	*25,000*	*25,000*	*30,000*
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	---
ICE - General	28,033	27,980	13,256
Pregnant & Postpartum Women	15,878	15,970	15,970
Strengthening Treatment Access and Retention	1,775	1,672	1,000
Recovery Community Services Program	5,236	2,445	2,445
Access to Recovery	98,954	98,268	93,776
Children and Family Programs	30,670	30,620	29,678
Treatment Systems for Homeless	41,650	41,571	41,571
Minority AIDS	65,988	65,863	52,359
Criminal Justice Activities	65,188	66,903	65,135
Addiction Technology Transfer Centers	9,081	9,064	8,081
Minority Fellowship Program	547	546	546
Special Initiatives/Outreach	2,000	2,267	1,436
Total, Substance Abuse Treatment PRNS	431,389	425,243	364,139
Substance Abuse Block Grant	$1,441,962	$1,456,106	$1,448,630
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*71,724*
Total, Substance Abuse Block Grant	1,441,962	1,456,106	1,448,630
Health Surveillance and Program Support			
Health Surveillance and Program Support	95,831	99,455	96,926
Public Awareness and Support	11,223	10,836	10,857
PHS Evaluation Funds (non-add)	---	---	*10,857*
Performance and Quality Information Systems	29,890	10,352	10,397
PHS Evaluation Funds (non-add)	*6,596*	---	*10,397*
Behavioral Health IT	4,200	---	---
Military Families	---	2,794	---
Tribal Prevention Grants	---	---	---
Total, Substance Abuse Prevention HSPS	141,144	123,438	118,179
Total, Substance Abuse Treatment	$2,014,495	$2,004,787	$1,930,948

MISSION

The Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA supports the *President's National Drug Control Strategy* through a broad range of programs focusing on prevention, treatment and recovery from substance abuse. Major programs for FY 2013 will include the Substance Abuse Block Grant, the new Substance Abuse – State Prevention Grant program, competitive grant programs reflecting Programs of Regional and National Significance (PRNS) and Health Surveillance and Program Support. These programs are administered through SAMHSA's Centers for Substance Abuse Prevention (CSAP) and Substance Abuse Treatment (CSAT) as well as through SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) and the Office of Communications.

METHODOLOGY

SAMHSA distributes drug control funding into two functions: prevention and treatment. Included in prevention are SAMHSA/CSAP funds supporting the new Substance Abuse – State Prevention Grant program, competitive grant programs, programs funded through the Prevention and Public Health Fund of the ACA Prevention Fund (including the new Behavioral Health – Tribal Prevention Grant program), and 20 percent of SAMHSA Program Management funds. Included in treatment are SAMHSA/CSAT funds supporting Programs of Regional and National Significance (PRNS), 100 percent of the Substance Abuse Prevention and Treatment Block Grant (SABG) funds, and 80 percent of SAMHSA Program Management funds.

The above methodology was the original methodology as approved by ONDCP. From time to time it is prudent to revisit the methodology as restructurings occur and programs change. In light of the restructuring proposed in the FY 2012 President's Budget and the appropriations account changes in the FY 2012 Consolidated Appropriations Act, SAMHSA is now considering a new methodology for calculating the drug budget under the new budget structure. Under the new methodology, all funding for the Substance Abuse Prevention and funding for the Substance Abuse Treatment activities are included in the drug budget. Most of the funding for Health Surveillance and Program Support would be included in the drug budget. Since the new PAS and PQIS represent the consolidation of funding from existing CSAT, CSAP and CMHS programs, 70 percent of funding for these activities would be included in the drug budget which represents the split between mental health and substance abuse for the entire agency. New agency-wide programs, such as Military Families and Behavioral Health-Tribal Prevention grants would be evenly split between mental health and substance abuse.

SAMHSA distributes drug control funding into two functions: prevention and treatment. Included in prevention are the funds in the new Substance Abuse Prevention appropriation, including the Substance Abuse Prevention Programs of Regional and National Significance and the Substance Abuse – State Prevention Grant program. Also included in prevention are 20 percent of the Performance and Quality Information Systems and Public Awareness and Support programs, a portion of the Agency-wide Initiatives including the new Behavioral Health – Tribal Prevention Grant program funded through the Prevention and Public Health Fund of the ACA, and 20 percent of the remaining funding in Health Surveillance and Program Support. Included in treatment are the funds in the new Substance Abuse Treatment appropriation, including the Substance Abuse Treatment Programs of Regional and National Significance and 100 percent of the Substance Abuse Block Grant funds. Also included in treatment are 80 percent of the Performance and Quality Information Systems and Public Awareness and Support programs, a portion of the Agency-wide Initiatives, and 80 percent of the remaining funding in Health Surveillance and Program Support.

BUDGET SUMMARY

In FY 2013, SAMHSA requests a total of $2,470,871 million for drug control activities, which is a decrease of $95.0 million from the FY 2012 level. The Budget directs resources to activities that have demonstrated improved health outcomes and that increase service capacity. SAMHSA has three major drug-related decision units: Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support. Each decision unit is discussed below:

Substance Abuse Prevention

Substance Abuse Prevention Programs of Regional and National Significance
Total FY 2013 Request: $65.9 million
(Reflects $10.2 million decrease from FY 2012)

The Substance Abuse Prevention Programs of Regional and National Significance (PRNS) support States and communities in carrying out an array of activities to improve the quality and availability of services in priority areas.

The FY 2013 President's Budget request for SAMHSA Substance Abuse Prevention PRNS includes $65.9 million which covers seven programmatic activities, a decrease of $10.2 million from the FY 2012 level. The request includes: $41.3 million for Minority AIDS; $; $1.0 million for the Fetal Alcohol Spectrum Disorders (FASD) contract; $7.5 million to continue provision of technical assistance to maximize effectiveness through the Centers for the Application of Prevention Technologies; $4.9 million for Mandatory Drug Testing and $4.1 million for other PRNS activities such as Science and Service Program Coordination, and Minority Fellowship Program.

Minority AIDS Initiative
Total FY 2013 Request: $41.3 million
(Reflects same level as FY 2012)

SAMHSA/CSAP's Minority AIDS Program, implemented in FY 1999, supports efforts to reduce health disparities in minority communities by delivering and sustaining high quality and accessible substance abuse and HIV prevention services. The program strategies include implementing evidence-based prevention practices targeting subpopulations, conducting HIV testing and referral for treatment, and preventing/reducing the risk of substance use disorders and/or HIV. Grantees are required to target one or more high-risk populations such as African American women, adolescents, or individuals who have been released from prisons and jails within the past two years.

In addition to the existing MAI cohorts, SAMHSA awarded grants for the FY 2011 Minority AIDS Initiative Targeted Capacity Expansion Integrated Behavioral Health/Primary Care Network Cooperative Agreements. This grant program will facilitate the development and expansion of culturally competent and effective integrated behavioral health and primary care networks, which include HIV services and medical treatment, within racial and ethnic minority communities in the 12 Metropolitan Statistical Areas and Metropolitan Divisions most impacted by HIV/AIDS. Expected outcomes include: reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas.

The FY 2013 Request supports 67 continuations and 16 new grants.

Fetal Alcohol Center of Excellence
Total FY 2013 Request: $1.0 million
(Reflects $8.8 million decrease from FY 2012)

SAMHSA's Fetal Alcohol Spectrum Disorder programming has focused on identifying and disseminating information about innovative techniques and effective evidence-based strategies for preventing Fetal Alcohol Spectrum Disorder and increasing functioning and quality of life for individuals and their families impacted by these disorders. In FY 2012, SAMSHA's will emphasize and expand prevention strategies to prevent alcohol use among women of childbearing age and will provide funding to support a new Contract.

The FY 2013 request will provide $1.0 million in continuation funding for the FASD contract.

Center for the Application of Prevention Technologies
Total FY 2013 Request: $7.5 million
(Reflects a $0.5 million decrease from FY 2012)

The Center for the Application of Prevention Technologies (CAPT) promotes state-of-the-art prevention technologies through three core strategies: 1) establishment of technical assistance networks using local experts from each of their five regions; 2) development of training activities; and 3) innovative use of communication media such as teleconference and video conferencing, online events, and Web-based support. These training and technical assistance activities are designed to build the capacity of SAMHSA grantees and develop the skills, knowledge, and expertise of their prevention workforce. These activities will help support the delivery of effective prevention programs and practices and the development of accountability systems for performance measurement and management.

During FY 2012, the CAPT expects to deliver approximately 1,400 capacity- building technical assistance services to more than 7,000 people and orchestrated 400 events for 10,000 people. Topics include the use of evidence-based environmental strategies to reduce underage drinking, the application of behavioral health indicators for substance abuse prevention planning, the use of traditional and cultural practices as prevention strategies within indigenous populations, and the diffusion of state-of-the-art methods to guide intra-State training and technical assistance (T/TA) prevention systems. In addition, the CAPT will develop workforce development products, including skills training, fact sheets, and a web-based toolkit; and will provide evaluation capacity-building technical assistance to 53 community-based prevention programs and to 24 Science-to-Service programs. They also will plan and facilitate a program for special populations including Pacific Islanders and Tribal grantees. Finally, the CAPT will develop training and materials for SAMHSA special issues, including webinars on best practices, epidemiological data, evidence- programs, and evaluation techniques.

The FY 2013 request provides $7.5 million in funding for a new CAPT contract to continue to promote prevention technologies.

Other PRNS Activities
Total FY 2013 Request: $4.1 million
(Reflects $0.7 million decrease from FY 2012)

In FY 2012, $4.8 million in funding will support contracts that provide technical assistance and training to States, Tribes, communities, and grantees around substance abuse prevention. In addition, $0.071 million funding will be provided for continuation of the Minority Fellowship Grants.

The FY 2013 request includes resources of $4.1 million for other PRNS activities such as Science and Service Program Coordination, and Minority Fellowship Program.

Substance Abuse –State Prevention Grant
Total FY 2013 Request: $404.5 million
(Reflects $49.5 million decrease from FY 2012)

The SA-SPGs draw upon the strengths of both Block Grant and discretionary approaches. First, through the 20 percent prevention set-aside of the current formula-based Substance Abuse Prevention and Treatment Block Grant (SABG) program, SAMHSA will ensure funding availability and decision-making authority for prevention at the State level. At the same time, SAMHSA has guided the development of data-driven, needs-based, evidence-proven methods for facilitating substance abuse prevention through its discretionary programs, including the SPF-SIG. The new SA-SPG program integrates key aspects of both approaches in a systematic and logical approach designed to avoid duplication, improve coordination, increase accountability, prioritize high-need communities, focus exclusively on substance abuse prevention and require States and Territories to support communities in achieving outcomes. The SA-SPG program will build on the success of the planning approach promoted through the SPF-SIG, bringing it to scale nationwide and shepherding successes into the next step of development.

The SA-SPG will provide formula-based prevention funding to ensure that every State and Territory is able to make prevention of substance abuse a priority. The SA-SPG will allow States and Territories to address substance abuse prevention at three levels: universal prevention, which addresses populations at large; selected prevention, which targets subgroups of the population that share common risks of developing substance use disorders (such as children with a family history of substance abuse or schools in high poverty areas); and indicated prevention, which addresses individuals with multiple risk factors, early symptoms, or behaviors that are precursors for substance abuse, but who do not require treatment for substance abuse. States/Territories and communities will be able to utilize environmental and individual prevention approaches to achieve measurable results. This new program supports SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative, which aims to support

individuals, families, schools, workplaces, communities and States and Territories take action to strengthen protective factors and reduce risk factors for substance abuse (including tobacco) and to create environmental changes that support community living without the use of substances of abuse

The FY 2013 Budget request is $404.501 million, a $49.479 million decrease from the comparable FY 2012 Enacted Level. The amount includes funding from the 20 percent prevention set-aside requirement of the SABG, and fully funding the $60.275 million of FY 2013 continuation grants under the current Strategic Prevention Framework program. The final allocation for this program will be determined by a formula that will be developed after discussion with State and Territory representatives and based on amounts appropriated by Congress.

Substance Abuse Treatment

Substance Abuse Treatment Programs of Regional and National Significance
Total FY 2013 Request: $364.1 million
(Reflects $61.1 million decrease from FY 2012)

The Substance Abuse Treatment Programs of Regional and National Significance (PRNS) support States and communities in carrying out an array of activities to improve the quality and availability of services in priority areas.

The FY 2013President's Budget request for SAMHSA Substance Abuse Treatment PRNS includes $364.1 million which covers fifteen programmatic activities, a decrease of $61.1 million from the FY 2012 level. The request includes: $93.8 million for Access to Recovery; $30.0 million for Screening, Brief Intervention and Referral to Treatment; $41.6 million for Treatment Systems for Homeless; $65.1 million for Criminal Justice Activities of which $42.9 million will fund Drug Courts and $18.5 million for Ex- Offender Reentry.

Access to Recovery
FY 2013 Request: $93.8 million
(Reflects $4.5 million decrease from FY 2012)

FY 2013 resources for ATR reflect $93.8 million to support continuations for the third cohort (approximately 30 grants). ATR is designed to: (1) allow recovery to be pursued through personal choice and many pathways; (2) require grantees to manage performance based outcomes that demonstrate client successes; and, (3) expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services. The program is administered through recognized Tribal Organizations or through the Single State Authority overseeing substance abuse activities. ATR uses vouchers, coupled with state flexibility and executive discretion, to offer an opportunity to create positive change in substance use disorder treatment and recovery service delivery across the Nation.

ATR was launched in 2004 when 15 three-year grants were awarded, which provided services to almost 200,000 clients. A second cohort of 24 three-year ATR grants was awarded in September 2007. The second ATR cohort was projected to serve a target number of 30,000 clients in its first year (FY 2008); however, the actual number served was more than 50,000. The number served in FY 2009 was approximately 89,600 which exceeded the target of 65,000 clients.

The third cohort of ATR, which began in FY 2010, was expanded to a four-year program. FY 2010 program outcome data show that 82.9 percent of the clients had success achieving and maintaining no past month substance use. In addition, by six month follow-up, 47 percent reported being housed; 96 percent had no involvement in the criminal justice system; and 91 percent reported being socially connected. The recommended target is 225,000 clients for this third cohort, with approximately 33,500 to be served in the first year, 70,750 clients to be served

in the two subsequent years, and 50,000 to be served in the final year. In its first year of operation, this cohort of ATR has exceeded its target of 33,500 having served over 47,000 clients.

In FY 2012,SAMHSA will fund the continuation of 30 grants and 1 contract. The FY 2013 Request supports 30 grant continuations.

Treatment Drug Courts
FY 2013 Request: $42.9 million
(Reflects $1.8 million decrease from FY 2012)

Drug courts are problem-solving courts which help reduce recidivism and substance abuse among offenders and increase an offender's likelihood of successful rehabilitation through early, continuous, and intense judicially supervised treatment, mandatory periodic drug testing, community supervision, and appropriate sanctions and other habilitation services. In FY 2010, SAMHSA funded 17 new adult Problem Solving Court grants and 8 new juvenile Problem Solving Court grants for three years at an average cost of $325,000 per year. There were also 3 new juvenile Problem Solving Court grants that were funded in collaboration with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the Department of Justice for four years at an average cost of $200,000 per year. These funds will provide services to support substance abuse treatment, assessment, case management, and program coordination for those in need of treatment drug court services. Priority for the use of funding will be given to address gaps in the continuum of treatment.

In FY 2010, SAMHSA and the Office of Justice Programs /Bureau of Justice Affairs (BJA) developed a joint program to enhance court services, coordination, and substance abuse treatment capacity of adult drug courts. The purpose of this joint initiative is for applicants to submit one application that outlines a comprehensive strategy for enhancing drug court capacity. SAMHSA and BJA jointly funded 28 new adult Problem Solving Court grants. Each grantee was awarded one separate grant from each agency, representing an innovative braided funding opportunity. This collaboration was modeled after a successful collaborative grant program initiated in FY 2009 between SAMHSA and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to support juvenile drug courts.

In FY 2012, SAMHSA will continue to provide technical assistance and support States and communities in implementing flexible solutions to address the burdensome problems of substance abuse, mental illnesses, and co-occurring disorders in the criminal justice system through collaboration between the Center for Substance Abuse Treatment and the Center for Mental Health Services. This approach helps local courts find the model that best meets their needs and capacities. It also encourages partnership with the behavioral health system to allocate treatment and recovery support services effectively and efficiently.

The FY 2013 Request supports 93 continuation and 22 new grants

Ex-Offender Re-Entry Program
FY 2013 Request: 16.4 million
(Reflects same level as FY 2012)

SAMHSA recognizes the need to continue efforts to return and reintegrate offenders back into the community by providing substance abuse treatment and other related re-entry services while also ensuring public safety for the community and family. The ex-offender re-entry grants provide screening, assessment and comprehensive treatment and recovery support services to offenders reentering the community, as well as offenders who are currently on or being released from probation or parole.

SAMHSA and DOJ/Bureau of Justice Assistance share a mutual interest in supporting and shaping offender re-entry-treatment services, as both agencies fund "offender re-entry" programs. These two Agencies have a longstanding partnership regarding criminal justice-substance abuse treatment issues. SAMHSA and DOJ/Bureau of Justice Assistance have developed formal agreements to further encourage and engage in mutual interests and activities related to criminal justice-treatment issues. SAMHSA and DOJ/Bureau of Justice Assistance will continue to plan and coordinate relevant activities. Offender Re-entry Program grantees are expected to seek out and coordinate with local Federally-funded offender re-entry initiatives, including DOJ/Bureau of Justice Assistance's Prisoner Re-entry Initiative or "Second Chance Act" offender re-entry programs, as appropriate.

In FY 2012, SAMHSA will fund the continuation of 29 grants and 3 contracts as well as 9 new grants. The FY 2013 Request supports 20 continuation and 18 new grants.

Treatment Systems for Homeless Programs
FY 2013 Request: $41.6 million
(Reflects same level as FY 2012)

SAMHSA/CSAT manages two grant portfolios under its Grants for the Benefit of Homeless Individuals (GBHI) program, both of which provide focused services to individuals with a substance use disorder or who have co-occurring disorders. Through a recovery and public health oriented system of care, grantees are encouraged to address gender, age, race, ethnicity, sexual orientation, disability status, veteran's status, and criminal justice status as these issues relate to both substance use disorder services and co-occurring disorder services for homeless individuals. .

The FY 2013 Budget request for this program is aligned with "Opening Doors: the Federal Strategic Plan to Prevent and End Homelessness" which was released in June 2010 by the U.S. Interagency Council on Homelessness. It is aligned with Objective 4: Provide permanent supportive housing to prevent and end chronic homelessness and Objective 7: Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness. The GBHI program is an essential piece to accomplishing the goals of the Plan.

In FY 2012, SAMHSA will fund the continuation of 95 grants and 2 contracts. The FY 2013 Request supports the continuation of 72 grants and 2 contracts as well as 23 new grants

Other PRNS Treatment Programs
FY 2013 Request: $163.7 million
(Reflects $54.3 million decrease from 2012)

The FY 2013 Budget includes resources of $163.7 million for several other Treatment Capacity programs including:; Strengthening Treatment Access and Retention; the Minority AIDS Initiative; Children and Family Programs; Pregnant and Post-Partum Women (PPW); Recovery Community Services Program (RCSP); Minority Fellowship Program; Special Initiatives/Outreach; Addiction Technology Transfer Centers; Military Families, Health Information Technology; and Targeted Capacity Expansion (TCE) General. The FY 2012 Budget includes funds for continuing grants and contracts in the various programs, and reflects discontinuation of one-time Congressional projects. Grant funding will be used to enhance overall drug treatment quality by incentivizing treatment providers to achieve specific performance targets. Examples of grant awards could include supplements for treatment providers who are able to connect higher proportions of detoxified patients with continuing recovery-oriented treatment; or for outpatient providers who are able to successfully retain greater proportions of patients in active treatment participation for longer time periods.

In FY 2012, SAMHSA will fund the continuation of 210 grants and 37 contracts as well as 103 new grants. The FY 2013 request supports the continuation of 194 grants and 21 contracts as well as 79 new grants and 7 new contracts.

Substance Abuse Block Grant
FY 2013 Request: $1.449 billion
(Reflects $7.5 million decrease from 2012)

The overall goal of the SABG is to support and expand substance abuse treatment services, while providing maximum flexibility to states. States and territories may expend their funds only for the purpose of planning, carrying out, and evaluating activities related to these services. States may provide SABG funds to community and faith-based organizations to provide services. Of the amounts appropriated for the SABG, 95 percent are distributed to states through a formula prescribed by the authorizing legislation. Factors used to calculate the allotments include total personal income; state population data by age groups (total population data for territories); total taxable resources; and a cost of services index factor. Remaining funds are used for data collection, technical assistance, and program evaluation, which are retained by SAMHSA for these purposes. The set-aside is distributed among CSAP, CSAT, and CBHSQ for purposes of carrying out the functions prescribed by the SABG legislation. The FY 2010 resources of $1.455 billion provided grant awards to 60 jurisdictions: states, territories, the District of Columbia, and the Red Lake Band of Chippewa Indians in Minnesota. These resources will support approximately 2 million treatment episodes. The SABG program in FY 2011 is funded at the same level as FY 2010, and will provide support to the current 60 jurisdictions for a similar level of prevention and treatment services. The FY 2012 request of $1.499 billion will provide support to the current 60 jurisdictions for a similar level of treatment services.

Health Surveillance and Program Support

The FY 2013 Request of $187.7 million, supports staffing and activities to administer SAMHSA programs. This includes:

Health Surveillance and Program Support
FY 2013 Request: $121.2 million
(Reflects $3. 2 million decrease from 2012)

Health Surveillance and Program Support provides funding for personnel costs, building and facilities, equipment, supplies, administrative costs and associated overhead to support SAMHSA programmatic activities as well as providing funding for SAMHSA national data collection and survey systems, funding to support the CDC NHIS Survey, and the data archive. This represents 100% of the total funding available for these activities which is which is split 80/20 between Treatment and Prevention.

Public Awareness and Support
FY 2013 Request: $13.6 million
(Reflects $0.03 million increase from 2012)

Public Awareness and Support provides funding to support the unified communications approach to increase awareness of behavioral health, mental disorders and substance abuse issues. . This represents 100% of the total funding available for these activities which is split 80/20 between Treatment and Prevention.

Performance and Quality Information Systems
FY 2013 Request: $13.0 million
(Reflects $0.06million increase from 2012)

Performance and Quality Information Systems provides funding to support the Consolidated Data Platform as well as the transition from legacy systems. This represents 100% of the total funding available for these activities which is split 80/20 between Treatment and Prevention.

Behavioral Health – Tribal Prevention Grant
FY 2013 Request: $40.0million
(New for FY 2013)

Behavioral Health – Tribal Prevention Grant, requested from ACA Prevention Fund to provide a formula-based grant program to deliver behavioral health services specifically to Tribal populations. This represents 100% of the total available for this activity, consistent with our Drug Budget methodology and of which 100% is allocated to Prevention.

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SAMHSA
Affordable Care Act Prevention and Public Health Fund
Summary of Programs
(Dollars in Thousands)

ACA Prevention Fund	FY 2011 Enacted	FY 2012 President's Budget	FY 2013 OMB Request	FY 2013 +/- FY 2012
Behavioral Health - Tribal Prevention Grants	---	---	$40,000	+$40,000
Primary and Behavioral Health Care Integration	35,000	35,000	28,000	-7,000
Screening, Brief Intervention, & Referral to Treatment	25,000	25,000	30,000	+5,000
Garrett Lee Smith Youth Suicide Prevention Activities	10,000	10,000	---	-10,000
STOP UAD Act	---	---	7,000	+7,000
Health Surveillance	18,000	18,000	---	-18,000
Total, ACA Prevention Fund	**$88,000**	**$88,000**	**$105,000**	**+$17,000**

The FY 2013 President's Budget Request for Affordable Care Act (ACA) Prevention and Public Health Funds is $105 million, an increase of $17 million from the FY 2012 Enacted Level. The Budget Request includes $40 million for the new Behavioral Health-Tribal Prevention Grants (new for FY 2013), $28 million for the Primary and Behavioral Health Care Integration program (a decrease of $7 million from FY 2012), $30 million for Screening, Brief Intervention, & Referral to Treatment (an increase of $5 million from FY 2012), and $7 million for STOP UAD Act program (an increase of $7 million from FY 2012).

The FY 2013 ACA Prevention Fund Budget Request includes the following increases:

Behavioral Health-Tribal Prevention Grants: (+$40.0 million)
$40 million for Agency-Wide Initiatives for the Behavioral Health – Tribal Prevention Grant, from the ACA Prevention Fund to provide a formula-based grant program to deliver behavioral health services specifically to Tribal populations.

Sober Truth on Preventing Underage Drinking Act (STOP UAD Act): (+$7.0 million)
$7 million requested from the ACA Prevention Fund (an increase of $7.0 million from FY 2012 ACA Prevention Funds). The activity level is funded at the Program Level.

Screening, Brief Intervention and Referral to Treatment: (+$5.0 million)
$30 million, requested from the ACA Prevention Fund (an increase of $5 million from the FY 2012 ACA Prevention Funds). When accounting for discretionary funds, the Budget includes a total reduction of -$23.2 million for the program.

The FY 2013 ACA Prevention Fund Budget Request includes the following decreases:

Primary and Behavioral Health Care Integration: (-$17.0 million)
$28.0 million, requested from the ACA Prevention Fund (a decrease of -$17.0 million from the FY 2012 ACA Prevention Funds). When accounting for discretionary funds, the Budget includes a total reduction of -$39.7 million for the program.

The FY 2013 Budget Request does not include funding for the following:

Garrett Lee Smith Youth Suicide Prevention Activities:
No ACA Prevention Funds are being requested for FY 2013. A total of $44.7 million is being requested from Discretionary Budget Authority for these programs. Additional details can be found in the Mental Health Chapter of this Congressional Justification.

Health Surveillance Activities:
No ACA Prevention Funds are being requested for FY 2013. A total of $74.2 million is being requested from Discretionary Budget Authority for Health Surveillance and Program Support activities. Additional details can be found in the Health Surveillance and Program Support Chapter of this Congressional Justification.

Behavioral Health - Tribal Prevention Grants

(Dollars in Thousands)

	FY 2011 Actuals	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Program Level	---	---	$40,000	+$40,000
ACA Prevention Fund (non-add)	---	---	*(40,000)*	*(+40,000)*

Authorizing Legislation .....Section 516 and 520A of the PHS Act and Section 4002 of the Patient Protection and Affordable Care Act

FY 2013 Authorization .....N/A

Allocation Method ..... Discretionary Grants

BH – TPG Budget Request

The FY 2013 Budget Request is $40.0 million, a $36.5 million increase over the comparable FY 2012 Enacted Level. This funding is requested through the Prevention and Public Health Fund of the ACA. The final distribution of $40.0 million will be determined by a formula that will be developed in consultation with Tribes.

SAMHSA recognizes that Tribes currently receive different levels of mental health and substance abuse prevention services. Through the Behavioral Health - Tribal Prevention Grant (BH-TPG), all Tribes would be eligible for a base funding amount, with the remaining funds distributed to best serve the Tribal populations. SAMHSA has held consultations consistent with SAMHSA's Tribal Consultation Policy and will utilize the outcome of these consultations to determine how these funds would be best distributed to address as many of the needs of the Tribes as possible. The BH-TPG provides enhanced substance abuse (including alcohol) and suicide prevention funding to the Tribes to assure that their pressing needs are being met. This effort follows the lead of the President and Congress who have emphasized the importance of emotional health, prevention, and health promotion, and who have shown a commitment to the trust relationship of the Federal government with and for Federally-recognized Tribes.

The program will provide formula-based funds to Tribes who choose to apply. This will enable Tribes to develop a comprehensive plan to address the most pressing need based on treatment data as well as in consultation with SAMHSA. The plan would address the prevention of substance abuse and suicide, and will provide for coordinated services. This planning activity is one of the basic components of the Tribal Law and Order Act (TLOA) and the Indian Alcohol and Substance Abuse Act, which SAMHSA is charged by statute to coordinate. Tribes will continue to be eligible for these funds beyond the three-year time frame so long as they meet the requirements of renewal applications, provide the necessary annual reports, and show continued movement toward implementing their approved plans.

The plan will reflect the results of an assessment of need, a review of the resources and capacity within the Tribal communities, a plan for carrying out the strategy, a monitoring of the strategy

as implemented, and an evaluation of the strategy to identify strengths and weaknesses. SAMHSA will review and approve the plans.

Tribes will be allowed to use a set percentage (determined based on consultations with the Tribes) of the funds for a combination of service and service-related activities, development and dissemination of prevention messages, and provider development and linkage building to support the Tribes in achieving outcomes. Funding for infrastructure activities will enable the Tribe to build service capacity. The Tribe will present data to support how the allocation will support infrastructure and/or provision of services. In carrying out these activities, the Tribe will be required to use comprehensive, evidence-based programming, and/or proven successful programming, based on either mainstream science or proven Tribal traditions. Up to 20 percent of the grant funds may be used to fund key support and development activities, such as operation of a Tribal prevention advisory group, support for a Tribal community coalition, access to an epidemiological work group, training and technical assistance to communities, data collection and evaluation, and oversight and monitoring of activities.

Approximately 75 percent of Federally-recognized tribes have a total enrollment of 2,000 or fewer persons and a greater percentage of these tribes have limited internal capacity or infrastructure in place to implement and support needed behavioral health services. Smaller Tribes will have the opportunity to work in collaboration with other small Tribes to maximize the impact of the resources. SAMHSA will continue to consult with the smaller Tribes to ensure that their needs are being met while reducing service overlap.

To ensure that providers in both the mental health and substance abuse fields are trained in both substance abuse and mental illness prevention and emotional health concepts and practices, Tribes will be able to use funds for coordinated workforce development, training in evidence-based practices, and the development of coordinated infrastructure and service delivery systems.

Outcomes and Outputs

Key Performance Indicators for Behavioral Health-Tribal Prevention Grants

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
2.3.92 Number of persons served (Output)	N/A	N/A	N/A	TBD	N/A
2.3.93 Percentage of youth age 12-20 who report drinking in the past month (Outcome)	N/A	N/A	N/A	TBD	N/A
2.3.98 Percentage of persons aged 12 and older who report suicide ideation (Outcome)	N/A	N/A	N/A	TBD	N/A

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Primary & Behavioral Health Care Integration

(Dollars in Thousands)

	FY 2011 Actuals	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Program Level	$62,790	$65,749	$28,000	-$37,749
ACA Prevention Funds (non-add)	(35,000)	(35,000)	(28,000)	(-7,000)

Authorizing Legislation	Sections 520A and 520K of the Public Health Service Act and Section 4002 of the Patient Protection and Affordable Care Act
FY 2013 Authorization	$50,000,000
Allocation Method	Competitive Grants

Program Description and Accomplishments

Physical health problems among people with mental illnesses impact quality of life and contribute to premature deaths, where these individuals die much earlier than the general population. While several factors contribute to this disparity, empirical findings indicate that early mortality among people with serious mental illnesses (SMI) is clearly linked to the lack of access to primary care services.

The PBHCI program supports the coordination and integration of primary care services into publicly-funded community behavioral health settings. The expected outcome of improved health status for people with serious mental illness will be achieved by encouraging grantees to engage in necessary partnerships, expand infrastructure, and increase the availability of primary health care and wellness services to individuals with mental illness. Partnerships between primary care and behavioral health organizations as well as information technology are deemed crucial to the success of this program**.** The population of focus for this grant program is individuals with serious mental illness and/or persons with co-occurring disorders served in the public mental health system.

In FY 2010, SAMHSA awarded 43 additional grants, mostly funded with the Affordable Care Act's Prevention Fund and awarded another 8 grants in FY 2011 (also with funds from the ACA Prevention Fund). In FY 2011, SAMHSA utilized $35.0 million in Affordable Care Act Prevention Fund for PBHCI to promote more integrated services between primary care services and mental health services. These funds were used to facilitate screening and referral for necessary primary care prevention and treatment needs. In total, SAMHSA has awarded 64 PBHCI grants to date.

In FY 2012, SAMHSA plans to continue support to 56 existing grants, and may fully fund a number of new grants from both Budget Authority and the ACA Prevention Fund under Section 520K. SAMHSA will continue to support the PBHCI-TTA center at a reduced level.

PBHCI Budget Request

The PBHCI program request is $28.0 million from the ACA Prevention Fund, -$17.0 million below FY 2012 ACA Prevention Fund Level. The Program Level funding includes a decrease of -$30.749 million in Budget Authority from FY 2012, which is partially offset by the $28.000 million requested in ACA Prevention Funds. The FY 2011 and FY 2012 funding from the ACA Prevention Fund allowed SAMHSA to strategically fully fund multi-year grants and monitor them in FY 2013. The FY 2013 requested level of funding will support 9 continuation grants originally awarded from Discretionary Budget Authority and 34 continuation grants originally awarded from ACA Prevention funds as well as the PBHCI-TA center at a reduced level.

Screening, Brief Intervention, & Referral to Treatment (SBIRT)

(Dollars in Thousands)

	FY 2011 Actuals	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Program Level	$51,662	$51,187	$30,000	-$21,187
ACA Prevention Funds (non-add)	(25,000)	(25,000)	(30,000)	(+5,000)

1/PHS is included in this amount

Authorizing Legislation	Sections 520A and 520K of the Public Health Service Act and Section 4002 of the Patient Protection and Affordable Care Act
FY 2013 Authorization	$50,000,000
Allocation Method	Competitive Grants

Program Description and Accomplishments

Screening, Brief Intervention and Referral to Treatment (SBIRT) was initiated in SAMHSA/CSAT in FY 2003, using cooperative agreements to expand and enhance the State or Tribal organization's continuum of care. The purpose of the program is to integrate screening, brief intervention, referral, and treatment services within general medical and primary care settings. According to SAMHSA's National Survey on Drug Use and Health (NSDUH), in 2009 approximately 21 million people who needed treatment for a substance use disorder did not receive it. Of those people, 95 percent did not feel they needed treatment. Therefore, most people with or at risk for a substance use disorder are unlikely to seek help from the specialty treatment system.

The SBIRT cooperative agreements require grant recipients to effect practice change throughout the spectrum of medical practice. This is achieved through implementation of SBIRT programs in all levels of primary care, including hospitals, trauma centers, health clinics, nursing home, employee assistance programs, and school systems. Practice change is also envisioned as altering the educational structure of medical schools by developing and implementing SBIRT curriculum as standard and permanent practice.

Substance abuse is one of our Nation's most significant public health challenges, and the SBIRT approach can intervene early in the disease process before individuals achieve dependency, and can motivate the addicted client to engage in substance abuse treatment. Research and clinical experience supports the use of the SBIRT approach to provide effective early identification and interventions in primary care and general medical settings. Early identification can decrease total healthcare costs by arresting progression toward addiction. SBIRT also can identify persons with more serious problems and encourage them to obtain appropriate specialty treatment services.

Since the beginning of this program, more than 1.4 million individuals have been screened. Of those, 19 percent required a brief intervention, brief treatment, or referral to specialty treatment programs. In 2008, in an effort to incorporate SBIRT into general health care practice, 11 grants were awarded to embed SBIRT training and practice in medical residency programs. In 2009, an additional six grants were awarded, increasing the number of medical residency programs to 17. In FY 2010, SAMHSA/CSAT supported continuation of eight State SBIRT grants and seventeen Medical Residency SBIRT Training grants. In 2011, over 213,000 clients were served by the SBIRT Program. The percentage of clients reporting abstinence at follow-up tripled compared to the percentage reporting abstinence at baseline.

SBIRT has great future potential for promoting changes to the entire primary care medical service delivery system. In FY 2012, SAMHSA will continue to diversify settings in which the SBIRT program would be expected to make an impact on health outcomes to include dentistry, pediatrics and adolescent care organizations, community health and mental health agencies, and other locations where primary care services are offered. As funding for new grants is reduced, efforts are underway to identify other funding streams to take this practice to scale. For example, new diagnostic codes have been adopted by 16 U.S. States, making it easier for doctors to get reimbursed for screening Medicaid patients. Likewise, alcohol screening is now available to Medicare beneficiaries as a preventive service without cost. In FY 2012, SAMHSA will fund the continuation of 27 SBIRT grants and two contracts as well as three new multi-year grants funded out of the ACA Prevention Fund and will continue to monitor the progress of the three FY 2011 multi-year ACA Prevention Fund grants.

SBIRT Budget Request

The SBIRT program request is $30.000 million from the ACA Prevention Fund. This reflects a decrease of $23.187 million in Budget Authority from FY 2012, partially offset by the $5.000 million increase in ACA Prevention Funds. This level of funding will support the continuation of 12 grants and 2 contracts as well as 22 new grants. The FY 2011 and FY 2012 funding from the ACA Prevention Fund allowed SAMHSA to strategically fully fund multi-year grants and monitor them in FY 201.

Outcomes and Outputs

Key Performance Indicators for Screening, Brief Intervention, and Referral to Treatment

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
1.2.40 Number of clients served (Output)	FY 2011: 213,250 Target: 139,650 (Target Exceeded)	139,650	139,650	75,015	-64,635
1.2.41 Percentage of clients receiving services who had no past month substance use (Outcome)	FY 2011: 36% Target: 50% (Target Not Met but Improved)	36%	36%	36%	Maintain

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Sober Truth on Preventing Underage Drinking (STOP) Act

(Dollars in thousands)

	FY 2011 Actuals	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Program Level	$7,009	$6,987	$7,000	$13
ACA Prevention Funds (non-add)	---	---	(7,000)	(+7,000)

Authorizing Legislation	Sections 520A and 520K of the Public Health Service Act and Section 4002 of the Patient Protection and Affordable Care Act
FY 2013 Authorization	$50,000,000
Allocation Method	Competitive Grants

Program Description and Accomplishments

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 is the nation's first comprehensive legislation on underage drinking. The Act recognizes underage drinking prevention as a public health priority and, as a result, authorizes a number of efforts that all aim to reduce the national prevalence of underage drinking. One of the primary components of the Act is the STOP Act grant program that provides additional funds to organizations that receive or have received grant funds under the Drug Free Communities Act of 1997. Through the STOP Act grant program, organizations are able to supplement their current prevention efforts, as well as strengthen collaboration and coordination among stakeholders in order to achieve a reduction in underage drinking in their communities. The initial program, funded in FY 2008, provided 79 four year grants to local communities with up to $50,000 per community per year. In FY 2011, a total of 99 grants received funding under this initiative. The FY 2012 level of funding supports 78 new grants for up to $50,000 per grant per year for up to four years.

Another component of the STOP Act is the National Adult-Oriented Media Public Service Campaign, with funding up to $1.0 million in FY 2012. The Underage Drinking Prevention campaign educates and urges parents to speak with their children, age 11-15, about underage drinking in order to delay the onset of, and ultimately reduce, underage drinking. Nationwide, 38.9 percent of the estimated 10 million underage drinkers were provided free alcohol by adults 21 or older—representing a slight increase from 2009 (2010 NSDUH). Further, research continues to show that parents of teens generally underestimate the extent of alcohol used by youth and its negative consequences--with the vast majority viewing underage drinking as "inevitable." Many parents also find it difficult to know how or when to start a conversation with their children about underage drinking. Through TV, radio, print, and outdoor activities, SAMHSA's multicultural campaign seeks to overcome parents' misperceptions about underage drinking by creating a greater urgency around the issue and encourages them to communicate with their children at an early age about alcohol. Parents and viewers are encouraged to visit www.stopalcoholabuse.gov, funded through the media campaign, to get information about teens and alcohol, as well as tips on how to initiate conversations with their children about underage drinking.

The third important component of the STOP Act is the Federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), which includes representatives from 15 Federal agencies and is funded at $1.0 million in FY 2012. The ICCPUD provides ongoing, high-level leadership on the issue of underage drinking and serves as a mechanism for coordinating Federal efforts aimed at preventing and reducing underage drinking. The ICCPUD also produces an Annual Report summarizing all programs and policies of Federal agencies designed to prevent and reduce underage drinking as well as the State-level activities pertaining to underage drinking prevention programs, policies, enforcement efforts, and expenditures. In FY 2012, the ICCPUD will work with the Surgeon General's office to draft a new National Strategy for Preventing Underage Drinking, updating and expanding the 2007 Surgeon General's Call to Action to Prevent Underage Drinking.

Performance data show that, for two consecutive fiscal years, the STOP Act grant program has exceeded targets of increasing the percentage of grantees that show a 5 percent or more reduction in past 30-day use of alcohol in at least two grade levels. This accomplishment is significant as reducing the prevalence of underage drinking is the primary legislative goal of the STOP Act. Additional performance data suggest that the program has demonstrated improvement in the percentage of grantees that report increases in levels of parental disapproval of substance use—showing a nearly 6 percentage point increase from FY 2009. However, the program has not met or improved on increasing youth perception of risk of harm—a key predictor to substance use. Likewise, the number of deaths as a result of underage drinking remains unchanged at approximately 5,000 annually. As part of SAMHSA's Strategic Initiative around Data, Outcomes, and Quality, Government Project Officers (GPOs) of all prevention programs have been working closely with analysts to identify and discuss challenges and barriers reported by grantees. Using a combination of qualitative and quantitative data, GPOs are gaining better insight into the needs of grantees and are providing the necessary technical assistance and guidance to improve program performance in these areas.

STOP Act Budget Request

The FY 2013 Budget Request is $7.0 million in the ACA Prevention Fund. This reflects a decrease of $6.987 million in Budget Authority offset by the $7.0 million increase in the ACA Prevention Fund. This level of funding will support 78 continuation grants, 22 new grants, 1 continuation contract, and 1 new contract.

Outcomes and Outputs

Key Performance Indicators for Sober Truth on Preventing Underage Drinking (STOP Act)[1]

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.3.01 Increase the percentage of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades (Outcome)	FY 2010: 67.3% Target: 41% (Target Exceeded)	46.7%	40%[2]	40%[3]	Maintain
3.3.02 Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades (Outcome)	FY 2010: 45.5% Target: 63.4% (Target Not Met)	63.4%	60.9%[4]	60.9%[5]	Maintain

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

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

[3] Target reflects close–out of Cohort II and the start up of future cohorts.

[4] Target has been changed from previously reported. Target has been decreased due to cohort effect. This target now reflects the close–out of Cohort I and start of Cohort III.

[5] Target reflects close–out of Chort II and start up of future cohorts.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2011 Actual Associated Target (FY 2012)	FY 2012 Enacted Associated Target (FY 2013)	FY 2013 PB Associated Target (FY 2014)	FY 2013 PB Associated Target (FY 2014) +/- FY 2012 Enacted Associated Target (FY 2013)
3.3.03 Percentage of coalitions that report improvement in youth perception of parental disapproval on the use of alcohol in at least two grades (Outcome)	FY 2010: 48.8% Target: 56.7% (Target Not Met but Improved)	56.7%	54.5%[6]	54.5%[7]	Maintain

[6] Target has been changed from previously reported. Target has been decreased due to cohort effect. Now, the target reflects close–out of Cohort I and start of Cohort III.

[7] Target reflects the close–out of Cohort II and the start up of future cohorts.

Substance Abuse and Mental Health Services Administration
Object Classification Tables – Mental Health *(Dollars in Thousands)*

Object Class-Direct Budget Authority	FY 2012 Estimate	FY 2013 Estimate	FY 2013 +/- FY 2012
Direct Obligations:			
Personnel Compensation:			
Full Time Permanent (11.1)	$1,200	$1,676	+ $476
Other than Full-Time Permanent (11.3)	58	81	+ 23
Other Personnel Compensation (11.5)	28	39	+11
Military Personnel Compensation (11.7)	100	143	+43
Special personal services payments (11.8)	1	1	-----
Subtotal Personnel Compensation:	**1,387**	**1,940**	**+ 553**
Civilian Personnel Benefits (12.1)	333	465	+132
Military Personnel Benefits (12.2)	50	72	+22
Benefits for Former Personnel (13.1)	-----	-----	-----
Subtotal Pay Costs:	**1,770**	**2,477**	**+ 707**
Travel (21.0)	49	37	-12
Transportation of Things (22. 0)	-----	-----	-----
Rental Payments to GSA (23.1)	-----	-----	-----
Rental Payments to Others (23.2)	-----	-----	-----
Communications, Utilities and Misc. Charges (23.3)	6	4	-2
Printing and Reproduction (24.0)	190	142	- 48
Other Contractual Services:			
Advisory and Assistance Services (25.1)	6950	5211	-1739
Other Services (25.2)	39645	29725	-9920
Other Purchases of Goods & Svc from Govt. Accts (25.3)	38549	28903	-9646
Operation & Maintenance of Facilities (25.4)	558	418	-140
Medical Care (25.6)	-----	-----	-----
Operation and Maintenance of Equipment (25.7)	-----	-----	-----
Subtotal Other Contractual Services:	**85947**	**64441**	**-21507**
Supplies and Materials (26.0)	81	60	-21
Equipment (31.0)	-----	-----	-----
Grants, Subsidies, and Contributions (41.0)	844991	835855	9136
Insurance Claims & Indemnities (42.0)	31	23	-8
Interest & Dividends (43.0)	-----	-----	-----
Subtotal Non-Pay Costs	**931050**	**900379**	**-30671**
Total Budget Authority:	**932820**	**902856**	**-29964**

Substance Abuse and Mental Health Services Administration
Object Classification Tables – Substance Abuse Prevention *(Dollars in Thousands)*

Object Class-Direct Budget Authority	FY 2012 Estimate	FY 2013 Estimate	FY 2013 +/- FY 2012
Direct Obligations:			
Personnel Compensation:			
Full Time Permanent (11.1)	**$92**	**$93**	**+ $1**
Other than Full-Time Permanent (11.3)	4	5	+ 1
Other Personnel Compensation (11.5)	2	2	-----
Military Personnel Compensation (11.7)	8	8	-----
Special personal services payments (11.8)	-----	-----	-----
Subtotal Personnel Compensation:	**106**	**108**	**+ 2**
Civilian Personnel Benefits (12.1)	26	26	-----
Military Personnel Benefits (12.2)	4	4	-----
Benefits for Former Personnel (13.1)	-----	-----	-----
Subtotal Pay Costs:	**136**	**138**	**+ 2**
Travel (21.0)	-----	-----	-----
Transportation of Things (22. 0)	-----	-----	-----
Rental Payments to GSA (23.1)	-----	-----	-----
Rental Payments to Others (23.2)	-----	-----	-----
Communications, Utilities and Misc. Charges (23.3)	-----	-----	-----
Printing and Reproduction (24.0)	264	81	- 183
Other Contractual Services:			
Advisory and Assistance Services (25.1)	4160	1275	- 2885
Other Services (25.2)	43350	13281	- 30069
Other Purchases of Goods & Svc from Govt. Accts (25.3)	4109	1259	- 2850
Operation & Maintenance of Facilities (25.4)	-----	-----	-----
Medical Care (25.6)	-----	-----	-----
Operation and Maintenance of Equipment (25.7)	89	27	- 62
Subtotal Other Contractual Services:	**51972**	**15923**	**- 36049**
Supplies and Materials (26.0)	-----	-----	-----
Equipment (31.0)	-----	-----	-----
Grants, Subsidies, and Contributions (41.0)	477953	447280	- 30673
Insurance Claims & Indemnities (42.0).	121	37	- 84
Interest & Dividends (43.0)	-----	-----	-----
Subtotal Non-Pay Costs	**530046**	**463240**	**- 66806**
Total Budget Authority:	**530182**	**463378**	**- 66804**

Substance Abuse and Mental Health Services Administration
Object Classification Tables – Substance Abuse Treatment *(Dollars in Thousands)*

Object Class-Direct Budget Authority	FY 2012 Estimate	FY 2013 Estimate	FY 2013 +/- FY 2012
Direct Obligations:			
Personnel Compensation:			
Full Time Permanent (11.1)	**$5163**	**$5959**	**+$796**
Other than Full-Time Permanent (11.3)	250	288	+38
Other Personnel Compensation (11.5)	120	138	+18
Military Personnel Compensation (11.7)	437	510	+73
Special personal services payments (11.8)	5	5	-----
Subtotal Personnel Compensation:	**5975**	**6900**	**+925**
Civilian Personnel Benefits (12.1)	1432	1652	+220
Military Personnel Benefits (12.2)	218	255	+37
Benefits for Former Personnel (13.1)	-----	-----	-----
Subtotal Pay Costs:	**7625**	**8807**	**+1182**
Travel (21.0)	46	37	-9
Transportation of Things (22. 0)	-----	-----	-----
Rental Payments to GSA (23.1)	-----	-----	-----
Rental Payments to Others (23.2)	-----	-----	-----
Communications, Utilities and Misc. Charges (23.3)	145	116	-29
Printing and Reproduction (24.0)	511	407	-104
Other Contractual Services:			
Advisory and Assistance Services (25.1)	2857	2275	-582
Other Services (25.2)	21350	16994	4356
Other Purchases of Goods & Svc from Govt. Accts (25.3)	1866	1486	-380
Operation & Maintenance of Facilities (25.4)	51	40	-11
Medical Care (25.6)	-----	-----	-----
Operation and Maintenance of Equipment (25.7)	52	41	-11
Subtotal Other Contractual Services:	**26878**	**21396**	**+18597**
Supplies and Materials (26.0)	95	76	-19
Equipment (31.0)	13	11	-2
Grants, Subsidies, and Contributions (41.0)	1740538	1680755	-59783
Insurance Claims & Indemnities (42.0)	-----	-----	-----
Interest & Dividends (43.0)	-----	-----	-----
Subtotal Non-Pay Costs	**1767524**	**1702238**	**-65286**
Total Budget Authority:	**1775149**	**1711045**	**-64104**

Substance Abuse and Mental Health Services Administration
Object Classification Tables – Health Surveillance and Program Support *(Dollars in Thousands)*

Object Class-Direct Budget Authority	FY 2012 Estimate	FY 2013 Estimate	FY 2013 +/- FY 2012
Direct Obligations:			
Personnel Compensation:			
Full Time Permanent (11.1)	**$42518**	**$41618**	**+$900**
Other than Full-Time Permanent (11.3)	2058	2014	-44
Other Personnel Compensation (11.5)	984	964	-20
Military Personnel Compensation (11.7)	3594	3561	-33
Special personal services payments (11.8)	38	37	-1
Subtotal Personnel Compensation:	**49192**	**48194**	**-998**
Civilian Personnel Benefits (12.1)	11786	11537	-249
Military Personnel Benefits (12.2)	1794	1778	-16
Benefits for Former Personnel (13.1)	-----	-----	-----
Subtotal Pay Costs:	**62772**	**61509**	**-1263**
Travel (21.0)	1050	715	-335
Transportation of Things (22. 0)	44	31	-13
Rental Payments to GSA (23.1)	6487	6551	+65
Rental Payments to Others (23.2)	-----	-----	-----
Communications, Utilities and Misc. Charges (23.3)	2	1	-1
Printing and Reproduction (24.0)	328	90	-238
Other Contractual Services:			
Advisory and Assistance Services (25.1)	-----	-----	-----
Other Services (25.2)	14080	1116	-12964
Other Purchases of Goods & Svc from Govt. Accts (25.3)	21408	3024	-18384
Operation & Maintenance of Facilities (25.4)	620	171	-449
Medical Care (25.6)	-----	-----	-----
Operation and Maintenance of Equipment (25.7)	63	17	-46
Subtotal Other Contractual Services:	**44082**	**11716**	**-32365**
Supplies and Materials (26.0)	330	231	-99
Equipment (31.0)	35	24	-11
Grants, Subsidies, and Contributions (41.0)	-----	-----	------
Insurance Claims & Indemnities (42.0)	1650	750	-900
Interest & Dividends (43.0)	-----	-----	-----
Subtotal Non-Pay Costs	**46097**	**12721**	**-33375**
Total Budget Authority:	**108869**	**74229**	**-34640**

Substance Abuse and Mental Health Services Administration
Salaries and Expenses *(Dollars in Thousands)*

Salary and Expenses	FY 2011 Actuals	FY 2012 Enacted	FY 2013 Pres. Budget	FY 2013 +/- FY 2012
Direct Obligations:				
Personnel Compensation:				
Full Time Permanent (11.1)	**$46702**	**$48973**	**$49346**	**+$373**
Other than Full-Time Permanent (11.3)	2259	2370	2388	+18
Other Personnel Compensation (11.5)	1081	1134	1143	+9
Military Personnel Compensation (11.7)	3686	4139	4222	+83
Special personal services payments (11.8)	41	44	43	-1
Subtotal Personnel Compensation:	**53769**	**56660**	**57142**	**+482**
Civilian Personnel Benefits (12.1)	12946	13577	13680	+103
Military Personnel Benefits (12.2)	1840	2066	2109	+43
Subtotal Pay Costs:	**68555**	**72303**	**72931**	**+628**
Travel (21.0)	1444	1145	789	-356
Transportation of Things (22. 0)	53	44	31	-13
Rental Payments to Others (23.2)	-----	-----	-----	-----
Communications, Utilities and Misc. Charges (23.3)	560	153	121	-32
Printing and Reproduction (24.0)	2746	1293	720	-573
Other Contractual Services:				
Advisory and Assistance Services (25.1)	16778	8115	5090	-3025
Other Services (25.2)	207101	116293	60016	-56277
Other Purchases of Goods & Svc from Govt. Accts (25.3)	23336	16650	8756	-7894
Operation & Maintenance of Facilities (25.4)	1530	1229	629	-600
Operation and Maintenance of Equipment (25.7)	330	204	85	-119
Subtotal Other Contractual Services:	**249074**	**142491**	**74576**	**-67915**
Supplies and Materials (26.0)	890	506	367	-139
Subtotal Non-Pay Costs	**254767**	**145632**	**76604**	**-69028**
Total, Salaries and Expenses	**323322**	**217935**	**149535**	**68400**
Rental Payments to GSA (23.1)	6422	6487	6551	+65
Grand Total, Salaries, Expenses, and Rent	**329745**	**224422**	**156086**	**-68335**
Direct FTE:	**497**	**524**	**524**	-----

Substance Abuse and Mental Health Services Administration
Detail of Full Time Equivalent (FTE)

	2011 Act. Civilian	2011 Act. Military	2011 Act. Total	2012 Act. Civilian	2012 Act. Military	2012 Act. Total	2013 Act. Civilian	2013 Act. Military	2013 Act. Total
CMHS									
Direct:	101	15	116	100	16	116	97	16	113
Reimbursable:	2	1	3	2	1	3	2	1	3
Total:	103	16	119	102	17	119	99	17	116
CSAP									
Direct:	81	12	93	74	13	87	67	13	80
Reimbursable:	7	4	11	7	4	11	7	4	11
Total:	88	16	104	81	17	98	74	17	91
CSAT									
Direct:	97	9	106	97	11	108	94	11	105
Reimbursable:	2	-----	2	2	-----	2	2	-----	2
Total:	99	9	108	99	11	110	96	11	107
OC									
Direct:	13	1	14	13	1	14	13	1	14
Reimbursable:	-----	-----	-----	-----	-----	-----	-----	-----	-----
Total:	13	1	14	13	1	14	13	1	14
IOA									
Direct:	7	-----	7	8	-----	8	8	1	9
Reimbursable:	-----	-----	-----	-----	-----	-----	-----	-----	-----
Total:	7	-----	7	8	-----	8	8	1	9
OFR									
Direct:	62	2	64	64	3	67	63	3	66
Reimbursable:	7	1	8	7	1	8	7	1	8
Total:	69	3	72	75	4	75	70	4	74
CBHSQ									
Direct:	30	4	34	47	6	53	60	5	65
Reimbursable:	1	-----	1	-----	-----	-----	-----	-----	-----
Total:	31	4	35	47	6	53	60	5	65
OPPI									
Direct:	29	-----	29	42	1	43	48	1	49
Reimbursable:	-----	-----	-----	-----	-----	-----	-----	-----	-----
Total:	29	-----	29	42	1	43	48	1	49
OMTO									
Direct:	52	1	53	51	1	52	46	1	47
Reimbursable:	-----	-----	-----	-----	-----	-----	-----	-----	-----
Total:	52	1	53	51	1	52	46	1	47
St. Elizabeths									
Direct:	-----	-----	-----	-----	-----	-----	-----	-----	-----
Reimbursable:	-----	6	6	-----	3	3	-----	3	3
Total:	-----	6	6	-----	3	3	-----	3	3
SAMHSA FTE Total:	**491**	**56**	**547**	**513**	**61**	**574**	**513**	**61**	**574**
Total Direct	**472**	**44**	**516**	**495**	**52**	**547**	**495**	**52**	**547**
Total Reimbursable	**19**	**12**	**31**	**18**	**9**	**27**	**18**	**9**	**27**

Substance Abuse and Mental Health Services Administration
Detail of Positions

	2011 Actual	2012 Estimate	2013 Estimate
Executive Level I	0	0	0
Executive Level II	0	0	0
Executive Level III	0	0	0
Executive Level IV	1	1	1
Executive Level V	0	0	0
Subtotal	1	1	1
Total - Exec Level Salaries	**$157**	**$157,169**	**$157,169**
SES	12	14	14
Subtotal	13	15	15
Total, SES salaries	**$1,855**	**$2,170,196**	**$2,170,196**
GM/GS-15/EE	71	71	71
GM/GS-14	138	138	138
GM/GS-13	145	146	146
GS-12	37	40	40
GS-11	16	20	20
GS-10	2	3	3
GS-09	21	22	22
GS-08	17	17	17
GS-07	13	18	18
GS-06	13	10	10
GS-05	4	9	9
GS-04	1	2	2
GS-03	0	1	1
GS-02	0	1	1
GS-01	0	0	0
Subtotal	**478**	**498**	**498**
Total, GS salaries	**$51,169,991**	**$52,867,091**	**$52,867,091**
CC-08/09	1	0	0
CC-07	1	1	1
CC-06	11	13	13
CC-05	14	16	16
CC-04	17	19	19
CC-03	9	10	10
CC-02	2	2	2
CC-01	0	0	0
Subtotal	**56**	**61**	**61**
Total, CC salaries	**$6,635,143**	**$7,298,164**	**$7,414,935**
Total Positions	**547**	**574**	**574**
	ES	ES	ES
Average ES salary	$157,169	$157,169	$157,169
Average SES level	SES	SES	SES
Average SES salary	$154,593	$155,014	$155,014
Average GS grade	12.6	12.4	12.4
Average GS salary	$107,050	$106,159	$106,159
Average CC level	4.5	4.6	4.6
Average CC salaries	$117,902	$119,642	$121,556

Substance Abuse and Mental Health Services Administration
Statement of Personnel Resources

	Total Full-Time Equivalents (Workyears)		
	FY 2011 Actual	**FY 2012 Estimate**	**FY 2013 Estimate**
Direct:			
Program, Project or Activity:			
Health Surveillance & Program Support	458	475	471
Mental Health Services	0	13	18
Substance Abuse Prevention	0	1	1
Substance Abuse Treatment	0	12	18
Normalized Attrition [1/]	0	-29	-39
SAMHSA Regional Staff	1	13	13
b. Substance Abuse Services and Prevention BG	40	44	46
c. PEPFAR	2	2	2
Total, Direct Ceiling FTE	**501**	**531**	**530**
Reimbursable:			
Program, Project or Activity:			
a. Program Management	10	6	6
b. Mental Health Block Grant (PHS Evaluation Funds)	15	16	17
c. Drug Free Communities	21	21	21
Total, Reimbursable Ceiling FTE	**46**	**43**	**44**
Total, Ceiling FTE	**547**	**574**	**574**
Total, Civilian FTE	**491**	**513**	**513**
Total, Military FTE	**56**	**61**	**61**

FY 2013 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

OPDIV Allocation Statement:

The **SAMHSA** will use **$269,021.00** of its **FY 2013** budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$55,957.00** is allocated to developmental government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$1,000.00
Line of Business - Grants Management	$1,866.00
Line of Business - Financial	$6,021.00
Line of Business - Budget Formulation and Execution	$4,421.00
Disaster Assistance Improvement Plan	$6,782.00
Federal Health Architecture (FHA)	$0.00
	35,867.00
Line of Business - Geospatial	$0.00
FY 2013 Developmental E-Gov Initiatives Total	**$55,957.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally,

NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

In addition, **$213,064.00** is allocated to ongoing government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Ongoing E-Gov Initiatives*	
E-Rule Making	$11,912.00
Integrated Acquisition Environment	$41,047.00
GovBenefits	$20,744.00
Grants.Gov	$139,361.00
FY 2013 Ongoing E-Gov Initiatives Total	**$213,064.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Mental Health Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
CAPACITY:						
Co-Occurring SIG						
Grants						
Continuations	-----	$ -----	-----	$ -----	-----	$ -----
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	-----	-----	-----	-----	-----	-----
Contracts						
Continuations	-----	-----	-----	-----	-----	-----
New/Competing	1	2168	-----	-----	-----	-----
Subtotal	1	2168	-----	-----	-----	-----
Total, Co-Occurring SIG	**1**	**2168**	-----	-----	-----	-----
Seclusion & Restraint						
Grants						
Continuations	-----	-----	-----	-----	-----	-----
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	-----	-----	-----	-----	-----	-----
Contracts						
Continuations	1	2449	1	2444	-----	-----
New/Competing	-----	-----	-----	-----	1	1149
Subtotal	1	2449	1	2444	1	1149
Total, Seclusion & Restraint	**1**	**2449**	**1**	**2444**	**1**	**1149**
Youth Violence Prevention						
Grants						
Continuations	1	6000	22	8035	26	5424
New/Competing	-----	-----	5	3385	13	9039
Subtotal	1	6000	27	11420	39	14463
Contracts						
Continuations	5	70967	4	11736	2	7393
New/Competing	1	708	-----	-----	1	1300
Subtotal	6	71675	4	11736	3	8693
Total, Youth Violence Prevention	**7**	**77675**	**31**	**23156**	**42**	**23156**
National Traumatic Stress Network						
Grants						
Continuations	47	25953	3	1792	71	39500
New/Competing	-----	-----	71	39500	2	1595
Suupplements	15	7997				
Subtotal	47	33950	74	41292	73	41095
Contracts						
Continuations	1	6427	1	3963	1	3907
New/Competing	1	338	-----	458	1	711
Subtotal	1	6765	1	4421	2	4618
Total, National Traumatic Stress Network	**49**	**40715**	**75**	**45713**	**75**	**45713**
Children and Family Programs						
Grants						
Continuations	7	4107	14	5722	14	5722
New/Competing	7	2141	-----	-----	-----	-----
Subtotal	14	6248	14	5722	14	5722
Contracts						
Continuations	2	2079	2	752	2	752
New/Competing	-----	867	-----	-----	-----	-----
Subtotal	2	2946	2	752	2	752
Total, Children and Family Programs	**16**	**9194**	**16**	**6474**	**16**	**6474**

Mental Health Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
CAPACITY:						
Consumer and Family Network Grants						
Grants						
Continuations	73	$5027	56	$3858	16	$1087
New/Competing	-----	-----	16	1087	38	2670
Subtotal	73	5027	72	4945	54	3757
Contracts						
Continuations	1	1209	1	1279	1	1209
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	1	1209	1	1279	1	1209
Total, Consumer & Family Network Grants	**74**	**6236**	**73**	**6224**	**55**	**4966**
MH System Transformation and Health Reform						
Grants						
Continuations	41	16339	31	8621	31	8621
New/Competing	11	2150	-----	-----	-----	-----
Subtotal	52	18489	31	8621	31	8621
Contracts						
Continuations	3	7298	2	1982	2	1982
New/Competing	1	728	-----	-----	-----	-----
Subtotal	4	8026	2	1982	2	1982
Total, MHSTHR	**56**	**26515**	**33**	**10603**	**33**	**10603**
Primary and Behavioral Health Care Integration						
Grants						
Continuations	58	32207	56	27250	43	20757
New/Competing	8	15035	22	35958	12	4977
Supplements	56	13789	-----	-----	-----	-----
Subtotal	122	61031	78	63208	55	25734
Contracts						
Continuations	1	1759	-----	2541	-----	270
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	1	1759	-----	2541	-----	270
Total, PBHCI	**123**	**62790**	**78**	**65749**	**55**	**26004**
Community Resilience and Recovery Initiative						
Grants						
Continuations	3	4163	-----	-----	-----	-----
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	3	4163	-----	-----	-----	-----
Contracts						
Continuations	1	747	-----	-----	-----	-----
New/Competing	-----	90	-----	-----	-----	-----
Subtotal	1	837	-----	-----	-----	-----
Total, CRRI	**4**	**5000**	-----	-----	-----	-----
Suicide Lifeline						
Grants						
Continuations	7	3720	12	726	7	4059
New/Competing	7	2065	2	5405	6	360
Subtotal	14	5785	14	6131	13	4419
Contracts						
Continuations	1	1290	-----	1086	-----	1093
New/Competing	1	152	-----	-----	-----	-----
Subtotal	2	1442	-----	1086	-----	1093
Total, Suicide Lifeline	**16**	**7227**	**14**	**7217**	**13**	**5512**

Mental Health Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
CAPACITY:						
GLS - Youth Suicide Prevention - States						
Grants						
Continuations	18	$8896	38	$21665	51	$23825
New/Competing	38	21677	17	8231	-----	-----
Subtotal	56	30573	55	29896	51	23825
Contracts						
Continuations	1	4151	2	5546	2	5549
New/Competing	1	515	-----	-----	-----	-----
Subtotal	2	4666	2	5546	2	5549
Total, GLS - YSP - States	**58**	**35239**	**57**	**35442**	**53**	**29374**
Youth Suicide Prevention - Campus						
Grants						
Continuations	22	2159	21	3079	37	3777
New/Competing	21	3120	23	2498	-----	-----
Subtotal	43	5279	44	5577	37	3777
Contracts						
Continuations	1	899	1	919	1	1081
New/Competing	-----	221	-----	-----	-----	-----
Subtotal	1	1120	1	919	1	1081
Total, YSP - Campus	**44**	**6399**	**45**	**6496**	**38**	**4858**
AI/AN Suicide Prevention Initiative						
Grants						
Continuations	-----	-----	-----	-----	-----	-----
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	-----	-----	-----	-----	-----	-----
Contracts						
Continuations	2	2944	2	2283	-----	885
New/Competing	-----	-----	-----	655	2	2053
Subtotal	2	2944	2	2938	2	2938
Total, AI/AN Suicide Prevention Initiative	**2**	**2944**	**2**	**2938**	**2**	**2938**
Homelessness Prevention Programs						
Grants						
Continuations	61	23371	74	20308	50	19124
New/Competing	23	805	10	3892	10	4260
Subtotal	84	24176	84	24200	60	23384
Contracts						
Continuations	3	4993	3	6572	3	7388
New/Competing	2	1661	-----	-----	-----	-----
Subtotal	5	6654	3	6572	3	7388
Total, Homelessness Prevention Programs	**89**	**30830**	**87**	**30772**	**63**	**30772**
Older Adult Programs						
Grants						
Continuations	-----	-----	-----	-----	-----	-----
New/Competing	5	1781	-----	-----	-----	-----
Subtotal	5	1781	-----	-----	-----	-----
Contracts						
Continuations	-----	235	-----	-----	-----	-----
New/Competing	1	799	-----	-----	-----	-----
Subtotal	1	1034	-----	-----	-----	-----
Total, Older Adult Programs	**6**	**2815**	-----	-----	-----	-----
Minority AIDS						
Grants						
Continuations	-----	-----	12	8150	12	8017
New/Competing	12	8162	-----	-----	13	13000
Subtotal	12	8162	12	8150	25	21017
Contracts						
Continuations	-----	170	2	1115	2	1136
New/Competing	2	951	-----	-----	1	617
Subtotal	2	1121	2	1115	3	1753
Total, Minority AIDS	**14**	**9283**	**14**	**9265**	**28**	**22770**

Mental Health Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
Adult Trauma Screening and Brief Intervention						
Grants						
Continuations	-----	$ -----	-----	$ -----	-----	$ -----
New/Competing	-----	-----	-----	-----	3	2896
Subtotal	-----	-----	-----	-----	-----	-----
Contracts						
Continuations	-----	-----	-----	-----	-----	-----
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	-----	-----	-----	-----	-----	-----
Total, GATSBI	-----	-----	-----	-----	**3**	**2896**
Criminal/Juvenile Justice Programs						
Grants						
Continuations	13	5219	13	5231	7	2754
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	13	5219	13	5231	7	2754
Contracts						
Continuations	1	925	2	1441	1	1370
New/Competing	1	539	-----	-----	-----	157
Subtotal	2	1464	2	1441	1	1527
Total, Criminal/Juvenile Justice Programs	**15**	**6683**	**15**	**6672**	**8**	**4281**
Subtotal, CAPACITY	**575**	**334162**	**541**	**259165**	**485**	**221466**
SCIENCE AND SERVICE:						
GLS - Suicide Prevention Resource Center						
Grants						
Continuations	1	4471	1	4471	1	4471
New/Competing	1	1000	1	1000	-----	-----
Subtotal	2	5471	2	5471	1	4471
Contracts						
Continuations	-----	486	-----	477	-----	477
New/Competing	-----	5	-----	5	-----	-----
Subtotal	-----	491	-----	482	-----	477
Total, GLS - SP Resource Center	**2**	**5962**	**2**	**5953**	**1**	**4948**
Practice Improvement and Training						
Grants						
Continuations	-----	-----	1	243	1	243
New/Competing	1	243	-----	-----	-----	-----
Subtotal	1	243	1	243	1	243
Contracts						
Continuations	7	6749	7	7320	7	7194
New/Competing	2	1065	1	300	-----	-----
Subtotal	9	7814	8	7620	7	7194
Total, Info. Dissemination & Training	**10**	**8057**	**9**	**7863**	**8**	**7437**
Consumer and Consumer Support Technical Assistance Centers						
Grants						
Continuations	5	1774	5	1775	5	1775
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	5	1774	5	1775	5	1775
Contracts						
Continuations	-----	153	-----	148	-----	148
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	-----	153	-----	148	-----	148
Total, Consumer/Cons. Support TA Ctrs	**5**	**1927**	**5**	**1923**	**5**	**1923**

Mental Health Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
Primary and Behavioral Health Care Integration TA						
Grants						
Continuations	-----	$ -----	-----	$ -----	-----	$ -----
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	-----	-----	-----	-----	-----	-----
Contracts						
Continuations	-----	-----	-----	-----	2	1996
New/Competing	-----	-----	2	1996	-----	-----
Subtotal	-----	-----	2	1996	2	1996
Total, PBHCI TA	-----	-----	**2**	**1996**	**2**	**1996**
Minority Fellowship Program						
Grants						
Continuations	-----	-----	5	3455	6	3465
New/Competing	5	3455	1	810	-----	-----
Subtotal	5	3455	6	4265	6	3465
Contracts						
Continuations	1	824	-----	824	-----	290
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	1	824	-----	824	-----	290
Total, Minority Fellowship Program	**6**	**4279**	**6**	**5089**	**6**	**3755**
Disaster Response						
Grants						
Continuations	-----	-----	-----	-----	-----	-----
New/Competing	-----	-----	-----	-----	1	2100
Subtotal	-----	-----	-----	-----	1	2100
Contracts						
Continuations	1	904	1	1052	1	850
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	1	904	1	1052	1	850
Total, Disaster Response	**1**	**904**	**1**	**1052**	**2**	**2950**
Homelessness						
Grants						
Continuations	-----	-----	-----	-----	-----	-----
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	-----	-----	-----	-----	-----	-----
Contracts						
Continuations	1	1118	2	2302	2	2302
New/Competing	1	1188	-----	-----	-----	-----
Subtotal	2	2306	2	2302	2	2302
Total, Homelessness	**2**	**2306**	**2**	**2302**	**2**	**2302**
HIV/AIDS Education						
Grants						
Continuations	-----	-----	-----	-----	-----	-----
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	-----	-----	-----	-----	-----	-----
Contracts						
Continuations	3	487	3	749	3	773
New/Competing	-----	-----	-----	-----	-----	-----
Supplements	-----	487	-----	24	-----	-----
Subtotal	3	974	3	773	3	773
Total, HIV/AIDS Education	**3**	**974**	**3**	**773**	**3**	**773**
Subtotal, SCIENCE AND SERVICE	**29**	**24409**	**30**	**26951**	**29**	**26084**
TOTAL, PRNS	**604**	**358571**	**571**	**286116**	**514**	**247550**

Children's Mental Health Services
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Children's Mental Health Services	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
Grants/Cooperative Agreements:						
Continuations	58	$83205	61	$77416	64	$76603
New/Competing	24	14013	18	18007	-----	-----
Supplements	-----	-----	-----	-----	-----	-----
Subtotal	**76**	**97218**	**79**	**95423**	**64**	**76603**
Contracts:						
Continuations	3	8530	3	10158	2	5988
New/Competing	-----	-----	-----	-----	-----	-----
Supplements	-----	-----	-----	-----	-----	-----
Subtotal	**3**	**8530**	**3**	**10158**	**2**	**5988**
Technical Assistance Grants:						
Continuations	1	2503	1	2503	1	2503
New/Competing	-----	-----	-----	-----	-----	-----
Supplements	-----	-----	-----	-----	-----	-----
Subtotal	**1**	**2503**	**1**	**2503**	**1**	**2503**
Technical Assistance Contracts:						
Continuations	3	9132	2	8811	2	3463
New/Competing	-----	-----	-----	-----	-----	-----
Supplements	-----	-----	-----	-----	-----	-----
Subtotal	**3**	**9132**	**2**	**8811**	**2**	**3463**
Report to Congress:	-----	**420**	-----	**420**	-----	-----
Total, Children's Mental Health	**83**	**117803**	**85**	**117315**	**69**	**88557**

Project LAUNCH
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Project LAUNCH	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
Grants/Cooperative Agreements:						
Continuations	23	$21300	25	$21300	28	$22800
New/Competing	-----	-----	10	8700	-----	-----
Supplements	-----	-----	-----	-----	-----	-----
Subtotal	**23**	**21300**	**35**	**30000**	**28**	**22800**
Contracts:						
Continuations	1	3206	1	4456	-----	1950
New/Competing	-----	200	-----	184	-----	-----
Supplements	-----	-----	-----	-----	-----	-----
Subtotal	**1**	**3406**	**1**	**4640**	-----	**1950**
Total, LAUNCH	**24**	**24706**	**36**	**34640**	**28**	**24750**

Substance Abuse Prevention Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
CAPACITY:						
Mandatory Drug Testing						
Contracts						
Continuations	4	$3816	5	$4835	3	$2128
New	1	1039	-----	361	2	2778
Subtotal	5	4855	5	5196	5	4906
Total, Mandatory Drug Testing	**5**	**4855**	**5**	**5196**	**5**	**4906**
Minority AIDS						
Grants						
Continuations	122	38562	133	39573	78	21048
New/Competing	11	1112	-----	-----	16	16660
Subtotal	133	39674	133	39573	94	37708
Contracts						
Continuations	-----	-----	1	1734	2	2599
New	1	1717	-----	-----	1	1000
Subtotal	1	1717	1	1734	3	3599
Total, Minority AIDS	**134**	**41391**	**134**	**41307**	**97**	**41307**
STOP Act						
Grants						
Continuations	99	4912	22	1100	78	3900
New/Competing	-----	-----	78	3887	22	1100
Subtotal	99	4912	100	4987	100	5000
Contracts						
Continuations	2	2097	2	2000	1	1000
New	-----	-----	-----	-----	1	1000
Subtotal	2	2097	2	2000	2	2000
Total, STOP Act	**101**	**7009**	**102**	**6987**	**102**	**7000**
Subtotal, CAPACITY	**240**	**53255**	**241**	**53490**	**204**	**53213**

Substance Abuse Prevention Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
SCIENCE AND SERVICE:						
Fetal Alcohol Center of Excellence						
Contracts						
Continuations	1	$9830	-----	$ -----	1	$1000
New	-----	-----	1	9802	-----	-----
Subtotal	1	9830	1	9802	1	1000
Total, Fetal Alcohol Center of Excellence	**1**	**9830**	**1**	**9802**	**1**	**1000**
Center for the Application of Prevention Technologies						
Grants						
Continuations	-----	-----	-----	-----	-----	-----
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	-----	-----	-----	-----	-----	-----
Contracts						
Continuations	2	8074	1	8059	-----	-----
New	-----	-----	-----	-----	1	7511
Subtotal	2	8074	1	8059	1	7511
Total, Center for the Application of Prevention Technologies	**2**	**8074**	**1**	**8059**	**1**	**7511**
Science & Service Program Coordination						
Contracts						
Continuations	5	4399	13	4780	2	4082
New	1	327	-----	-----	-----	-----
Subtotal	6	4726	13	4780	2	4082
Total, Science & Service Program Coordination	**6**	**4726**	**13**	**4780**	**2**	**4082**
Minority Fellowship Programs						
Grants						
Continuations	1	71	1	71	1	71
New/Competing	-----	-----	-----	-----	-----	-----
Subtotal	1	71	1	71	1	71
Total, Minority Fellowship Programs	**1**	**71**	**1**	**71**	**1**	**71**
Subtotal, SCIENCE AND SERVICE	**10**	**22701**	**16**	**22712**	**5**	**12664**
Total, PRNS	**250**	**75956**	**257**	**76202**	**209**	**65877**

Substance Abuse Treatment Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
CAPACITY:						
Co-occurring State Incentive Grants (SIGs)						
Grants						
Continuations	2	$1100	0	$0	0	$0
New/Competing	0	0	0	0	0	0
Subtotal	2	1100	0	0	0	0
Contracts						
Continuations	0	718	0	0	0	0
New/Competing	1	2355	0	0	0	**0**
Subtotal	1	3073	0	0	0	0
Total, Co-occurring St. Incentive Grants (SIGs)	**3**	**4173**	**0**	**0**	**0**	**0**
Opioid Treatment Programs/Regulatory Activities						
Grants						
Continuations	1	494	2	998	1	499
New/Competing	1	500	0	0	1	499
Subtotal	2	994	2	998	2	998
Contracts						
Continuations	6	3224	12	7888	6	5533
New/Competing	2	4335	0	0	3	2355
Subtotal	8	7559	12	7888	9	7888
Total, Opioid Treatment Programs/Regulatory Activities	**10**	**8553**	**14**	**8886**	**11**	**8886**
Screening, Brief Intervention and Referral to Treatment						
Grants						
Continuations	21	15325	27	25293	12	12210
New/Competing	9	34968	3	25000	22	15925
Subtotal	30	50293	30	50293	34	28135
Contracts						
Continuations	2	2570	2	2894	2	1865
New/Competing	0	799	0	0	0	0
Subtotal	2	3369	2	2894	2	1865
Total, Screening, Brief Intervention and Referral to Treatment	**32**	**53662**	**32**	**53187**	**36**	**30000**
TCE - General						
Grants						
Continuations	31	11770	46	14727	30	8083
New/Competing	29	8033	3	2520	0	0
Subtotal	60	19803	49	17247	30	8083
Contracts						
Continuations	6	8230	6	10733	2	5173
New/Competing	0	0	0	0	0	0
Subtotal	6	8230	6	10733	2	5173
Total, TCE - General	**66**	**28033**	**55**	**27980**	**32**	**13256**
Pregnant & Postpartum Women						
Grants						
Continuations	11	4681	20	9678	26	12764
New/Competing	20	9696	6	3082	0	0
Subtotal	31	14377	26	12760	26	12764
Contracts						
Continuations	1	1501	1	3210	1	3206
New/Competing	0	0	0	0	0	0
Subtotal	1	1501	1	3210	1	3206
Total, Pregnant & Postpartum Women	**32**	**15878**	**27**	**15970**	**27**	**15970**

Substance Abuse Treatment Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
Strengthening Treatment Access and Retention						
Grants						
Continuations	0	$0	0	$0	0	$0
New/Competing	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Contracts						
Continuations	1	1400	1	1672	0	0
New/Competing	0	375	0	0	1	1000
Subtotal	1	1775	1	1672	1	1000
Total, Strengthening Treatment	**1**	**1775**	**1**	**1672**	**1**	**1000**
Recovery Community Services Program						
Grants						
Continuations	5	1728	6	2146	6	1725
New/Competing	8	2200	0	0	2	421
Supplements	4	600	-----	-----	-----	-----
Subtotal	13	4528	6	2146	8	2146
Contracts						
Continuations	2	708	1	299	0	0
New/Competing	0	0	0	0	1	299
Subtotal	2	708	1	299	1	299
Total, Recovery Community Services Program	**15**	**5236**	**7**	**2445**	**9**	**2445**
Access to Recovery						
Grants						
Continuations	30	94739	30	96771	30	91943
New/Competing	0	0	0	0	0	0
Subtotal	30	94739	30	96771	30	91943
Contracts						
Continuations	1	2685	1	1497	1	1833
New/Competing	0	1530	0	0	0	0
Subtotal	1	4215	1	1497	1	1833
Total, Access to Recovery	**31**	**98954**	**31**	**98268**	**31**	**93776**
Children and Family Programs						
Grants						
Continuations	48	14332	34	10555	12	4291
New/Competing	0	-----	12	4283	38	11338
Subtotal	48	14332	46	14838	50	15629
Contracts						
Continuations	4	13509	3	15782	3	12769
New/Competing	1	2829	0	0	2	1280
Subtotal	5	16338	3	15782	5	14049
Total, Children and Family Programs	**53**	**30670**	**49**	**30620**	**55**	**29678**
Treatment Systems for Homeless						
Grants						
Continuations	72	26082	95	35878	72	26884
New/Competing	23	9864	0	0	23	8985
Subtotal	95	35946	95	35878	95	35869
Contracts						
Continuations	-----	2796	2	5693	2	5702
New/Competing	2	2908	0	0	0	0
Subtotal	2	5704	2	5693	2	5702
Treatment Systems for Homeless	**97**	**41650**	**97**	**41571**	**97**	**41571**

Substance Abuse Treatment Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
Minority AIDS						
Grants						
Continuations	127	$57134	74	$28557	91	$38556
New/Competing	11	1800	64	30267	16	6776
Subtotal	138	58934	138	58824	107	45332
Contracts						
Continuations	3	6017	5	7039	5	7027
New/Competing	2	1037	0	0	0	0
Subtotal	5	7054	5	7039	5	7027
Total, Minority AIDS	**143**	**65988**	**143**	**65863**	**112**	**52359**
Criminal Justice Activities						
Grants						
Continuations	156	49134	82	26228	123	41158
New/Competing	21	5356	90	31594	40	13822
Subtotal	177	54490	172	57822	163	54980
Contracts						
Continuations	4	8586	6	9081	3	9160
New/Competing	2	2112	0	0	1	995
Subtotal	6	10698	6	9081	4	10155
Total, Criminal Justice Activities	**183**	**65188**	**178**	**66903**	**167**	**65135**
Services Accountability						
Contracts						
Continuations	0	21079	0	-----	0	-----
New/Competing	0	0	0	0	0	0
Subtotal	0	21079	0	0	0	0
Total, Services Accountability	**0**	**21079**	**0**	**0**	**0**	**0**
Subtotal, Capacity	**666**	**440839**	**634**	**413365**	**578**	**354076**

Substance Abuse Treatment Programs of Regional and National Significance
Mechanism by Summary Listing of Activity Tables *(Dollars in Thousands)*

Programs of Regional & National Significance	FY 2011 Actual		FY 2012 Enacted		FY 2013 Pres. Budget	
	No.	*Amount*	*No.*	*Amount*	*No.*	*Amount*
SCIENCE AND SERVICE:						
Addiction Technology Transfer Centers						
Grants						
Continuations	15	$7800	0	$0	15	$7831
New/Competing	0	0	15	8814	0	0
Supplements	3	250	0	0	0	0
Subtotal	15	8050	15	8814	15	7831
Contracts						
Continuations	0	0	1	250	1	250
New/Competing	0	1031	0	0	0	0
Subtotal	0	1031	1	250	1	250
Total, Addiction Technology Transfer Centers	**15**	**9081**	**16**	**9064**	**16**	**8081**
Minority Fellowship Program						
Grants						
Continuations	0	547	0	546	0	546
New/Competing	0	0	0	0	0	0
Subtotal	0	547	0	546	0	546
Total, Minority Fellowship Program	**0**	**547**	**0**	**546**	**0**	**546**
Special Initiatives/Outreach						
Grants						
Continuations	1	300	1	300	1	300
New/Competing	0	0	0	0	0	0
Subtotal	1	300	1	300	1	300
Contracts						
Continuations	2	1700	1	1967	1	1136
New/Competing	0	0	0	0	0	0
Subtotal	2	1700	1	1967	1	1136
Total, Special Initiatives/Outreach	**3**	**2000**	**2**	**2267**	**2**	**1436**
Subtotal, Science and Service	**18**	**11628**	**18**	**11877**	**18**	**10063**
Total, CSAT	**684**	**431389**	**652**	**425243**	**596**	**364139**

Physicians' Comparability Allowance (PCA) Worksheet
SAMHSA

Table 1

	PY 2011 (Actual)	CY 2012 (Estimates)	BY 2013* (Estimates)
1) Number of Physicians Receiving PCAs	3	2	2
2) Number of Physicians with One-Year PCA Agreements	3	2	2
3) Number of Physicians with Multi-Year PCA Agreements	0	0	0
4) Average Annual PCA Physician Pay (without PCA payment)	$143,238	$143,238	$145,387
5) Average Annual PCA Payment	$19,333	$19,333	$19,623
6) Number of Physicians Receiving PCAs by Category (non-add)			
Category I Clinical Position	0	0	0
Category II Research Position	0	0	0
Category III Occupational Health	0	0	0
Category IV-A Disability Evaluation	0	0	0
Category IV-B Health and Medical Admin.	3	2	2

*FY 2013 data will be approved during the FY 2014 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

N/A

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

The maximum annual PCA amount paid was $30,000.00 to Category IV-B physician who was determined to qualify for priority mission by the SAMHSA Administrator. The approved allowance is based on years of service and retention allowance is based on number of years contract is signed.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

SAMHSA has continually requested applicant certifications for qualified physicians from HHS, looked at PHS Commissioned Corps Officers, and have advertised number positions that were unsuccessfully filled in the past.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

Of the three medical officers employed at SAMHSA in FY 2012, SAMHSA was only able to retain two while the third resigned to return to the private sector.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

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Substance Abuse and Mental Health Services Administration
SIGNIFICANT ITEMS IN SENATE AND CONFERENCE APPROPRIATIONS REPORTS

FY 2012 Consolidated Appropriation Act and Senate Report Language
(H.R. 2055/ P.L.112-74)

General Items

Item

Project LAUNCH - The Committee recommendation includes $34,706,000 for the Project LAUNCH program, which funds mental health prevention and promotion strategies for young children aged zero to eight. The Committee notes that many prevention interventions that reduce risk factors and increase resilience are funded in other agencies such as HRSA and the Administration for Children and Families. The Committee intends that funds provided to Project LAUNCH not duplicate activities eligible for funding elsewhere in the Department. The Committee requests a list of all grant awards made under this program, along with a description of the activities undertaken by grantees.

Action taken or to be taken

The following are a list of the grantees and description of activities for each:

RHODE ISLAND STATE DEPT OF HEALTH: Build on the RI Successful Start Initiative to ensure that all children (birth to 8) succeed in school by building social-behavioral capacities into community based early childhood systems of care that promote and integrate physical and behavioral health wellness. RI LAUNCH targets Providence, RI, the main urban core of the state.

The goals of RI LAUNCH at the State level are to: 1) Implement early childhood systems building activities as described in the Successful Start strategic plan focused on aligning state policies, reducing redundancies in service deliveries, and securing sustainable funding for needed programs; 2) Develop and support an organizational structure that facilitates the implementation of all components of Rhode Island's Early Childhood Systems plan goals and intervention; 3) Evaluate the implementation of RI LAUNCH activities as conducted at the local level to inform expansion of the program statewide.

The goals of RI LAUNCH at the Local level are to use mental health consultation to improve the quality of care delivered within pediatric and child care arenas, and strengthen their protective capacity in the context risk related to poverty. This will be accomplished by 1) Building mental health consultation (MHC) into primary care medical; 2) Linking parent support and education within the context of the medical home; and 3) Expanding MHC in child care settings.

NEW MEXICO STATE DEPARTMENT OF HEALTH: Develop and implement a demonstration project in the County of Santa Fe to promote wellness of children ages zero to eight years by coordinating key child-serving systems and integrating behavioral and physical health services. The project expects to significantly improve the outcomes of children from Santa

Fe County's lowest-income highest-risk neighborhoods and advance the seven strategic goals of New Mexico's Early Childhood Action Network: 1. FAMILY ENGAGEMENT: Strengthen the leadership of families with young children in policy development and implementation 2. HEALTH: All children, their parents, and all pregnant women have access to continuous preventative, acute, and chronic health care, including behavioral and oral health. 3. DEVELOPMENT: All developmental concerns of young children and their families are addressed prior to kindergarten. 4. EARLY LEARNING: High quality early learning and care meets the needs of all families and promotes optimum development and school readiness for children.5. INVESTMENT: Invest in young children and their families to promote healthy development and school readiness to improve the quality of life for all New Mexicans. 6. FAMILY FRIENDLY COMMUNITIES AND SERVICES: Family friendly policies and practices are implemented in communities, in business, in service, and in education systems. 7. PUBLIC ENGAGEMENT: The public actively embraces the importance of early childhood development and is engaged in supporting policies and programs at all levels that support children and families to thrive.

WASHINGTON STATE DEPARTMENT OF HEALTH: Work with state agencies, Yakima County, and other stakeholders to expand child wellness (physical, social, emotional, mental and behavioral health) efforts for children birth to eight and their families. A state Child Wellness Council will coordinate key child-serving systems. In Yakima County, a range of evidence-based services and programs will be provided to at-risk children and families. The goal of Project LAUNCH Washington is to create a shared vision for the wellness of young children that drives the development of state and local networks for the coordination of key-child serving systems and the integration of behavioral and physical health services. The expected result of Project LAUNCH is for children to be thriving in safe, supportive environments and entering school ready to learn and able to succeed. The target population for Project LAUNCH is children and families, who face multiple risk factors.

A range of evidence-based practices will be provided, including behavioral health consultation, Incredible Years, Positive Behavior Support, Valley Intervention Program, Parents as Teachers, and SafeCare. This project will address the interconnected challenges facing young children and their families, including learning, behavior, and mental health problems; poverty; substance abuse; domestic violence; and child abuse and neglect.

ARIZONA STATE DEPARTMENT OF HEALTH SERVICES: The Tapestry Project will support immediate and sustainable interventions to improve the wellbeing of young children in the South Mountain community in Phoenix by enhancing access to mental health and wellness services, promoting developmental screenings across a range of settings, coordinating integration of behavioral health with primary care, improving parenting skills of families with young children, and fostering early childhood social and emotional development. Individual, family and

community conditions in the South Mountain community, including economic and family instability, incarceration, involvement with Child Protective Services, patterns of antisocial behavior and criminality, and educational deficits, put children at extreme risk.

We propose implementation of five evidenced-based programs at the local level: Incredible Years, Parents as Teachers, Strengthening Multi-Ethnic Families and Communities, Parenting Wisely and Healthy Steps. These curricula were selected because of their developmental appropriateness, their demonstrated cultural competence, and their research recognition for successfully addressing the identified risk and protective factors.

With Project LAUNCH grant funds, Arizona will maximize partnerships recently established between state, city, and county agencies focused on youth development, positive family outcomes, and crime prevention. The families and children in the area will benefit from the additional application of resources that support early childhood development and by addressing the roots that lead to juvenile and adult criminal activity and incarceration.

MAINE STATE DEPT/HEALTH/HUMAN SERVICES: The Community Caring Collaborative (CCC) is a grassroots coalition of 33 agencies and tribal entities serving high-risk, substance-exposed young children ages 0 through 8 and their families in rural Washington County, Maine. Through Project LAUNCH, the CCC and Maine CDC will partner to build a sustainable system of care that is strength-based, family driven, culturally competent and based on an integrated public health model.

Tucked away in the northeastern coastal corner of Maine, Washington County is home to 2,000 Passamaquoddy Tribal members on two reservations and approximately 31,000 additional residents. Washington County is the most impoverished county in Maine, with a child poverty rate of 28.4%. Due to large distances between towns and lack of service coordination among health care and other providers, these babies and their families often do not come to the attention of child-serving agencies until ages 3-5. In 2003, the state received an Early Childhood Comprehensive Systems (ECCS) grant and developed a plan for a comprehensive early investment in young children. Through Project LAUNCH, the state and the CCC will build on and enhance this plan. Locally, the CCC will deliver wraparound service planning, DC: 0-3R assessments, mental health consultation and other evidence-based practices to 125 families per year (600 over the project period), with ""all doors"" leading to integrated services. The Maine CDC and its partners will support the CCC through training, planning, service coordination, infrastructure development and evaluation.

RED CLIFF BAND OF LAKE SUPERIOR CHIPPEWA: Through SAMHSA's Project LAUNCH, the Red Cliff Band of Lake Superior Chippewa, a federally recognized tribe, will create a supportive, family-driven accessible system of care comprised of a unique weaving of traditional values and evidence-based practices to enhance the social, emotional, physical and behavioral wellness of children aged 0 - 8 and their families

A Council on Young Child Wellness, with representation from families, the community, traditional healers, Early Childhood, Public School, Physical Health, Mental Health, Substance Abuse Treatment, Domestic Violence and Social Services will create a shared vision of child wellness. Harvard's Project on Effective Interventions School Readiness Pathway, coupled with local community knowledge, will identify existent service system gaps. To enhance cross-agency collaboration, increase knowledge of child development and engage families, 200 family-serving personnel will be trained in culturally-adapted Touchpoints.
Project LAUNCH goals are 1) Our Children are Developmentally On-track; 2) Our Families are Strong, Nurturing and Connected; 3) Our System of Care is Connected, Informed and built upon Traditional Wisdom; and 4) Our Actions Today will Strengthen the next Seven Generations (Sustainability). Expected project outcomes include improved child health and school readiness; developmentally-appropriate screenings across settings; increased access to prevention and early intervention programs and pediatric and adult mental health services; increased connectedness between providers, families, and schools; increased integration of physical health, mental health and traditional wisdom and, by project end, a sustainable system of care.

ILLINOIS STATE DEPARTMENT OF HUMAN SERVICES: The purpose of Illinois' Project LAUNCH initiative (IPL) is to integrate behavioral health and primary care to promote child health and wellness. This project will build upon Illinois' Children's Mental Health Partnership and on the innovative All Our Kids Early Childhood Networks. IPL will provide more preventive services for young children and improve the service delivery system and develop the early childhood workforce. At the state level, IPL will enhance the collaboration between the Illinois Department of Human Services and the Illinois Children's Mental Health Partnership in order to improve the ability of MCH programs to respond to the needs of children with emotional or behavioral problems. At the local level, IPL's goals are to ensure that children maintain physical and emotional health, that families are linked to the services that they need and that children enter school ready to learn. The project will serve 12,200 children each year and an estimated 19,100 children over the life of the project.

DC DEPARTMENT OF HEALTH: Through Project LAUNCH, the District of Columbia (DC) Department of Health proposes to create a system of connected programs that will increase and improve services to children ages 0-8 and their families in the city's poorest neighborhoods. The target population for this project will be children residing in Wards 7 and 8 - areas that demonstrate alarming health and economic disparities and suffer disproportionately from elevated levels of indicators of ill health. Children living in these communities are largely poor, African-American and living in single-parent households, and they have limited access to primary and mental health services compared to their counterparts through the city. During year one, Project LAUNCH will serve 1440 children and families through a variety of evidence-based programs including 1.) Incredible Years (2-8 years and parents/caregivers); 2.) Primary Project

(children 5-8 years); 3.) Ages and Stages Questionnaire/ASQ; SE (children 6 months-5-years); 4.) Parents as Teachers; Born to Learn (prenatal-2 years and parents); and 5.) Strengthening Families (children 3-8 years and parents).

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH: California Project LAUNCH (CPL) is a unique opportunity for the California Department of Public Health and the County of Alameda to leverage the tremendous systems and neighborhood level work already underway in Alameda County to create a continuum of age-appropriate developmental services in five years for over 4500 children ages 0-8 years. Through CPL, the State and local MCAH programs will partner with First 5 Alameda County (F5AC) to demonstrate the feasibility and impact of recommended policy changes intended to support local government efforts to establish and sustain more comprehensive developmental care continuums for children from birth through 8 years of age. CPL programs and evidence-based practices will support young child wellness and anticipates that 919 unduplicated children will be served through CLP annually.

NEW YORK STATE DEPARTMENT OF HEALTH - TITLE V: New York State's Project LAUNCH will expand and enhance existing programs to provide a complete range of developmentally supportive services to families with young children (pre-birth to age 8) in three targeted communities in Westchester County, New York: southwest Yonkers, Port Chester and Ossining. Health care, home visiting, parenting education, and early care and education programs will be expanded to locations where they are missing, strengthened where they exist, and integrated across disciplines to achieve the vision articulated in the State's Early Childhood Comprehensive Systems Plan (ECCS) and The Children's Plan. Universal screenings will be completed in an ecological setting, which could reach 3500 children over the course of the grant. Family Support Services designed for families of children with early identified behavioral issues will reach an estimated 250 families over the project period and home visiting programs will reach an estimated 225 families in the project period.

NC STATE DEPT/HEALTH & HUMAN SERVICES: NC LAUNCH will implement a state and local collaborative effort, based in Guilford County, that will promote environments for children ages 0-8 that support each child's physical, emotional, cognitive and behavioral health and provide children the resilience they need to enter school ready to achieve and on their way to success in life. NC LAUNCH's goal will be achieved by implementing or enhancing evidence-based practices in the following areas: developmental assessments, integration of behavioral health care into primary care, home visiting programs, mental health consultation and family strengthening and parent skills training. Poverty is widespread in Guilford County; approximately 15.5 percent of the county residents live below federal poverty guidelines in 2007. Examples of measurable objectives include number of families receiving antenatal and postnatal

home visits, numbers of person receiving enhanced mental health consultation, parent satisfaction with services provided and fidelity of model implementation.

MASSACHUSETTS STATE DEPARTMENT OF PUBLIC HEALTH: Mass LAUNCH, an initiative of the Massachusetts Department of Public Health (MDPH), will develop the state's early childhood service system for children from birth to age 8. The department has chosen the Boston Public Health Commission, working in partnership with the Boston Mayor's Thrive in Five (Ti5) Initiatives, as its local partner to enhance local systems of care for Boston children ages birth to 8. The project will focus on families experiencing child abuse or neglect, domestic violence, substance abuse, maternal depression or other parental mental health problems. The combined number of children birth-8 served by the project is 11,500. An additional 7,500 are served for years 3-5 for a total of 19,000 children.

IOWA STATE DEPARTMENT OF PUBLIC HEALTH: Iowa's Project LAUNCH seeks to develop the necessary infrastructure and system integration to assure that Iowa children are thriving in safe, supportive environments and entering school ready to learn and able to succeed. Iowa's Project LAUNCH targets children ages 0-8 and their families in a seven-zip code area in inner city Des Moines (Polk County, Iowa) with a focus on low-income and minority populations who are traditionally underserved. Outreach, recruitment, and retention efforts will specifically target African American, Hispanic, Asian, Non/Limited English Speaking Immigrant/Refugee and low-income populations. Overall, project goals are to: 1.) Build state and local infrastructure to increase the capacity and integration of the children's mental health system into a comprehensive early childhood system of care; 2.) Deliver family-centered, fully integrated evidenced-based services for children living in a targeted community at-risk for poor social emotional outcomes; and 3.) Promote sustainability and statewide spread of best practices for system development.

PUBLIC HEALTH SERVICES: Oregon LAUNCH's purpose is to create a shared vision for the wellness of young children that drives development of state and local coordinated child-serving systems and the integration of behavioral and physical health services. Oregon LAUNCH will foster an integrated and holistic system of wellness, prevention and treatment services to assist 1,500 children, aged birth-8, and families in Deschutes County, Oregon over a five-year period. Many children experience risk factors for neglect and abuse due to poverty, substance abuse and multiple barriers to care such as lack of parent awareness of services, lack of insurance, and a "medical home." A number of evidence-based practices will be provided, including: universal screening using Ages and Stages Questionnaire (ASQ), ASQ-Social-Emotional, Parents Evaluation of Developmental Status, and Devereaux; mental health consultation; Promoting First Relationships; Parenting Wisely; Incredible Years; Parents as Teachers and Parent Child Interaction Therapy.

OHIO STATE DEPARTMENT OF HEALTH: The goal of Project LAUNCH for Appalachian Ohio is to create a shared vision for young child wellness that builds a solid foundation for sustaining effective, integrated services and systems to support and promote the wellness of young children and their families. To achieve that goal, Ohio has two objectives: 1.) To build infrastructure and 2.) To enhance and expand service delivery by coordinating physical and behavioral health services for young children across systems and develop and implement a model for coordination of physical and behavioral health services that is appropriate for Ohio's Appalachian region. Project LAUNCH for Appalachian Ohio will serve over 11,000 children birth to age 8 living in four counties of rural Appalachian Ohio: Athens, Hocking, Vinton, and Meigs.

KANSAS STATE DEPT OF HEALTH AND ENVIRONMENT: The Kansas Project LAUNCH Initiative enhances the Kansas Early Childhood Comprehensive Systems (KECCS) and develops a parallel system in Finney County-a diverse rural community where 22 languages are spoken in the schools. The state/local focus utilizes a public health approach to address needs of at-risk populations and promote healthy child development. Over 605 families (121 annually) will be served through Parents as Teachers, the Incredible Years, Healthy Families, and mental health consultation. Overall, the program will target 39,000 residents of Finney County.

MICHIGAN STATE DEPARTMENT OF COMMUNITY HEALTH: The purpose of Project LAUNCH Michigan (MI) is to improve the comprehensive wellness of all young children 0-8 and their families by using the public health approach to expand and enhance early childhood systems of care. MI LAUNCH will increase the use of evidence-based practices such as Healthy Families America, Parents as Teachers, Incredible Years, Parenting Wisely, Mental Health Consultation and the Ages and Stages Questionnaire that promote comprehensive wellness as well as the integration of behavioral health into primary care. MI LAUNCH will partner with Saginaw County, population 205,000. Seventy percent of the population to be served by MI LAUNCH in Saginaw will be drawn from its largest city and 30% from its rural, isolated hamlets. MI LAUNCH will impact 1,000-1,500 children per year during its five year project period, resulting in up to 7,000 children receiving the direct benefit of the project.

WISCONSIN DEPARTMENT OF HEALTH SERVICES: Wisconsin's Well-Child Connections (WCC) will provide primary prevention services in 8 central city zip codes in Milwaukee to promote health for infants and children from birth to age 8 years. The target neighborhoods of the WCC project are excessively burdened by issues associated with poor child health, including a high percentage of infants born at low birth weight, late entry of pregnant women into prenatal care, and childhood lead poisoning. Overall, project goals are to: 1) Build

on existing state level-infrastructure to support the work of the WCC project; 2) Develop a local Child Wellness Council for a comprehensive child wellness system; 3) Build upon/sustain evidence-based programming and increase the capacity of the community; and 4) Enhance and promote child wellness in all areas of development.

MULTNOMAH EDUCATION SERVICE DISTRICT: The Multnomah LAUNCH project will assure that all young children, ages 0-8, in Multnomah County will thrive: 56,050 children will benefit from increased pediatric primary care use of developmental and behavioral screenings, and increased community coordination around service provision, and 1,200 children particularly at risk of negative outcomes will receive mental health consultation support and improved care environments.

UNIVERSITY OF MISSOURI-COLUMBIA: Through the Boone County Project LAUNCH, the University of Missouri's Department of Psychiatry, Missouri Psychiatric Center (MUPC), in partnership with community agencies, families and state agency partners, will come together in a comprehensive county-wide approach to promote the healthy development of the county's youngest citizens. The project's purpose is to create a coordinated system to support children, ages 0-8, to thrive in safe, supportive environments and enter school ready to learn and able to succeed.

Boone County, Missouri is the project site, capitalizing on the county's strong focus on the young child and rich cultural diversity. Through the proposed activities it is estimated that 1230 young children and their families will be served throughout the life time of the project with 30 served in year one and 300 served annually in years two through five.

This project has four goals: 1) Create a coordinated system to improve the integration and efficiency of the child-serving system in promoting the wellness of young children in Boone County; 2) Enhance and expand the delivery of evidence-based programs and practices that promote the wellness of young children and their families; 3) Enhance the expertise of child-serving agency personnel in young child wellness and healthy child development through workforce development activities; and 4) Increase public awareness and knowledge of child wellness.

WHEELER CLINIC: Promising Starts: Early Childhood Wellness Consortium is designed to promote the positive development of at-risk children 0 to 8 years by (1) building a coordinated, community-based, enhanced capacity system of care, (2) providing universal behavioral health assessment in pediatric practices, (3) strengthening services through effective referral, collaboration, case management, and comprehensive pre-service and in-service training of providers, (4) implementing the evidence based Child FIRST parenting, mental health consultation, and home visiting model, and (5) building system-wide competency to address these needs. Promising Starts will serve over 300 high risk families with young children in the

city of New Britain, CT. Universal assessment in pediatrician offices, screening in day care and early learning environments, and engagement with adult obstetric, mental health, and substance abuse treatment centers will help to identify children at risk. Development of a compendium of referral resources, provision of case management and consultation services to pediatric practices, and culturally sensitive, family friendly support to connect families with services will facilitate successful engagement of families with resources. Using the Michigan Association of Infant Mental Health competencies guidelines, representatives from multiple stakeholder groups, including faculty from local colleges, will complete training leading to endorsement, increasing the community's capacity to provide services to high risk families and to train the next generation of service providers.

NORTH COLORADO HEALTH ALLIANCE: Project LAUNCH will aid Weld County, Colorado, in implementing a community-wide systems navigation program to ensure young children (ages 0-8) and their families will receive a standardized screening package, referrals, and assistance navigating the system regardless of the point of access by professionals using evidence-based, culturally competent interventions. Over the course of the 5 years, 19,196 children and parents will be served and 248 professionals trained. This will be accomplished through four primary goals. Goal 1) Establish Project Launch and Develop a Community Vision and Plan that will expand on the work of the Local Early Childhood Council which has a commitment to promote school readiness, quality child care and early intervention, and physical health. Goal 2) Expand Multi-Agency Screenings, Referrals and Intervention Systems to integrate universal screenings in medical clinics, human services, community organizations, early childhood settings, public health and behavioral health agencies. Goal 3) Improve Collaboration and Integration to increase the use of the existing inter-agency electronic health record to track data and progress that supports seamless coordination between all agencies. Goal 4) Improve Children's Wellness by providing intervention at multiple agencies to promote school readiness, decrease impacts of trauma and increase protective factors and cooperative behaviors.

FUND FOR PUBLIC HEALTH IN NEW YORK, INC: New York City's Project LAUNCH will support and expand existing partnerships among public and community stakeholders to re-design the early childhood system in Harlem and the South Bronx with the goal of improving wellness outcomes for 6276 children and their families. The Fund for Public Health in New York will serve as the applicant, and the New York City Department of Health and Mental Hygiene will be the critical implementation and policy development partner and provide direction to the Young Child Wellness Coordinator (YCW Coordinator). Utilizing the promulgated New York State Children's Plan, which serves as the policy framework for transformation of early childhood services statewide, the CYCW will work with national technical assistance resources to develop a common vision of a holistic system that supports children under 8 and their families in achieving healthy and productive lives in two of NYC's most distressed communities.

Evidence based practices to be implemented in early childhood and primary health care settings include: 1) Utilization of a validated instrument, the Ages and Stages Questionnaires Social-Emotional to conduct developmental assessments 2) Utilization of the SAMHSA identified Georgetown Early Childhood Mental Health Consultation model. 3) Co-location of mental health consultants in primary care as a mental health integration model 4) Enhancement of our Nurse-Family Partnership Home Visiting Program with mental health consultation. 5) Expansion of the SAMHSA/CSAP promising program Strengthening Multi-Ethnic Families and Communities to assist parents and the SAMHSA/NREPP Incredible Years model to train child care workers and early childhood educators on positive approaches to meeting children's needs. The Project will serve 458 children and families in year 1; 1466 in year 2; 1459 in year 3; 1452 in year 4 and 1441 in year 5.

ALIVIANE, INC.: Aliviane, Inc. and its project partners, through "El Paso Project LAUNCH" will develop and implement a comprehensive Young Child Wellness System to serve the wellness needs of children in El Paso County, Texas ages birth through 8 years. In the first year of the project, a local Young Child Wellness Council will be formed, with the membership consisting of partner agencies, area stakeholders, parents representing the population of focus, and others committed to bringing about system change, developing strong and formal inter-agency collaboration and coordination, and forming a comprehensive network of young child wellness services. The youth to be served through El Paso Project LAUNCH consists of young children age 0 through 8. The overwhelming majority of the population to be served by this project will be Hispanic children living in a U.S./Mexico border community. It is projected that the majority of the clients to be served through the project will be living at or below poverty level. The project will serve at least 40 children and their families during the first project year, and 172 clients and families in each of the second through fifth years, for a total of 728 clients and families. Services will include developmental assessments in primary care and other settings, in home parent training and home visits, integration of mental health services into primary care, case management, mental health therapy, family strengthening, support service referrals, and "wraparound" support services.

Item

Addiction Services Workforce - The Committee notes the growing workforce crisis in the addictions field due to high turnover rates, worker shortages, an aging workforce, stigma and inadequate compensation. The Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act are anticipated to increase the number of individuals who will seek substance use disorder services and may exacerbate current workforce challenges. As the provision of quality substance use disorder services is dependent on an adequate qualified workforce and SAMHSA is the lead Federal agency charged with improving these services, the Committee expects SAMHSA to focus on developing the addiction workforce and identify ways to address the current and future workforce needs of the addiction field. The Committee directs SAMHSA to submit a report by March 31, 2012, on current workforce issues in the addiction field, as well as the status and funding of its substance use disorder services workforce initiatives. This report should also detail how SAMHSA is working with HRSA to address addiction service workforce needs and should identify the two agencies' specific roles, responsibilities, funding streams and action steps aimed at strengthening the addiction services workforce.

Action taken or to be taken

SAMHSA is developing the report in conjunction with its Health and Human Services Behavioral Health Coordinating Council members. It will include the current state of the behavioral health workforce, issues around data on the workforce and a description of SAMHSA's work with Health Resources and Services Administration.

Item

Underage Drinking - The Committee has provided $1,000,000 for the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) and expects this interagency group to explicitly address the issue of underage, high risk drinking on college campuses through an identification of best practices, strategies and policies currently being implemented on college campuses to deal with this persistent and pervasive public health issue. The Committee expects to see this specific information included in the next ICCPUD report.

Action taken or to be taken

SAMHSA will address the issue of underage, high risk drinking on college campuses through an identification of best practices, strategies and policies currently being implemented on college campuses in the next ICCPUD report.

Item

Health Surveillance and Program Support - The Committee is concerned by the reliance of SAMHSA on contractors for the provision of technical assistance. The Committee believes that dependence on contractors is detrimental to building and maintaining specific knowledge and expertise within SAMHSA's workforce. In addition, the Committee notes a recent report by the Project on Government Oversight showing that the Federal government pays billions more annually in taxpayer dollars to hire contractors than it would to hire Federal employees to perform comparable services. In this time of fiscal constraint, the Committee is concerned that overuse of contractors may not maximize the amount of agency funding going to service provision. The Committee requests a report no later than 3 months after enactment, detailing all agency technical assistance contracts issued with fiscal year 2011 funding. The report should include descriptions of each contract, the entities receiving contracts and the amount provided.

Action taken or to be taken

SAMHSA will provide Congress with a report on all Agency technical assistance contracts issued with fiscal year 2011 funding no later than March 23rd, 2012.

FY 2012 Senate Appropriation Committee Report Language (H.R. 2055)

Item

Clinical Training - The Committee is aware that a new clinical accreditation program is being developed by the Psychological Clinical Science Accreditation System to ground training of practitioners in empirically supported treatments. SAMHSA is encouraged to continue its collaboration with relevant professional organizations regarding this program so that those seeking services are assured of receiving scientifically sound treatment. (p. 118-119)

Action taken or to be taken

Subsequent to the release of the Senate Appropriations Committee Report, SAMHSA staff met with the Psychological Clinical Science Accreditation System (PCSAS) and the Association for Psychological Science (APS) on this subject.

SAMHSA also promotes scientifically sound treatment for those seeking services through sponsoring the National Registry of Evidence-based Programs and Practices (NREPP) which is an online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers on the quality of the research supporting intervention outcomes and the quality and availability of training and implementation materials. The purpose of this registry is to assist in identifying scientifically based approaches to preventing and treating mental and/or substance use disorders 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. Additionally, SAMHSA also promotes the adoption of Evidence Based Practices through both its discretionary and Mental Health and Substance Abuse Prevention and Treatment Block Grants.

Item

Disabilities - The Committee recognizes the important role that SAMHSA plays relative to many Americans with disabilities. Emerging research indicates that persons with severe mental illness experience additional conditions that impact their ability to function within the community. These co-occurring or other functional disorders can include substance use disorder, hidden traumatic brain injury, chronic medical conditions, or other conditions. The Committee urges SAMHSA to continue making a substantial commitment to the development of new interventions and services for individuals with mental health conditions who have co-occurring or multiple disabilities. (p. 119)

Action taken or to be taken

SAMHSA continues making a substantial commitment to the development of new interventions and services for individuals with mental health conditions who have co-occurring or multiple disabilities through its Primary and Behavioral Healthcare Integration program and Military Families Strategic Initiative.

Item

Primary and Behavioral Healthcare Integration - The Committee notes that adults with serious mental illness have chronic health conditions, such as heart disease, hypertension, diabetes and chronic respiratory conditions, at higher rates than adults in the general population. The Committee continues to believe aggressive action is necessary to eliminate this disparity and has continued funding for Primary and Behavioral Health Care Integration grants at SAMHSA. The Committee provides $62,807,000 for this program, which includes $27,807,000 provided in discretionary appropriations and $35,000,000 in transfers from the PPH Fund. This is the same as the comparable level for fiscal year 2011. The Committee directs SAMHSA to ensure that new grants awarded for fiscal year 2012 are funded under the authorities in section 520(k) of the PHS Act. (p. 119)

Action taken or to be taken

SAMHSA intends to award all fiscal year 2012 grants under the authorities in section 520K of the Public Health Service Act.

Item

Suicide Prevention in Indian Populations - The Committee continues to be concerned about the high incidence of drug and alcohol abuse and suicide in American Indian populations. SAMHSA is encouraged to develop culturally competent suicide prevention training courses to be used with selected gatekeepers in Indian country. The Committee further urges SAMHSA to collaborate with the Indian Health Service to identify priority communities to pilot this gatekeeper initiative and to develop a plan to help insure the sustainability within American Indian and Alaska Native communities. (p. 119-120)

Action taken or to be taken

SAMHSA has provided significant support for the provision of suicide prevention training in Indian Country to a broad array of gatekeepers. As of January 2012, Tribal Garrett Lee Smith grantees have conducted 774 trainings that have trained 16,710 people. Additionally, State Garrett Lee Smith grantees have trained an additional 14,389 people who are American Indian Alaska Native. In addition, SAMHSA has funded the adaptation of an evidenced based intervention in Emergency Departments for youth suicide attempters for tribal use in the White Mountain Apache community, has funded the development of a dissemination manual for a comprehensive youth suicide prevention program developed in Indian Country, and has created the resource; "To Live To See The Great Day That Dawns" to assist tribes in adapting culturally competent suicide prevention practices in their communities.

Item

Addiction Technology Transfer Centers [ATTCs] - The Committee directs SAMHSA to ensure that ATTCs continue to maintain a primary focus on addiction treatment and recovery services in order to strengthen the addiction workforce. As more individuals become eligible for substance abuse services through Medicaid and private insurance, the ATI'C network is critical to ensure there is a skilled workforce able to meet the demand in substance use disorder services. (p. 122)

Action taken or to be taken

SAMHSA will continue supporting the ATTC Network national activities in response to the emerging challenges facing the substance use disorders treatment workforce. In fiscal year 2011, data shows that over 25,000 people were trained, exceeding the target of 20,516. In fiscal year 2012, SAMHSA will fund a new cohort of grants.

Item

Drug Courts - The Committee directs SAMHSA to ensure that all funding appropriated to CSAT for drug treatment courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. In addition, the Committee urges SAMHSA to ensure that State substance abuse agencies are eligible to apply for all drug treatment court grant programs in its portfolio. The Committee expects SAMHSA to ensure that non-State substance abuse agency applicants for these grants continue to demonstrate evidence of working directly and extensively with the corresponding State substance abuse agency in the planning, implementation and evaluation of the grant. (p. 122)

Action taken or to be taken

SAMHSA will ensure all funding appropriated to Center for Substance Abuse Treatment (CSAT) for drug treatment courts will continue to support and provide technical assistance to State and community programs where substance abuse is the primary focus. In fiscal year 2012 CSAT proposes to fund grants for the provision of services to populations where their primary condition is substance abuse related.

Item

Hepatitis Testing - The Committee continues to recognize the high incidence of hepatitis among substance abusers. The Committee encourages SAMHSA to develop a demonstration project on hepatitis education and testing for patients and providers. (p. 122-123)

Action taken or to be taken

In fiscal year 2011, SAMHSA supported a program to serve 12 Opioid Treatment Program clinics promoting hepatitis education, screening, testing and vaccination for patience patients and providers.

Item

Screening, Brief Intervention, and Referral to Treatment (SBIRT) - The Committee recommendation includes $53,237,999 for the SBIRT program, which includes $28,237,000 in discretionary and evaluation tap funding, along with $25,000,000 in transfers from the PPH Fund. The Committee directs SAMHSA to ensure that funds provided for SBIRT are used for existing evidence-based models of providing early intervention and treatment services to those at risk of developing substance abuse disorders. (p 123)

Action taken or to be taken

All SBIRT funds will utilize the existing evidence base and provide funds to applicants who demonstrate the ability to provide early intervention and substance abuse treatment referral services to those in need.

Item

Substance Abuse Testing - The Committee notes the scientific progress that has been made on alternative means of substance abuse testing, including oral fluid testing, and encourages SAMHSA to continue to update its drug testing guidelines in order to take advantage of these new opportunities. (p. 123)

Action taken or to be taken

SAMHSA will utilize fiscal year 2012 funds for Federal Workplace Drug Testing to include oral fluid as an alternative specimen to urine, and also to include additional Schedule II prescription medications (e.g., oxycodone, oxymorphone, hydrocodone and hydromorphone) in the drug testing protocol. These changes are based on recommendations from the Drug Testing National Advisory Council on July 13, 2011. SAMHSA continues to partner with National Institute of Health/National Institute on Drug Abuse to ascertain the scientific evidence needed to set standards for the Drug Testing Guidelines.

Item

Programs of Regional and National Significance - The Committee recognizes substance abuse prevention as a unique and distinct field and urges SAMHSA to promote programming consistent with this finding. The Committee intends that funds specifically appropriated for bona fide substance abuse and underage drinking prevention purposes shall not be consolidated with, reallocated to or used for any other programs or initiatives in SAMHSA which do not have youth drug and underage alcohol abuse as a primary purpose, even if it may have secondary effects on these goals. (p 124-125)

Action taken or to be taken

SAMHSA only will use funds specifically appropriated for bone fide substance abuse and underage drinking prevention purposes for programs that have youth drug and underage alcohol abuse as a primary purpose.

Substance Abuse and Mental Health Services Administration
SIGNIFICANT ITEMS IN SENATE AND CONFERENCE APPROPRIATIONS REPORTS

FY 2012 Consolidated Appropriation Act Report Language (P.L.112-74)

Item

The conferees expect that SAMHSA shall not make changes to any program, project, or activity as outlined by the budget tables included in this Statement of the Managers without prior notification to the House and Senate Committees on Appropriations. (p. 40)

Action taken or to be taken

SAMHSA will not make changes to any program, project, or activity as outlined by the budget tables included in this Statement of the Managers without prior notification to the House and Senate Committees on Appropriations.

Item

The conferees intend that funds provided to Project LAUNCH should not duplicate activities eligible for funding elsewhere in HHS. (p. 42)

Action taken or to be taken

Project LAUNCH makes ongoing efforts at the national, state and local levels to ensure that grant activities expand and enhance other efforts and are not duplicative of them. This is why grantees are required to: (1) bring together a wide range of child-and-family-serving agencies as part of the LAUNCH Councils at the state and local levels so that they are integrating programs, funding, and policies rather than acting in duplicative silos; (2) conduct environmental scans of existing state and community resources so that they are aware of what programs exist and design their strategic plans and implementation approaches to address gaps in service; and (3) at the local level, focus on enhancing existing services and systems by training the workforce, increasing access to care, increasing the quality of care, and raising awareness and knowledge of healthy child development.

Project LAUNCH leaders at the state level are integrally involved in work on other early childhood national initiatives such as the Maternal, Infant, and Early Childhood Home Visiting Initiative, Race to the Top Early Learning Challenge grants, Strengthening Families, and Help Me Grow. One important goal of this collaboration to ensure that the programs are coordinated and integrated, and lessons learned can be shared.

Item

The conferees direct SAMHSA to ensure that Addiction Technology Transfer Centers continue to maintain a primary focus on addiction treatment and recovery services in order to strengthen the addiction workforce. (p. 44)

Action taken or to be taken

SAMHSA will ensure the ATTCs continue to maintain primary focus on developing and strengthening the addiction treatment workforce providing training and technical assistance to improve the delivery of substance abuse treatment and recovery support services.

Item

The conferees direct SAMHSA to ensure that all funding appropriated to the Center for Substance Abuse Treatment for drug treatment courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. (p. 44)

Action taken or to be taken

SAMHSA will ensure all funding appropriated to the Center for Substance Abuse Treatment (CSAT) for drug treatment courts, will continue to support and provide technical assistance to State and community programs were substance abuse is the primary focus. In fiscal year 2011, through a collaboration between the Center for Substance Abuse Treatment and the Center for Mental Health Services, SAMHSA awarded grants to Develop and Expand Behavioral Health Treatment Court Collaborative, supporting treatment and recovery support for people in the justice system. In fiscal year 2012 CSAT is proposing to fund grants for the provision of services to populations whom primary issues is substance abuse related.

Item

The conferees direct SAMHSA to ensure that funds provided for SBIRT are used for existing evidence-based models of providing early intervention and treatment services to those at risk of developing substance abuse disorders. (p. 44)

Action taken or to be taken

All SBIRT funds will utilize the existing evidence base and provide funds to applicants who demonstrate the ability to provide early intervention and substance abuse treatment referral services to those in need.

Item

The conferees direct SAMHSA to fund the remaining cohort of Strategic Prevention Framework State Incentive Grant grantees at amounts not less than what they received in fiscal year 2011. (p. 45)

Action taken or to be taken

In fiscal year 2012, SAMHSA will full fund 35 SPF SIG continuations and 5 Partnerships for Success continuations at the same level as fiscal year 2011.

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