SAMHSA
Portfolio of Programs and Activities

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Co-Occurring Disorders

Co-Occurring Mental and Substance Use Disorders

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

In 2002, SAMHSA published the Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders. The report concluded that persons with co-occurring disorders are only treated for one disorder if they are treated at all. The report also highlighted the profound lack of local integrated services for people who suffer from both a mental illness and substance use disorder. There was no identified public-funded systems integration for this population. SAMHSA determined in 2006, that 5 million U.S. adult citizens have a serious mental illness and a co-occurring substance use disorder. Research has found that 73 % of persons with a drug dependence disorder in substance abuse treatment had a co-occurring mental disorder at some point during their lifetime. Approximately 50 percent of all people who are homeless in any given year have a co-occurring disorder.

The Co-Occurring Mental and Substance Use Disorders program has two primary goals: to develop and enhance the infrastructure of States and their treatment service systems and to increase the capacity of States to provide accessible, effective, comprehensive, coordinated/integrated, evidence-based treatment services to persons with co-occurring mental and substance use disorders and their families. This is a joint effort funded across the Center for Mental Health Services and the Center for Substance Abuse Treatment. Funding for the Co-Occurring Center for Excellence, which supported training and technical assistance, ended in March, 2009.

Where do we want to go?

The Center for Excellence has provided training and technical assistance to 38 States. SAMHSA will continue to support the current COSIG grants, and a cross-site evaluation, as well as technical assistance and training to support adoption of evidence-based practices for treatment of persons with CODs.

How will we get there?

There have been 19 infrastructure grants provided to States in a competitive manner and include Hawaii, Missouri, Pennsylvania, Louisiana, Texas, New Mexico, Arizona, the District of Columbia, Oklahoma, Vermont, Maine, Connecticut, Virginia, Alaska, South Dakota, South Carolina, Rhode Island, Minnesota, and Delaware. Grants were approximately $500,000 for the first three years and $100,000 for the last two years. Each grant had an evaluator and a process evaluation was conducted by an independent contractor. Final data has not been submitted. At least 19 additional States are attempting to put some infrastructure in place because of awareness of the cost benefits of this approach to public health.

Funding Mechanism: Grant

How will we stay on course?

After five years of building State-level infrastructure to support local integrated services, 19 grantees (States) are well on the way to having built a statewide system of local integrated service capacity in both behavioral health and hospital environments. Funding for this program has ended; however State by State results show significant systems change, some only within a single institution, others State-wide.

Overview Program/Project/Activity Management:

- Funding Source

Center for Mental Health Services and Center for Substance Abuse Treatment - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$13,715,000	*
2006	$11,955,000	*
2007	$7,526,000	*
2008	$2,113,000	*
2009	$3,611,000	*
2010	*	*
2011	*	*
2012	*	*

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Co-Occurring Disorders

State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (Co-Occurring State Incentive Grants - COSIG Grants)

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

The Co-Occurring State Incentive Grants (COSIG) build on SAMHSA's *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders.* The report concluded that many persons with co-occurring disorders (CODs) are only treated for one disorder, if they are treated at all. The COSIG program helps implement SAMHSA's action plan to assist States in creating a system for the treatment of people with CODs, as part of a comprehensive treatment program. The COSIG program has two primary goals: to develop and enhance the infrastructure of States and their treatment service systems and to increase the capacity of States to provide accessible, effective, comprehensive, coordinated/integrated, evidence-based treatment services to persons with co-occurring mental and substance use disorders and their families.

The COSIG portfolio consists of 15 grants. The first COSIG grants were awarded to seven States in 2003. The most recent awards were made in 2007. The COSIG grants support capacity-building, infrastructure development, and enhancement goals and activities over the five-year term of the projects. States identified the following elements as important for infrastructure development and enhancement: screening and assessment; complementary licensure and credentialing requirements; service coordination and network building; financial planning and information sharing. The program is administered collaboratively by the Center for Mental Health Services and the Center for Substance Abuse Treatment. While the COSIG program focuses primarily on infrastructure development and enhancement, several grantees have exercised an option to conduct pilot services projects within their States. The grants were also supported by the Co-Occurring Center for Excellence (COCE) that provided training and technical assistance. The COCE contract expired in March, 2009.

Where do we want to go?

SAMHSA will continue to support the current COSIG grants, and a cross-site evaluation, as well as technical assistance and training to support adoption of evidence-based practices for treatment of persons with CODs. Four of the original seven grants have ended, with three continuing into FY 2009 on no-cost extensions. The 12 grants funded from 2004-2007 continue to work toward the COSIG goal of developing and enhancing the infrastructure of States and their treatment service systems.

How will we get there?

To obtain and retain support at the highest level of the State for this multi-agency effort, only the immediate Office of the Governor of States could apply for COSIG awards. State agencies and activities involved in the COSIG grants include: substance abuse and mental health entities, Medicaid and other health care funding, licensing and accreditation, management information/data gathering and analysis systems, and liaison with State legislators and legislative committees. Governors designated lead officials to be Project Directors. Amounts awarded varied during the course of the grant term, and according to whether the grantee engaged in a pilot project as shown in the following:

> **Phase I** - The first three years of the grant focus on infrastructure development/enhancement: awards up to $1.1 million each year.
>
> **Phase II** - Additional two years for evaluation and continued collection and reporting of performance data:
>
> > *Without service pilots:* up to $100,000 per year, years 4 and 5.
> > *With service pilots:* up to half the year 3 award in year 4 and up to 100,000 in year 5.

In FY 2007, grants were funded at up to $550,000 per year for five years.

COSIG grants have been awarded to: Arkansas (2003), Pennsylvania (2003), Hawaii (2003), Missouri (2003), Texas (2003), Alaska (2003), Louisiana (2003), New Mexico (2004), Arizona (2004), Oklahoma (2004), Virginia (2004), District of Columbia (2005), Connecticut (2005), Vermont (2005), Maine (2005), Minnesota (2006), South Carolina (2006), Delaware (2007), South Dakota (2007).

Funding Mechanism: Multiple

How will we stay on course?

All COSIG projects conduct a project evaluation, and SAMHSA supports a cross-site process evaluation. COSIG projects potentially involve and/or affect State officials, staff, and initiatives, including policy makers, administrators, and directors of State activities (e.g., management information systems, Medicaid, licensing and credentialing entities, etc.); providers of services to persons with substance use disorders and/or mental problems; persons needing, seeking, and receiving treatment and their families. Program results include noticeable progress in the areas cited above, all tailored to the particular needs, circumstances, and resources of the State grantees.

The following reports, data collection and other activities ensure accountability and track performance of the program: Quarterly Progress Reports; GPRA data from pilots involving direct services; COSIG-specific data on treatment provider activities; client-level data on screening, assessment, and treatment; assessment results; type of treatment provided; and program-level data on screening and assessment, treatment and referral. The COSIG program has evolved into a collaborative learning community which includes monthly conference calls, self-management of grantee meetings, and cross-site evaluations, serving to provide a mix of anecdotal and statistical/factual information for monitoring project progress and circumstances.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Treatment and Center for Mental Health Services - Programs of

Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$15,800,000	*
2006	$13,100,000	*
2007	$8,900,000	*
2008	$4,800,000	*
2009	$7,874,000	*
2010	*	*
2011	*	*
2012	*	*

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Substance Abuse Treatment Capacity

Access to Recovery

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

According to SAMHSA's National Survey on Drug Use and Health, in 2007, 20.8 million of the 23.2 million people needing treatment for an illicit drug or alcohol use problem did not receive treatment. Of the 20.8 million, only 1.3 million reported that they felt they needed treatment for their drug or alcohol use problem, including 380,000 people who made an effort to get treatment, but were unable to find care. Concerned about treatment for people who sought help but were unable to access care, ATR was launched in August 2004 when the first three year grants were awarded to 14 states and one tribal organization.

Approximately $300 million in funds were awarded to the first ATR grantees and more than 170,000 people with substance abuse problems received treatment and/or recovery support services, exceeding the three-year target of 125,000 people. Of those clients who reported using substances at intake into ATR, 74.3% were abstinent at discharge. Of those who were involved with the criminal justice system, 87.8% reported no involvement at discharge.

The cumulative total of people with substance use disorders who have received clinical treatment and/or recovery support services through ATR since 2004 is over 200,000.

SAMHSA worked closely with the Office of National Drug Control Policy (ONDCP) on the development and implementation of ATR.

Where do we want to go?

ATR grantees are expected to use their grant funds to facilitate individual choice and promote multiple pathways to recovery through the development and implementation of substance abuse treatment and recovery support service voucher systems. 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 vouchers, and to link clinical treatment with critical recovery support services such as childcare, transportation, and mentoring.

How will we get there?

In September 2007, after a competitive grant review of 40 applications, 24 new 3-year Access to Recovery grants were awarded to: Louisiana, Hawaii, Missouri, New Mexico, Oklahoma Cherokee Nation, California, Alaska Southcentral Foundation, Inter-Tribal Council of Michigan, Indiana, Illinois, Connecticut, Tennessee, Oklahoma, Montana-Wyoming Tribal Leaders Council, District of Columbia, California Rural Indian Health Board, Arizona, Rhode Island, Washington, Ohio, Iowa, Texas, Colorado, and Wisconsin.

These awards total just under $100 million annually for three years to help the grantees increase access to clinical treatment and recovery support services for an estimated 160,000 individuals. Of the total available each year, $25 million must be spent on addressing methamphetamine issues.

An independent evaluation of the ATR program is being conducted by Research Triangle Institute. The evaluation will assess the effectiveness of the initiative, including the use of a voucher–based management system to provide services. Funding for the evaluation is approximately $2 million per year for three years.

Funding Mechanism: Multiple

How will we stay on course?

The President's budget for Fiscal Year 2010 includes funding for a third cohort of ATR grants. The program will prioritize funding to treat individuals with methamphetamine addictions. The project period is four years and it is expected that approximately 225,000 clients will be served. Lessons gleaned from the first and second ATR cohorts related to developing electronic voucher systems and sustainability efforts will be incorporated into this next phase of program design.

For the ATR program, SAMHSA assesses program performance through accountability measures as well as through outcome measures. Accountability measures include:

- Target number of clients to be served
- Number of vouchers issued and redeemed
- Number of eligible clinical treatment providers – total number of providers, providers identified as grass-roots providers, providers identified as faith-based and providers identified as secular
- Number of eligible recovery support service providers – total number of providers, providers identified as grass-roots providers, providers identified as faith-based and providers identified as secular
- Clinical treatment services – total clients served, clients served by grass-roots organizations, clients served by faith-based organizations and clients served by secular organizations
- Recovery support services – total clients served, clients served by grass-roots organizations, clients served by faith-based organizations and clients served by secular organizations

Outcome measures include the client's substance use, family and living conditions, employment status, social connectedness, access to treatment, retention in treatment and criminal justice status. Outcome data must be collected at the time of entry to and at exit from an episode of care and six months post entry.

The currently active grants have served 98,558 clients as of April 27, 2009. Outcomes from intake to six-month follow-up are as follows:

- Clients reporting no substance use have increased 47.1%
- Clients reporting no arrests have increased 4.4%
- Clients reporting being employed have increased 38.8%
- Clients reporting being socially connected have increased 2.8%
- Clients reporting being housed have increased 21.2%

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$99,200,000	*
2006	$98,200,000	*
2007	$98,700,000	*
2008	$96,777,000	*
2009	$98,954,000	*
2010	*	*
2011	*	*
2012	*	*

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Substance Abuse Treatment Capacity

Addiction Technology Transfer Centers

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

Recent reports commissioned by SAMHSA (*Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce* and *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion*) point to the critical need to build the capacity of the addictions treatment and recovery workforce. To help ensure that all Americans who need services for an addictive disorder receive quality care, it is crucial that addictions counselors have the latest knowledge about effective treatment and the skills to implement evidence-based practice. The purpose of the Addiction Technology Transfer Centers (ATTC) program is to assess training and development needs in the States and develop and conduct training and technology transfer activities to meet the identified needs.

Since 1993, CSAT has supported the ATTC Network in providing training and technical assistance to States and providers. The Network is a national resource with a strong infrastructure that works to shorten the gap in time between the release of new scientific findings and evidence-based practices and the implementation of new evidence-based treatment interventions by front-line clinicians. The program was continued for five years with a new round of ATTC grants awarded in September 2007, in the amount of $7.8 million.

As part of the ATTC Program, SAMHSA partners with the National Institute of Drug Abuse (NIDA) on a collaborative initiative to develop training packages and other resource materials that make scientific findings from NIDA's Clinical Trials Network readily available and accessible to front-line treatment practitioners. Through a formal Intra-Agency Agreement, NIDA transfers $1.5 million per year to the ATTC Program to support the NIDA-SAMHSA Blending Science and Service ("Blending") Initiative. The products developed under this initiative have been received enthusiastically by the field.

Where do we want to go?

ATTC grantees are expected to use their funds to develop and conduct activities that build the knowledge and skills of the addictions treatment workforce. The majority (60%) of funds for ATTC grantees are to be directed toward front-line clinicians in specialty addictions treatment settings and/or for students in academic settings preparing for careers as addictions counselors. The ATTCs are permitted to expend up to 35% of their funds for training and technology transfer activities for multidisciplinary professionals who work with individuals with addictive disorders, such as professionals in the criminal justice, domestic violence, child welfare, and primary care systems. In addition, ATTCs participate in Network-wide activities that have a national scope, such as the development of curricula that can be used throughout the Network, a unified ATTC Network website that serves as a resource to stakeholders across the country, and national training of trainers events to ensure consistency and quality of instruction across the Network. The ATTC

Network has produced publications of critical importance to the addictions treatment field, such as the core competencies for addictions counselors and *The Change Book*, which outlines a methodology for implementing evidence-based practices in organizations and systems.

How will we get there?

In September 2007, after a competitive review of 19 applications, 15 new 5-year ATTC grants were awarded to develop training and technology transfer activities that build the knowledge and skill of the addictions treatment workforce. Activities include face-to-face training and technical assistance events, distance education, academic courses for students and resource materials for educators, training guides and manuals, a comprehensive Network website, and related initiatives. The ATTCs are also conducting a survey of the addiction services workforce, designed to provide State-by-State data that can be aggregated to provide a national snapshot on the composition and demographics of the workforce, as well as national needs for workforce training and development.

The ATTC Program accomplishes its goals through the cooperative agreement mechanism. Eligible organizations are domestic public and private nonprofit entities. Many of the ATTC projects are housed in institutions of higher education, although there are a few in other settings, such as nonprofit organizations and a State certification board. The composition of the regions was reconfigured for the 2007 Request for Applications, based on feedback from the field on the need for more equitable distribution of ATTC resources throughout the country. The level of funding per ATTC regional center varies from $500,000 to $550,000 per year, depending on the number of providers in the region, as well as the geographic size of the region served. The ATTC national office is funded at $550,000 per year.

The ATTC Program coordinates its activities with other CSAT and SAMHSA efforts focused on workforce development, such as the CSAT Partners for Recovery (PFR) Initiative and the SAMHSA Behavioral Health Workforce Development contract. Regular meetings among the Federal and contractor staff are conducted to help ensure coordination among the various initiatives focused on workforce development, to avoid duplication of effort, and to maximize opportunities to leverage and stretch Federal dollars for workforce development.

The ATTC Network is viewed as a leader in the field in the area of technology transfer, and enjoys collaborative relationships with key stakeholder groups concerned with advancing the addictions workforce. For example, several ATTC regional centers are partnering with the Network for the Improvement of Addiction Treatment (NIATx) on a project to test NIATx process improvement (PI) diffusion approaches in the field by implementing PI learning collaboratives to improve client access to and retention in treatment. The ATTCs have also collaborated with NAADAC, the national professional organization for addictions counselors, on a recruitment campaign (*Imagine Who You Could Save?*) designed to attract new workers to the addictions services field, and are also working with NAADAC on developing academic standards for addictions curricula. Several ATTC regional centers are partnering with Area Indian Health Boards to provide targeted technical assistance to the Tribes, and the National Office ATTC has a special initiative with Historically Black Colleges and Universities (HBCUs) to enhance leadership skills among young faculty members who teach behavioral health courses in HBCUs.

Funding Mechanism: Multiple

How will we stay on course?

Through the Government and Performance Act (GPRA) data collected for the ATTC program, SAMHSA assesses program performance through accountability measures that include:

- the number of participants served by each ATTC center annually
- the number of events conducted by each ATTC center annually
- the percentage of participants in ATTC events who report satisfaction with those events
- the percentage of participants in ATTC events who report applying knowledge and/or skills acquired at ATTC events in their work settings

Performance monitoring data indicate that ATTC events have served over 36,000 participants for which 94.1% report a high level of satisfaction and 90.3% report applying the knowledge or skills acquired in their work settings.

In addition, CSAT is funding an independent evaluation of the ATTC Network that will:

- identify the successes of technology transfer efforts and build up on them in the future;
- share the lessons learned across regions for the enhancement of all regions' activities;
- and distinguish between region-specific and more cross-regional processes and outcomes.

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$8,200,000	*
2006	$9,200,000	*
2007	$10,600,000	*
2008	$9,100,000	*
2009	$9,100,000	*
2010	*	*
2011	*	*
2012	*	*

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Substance Abuse Treatment Capacity

Family Centered Substance Abuse Treatment for Adolescents and their Families

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

Despite the availability of effective substance abuse treatment practices for adolescents and their families/primary caregivers, these practices are not being adequately utilized in the field. In response, SAMHSA created the Adolescent Treatment grants which 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.

Thirty-two 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 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.

Where do we want to go?

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.

How will we get there?

Thirty-two eligible grant applicants were chosen from 252 applicants including domestic public and private nonprofit entities, State and local governments, public and private universities and colleges, community and faith-based organizations, federally and State recognized tribes, urban Indian organizations, and tribal organizations. In 2006, 15 of these three-year grants were funded and in 2007 an additional 17 grants were funded. For FY 2010, 14 new grants are planned, and the President's Budget request for FY 2010 includes funding for approximately 14 new awards. There are contracts in place that provide training and certification for the intervention as well as technical assistance for the program.

Funding Mechanism: Multiple

How will we stay on course?

SAMHSA will assess program performance through accountability measures as well as outcome measures. Outcome measures include the client's substance use, family and living conditions, employment/ school status, social connectedness, access to treatment, retention in treatment and criminal justice status. Outcome data must be collected at the time of entry to and at exit from an episode of care and six months post entry.

Each site also conducts its own local program assessment that addresses the following outcome components:

- What is the effect of the intervention on the participants?
- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes?
- How durable are the effects?
- How closely did implementation match the plan?
- What deviations from the plan occurred?
- What led to the deviations?
- What were the effects of the deviation on the planned intervention?
- Who provided what services to whom, in what context and at what cost?

The currently active grants have served 2,572 clients as of April 27, 2009. Outcomes from intake to 6 month follow-up are as follows:

- Clients reporting no substance use have increased 54.2%
- Clients reporting no arrests have increased 5.2%
- Clients reporting being employed have increased 5.1%
- Clients reporting being socially connected have increased 4.3%
- Clients reporting being housed have increased 1.0%

Overview Program/Project/Activity Management:

- Funding Source

Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	$4,600,000	*
2007	$9,600,000	*
2008	$9,600,000	*
2009	$8,800,000	*
2010	*	*
2011	*	*
2012	*	*

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Substance Abuse Treatment Capacity

National Alcohol and Drug Addiction Recovery Month

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

National Alcohol and Drug Addition Recovery Month (Recovery Month) is an annual observance, now in its 20th year, that takes place during the month of September. Recovery Month highlights the societal benefits of substance abuse treatment, lauds the contributions of treatment providers, and promotes the message that recovery from substance abuse in all its forms is possible. Each year during Recovery Month, more than a million individuals in recovery as well as treatment programs around the country celebrate their successes and share them with their neighbors, friends, and communities in an effort to educate the public, the elected and appointed officials, the corporate sector and others about addiction, treatment, and recovery issues.

Where do we want to go?

Recovery Month will continue to educate the public, the media, policymakers, the justice system, heath care providers and insurers on substance abuse as a national health crisis, and highlight the benefits of treatment and recovery for not only the affected individual, but for their family, friends, co-workers, and society as a whole. The observance is responsible for reaching out to the more than 20 million people who need treatment so that they may decide to call for help and seek referrals to treatment. Recovery Month will continue to encourage citizens to take action to help expand and improve the availability of effective treatment and recovery services for those in need.

How will we get there?

Recovery Month materials and activities include the following:

- Printed and web-based materials for hosting events and education
    - Toolkits – 75,000 printed and available for downloading and customizing on-line
    - Commemorative posters – 10,000
    - Flyers – 10,000 English and 5,000 Spanish
    - Slim Jims (small promotional flyers) - 10,000 English and 5,000 Spanish

- Butterfly and Lock and Key Public Service Announcements (PSAs) for Television and Radio in English and Spanish. (The 2009 PSAs are still in production.)
    - The 2008 television PSAs aired 17,115 times (equaling 129 broadcast hours) through 642 outlets reaching 186 markets, at an estimated earned media value of $854,509 with 91,907,061 viewer impressions.
    - From 2002 through December 2008, the 22 spots released in previous years continued to air, producing an estimated earned media value of $21,425,000 and 2,174,179,901 in viewer impressions. In total, the overall estimated earned media

value for all television PSAs released from 2002 through 2008 is $22,279,509 with a collective viewership of 2,266,086,962.
    - The 2007 radio PSAs were aired 20,591 times from June through December (equaling 158.29 broadcast hours) via 153 outlets, reaching 136 cities in 44 states, and resulting in an estimated earned media value of $1,084,257 with 144,700,430 listener impressions.
    - From 2002 through December 2008, 22 additional spots from previous Recovery Month efforts continued to air, producing an estimated earned media value of $11,168,463, with 1,211,611,779 listener impressions. In total, the overall estimated earned media value for all radio PSAs released from 2002 through 2008 is $12,252,720 with a collective audience of 1,356,312,209.

- The Road to Recovery Series – A Television and Radio programming series
    - Television programming is viewed in 50 states (including America Samoa) on 467 stations reaching more than 22.5 million households, generating $13.5 million in free airtime annually.
    - Radio programming, new in 2008, is being aired on 24 Native radio stations reaching 725,000 listeners.
    - Additionally, Road to Recovery will begin airing on DishNetwork, Channel 94.12, in March 2009. DishNetwork reaches 20 million households. If SAMHSA had to buy that time through a broker, it would cost approximately $2,000 per hour.
    - Between the cable stations and the satellite distribution, Road to Recovery, now reaches 40% of all households in the United States.
    - Topics vary for each show and cover addiction-, treatment- and recovery-related topics such as youth, families, criminal justice system, on-line services, workplace and others. The show listings are available in the multimedia section at http://www.recoverymonth.gov/.

- Interactive Web Site – http://www.recoverymonth.gov/
    - More than 16.8 million hits annually
    - More than 952,938 million unique visitors annually
    - 853 nationwide events posted in 2008, reaching nearly 1 million people
    - Together with Arts & Entertainment Television (A&E) SAMHSA and the Recovery Month Planning Partners sponsored the Recovery Rally in New York and are collaborating with A&E as part of the Emmy-nominated television series Intervention on The Recovery Project, an initiative to break the misconceptions of addiction, raise awareness that addiction is a treatable disease and show that recovery is possible.
    - Materials available to customize, download and order
    - Multimedia audio/visual products – PSAs and Webcasts – available to order and customize Voices for Recovery – stories of individuals in recovery
    - Posting of events held throughout the country
    - Posting of proclamations issued throughout the country
    - Resources listed for national and local organizations

- 2008 SAMHSA-Sponsored Recovery Month events
    - Hosted in every state
    - 102 events targeted to meet the needs of the locality and include town hall meetings, walks/runs, family picnics, sober motorcycle rides, conferences, and more

- Engaged 47,281 people nationwide
- Culturally targeted, minority-focused

Recovery Month supports and promotes other SAMHSA programs and initiatives such as Access to Recovery (ATR), Recovery Community Services Program (RCSP), Screening, Brief Intervention and Referral to Treatment (SBIRT), Partners for Recovery (PFR), Medication-Assisted Therapies, as well as SAMHSA publications and reports. It also promotes best practices as part of the topics selected for discussion on each one of CATV and webcasts programs.

In addition, other Consumer Affairs programs are highlighted through Recovery Month and include collaborations to engage external organizations and constituencies in Recovery Month. Efforts include the following projects: Partnering with Faces and Voices of Recovery to help educate and engage people in recovery and recovery services to be actively involved in their own recovery as well as to educate others about the effectiveness of treatment and the need for expanded services; working with the National Council on Patient Information and Education to educate parents, youth and youth influencers about the dangers of misusing prescription medications; and work done through an interagency agreement with the Food and Drug Administration on the safe and effective use of methadone in the treatment of pain and medication-assisted therapy for the addiction to opioids.

With the assistance of a planning partners group, Recovery Month engages a variety of public and private sector entities and national and local coalitions and organizations as well as those in recovery and recovery services that work in collaboration to determine the theme and audience for each Recovery Month observance and plan activities and events throughout the country. The views of the planning partners help SAMHSA establish the direction and tone of the observances to best meet the needs of the field and be responsive to emerging trends in the treatment and recovery communities. Partner organizations external to the Federal Government number more than 80 and are listed at http://www.recoverymonth.gov/2008/partners.aspx.

Recovery Month partnering Federal agencies include: the Office of National Drug Control Policy, Executive Office of the President, the Department of Labor, the Department of Justice, the Department of Transportation, the Drug Enforcement Administration, and the Small Business Administration. HHS partnering agencies include the Health Resources and Services Administration, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism. Single State Agencies, such as the State of Pennsylvania and Minnesota are also planning partners. Government agencies participate in Recovery Month as a means to unify the message around addiction, treatment and recovery services.

Funding Mechanism: Multiple

How will we stay on course?

CSAT prepares an annual report on all of the year's accomplishments. At the first planning partners' meeting each year there is a review of accomplishments and the planning for subsequent years is based on the previous years' results and on stretch goals from previous years' accomplishments.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Treatment – Programs of Regional and National Significance

(PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$2,300,000	*
2006	$2,000,000	*
2007	$2,400,000	*
2008	$2,472,000	*
2009	$2,556,000	*
2010	*	*
2011	*	*
2012	*	*

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Substance Abuse Treatment Capacity

Recovery Community Services Program

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

The Recovery Community Services Program (RCSP) responds to the need, consistently voiced by people in recovery and their families, for community-based recovery support services that help prevent relapse and promote long-term recovery. Such services can reduce the strain that relapse places upon the already overburdened treatment system and 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.

In FY 2003, ten awards were made for a total of $ 3.25 million. In FY 2004, eight projects received awards in the amount of $2.8 million. In FY 2006, seven awards were made for a total of $2.4 million. Most recently, in FY 2007, eight awards were made for a total of $2.8 million (project period up to four years).

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.

Where do we want to go?

The primary targets for the RCSP initiative are people with a history of alcohol and/or drug problems who are in or seeking recovery, along with their family members and significant others, and include both providers and recipients of recovery support services. The objectives of the RCSP service models are:

- to encourage people to enter treatment;
- to assist people to stay engaged in treatment;
- to help prevent relapse and promote timely re-entry into treatment if relapse occurs;
- to promote sustained recovery and enhanced quality of life for the participants;
- to recognize and support the value of peer recovery support services;
- and to foster value of services and supports unique to a recovery community.

These types of services expand treatment capacity by preventing relapse and promoting long-term recovery, thereby reducing the strain on an already overburdened treatment system. The peer recovery support services programs are intended to build strong and mutually supportive relationships within community networks by involving treatment programs as well as local housing, transportation, justice and education systems.

How will we get there?

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.

Currently, there are 15 RCSP grantees, a result of two cohort grant cycles in 2006 and 2007 respectively. The current expenditure for these four year grants is $5.2 million annually. Grantees are domestic public and private nonprofit entities that are either recovery community organizations led and run by people in recovery or their family members, or facilitating organizations that host a peer-run recovery support service program. The President's budget request for FY 2010 includes approximately $2.2 million for six new RCSP awards.

CSAT works with the recovery community on a variety of levels. The RCSP is represented in the larger recovery-oriented systems approaches such as the Access to Recovery Program and the Targeted Capacity Expansion/Recovery-Oriented Systems of Care Program. RCSP grantees are active with Recovery Month and participate in collaborations with Faces and Voices of Recovery, the national organizing and advocacy group for people in recovery

Funding Mechanism: Multiple

How will we stay on course?

The currently active grants have served 3,559 clients as of April 27, 2009. Outcomes from intake to 6 month follow-up are as follows:

- Clients reporting no substance use have increased 14.0%
- Clients reporting no arrests have increased 0.9%
- Clients reporting being employed have increased 38.4%
- Clients reporting being socially connected have decreased 0.7%
- Clients reporting being housed have increased 39.6%

The value of recovery support services is being recognized throughout SAMHSA, and the RCSP program is instrumental in facilitating peer recovery support services. Input from the recovery community will continue to be incorporated into SAMHSA/CSAT initiatives. RCSP grantees are incubators for new ideas. Innovations like recovery community centers and telephone recovery support services were pioneered by RCSP grantees. RCSP grantees have leveraged tens of thousands of volunteer hours from individuals in their communities each year to support people who are beginning the recovery process or seeking recovery. The RCSP program through its design, operationalizes the recovery principles of participatory process, authenticity, inclusion, and leadership development.

Overview Program/Project/Activity Management:

- Funding Source

  Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$9,200,000	*
2006	$9,400,000	*
2007	$9,300,000	*
2008	$5,236,000	*
2009	$5,236,000	*
2010	*	*
2011	*	*
2012	*	*

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Substance Abuse Treatment Capacity

Regulation and Oversight of Opioid Addiction Treatment

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

Grants for Opioid Treatment Program Accreditation

The OTP accreditation support program was introduced in October 2001 to assist OTPs in transitioning to the new accreditation requirement established in March 2001. SAMHSA facilitated the transition from the FDA regulatory-inspection model to the SAMHSA regulatory-accreditation model in order to ensure continuity of OTP operations, prevent instability in the provision of treatment services, improve quality of treatment in opioid treatment programs, and ensure that OTPs meet minimum standards of care. The goal of the OTP accreditation grant program is to reduce the cost of basic accreditation education and accreditation/reaccredidation surveys for OTPs participating in the accreditation process. SAMHSA funding supported the accreditation of over 1,100 OTPs during the first cycle (2002-2005) and approximately 1,167 OTPs during the second cycle (2005-2008). For the third and final cycle (2008 – 2010), we estimate that funding will provide assistance for over 1,315 OTPs.

Cooperative Agreement for the Physician Clinical Support System for the Treatment of Substance Use Disorders with Buprenorphine (PCSS-B)

The SAMHSA-funded Physician Clinical Support System (PCSS) is designed to assist practicing physicians, in accordance with the Drug Addiction Treatment Act of 2000, in incorporating into their practices the treatment of prescription opioid and heroin dependent patients using buprenorphine. (Note: The Drug Addiction Treatment Act {DATA} allows trained, qualified physicians to receive a waiver for prescribing specifically approved controlled substances for the treatment of opioid addiction in their office settings and in traditional opioid treatment programs.) The goal of PCSS is to expand access to office-based buprenorphine treatment by providing expert education and training to physicians to address their concerns, such as lack of experience, practical issues, limited understanding of the appropriate role of medication in opioid treatment, and addiction stigma that could otherwise prevent or slow adoption of this effective treatment modality.

The PCSS service is available, at no cost, to interested physicians and staff to assist in implementing office-based treatment of opioid dependence with buprenorphine. The PCSS consists of a medical director, a national network of trained physician mentors with expertise in buprenorphine treatment who are skilled clinical educators, and support from national experts in the use of buprenorphine.

The PCSS program continues to implement and accomplish the action steps and milestones established in the original project grant. In addition, the grantee, American Society of Addiction Medicine (ASAM), has created new systems to respond effectively to continuous feedback mechanisms in place that enable mentors, steering committee members and PCSS participants to shape the project's expansion and strategic growth.

Cooperative Agreement for a Physician Clinical Support System for the Appropriate Use of Methadone in the Treatment of Pain and Opioid Addiction (PCSS-M)

PCSS-methadone is a new cooperative agreement awarded in FY 2008. Similar to PCSS-B, the purpose of this project is to establish a national mentoring network offering support (clinical updates, evidence-based outcomes and training) free of charge to physicians and other medical professionals in the appropriate use of methadone for the treatment of chronic pain and opioid addiction. This initiative will help address the nation's rise in methadone-associated deaths that has been spurred mainly by misuse/abuse of methadone prescribed for treatment of pain, and fatal drug interactions involving methadone and other prescription medications, over the counter medications, and illicit drugs.

Where do we want to go?

Grants for Opioid Treatment Program Accreditation

OTPs are required to attain accreditation every three years as a part of the process of SAMHSA certification. Certification is the process by which SAMHSA determines that an OTP is qualified to provide opioid treatment under the Federal opioid treatment standards established by the Secretary of Health and Human Services. The OTP Accreditation Grant Program was never intended to become permanent. It was developed specifically to assist OTPs in transitioning to the new accreditation process. Over the first two cycles of the program, the vast majority of OTPs achieved accreditation and were reaccredited. Because of the successful implementation of the accreditation process, CSAT believes it is now time to phase out the program. During the final cycle of the program which began in FY 2008, the support available to defray the costs of basic accreditation education and accreditation surveys is being reduced by about 50 percent from the level available under previous cycles of the program. This final grant cycle will allow OTPs to prepare to assume the full costs of accreditation after the program ends.

PCSS–B

This project is moving forward according to schedule, and has made creative use of resources to maximize the penetration and coverage of the mentor network. There are currently over 3,500 active PCSS participants in the mentor network nationwide out of 16,000 physicians with a DATA waiver. The PCSS continues to: 1) Provide mentoring support, observation of practice, and consultative services by phone and email that promote and support physician implementation of office-based practice for the treatment of opioid dependence; 2) Educate prospective practitioners through web-site and published resources, such as CSAT's Treatment Improvement Protocols (TIPS) containing science-based best-practice guidelines for the treatment and maintenance of opioid dependent patients, and 3) Reduce barriers physicians encounter when seeking waivers to use buprenorphine products to treat opioid dependent patients.

PCSS–M

The goals of PCSS-methadone are similar to those of PCSS-Buprenorphine, and include: to 1) Provide mentoring support, observation of practice, and consultative services by phone and email that promote and support physician implementation of office-based practice ; 2) Educate prospective practitioners through web-site and published resources, such as Treatment Improvement Protocols (TIPS) and; 3) Increase knowledge on the safe and effective use of methadone in addiction and pain treatment to reduce the overall morbidity and mortality.

How will we get there?

Grants for Opioid Treatment Program Accreditation

In September 2008, the final cycle of three grant awards were announced to The Joint Commission, the Commission on Accreditation of Rehabilitation (CARF), and the National Commission on Correctional Health Care (NCCHC). The total amount for the grant award period is approximately $3 million. The maximum allowable annual award to an accreditation body is $500,000. The amount of each award is determined by an estimate of the number of OTPs the grantee is expected to accredit/reaccredit.

Funding Mechanism: Grant
Company Name: The Joint Commission,The National Commission on Correctional Healthcare (NCCHC), Commission on Accreditation of Rehabilitation Facilities (CARF)
RFA Number: TI-08-008
Start Date: 09/01/2008
End Date: 08/30/2011

PCSS–B

In a report provided by the American Society of Addiction Medicine (ASAM), PCSS-buprenorphine has proven to be a great success among health care providers in addiction medicine. Because of this success, the PCSS Cooperative Agreement was renewed in 2007 for an additional three years. The President's budget for FY 2010 includes funding to continue the PCSS-B program.

Funding Mechanism: Cooperative Agreement
Company Name: American Society of Addiction Medicine
RFA Number: TI019115
Start Date: 09/30/2007
End Date: 09/29/2010

PCSS–M

The PCSS-M is a three-year cooperative agreement that mirrors the PCSS-buprenorphine agreement. In the upcoming months, the PCSS expert faculty will form a steering committee to strategize the best way to integrate the PCSS-methadone into the existing PCSS format.

Funding Mechanism: Cooperative Agreement
Company Name: American Society of Addiction Medicine
RFA Number: TI-08-014
Start Date: 09/30/2008
End Date: 09/29/2011

Funding Mechanism: Multiple

How will we stay on course?

Grants for Opioid Treatment Program Accreditation

The OTP Accreditation program monitors the accreditation results of approximately 1,200 OTPs to ensure that policies, practices, and patient services are consistent with SAMHSA regulations and accreditation guidelines. OTPs must achieve accreditation to maintain their SAMHSA certification. Opioid treatment programs that are non- compliant with accreditation requirements may be subject to SAMHSA regulatory action including suspension or decertification. Disciplinary actions are addressed in collaboration with the Office of the Administrator and the Office of General Counsel.

PCSS-B

As of September 1, 2008, there have been 3,497 individuals registered into the PCSS from all 50 US states, Washington DC, and Puerto Rico. The PCSS currently has 87 mentor physicians and six clinical experts located in 63 cities across 33 states and Puerto Rico. These mentors have logged a total of 1,271 contacts with 564 participants. The top clinical areas for which support was requested included the following: medication dose management (34% of all clinical contacts), dosing induction procedure (33%), induction procedure timing (26%), clinical logistical assistance (20%), and chronic pain (12%). The top logistical areas for which support was requested included: scheduling (42% of logistical contacts), payment (34%), provider availability (29%), paperwork (25%), and medication supply (22%).

The percentage of physicians satisfied with educational and support services and percentage of physicians who report that consultation or training events that resulted in appropriate practice change(s) is monitored. Physician satisfaction was assessed in a survey containing a series of follow-up questions. Nearly all who reported having received mentoring were positive about the overall quality (39% satisfied, 48% very satisfied) and experience (35% satisfied, 55% very satisfied) in the PCSS project. Most found the project to be useful (31%) or very useful (45%) regarding use of buprenorphine in their practice, and 83% reported having applied something from the project to their work. Nearly all were satisfied with their mentor (90% satisfied overall, 61% very satisfied).

PCSS-M

Once established, the same data collected for the existing PCSS will also be collected for PCSS-M.

Overview Program/Project/Activity Management:

- Funding Source

  Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	$1,944,000	*
2007	$2,192,000	*
2008	$1,975,000	*
2009	$1,955,000	*
2010	*	*
2011	*	*
2012	*	*

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Substance Abuse Treatment Capacity

Residential Treatment for Pregnant and Postpartum Women and Residential Treatment for Women and their Children (PPW/RWC)

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

According to the 2007 National Survey on Drug Use and Health (NSDUH), approximately 41.8% of women ages 12 or older reported using an illicit drug at some point in their lives. Approximately 11.6% of females ages 12 and older reported past year use of an illicit drug, and 5.8% reported past month use of an illicit drug. It is estimated that 5.3 million women in the United States use alcohol in a way that threatens their health, safety, and general well-being (NIAAA, 2005). Scientific evidence indicates women with substance use disorders and their children, particularly those living at or near the poverty line, are among the most vulnerable populations. Women with substance use disorders often have histories of physical violence, sexual abuse, co-occurring mental health disorders, and HIV/AIDS. Their children often have multiple health, developmental, and social problems, and are at risk for neglect, abuse, and removal from their families and communities. The risk of infant mortality is highly correlated with a pregnant mother's substance abuse, lack of prenatal care, and demographic factors, such as poverty and lower level of education (Kiel, 2007). Alcohol is the leading known preventable cause of birth defects and mental retardation (CDC, 2005).

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

SAMHSA supports a program of gender and culturally specific residential treatment service grants for pregnant, postpartum, and other parenting women. Using a family-centered treatment approach, with women and their minor children at the center, the program builds on the strengths and resources of the entire family, supports sustained recovery for individual family members, and improves overall family functioning.

The PPW/RWC program is designed to improve outcomes for women, children and families with, and/or at risk for, substance use, mental health and other co-occurring disorders by increasing access to a continuum of cost effective, comprehensive, integrated, culturally and linguistically competent residential and recovery support services, including treatment, prevention, and early intervention that can be sustained over time. The program is designed to strengthen the national

substance abuse treatment infrastructure that serves women, children, and families by expanding and enhancing treatment capacity. To promote and accomplish a comprehensive service system, substance abuse treatment providers and organizations are expected to partner with others in the public and private sectors to ensure that treatment services are well-coordinated, integrated, and comprehensive.

Where do we want to go?

The PPW/RWC grants provide cost effective, comprehensive, coordinated systems of care to improve outcomes for the entire family that can be sustained over time. To accomplish this comprehensive service system, it is necessary to partner with multiple systems of care. These partnerships include agencies/organizations such as local public housing authorities (for permanent housing for families), child welfare, health, mental health, family court, criminal justice, employment, education programs, and child-serving agencies. Memoranda of Understanding (MOUs) or Memoranda of Agreements (MOAs) are developed with key agencies and organizations. Strengthening these partnerships is a key strategy for sustaining treatment capacity developed under this grant program. SAMHSA/CSAT is coordinating and implementing initiatives and activities to provide a venue for experts in the substance abuse, mental health, primary health, child welfare, and other fields at the Federal, State, local, and provider levels to examine, coordinate and implement strategies to move toward a Family Systems Model of Care for those with, and/or at risk for, substance abuse, mental health and other co-occurring disorders.

The PPW/RWC program is designed to accomplish the following objectives:

- Decrease the use and/or abuse of prescription drugs, alcohol, tobacco, illicit and other harmful drugs (e.g., inhalants) among pregnant, postpartum, and other parenting women;
- Increase safe and healthy pregnancies, improve birth outcomes, and reduce related effects of maternal drug abuse on infants and children;
- Improve the mental and physical health of the women and children;
- Improve family functioning, economic stability, and quality of life; and
- Decrease involvement in and exposure to crime, violence, sexual and physical abuse, and child abuse and neglect.

How will we get there?

Since 2003, SAMHSA/CSAT has funded 44 PPW/RWC grants with the goal of improving outcomes for women with substance use, mental health and other co-existing disorders, improving outcomes for their children, and increasing family involvement, reunification and preservation. SAMHSA/CSAT is using knowledge and data from the PPW cross-site evaluation (initiated 2006), Government Performance Results Act (GPRA) performance data, and lessons learned at the provider level to identify effective approaches, gaps in service delivery systems, challenges to system integration, and strategies to transform existing infrastructures at Federal, State, local, and provider levels to improve outcomes. Development of the knowledge base and data collection will also be used to inform future directions of the PPW/RWC programs.

External collaborators for the PPW Program include: the Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB-HRSA); the Administration for Children and Families (ACF); and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Funding Mechanism: Multiple

How will we stay on course?

Since FY 2003, the PPW/RWC program has served 3,234 women through a total of 44 funded PPW/RWC grants. SAMHSA/CSAT launched the PPW Cross-site Evaluation in Fiscal Year 2006 to measure the outcomes of treatment for women and their minor children served at each grantee site. The cross-site evaluation demonstrated the following outcomes from treatment intake to 6 months post discharge:

- Decreased use and/or abuse of prescription drugs, alcohol, tobacco, and illicit drugs among pregnant and postpartum women across the projects.
- Improved mental and physical health and family functioning for women and their minor children.
- Decreased involvement and intent for involvement in crime, violence, and abuse of all kinds, both as victims and perpetrators.
- Improved quality of life from the client's perspective related to health, social functioning, and environmental support.
- Decreased barriers to accessing treatment, resulting in early entry into treatment in the first trimester of pregnancy.
- Decreased barriers to accessing project-related services.

The results will be used to assess the effectiveness of SAMHSA's targeted PPW/RWC efforts, to design program improvements, to coordinate systems of care, and to provide technical assistance to ensure that such programs can contribute appropriately to treatment and prevention of substance abuse.

The currently active grants have served 2,289 clients as of April 27, 2009. Outcomes from intake to 6 month follow-up are as follows:

- Clients reporting no substance use have increased 111.6%
- Clients reporting no arrests have increased 10.8%
- Clients reporting being employed have increased 139.5%
- Clients reporting being socially connected have increased 6.8%
- Clients reporting being housed have increased 5.9%

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$9,900,000	*
2006	$10,400,000	*
2007	$10,100,000	*
2008	$11,800,000	*

Fiscal Year	Awarded Amount	Planned Amount
2009	$16,000,000	*
2010	*	*
2011	*	*
2012	*	*

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Substance Abuse Treatment Capacity

Screening, Brief Intervention and Referral to Treatment

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

The specialist treatment system is often not appropriate for persons at risk for a substance use disorder (i.e, substance abuse or dependence), nor can that system alone address the needs of all those persons diagnosed with either substance abuse or dependence. According to SAMHSA's National Survey on Drug Use and Health (NSDUH), in 2007 approximately 21 million people needed treatment for a substance use disorder but did not receive it. Of those, 95 percent did not even recognize they had a problem. Therefore, most people with or at risk for a substance use disorder are unlikely to seek help from the specialty treatment system. They are far more likely to present in some other medical setting.

Research and clinical experience supports use of the Screening, Brief Intervention and Referral to Treatment (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 services.

CSAT's SBIRT Initiative consists of a systems-level approach to screening and brief intervention within primary care, general medical and community settings—including physician offices, hospitals, educational institutions, and mental health centers. Grantees have implemented SBIRT in primary and general practice settings, including trauma centers/emergency rooms, community clinics, federally qualified health centers, tribal communities and school clinics. Preliminary data from our grants suggest that the approach is successful in modifying the consumption/use patterns of those who consume five or more alcoholic beverages in one sitting and those who use illegal substances.

The first cohort of SBIRT cooperative agreements was awarded in 2003 to 6 States and 1 Tribal entity. Cooperative agreements were awarded to 4 more States in 2006 and 4 in 2008. In 2005, 12 Treatment Capacity Expansion - Screening and Brief Intervention (TCE-SBI) grants were awarded to 12 colleges and universities to address campus drinking and drug use. In 2008, in an effort to institutionalize SBIRT into general health care practice, 11 grants were awarded to embed SBIRT training and practice in medical residency programs and promote SBIRT for practicing health care professionals.

The initial 2003 cohort of cooperative agreements was funded at an average of $3.5 million per project per year for a lifetime total of $122,500,000. The second cohort of agreements was funded at $2.8 million per project per year for a projected total of $54,600,000 by the year 2011. The latest cohort of 4 cooperative agreements (awarded in 2008) at $2.5 million per project per year, is projected to expend $47,000,000 over the 5-year life of the projects. The TCE-SBI College and University Grants (awarded in 2005) were funded at up to $500,000 per project per year, and over the 3-year life span of the grants they have expended close to $15,400,000. The 11 SBIRT Medical Residency grants of up to $375,000 per year (awarded in 2008) were developed to promote

practice change in primary care through curriculum development and adoption at the medical school level and community based training for practicing health care professionals.

As of October, 2008, a total of 750,987 clients had received SBIRT services over the past 5 years. Of these individuals, 576,813 screened negative while 124,315 screened positive and received brief intervention. In addition, for those who screened positive, 22,938 received brief treatment, and 26,921 were referred to specialty treatment.

Where do we want to go?

The SBIRT cooperative agreements and grants require 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 homes 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.

SBIRT has great future potential for promoting changes to the entire primary care medical service delivery system. Continued expansion of the SBIRT program will include private practices, dentistry, pediatrics and adolescent care organizations, community health and mental health agencies along with any other location where primary care services are offered.

How will we get there?

The Cooperative Agreements will continue to implement and demonstrate the effectiveness of SBIRT in clinical settings and the Medical Residency grants will build best practices through changes in curricular activities and training. As mentioned above, SAMHSA, in 2008 has awarded a third cohort of 4 State/Tribal Entity cooperative agreements to continue the efforts of transforming the primary care practice system. Awards were made to the following recipients: States of Missouri, Georgia, West Virginia and the Dena Tanana Chiefs Tribal Council in Alaska. In addition, 11 Medical School Residency Grants were awarded to the following recipients: University of Pittsburgh, University of California at San Francisco, Children's Hospital Corporation in Boston Massachusetts, Howard University in Washington DC, Access Health in Chicago Illinois, University of Texas Health Sciences University, Natividad Medical Center in Salinas California, Albany Medical School in New York, Oregon Health Sciences University, Yale University and Kettering Medical Center in Ohio. An independent cross-site evaluation of the SBIRT program is being conducted by Research Triangle Institute. The evaluation will identify the best practice delivery models for SBIRT, cost effectiveness, practice standards fidelity, screening validity, outcome measures and implementation barriers.

SAMHSA works closely with the Office on National Drug Control Policy (ONDCP) on the development and implementation of SBIRT. CSAT also collaborates with the National Highway Traffic Safety Administration (NHSTA), Health Resource Services Administration (HRSA), the Indian Health Service (IHS) and the Centers for Disease Control and Prevention (CDC).

CSAT has played and continues to play an important role in the establishment of Medicaid (H), Medicare (G) and Commercial Insurer (CPT) codes for the reimbursement of SBIRT services. The codes have been approved at the national level for the States to adopt as appropriate. Although in the early stages of this effort, at least 15 States have progressed on reimbursement billing codes. States with SBIRT grants have made immense efforts to encourage their legislatures to adopt the codes. Adoption of policy changes needed to foster the widespread implementation of SBIRT is a critical aspect of the SBIRT cooperative agreements awarded to States.

Funding Mechanism: Multiple

How will we stay on course?

For the SBIRT program, SAMHSA will assess program performance through accountability measures as well as through outcome measures. Accountability measures include:

- Target numbers of clients to be screened
- Target numbers of clients receiving brief interventions
- Target numbers of clients receiving referral to brief treatment
- Target numbers of clients receiving referral to specialty treatment
- Target numbers of clients receiving discharge and/or follow up interviews
- Adherence to implementation plans in terms of types and numbers of primary care locations engaged in SBIRT services
- Number of trainings and dissemination events promoting SBIRT
- State efforts in adopting Medicare/Medicaid and Commercial Insurance billing codes Continued collaboration with ONDCP, HRSA, NHTSA, IHS and CDC

The currently active grants have served 690,364 clients as of May 5, 2009. Outcomes from intake to 6 month follow-up are as follows:

- Clients reporting no substance use have increased 175.9%
- Clients reporting no arrests have increased 2.0%
- Clients reporting being employed have increased 19.6%
- Clients reporting being socially connected have decreased 2.3%
- Clients reporting being housed have increased 6.7%

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$25,900,000	*
2006	$29,600,000	*
2007	$29,600,000	*
2008	$29,106,000	*
2009	$29,106,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 6/10/2009 11:30:28 AM

Substance Abuse Treatment Capacity

Substance Abuse Prevention and Treatment Block Grant

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

The Substance Abuse Prevention and Treatment (SAPT) Block Grant is the cornerstone of the States' substance abuse prevention and treatment systems and accounts for approximately 35 percent of all public funds expended by State agencies responsible for planning, carrying out, and evaluating authorized activities to prevent and treat substance abuse. The formula grant program is administered by SAMHSA's Center for Substance Abuse Treatment, in collaboration with the Center for Substance Abuse Prevention which is responsible for the primary prevention set-aside and prevention of the sale of tobacco products to individuals under the age of 18. The SAPT Block Grant Program was authorized by the ADAMHA Reorganization Act of 1992 (P.L. 102-321) and the Children's Health Act of 2000 (P.L. 106-310).

The SAPT Block Grant distributes funds to 60 States and Jurisdictions to plan, carry out, and evaluate substance abuse prevention activities and treatment services provided to individuals, families, and communities impacted by substance abuse and substance use disorders. Each State and Jurisdiction has the flexibility to distribute SAPT Block Grant funds to units of local government such as a county, or an intermediary (e.g. administrative service organization), and subsequently to community-based organizations (non-governmental organizations) who deliver substance abuse prevention activities and treatment services.

The overall goal is to support and expand substance abuse prevention and treatment services while providing maximum flexibility to the States. Ninety-five percent of the funding appropriated for the Block Grant Program is distributed to States through a formula prescribed by the authorizing legislation. During the latest year for which data are available, the Block Grant Program has been successful in expanding treatment capacity by supporting over 1.8 million admissions to treatment programs receiving public funding. Outcome data for the Block Grant Program also show positive results. At discharge, clients have demonstrated high rates of abstinence from use of both illegal drugs (71 percent) and alcohol (76 percent).

Where do we want to go?

According to SAMHSA's 2007 National Survey on Drug Use and Health (NSDUH), the estimated number of persons aged 12 or older needing treatment for an alcohol or illicit drug problem was 23.2 million. Of these, 2.4 million received treatment at a specialty facility, while 20.8 million persons received no treatment. Based on the FY 2009 funding level for the SAPT Block Grant Program, the output target for FY 2009 was set at 1,881,515 admissions to substance abuse treatment programs receiving public funding.

A program assessment of the Block Grant Program conducted by the Office of Management and Budget (OMB) in 2003 identified two deficiencies which were subsequently resolved: an absence of

performance measures from all States and no independent evaluation. The OMB program assessment cited clear program purpose and collaboration with other agencies as strong attributes of the program. As a result of the assessment, the program has included performance measures in the block grant application and completed an independent and comprehensive program evaluation.

SAMHSA has been working closely with States and other stakeholders to move the management of the substance abuse prevention and treatment systems to a performance oriented system, and this change is beginning to show results. The FY 2008 Block Grant application was the first year that the submission of performance measures was mandatory for all States. Prior to 2008, the submission of performance measures was voluntary. SAMHSA has been working with States and Jurisdictions to develop systems to collect, analyze and share performance data for the purpose of improving client outcomes. SAMHSA plans to continue improving data collection and refine the use of data for performance improvement. In addition, efforts are underway for implementing a robust and meaningful accountability system which can be used by providers, States and SAMHSA.

States and Jurisdictions responsible for the administration of the SAPT Block Grant will continue to work closely with the regional Addiction Technology Transfer Centers (http://www.attcnetwork.org/index.asp) and institutions of higher education to recruit, train, and develop the workforce for the 21st century. States and Jurisdictions will continue to promote the diffusion and adoption of evidence-based practice to improve the quality of substance abuse treatment and recovery support services.

Community advocacy organizations at the national level, e.g., Faces and Voices of Recovery (http://www.facesandvoicesofrecovery.org), National Council on Alcoholism and Drug Dependence (http://www.ncadd.org), and numerous other organizations (http://www.ncadd.org/links/index.html) provide education and outreach to individuals, families, and communities impacted by alcoholism and drug addiction. They also work closely with policymakers and other stakeholders at the State and local level through affiliate organizations to improve access to addiction treatment services and to promote recovery.

How will we get there?

States and Jurisdictions annually submit an application for Federal SAPT Block Grant funds. Their respective allocations are determined by formula and are available for obligation and expenditure for a 2-year period. Only 60 entities are eligible to apply for and receive SAPT Block Grant funds: 50 States and 10 Jurisdictions (District of Columbia, Commonwealth of Puerto Rico, United States Virgin Islands, American Samoa, Commonwealth of the Northern Marianas Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, Republic of Palau and the Red Lake Band of the Chippewa Indians in Minnesota). The Chief Executive Officer (or designee) of each State and Jurisdiction is required to provide an assurance to the Secretary that the State or Jurisdiction will comply with all Block Grant statutory and regulatory requirements.

States and Jurisdictions are required to annually report performance and outcome data related to substance abuse prevention activities and treatment services. The performance and outcome data is posted on SAMHSA's National Outcome Measures Website http://www.nationaloutcomemeasures.samhsa.gov/.

The National Association of State Alcohol and Drug Abuse Directors (http://www.nasadad.org), in collaboration with SAMHSA's Center for Substance Abuse Treatment, established a Performance Data Working Group and created a National Data Infrastructure Improvement Consortium (NDIIC) to provide targeted technical assistance to the States and Jurisdictions to improve their capacity to collect, analyze, and report performance and outcome data to SAMHSA and to improve their systems of care through information-based decision making. In addition, the State Associations of

Addictions Services (http://www.saasnet.org), the National Association of Alcohol and Drug Abuse Counselors (http://www.naadac.org), and the American Association for the Treatment of Opioid Dependence (http://www.aatod.org), and others have worked collaboratively with SAMHSA and their members to improve performance and outcomes.

Funding Mechanism: Multiple

How will we stay on course?

Through constant monitoring and use of the State's performance and outcome data, SAMHSA and the States will implement a full performance improvement and accountability system which will ensure the most effective and efficient use of federal and state dollars.

SAMHSA's National Outcome Measures (NOMS) are submitted by States in their annual application for SAPT Block Grant funds. The aggregate results of the FY 2007 Substance Abuse Treatment NOMS are as follows:

- Clients reporting being employed or in school at discharge: 43%
- Clients reporting no involvement in the criminal justice system at discharge: 92%
- Clients reporting stable housing at discharge: 93%
- Clients reporting abstinence from alcohol at discharge: 76%
- Clients reporting abstinence from drugs at discharge: 71%

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Treatment, Substance Abuse Prevention and Treatment Block Grant

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,775,554,720	*
2006	$1,758,591,000	*
2007	$1,758,591,000	*
2008	$1,758,728,000	*
2009	$1,778,591,000	*
2010	*	*
2011	*	*
2012	*	*

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Substance Abuse Treatment Capacity

Targeted Capacity Expansion Program – General

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

The Targeted Capacity Expansion (TCE) – General program was initiated by CSAT in FY 1998 to address the "treatment gap" in communities. TCE funding supports grants to units of State and local governments, Tribes, Tribal organizations, and domestic public and private, non-profit organizations to expand or enhance a community's ability to provide a rapid, strategic, comprehensive, integrated, community-based response to a specific, well-documented substance abuse capacity problem. The TCE program is designed to address the needs of specific populations or geographic areas that are ready to address their serious and emerging substance use problems. Grants have been awarded that address the following targeted populations or urgent, unmet, and emerging treatment needs: American Indians, Alaska Natives, Asian Americans, Pacific Islanders, rural areas, methamphetamine abuse, e-therapy, grassroots partnerships, and other populations. The TCE program currently has 58 funded grants.

The cornerstone of the TCE program is its flexibility which enables communities to address their specific program priority areas such as: co-occurring disorders, children, youth and families, homelessness, older adults, HIV/AIDS, criminal and juvenile justice. TCE projects must use grant funding to expand and/or enhance treatment capacity using evidence-based practices, report on performance measurements, address cultural relevance in their treatment, and recovery services.

Where do we want to go?

The TCE program will continue to address critical gaps in treatment services by helping communities implement evidence-based practices to expand or enhance treatment capacity to meet their unique treatment needs. The TCE program will fund a range of projects providing substance abuse outreach and recovery support services. This can be achieved through funding projects that involve substance abuse treatment services which include outreach, pretreatment, and treatment recovery support services. The projects will be closely monitored for effectiveness in terms of positive client outcomes and efficiency in the use of Federal grant resources.

The TCE program design includes performing comprehensive assessments that determine appropriate treatment services for clients with co-occurring substance use and mental disorders. In addition, the program emphasizes developing linkages with community-based organizations that provide ancillary services to the communities, such as: primary health care; mental health care; community-focused educational and preventive efforts; school-based activities such as after school programs; private industry-supported work placements for recovering persons; faith-based organizational support; support for the homeless; HIV/AIDS community-based outreach projects; opioid treatment programs; health education and risk reduction information; and access/referral to STD, hepatitis B (including immunization) and C, and TB testing in public health clinics.

How will we get there?

The TCE program collects National Outcome Measures. In addition, to ensure that the TCE program remains effective, a project assessment component is built into the program, which includes performance measures, outcome and process evaluation. The assessment components are designed to help projects meet their goals, objectives and outcome targets. The following are examples of the outcome and process questions that projects address:

- What was the effect of intervention on participants?
- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes?
- How durable were the effects?
- How closely did implementation match the plan?
- What types of deviation from the plan occurred and what led to the deviations?
- What effect did the deviations have on the planned intervention and performance assessment?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

TCE projects are encouraged to develop formal relationships with state, Federal, local, faith and community-based organizations to help ensure the continuum of care of their clients.

Funding Mechanism: Multiple

How will we stay on course?

In order to comply with the Government Performance and Results Act (GPRA), all TCE program grantees are required to report performance in the following domains: Client's substance use, family and living conditions, employment status, social connectedness, access to treatment, retention in treatment, and criminal justice status. GPRA data must be collected at baseline (i.e. client's entry into the project), discharge, and at 6-month post baseline.

The currently active grants have served 5,816 clients as of April 27, 2009. Outcomes from intake to 6 month follow-up are as follows:

- Clients reporting no substance use have increased 39.0%
- Clients reporting no arrests have increased 6.7%
- Clients reporting being employed have increased 22.7%
- Clients reporting being socially connected have increased 1.9%
- Clients reporting being housed have increased 16.2%

Overview Program/Project/Activity Management:

- Funding Source

Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$33,400,000	*
2006	$29,800,000	*
2007	$30,700,000	*
2008	$28,989,000	*
2009	$28,989,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 6/12/2009 10:33:56 AM

Alternatives to Seclusion and Restraint

Alternatives to Seclusion and Restraint State Incentive Grants

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The purpose of the Alternatives to Seclusion and Restraint State Incentive Grants (SIG) program is to support States/Tribes in their efforts to reduce and ultimately eliminate the use of seclusion and restraint in institutional and community-based settings that provide mental health services (including services for people with co-occurring substance abuse and mental health disorders). Through the Alternatives to Seclusion and Restraint SIG program, States/Tribes receive funding to increase the number of programs that implement alternative models to reduce/eliminate seclusion and restraint, including staff training models and other multi-faceted approaches.

In 1998, a prominent New England newspaper published an expose' documenting deaths directly associated with the inappropriate use of seclusion and restraint by staff in care and treatment facilities. Congress requested an evaluation of this issue by the Government Accountability Office (GAO) which concluded that the full extent of injuries and deaths related to the inappropriate use of seclusion and restraint was unknown and that there was no comprehensive national reporting system to track injuries, deaths, or rates of seclusion and restraint. Enactment of the Children's Health Act of 2000 resulted in actions taken to ensure that the rights of residents of certain facilities are recognized and that residents are protected against the inappropriate use of seclusion and restraint. HHS was authorized to develop guidelines to assist States in establishing appropriate staff training models, licensure/certification standards, and effective State monitoring processes focused on improved outcomes for residents and staff that reduce/eliminate the misuse of seclusion and restraint. In response, in FY 2001, 2004, and 2007, SAMHSA funded competitive 3-year demonstration grants. The grants were awarded to support States in their efforts to adopt best practices, reduce and ultimately eliminate the use of seclusion and restraint in institutional and community-based settings that provide mental health services.

Where do we want to go?

SAMHSA's Alternatives to Restraint and Seclusion SIG Program assists States in developing alternatives to seclusion and restraint within any setting that provides services to individuals with mental illness. The Center for Mental Health Services (CMHS), which administers the program, intends to broaden the scope of the grant program to include all relevant populations across the life span and to increase the impact of the program through grants to additional states.

How will we get there?

Grant funding will continue to support the following activities and objectives: infrastructure development such as implementing a model of alternatives to the use of seclusion and restraint; training staff; modifications to policies and procedures; changes in physical facility environments; and involvement of consumers, family members, and advocates in planning for and implementation

of related activities. The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Grants provide funding to each designated Protection and Advocacy agency within the States, which provide services to protect and advocate for the rights of individuals with mental illness and investigate reports of abuse and neglect in facilities that care for or treat individuals with mental illness. Additionally, the PAIMI programs collect data about the incidence of seclusion and restraint as well as deaths related to these practices. The Alternatives to Seclusion and Restraint SIG grants are supported by a Coordinating Center which is funded through a contract awarded to the National Association of State Mental Health Program Directors (NASMHPD) Office of Technical Assistance (OTA) to provide onsite technical assistance and work in close collaboration with the eight grant recipients.

Funding Mechanism: Grant

How will we stay on course?

CMHS has contracted with CSR, Incorporated to conduct an evaluation of activities under this program. The evaluation will entail collecting data and reporting on performance indicators, such as the number of programs that adopted the best practices proposed in the SIG application, the use of seclusion and restraint, characteristics of those involved, frequency, episode location, and precipitants. A similar evaluation was conducted on grantees in the FY 2004 – 2006 cohort. The final evaluation report will be submitted in early 2009. The final report on both cohorts will be distributed internally within SAMHSA.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,847,421	*
2006	$1,847,421	*
2007	$1,711,000	*
2008	$2,449,000	*
2009	$2,449,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 11:00:25 AM

Alternatives to Seclusion and Restraint

Coordinating Center to Support Alternatives to Seclusion and Restraint State Incentive Grants

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The use of seclusion and restraint on persons with mental health and/or addictive disorders has resulted in deaths, serious physical injury, and psychological trauma. Children have been noted at especially high risk for death and serious injury. Individuals with addictive or co-occurring mental health and substance use disorders also appear to be at high risk due, in part, to the possibility of increased agitation.

SAMHSA has set forth a vision to reduce and ultimately eliminate the use of seclusion and restraint practices for all age groups in behavioral health care settings both institutional and community-based. In FY 2001, SAMSHA sponsored an initiative to gather data and assess the issues related to the use of seclusion and restraint by awarding grants to five demonstration sites. Each site developed and implemented best-practice models focused on alternative training approaches to be used by facility staff to reduce the inappropriate use of seclusion and restraint of children and/or youth with serious emotional disorders and behavioral management issues. In FY 2004, SAMHSA funded a 3-year grant program, the Alternatives to Restraint and Seclusion State Incentive Grants (SIG) to support States in their efforts to reduce seclusion and restraint in institutional and community-based settings that provide mental health services. Additional grant awards were made for FY 2007 – FY 2009. To support these initiatives, a Seclusion and Restraint Coordinating Center (S&R CC) was developed and funded through a contractual arrangement. The S&R Coordinating Center supports the activities of the grant by serving as a resource center for the S&R SIG grantee sites and other interested states/stakeholders, disseminating best and promising practices and lessons learned to a national audience, and providing onsite and offsite technical assistance to S/R-SIG grantees.

Where do we want to go?

The goal of the S&R CC is to continue to promote the implementation and evaluation of best practice alternatives to the use of S&R which will result in safe outcomes for persons served and staff by reducing and eventually eliminating the use of S&R.

How will we get there?

The program will continue to link Alternatives to Seclusion and Restraint Grant efforts with the support of a S&R CC to enhance state efforts to develop, implement, and adopt best practices that reduce S&R use in a variety of settings, with a diverse group of service users. In addition, recommendations will be made to SAMHSA which are designed to inform national policy and develop evidenced based practice. The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Grants provide funding to each designated Protection and Advocacy agency within the

states to protect and advocate for the rights of individuals with mental illness and investigate reports of abuse and neglect in facilities that care for or treat individuals with mental illness. The PAIMI Programs will continue to collect data about incidence of Seclusion and Restraint and on particular deaths related to these practices.

Funding Mechanism: Contract

How will we stay on course?

The Alternatives to Seclusion and Restraint Grants are being evaluated by CSR, Incorporated. They are collecting data and will report on performance indicators, such as the number of programs that adopted the best practices proposed in the SIG application, the use of seclusion and restraint, characteristics of those involved, frequency, episode location and precipitants. A similar evaluation was conducted on the grantees in the FY 2004 – 2006 cohort and the final evaluation report will be submitted in early 2009.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Program Management

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$411,983	*
2008	$438,055	*
2009	$427,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 8:35:38 AM

Alternatives to Seclusion and Restraint

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Individuals with mental illnesses and serious emotional disturbances who reside in treatment facilities are among the groups most vulnerable to potential neglect and abuse. To help ensure that individuals receive appropriate care and treatment, each State has a system, designated by the governor, to protect and advocate for the rights of people with mental illnesses. The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program, which is administered by the Center for Mental Health Services (CMHS), advocates for individuals with mental illness and includes the following services to eligible adults, youth, and children: providing general information; making referrals; investigating alleged abuse, neglect, and rights violations in facilities; and use of legal, legislative, systemic, and other remedies to correct verified incidents.

In 1975, HHS established a program, pursuant to Part C of the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), that provided formula grants to support legal-based systems designated by the Governor of each State, the District of Columbia and the Territories to protect and advocate for the rights of persons with disabilities. In the early 1980s, Congress found that adults with significant mental illness and children with significant emotional impairments were vulnerable to abuse, serious injury, and neglect, and that State systems for monitoring compliance with respect to the rights of these individuals varied widely and were frequently inadequate.

In 1986, Congress enacted the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act which extended the protections of the DD Act to persons with significant mental illness and children with emotional impairments. On October 17, 2000, the Children's' Health Act (CHA) of 2000 gave PAIMI Programs the option of serving persons with significant mental illness and their families who reside in the community, including their own homes, when the annual PAIMI funding-level exceeded at least $30 million (with PAIMI-eligible persons in residential care and treatment settings receiving service priority). The CHA also created the American Indian Consortium Protection and Advocacy (P & A). PAIMI programs are authorized to protect and advocate for the rights of persons with severe mental illness and severe emotional impairments, who are at risk for, or in danger of, abuse, neglect, and civil rights violations; to investigate reports of abuse, particularly incidents involving the inappropriate use of seclusion and restraint, reports of neglect, and civil rights violations in facilities that either provide care or treatment to individuals with significant mental illness and/or severe emotional impairment; and to ensure enforcement of the United States Constitution, Federal laws and regulations, and State statutes.

Where do we want to go?

The ultimate goal of the PAIMI Program is for individuals with mental illness to be free from abuse, neglect, exploitation and discrimination and to have full and equal access to all opportunities

available to all citizens. The programs pursue this goal through both individual and systemic interventions which include consumer input and participation through the P & A Governing Board and the PAIMI Advisory Council.

How will we get there?

CMHS/SAMHSA currently funds PAIMI P & A systems in each State, the District of Columbia, the American Indian Consortium and 5 Territories - American Samoa, Guam, the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands. The PAIMI Program provides a funding source to support protection and legal-based advocacy for eligible adults, children and youth. State P & A systems pursue administrative, legal (individual and class action litigation), systemic and legislative activities, or other appropriate remedies/strategies to redress complaints of abuse, neglect, and civil rights. The CMHS Division of State and Community Systems Development (DSCSD) provides statutory oversight of the States use of PAIMI funds through review of applications and Program Performance Reports (PPR) and onsite monitoring reviews. DSCSD also identifies needs for and provides technical assistance to the PAIMI programs in a broad range of areas. Using the PPR, DSCSD collects and submits data on numbers and characteristics of persons served, program activities, and outcome measures including an efficiency measure, to assure accountability and efficiency of program operations. The National Disability Rights Network (NDRN) is the nonprofit membership organization that works in partnership with the federally-mandated Protection and Advocacy (P & A) Systems. Through training and technical assistance, legal support, and legislative advocacy, NDRN works to create a society in which people with disabilities are afforded equality of opportunity and are able to fully participate by exercising choice and self-determination.

Funding Mechanism: Grant

How will we stay on course?

The PAIMI program underwent a performance assessment in 2005. The assessment cited the fact that the program serves a clear need and is reporting positive outcomes as strong attributes of the program. As a result of the perfomance assessment, the program has provided grantees with guidelines as to how to calculate the number of PAIMI-eligible individuals impacted; has provided technical assistance on the right to access facilities, consumers, and information through the National Disability Rights Network; and is conducting an evaluation of the program.

In FY 2005, two efficiency measures were introduced into the PAIMI outcome measures: "ratio of persons served/impacted per activity/intervention" and "cost per 1,000 individuals served/impacted." The targets for these two measures have been met or exceeded two out of the three subsequent reporting years.

Overview Program/Project/Activity Management:

- Funding Source

  Center for Mental Health Services - Protection Advocacy for Individuals with Mental Illness (PAIMI)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	$34,000,000	*
2007	$34,000,000	*
2008	$34,880,000	*
2009	$35,880,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/21/2009 10:34:55 AM

Strategic Prevention Framework

Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD)

Substance Abuse and Mental Health Services Administration

OPPB

Where are we now?

Underage drinking is a significant public health and safety problem in the United States, with consequences for individuals, families and communities. In 2003, the National Academies of Science/Institute of Medicine released Reducing Underage Drinking: A Collective Responsibility. This report recommended that the ICCPUD be created to strengthen coordination of Federal underage drinking prevention activities. In 2004 Congress directed the Secretary of Health and Human Services (HHS) to establish the ICCPUD and Secretary Thompson directed the Administrator of SAMHSA to convene the ICCPUD in the spring of that year. In the fall of 2006, Congress passed the STOP Act, which established the ICCPUD in statute. The ICCPUD is chaired by the SAMHSA Administrator at the direction of the Secretary of HHS. In addition to SAMHSA, current members of the ICCPUD include representatives from the Administration for Children and Families, the Alcohol and Tobacco Tax and Trade Bureau, the Centers for Disease Control and Prevention, the Department of Defense, the Federal Trade Commission, the National Highway Traffic Safety Administration, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, the Office of the HHS Assistant Secretary for Planning and Evaluation, the DOJ Office of Juvenile Justice and Delinquency Prevention, the Office of National Drug Control Policy, the Office of Safe and Drug Free Schools and the Office of the Surgeon General. The work of ICCPUD is supported by a group of agency representatives, who report to the members of the Committee, and meet frequently. This group, which consists of agency staff with expertise and responsibilities in the area of alcohol prevention, is chaired by the Associate Administrator for Alcohol Policy at SAMHSA.

Where do we want to go?

The purpose of the ICCPUD, as stated in the statute, is to "guide policy and program development across the Federal Government with respect to underage drinking, provided, however, that nothing in this section shall be construed as transferring regulatory or program authority from an Agency to the Coordinating Committee". As such it provides a mechanism by which Federal programs are coordinated to create a comprehensive Federal approach to preventing underage drinking, while avoiding duplication of efforts. Through its activities and its various members, the ICCPUD also provides a common Federal vision that has been conveyed to States and communities, most recently through the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking. The ICCPUD and its member agencies provide information and support services for a variety of groups including States, communities, parents, and youth.

How will we get there?

Reporting on the Federal government's progress in preventing and reducing underage drinking is required by the STOP Act as part of the annual Report to Congress. As such, the ICCPUD can

continue to play a valuable role in assisting the new Administration in creating and implementing a coordinated approach to underage drinking prevention. There are numerous steps required to achieve continuity of these Federal efforts. Once the new Administration articulates its priorities, a first step would be to assemble the ICCPUD principals to begin the development and implementation of the Administration's vision. Once an approach has been agreed upon, communication of that approach could be accomplished through another National Meeting of the States in the fall of 2010. This would provide an opportunity for the Secretary, the Surgeon General, the SAMHSA Administrator, and the other ICCPUD principals to bring their vision to the States. It would also provide a forum for the States to begin planning how they can become part of a national effort to address the problem. As an alternative, the ICCPUD could work through established associations and public health groups to communicate the Administration's vision to other levels of government and the field. Work on the statutorily required annual Report to Congress and the Report on State Underage Drinking Prevention and Enforcement Activities is ongoing, as is maintenance of the ICCPUD website: http://www.stopalcoholabuse.gov. These activities have been and will continue to be funded through the Office of Policy, Planning and Budget's (OPPB) logistics contract, and through CSAP's underage drinking contract. Internally, SAMHSA's Centers and the Office of Applied Studies (OAS) play an important role in ICCPUD's comprehensive approach to underage drinking prevention. Therefore, it will be important that ICCPUD activities continue to coordinate with key Center and OAS projects such as the grants to communities required by the STOP Act, Town Hall Meetings, and questions related to the prevention of underage drinking in the National Survey on Drug Use and Health (NSDUH). Externally, the SAMHSA Administrator, as the ICCPUD Chair, and the Associate Administrator for Alcohol Policy, as the chair of the ICCPUD agency representatives groups, play key roles in linking SAMHSA with the ICCPUD agencies, and with interested parties, including public health groups, advocacy groups and the alcohol beverage industry.

Funding Mechanism: Contract

How will we stay on course?

Current ICCPUD objectives include reducing the prevalence of underage alcohol use and binge drinking, and increasing the age of first use. Recent data from the NSDUH support an assessment of modest progress, with most of the results across a wide range of underage drinking-related measurements moving in the desired direction or at least not in the wrong direction. Further, data from the Monitoring the Future (MTF) and Youth Risk Behavior Survey (YRBS) surveys related to underage drinking suggest movement in the same direction. This alignment within and across surveys, even without statistical significance, is a positive sign. However, it is too early to suggest a definite downward trend in underage alcohol consumption.

Overview Program/Project/Activity Management:
- Funding Source
  Program Reserve

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$700,000	*
2006	$200,000	*
2007	$200,000	*
2008	$491,000	*
2009	$1,000,000	*

Fiscal Year	Awarded Amount	Planned Amount
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 1:25:04 PM

Strategic Prevention Framework

National Leadership Forum

Substance Abuse and Mental Health Services Administration

OPPB

Where are we now?

The Leadership to Keep Children Alcohol Free is a unique coalition of Governor's spouses, Federal agencies, and public and private organizations, is an initiative to prevent the use of alcohol by children 9- to 15- years old. The initiative was founded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and The Robert Wood Johnson Foundation (RWJ); SAMHSA has been a Federal sponsor of the Leadership's activities since its inception in 1999. Beginning in FY 2006 SAMHSA has subcontracted with the Leadership Foundation to support a wide range of activities including: (1) working with Leadership members to host and organize visits by the Acting Surgeon General to conduct State "roll outs" of the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking (CTA); (2) a meeting of the Leadership in conjunction with CSAP's Prevention Day and the Community Anti-Drug Coalitions of America (CADCA) Forum, linking Leadership members to SAMHSA grantees; (3) recruitment; (4) collaboration with communities that held Town Hall meetings; (5) promotion of Ad Council Public Service Announcements (PSAs), (6) State meetings with the spouses and pediatricians to encourage screening for alcohol during routine visits; (7) and State meetings with judges and the Governor's spouses to encourage greater attention to underage drinking by the judicial system in general, and by family court judges in particular.

Where do we want to go?

Key projects for FY 2010 include continuing all of the above mentioned activities which will further the goal of reducing underage drinking and raising awareness about this important public health issue.

How will we get there?

We will continue to subcontract with the Leadership Foundation to support member spouses in conducting the activities enumerated above, and will continue to work with National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the Office of the Surgeon General on these projects as appropriate. Leadership support for the spouses under this subcontract includes such activities as providing assistance in planning, coordinating and implementing roll outs of the Call to Action In their States, assisting in organizing press events, connecting the spouses with various SAMHSA and Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) counterparts in the States, and paying the costs associated with the annual meeting held in conjunction with Prevention Day and the CADCA Forum. Overall, this project links SAMHSA grantees to Leadership members, which results in high level State support for SAMHSA-funded prevention activities, such as underage drinking focused Town Hall Meetings, and "Sober Truth on Preventing Underage Drinking (STOP) Act" grants to community coalitions. Similarly, this activity links ICCPUD member agency grantees and counterparts with the Governor's spouses, and assists

in providing a coordinated and comprehensive approach to preventing underage drinking in the States.

Funding Mechanism: Other

How will we stay on course?

Since the Leadership project involves planning activities in concert with the highest levels of the Federal and State governments, any targets established are subject to change. That said, a reasonable goal for FY 2010 is to enlist the spouses in the roll out of the new Ad Council PSAs in at least 10 States, to hold a meeting of 10-15 Governor's spouses in conjunction with CSAP's Prevention Day and the CADCA Forum, to enlist the spouses' support for CSAP sponsored Town Hall meetings in the spring of 2010, and to continue to recruit sufficient spouses to maintain membership of approximately 38 active spouses, and, depending on the priorities of the new Surgeon General, conduct roll outs of the Surgeon General's Call to Action in at least 3 additional States.

Overview Program/Project/Activity Management:
- Funding Source
  Program Reserve

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$115,000	*
2006	$115,000	*
2007	$250,000	*
2008	$244,000	*
2009	$560,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/20/2009 9:39:44 AM

Strategic Prevention Framework

Drug Free Communities Support Program (DFC)

Substance Abuse and Mental Health Services Administration

CSAP / DCP

Where are we now?

The Drug Free Communities (DFC) Program was enacted by Congress and signed into law in 1997. This program was extended for five years in 2001 and was reauthorized in 2006. A provision in the law allows the Office of National Drug Control Policy (ONDCP) to delegate the execution of grants to another agency by virtue of an Interagency Agreement. In 2004, SAMHSA became the executor of DFC grants.

Presently, there are 800 active grants in the program representing 769 community anti-drug coalitions and 31 coalitions who have grants to mentor new coalitions in their development. The two goals of the DFC program are (1) to reduce substance abuse among youth and over time, among adults and (2) to strengthen collaboration among communities, Federal, State, local, and tribal governments. In the DFC Act, Congress specifically directed funds to the Community Anti-Drug Coalitions of America (CADCA) to provide training and technical assistance for developing and strengthening the capacity of coalitions to address substance abuse issues and to help prepare coalition applicants to successfully apply for grant funding under the DFC program.

Where do we want to go?

As the coalition development has begun to create systemic change in communities across the country, an increased number of communities make application to the program, but do not receive funding due to limited availability of funds in the annual budget appropriations.

As the National Coalition Academy continues to strengthen communities all across the country, there is a need to network these grantees for increased sharing and learning about what strategies are performing the best for their coalition. The grantees need to become more connected electronically and take advantage of online learning and sharing from each other while saving travel funding. CSAP Project Officers can play a vital role in directing this assistance.

By creating state networks or associations of these communities, the coalitions will more effectively leverage additional Federal, State, local and private resources to further sustain their efforts after their Federal grant funding ends. A strong, connected network of coalitions would further the ability of population level change to be aggregated at the state level and begin to show improved outcome measures for the entire state and ultimately move the needle for the country. These networks would also bring together other partner agencies that have resources that focus on substance abuse reductions to help leverage additional resources that would support the coalitions' efforts.

How will we get there?

The most recent results from the national evaluation of the DFC program indicated that coalitions funded through the DFC program show reduced rates of drug abuse at a more rapid pace than non-funded coalitions. The Administration has placed a priority on funding programs that work and curtailing funding for programs that do not show evidence of being effective. Since this program has demonstrated positive success and there are more coalitions seeking support under this program, continuing the program will allow more applicants to be funded and continue to reduce drug abuse in more communities across the country.

CSAP staff have begun to host webinars as a means of networking grantees around specific subject matter areas. This type of communication will be expanded to include other forms of social networking to more efficiently and effectively communicate with grantees and encourage greater sharing among grant cohorts.

By expanding the focus and available resources of the current mentoring program to create a statewide coalition of coalitions, the Drug Free Communities initiative will better organize and strengthen the effort to connect the DFC coalitions to the State systems. SAMHSA will support this effort by providing state and regional meetings of DFC coalitions and partner agencies that would help foster the development of these state networks and leverage support of partner agencies.

Funding Mechanism: Grant

How will we stay on course?

In October 2008, ONDCP released the results from an Interim National Evaluation of the DFC program, which demonstrated the program's effectiveness in preventing substance use and abuse among teens. The analysis indicated current substance use rates among high school students (the number of high school students who report consuming alcohol, tobacco, or marijuana in the past 30 days) within DFC communities are significantly lower than national rates. At a federal level, SAMHSA could facilitate this process by hosting federal partner meetings to discuss streamlining funding processes to more efficiently and effectively fund these coalitions.

Funding for the program receives appropriation under the Transportation and Treasury Committee as part of the ONDCP annual budget. The Interagency Agreement to manage this program for ONDCP has a fixed cap of 5 percent of the overall 8 percent administrative budget. Presently, SAMHSA receives $4.5 million dollars for management costs. Ninety two percent of the DFC budget is allocated for coalition grants.

Overview Program/Project/Activity Management:

- Funding Source
  Interagency Agreement between CSAP and the Office of National Drug Control Policy (ONDCP)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$77,800,000	*
2006	$75,600,000	*
2007	$78,100,000	*
2008	$87,100,000	*

Fiscal Year	Awarded Amount	Planned Amount
2009	$88,383,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 4:05:55 PM

Strategic Prevention Framework

Sober Truth on Preventing Underage Drinking (STOP) Act

Substance Abuse and Mental Health Services Administration

CSAP / DCP

Where are we now?

The STOP Act was enacted by Congress and signed into law in 2006. SAMHSA is the designated administrator of this program in consultation with the Director of the Office of National Drug Control Policy. One provision of the STOP Act is a community-based grant program for coalitions that currently have a Drug Free Communities (DFC) grant or have had a previous DFC grant. The STOP Act community-based grant program provides $50,000 to fund underage drinking prevention strategies in communities who have already mobilized around substance abuse issues and have the capacity to quickly implement targeted efforts toward reducing alcohol use by youth as part of an existing comprehensive community plan.

Presently, there are 102 funded STOP Act community-based grants. 79 grants were funded in FY 2008 and an additional 23 grants were funded in FY 2009. The main purposes of the program are to prevent and reduce alcohol use among youth in communities throughout the United States, to strengthen collaboration among communities, Federal, State, local, and tribal governments, to enhance intergovernmental cooperation and coordination on the issue of alcohol use among youth, serve as a catalyst for increased citizen participation and greater collaboration among all sectors of the community's commitment to reducing alcohol use among youth, disseminate to communities timely information regarding state-of-the art practices and initiatives that have proven to be effective in preventing and reducing alcohol use among youth, and enhance, not supplant, effective local community initiatives for preventing and reducing alcohol use among youth.

The FY 2009 STOP Request for Application was published on April 3, 2009. Approximately 20 grants up to $50,000 were awarded to current or former DFC coalitions, for up to 4 years of funding. In addition, all FY 2009 STOP continuations applications will receive funding.

Where do we want to go?

Increase the number of current or previous DFC grants receiving targeted underage drinking prevention implementation funds under this grant program to at least 50 percent of the coalitions who demonstrate sustainable capacity to generate measurable reductions in youth alcohol in targeted communities.

How will we get there?

The ability to implement additional interventions in each community receiving annual STOP funds will enhance national outcomes. SAMHSA will facilitate this developmental process by increasing federal partner collaborations with agencies that target substance abuse, crime, education, and labor to plan more effective ways of jointly funding coalitions and streamlining the grantmaking process.

In addition, SAMHSA is working with NIAAA to expand research efforts to test evidence-based strategies to effectively reduce underage alcohol use. Discussions are ongoing on where to concentrate future funding efforts to support STOP coalitions.

On February 9, 2009, CSAP held a STOP New Grantee meeting in conjunction with Community Prevention Day. The purpose of this meeting was to discuss STOP program expectations, introduce Federal staff, and provide important technical resources. Most importantly, the session trained grantees on how to develop and implement effective strategies to change systems and policies to create healthier environments using the community strategy framework.

Furthermore, CSAP collaborated with the Community Anti-Drug Coalitions of America (CADCA) to include an underage drinking track during the National Leadership Forum. CSAP and CADCA worked together to create this track for STOP grantees and others to expand their knowledge and skills in best practices to reduce underage drinking. Topics in this three-day track included 1) best practices in environmental, brief intervention, and school and family interventions; 2) overview of participatory research; 3) "meet and greet" the researchers; and 4) understanding interventions.

Funding Mechanism: Grant

How will we stay on course?

CSAP will continue to track coalitions receiving STOP funds for a comparison of their reductions to those not receiving targeted implementation dollars through STOP or other funding streams. The Coalition Online Management and Evaluation Tool (COMET) is the mechanism being used for semiannual reporting for the STOP program.

As part of the continuation process, grant work plans have been analyzed to determine what types of training and technical assistance resources and activities should be offered to ensure STOP grantees understand and implement best practices. Second, CSAP and NIAAA have provided a listserv, "CSAP says STOP," which was implemented in FY 2009. This communication effort was developed to ensure grantees receive current research findings, time-sensitive program updates, and notices about grant requirements. More importantly, this forum will foster ongoing dialogue among the grantee community, CSAP Project Officers, researchers, policy advisors, and technical assistance providers.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	$3,930,000	*

Fiscal Year	Awarded Amount	Planned Amount
2009	$5,000,000	*
2010	*	*
2011	*	*
2012	*	*

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Strategic Prevention Framework

Methamphetamine and Inhalant Prevention Initiative

Substance Abuse and Mental Health Services Administration

CSAP / DCP / CGPDB

Where are we now?

While the rates of methamphetamine use and numbers of new users have declined in recent years, prevention remains CSAP's first line of defense. In FY 2009, SAMHSA/CSAP provided supplements to the current 12 Prevention of Methamphetamine Abuse grantees to support the expansion of methamphetamine prevention services and grant activities initially awarded in FY 2006.

In FY 2006, SAMHSA/CSAP awarded 10 grants to eight different states (Colorado, Illinois, Massachusetts, Oregon, Oklahoma (2), Tennessee (2), Texas, and Washington), to support the expansion of methamphetamine prevention interventions and/or infrastructure development; and in FY 2007 two additional grants were awarded to the states of California and Texas. These programs address the growing problem of methamphetamine abuse and addiction by assisting localities to expand substance abuse prevention interventions that are effective and evidence based.

Grant recipients are using these awards in a number of ways, such as implementing evidence-based community prevention programs that target populations at greatest risk for methamphetamine abuse; training and education of professionals, educators, law enforcement personnel, families, and others about the signs of methamphetamine abuse and prevention options; and testing and evaluating pilot programs focused on drug-endangered children.

Where do we want to go?

In order to continue addressing the prevention of methamphetamine abuse, SAMHSA/CSAP will keep on funding grants that reach the community level. In awarding funding to communities with the greatest need to combat against methamphetamine and/or inhalant use, CSAP was specifically interested in addressing two objectives under this initiative: (1) building capacity and infrastructure at the community level to support interventions; and (2) assisting communities to initiate or develop interventions designed to change attitudes and norms regarding methamphetamines and inhalants and to prevent and/or delay their use.

How will we get there?

The impact of methamphetamine abuse reaches far beyond the individual user. Methamphetamine continues to destroy families and communities and places an even greater burden on the economy. To address this problem, grantees will use supplemental funds to expand their existing prevention efforts to address the problem of methamphetamine abuse and addiction in their local communities. The goal is to intervene effectively to prevent, reduce, and/or delay the use of methamphetamine abuse. These 12 grantees will continue to carry out the activities of this program due to their past accomplishments in establishing methamphetamine prevention programs

in their local communities, developing school-based programs for at-risk children, coordinating with law enforcement and community coalitions to educate the public on the dangers of methamphetamine manufacturing and use, developing appropriate responses for drug-endangered children as a result of methamphetamine production and use by adults, and providing data to demonstrate the success of their efforts. In addition, CSAP conducted its Methamphetamine Prevention Technical Assistance Grantee Meeting in Washington, D.C., June 23-25, 2009. This meeting allowed grantees to participate in workshops that will further their sustainability efforts; encourage them to network with other organizations; and address challenges they have occurred. CSAP, CSAT, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the Office of Minority Health, the Office on Women's Health, the National Institute on Drug Abuse, and several components of the Department of Justice came together and participated in a three-day summit titled Methamphetamine: The National Summit to Promote Public Health, Partnerships, and Safety for Critically Affected Populations. The Summit took place on November 16-19, 2008, at the Hilton Washington Hotel in Washington, D.C. Twenty State Prevention Directors and State Alcohol and Drug Abuse Agency Directors also participated on their State Teams (i.e., State Health Authorities, State HIV/AIDS/STD Directors, program directors for community-based organizations, government agency representatives, research leaders, clinicians, and key national organizations, and faith-based leaders). Each state is implementing their individual State Plan to address emerging problems in communities that are threatened by methamphetamine; since the Summit, the 20 State/Territory teams have been working to implement their Action Plans. The first edition of "Meth Minutes" was recently published to provide updates and encourage the sharing of presentations, data and other products.

Funding Mechanism: Grant

How will we stay on course?

Because SAMHSA/CSAP supplemented the current 12 methamphetamine prevention grantees for an additional year (FY 2009-2010), CSAP anticipates receiving their latest data with more robust and measurable outcomes that will also become available to inform future planning efforts on methamphetamine and inhalant prevention activities. The methamphetamine prevention grantees will continue to evaluate their projects, and will be required to develop an evaluation plan including both process and outcome components. In addition, grantees are required to report on SAMHSA's National Outcome Measures (NOMS) to assess individual and/or community level changes as appropriate to each grantee's project. At the end of the supplement (combination of the three-year time frame and the additional year) for this program, grantees will be able to report on the following NOMS: abstinence from drugs/alcohol, decreased mental illness, symptomatology/functioning, increased/retained employment or return to/stay in school, decreased criminal justice involvement, increased stability in housing, increased access to direct prevention services to participants, increased retention in treatment for substance abuse, reduced utilization of psychiatric inpatient beds for mental health services, increased social support/social connectedness, client perception of care, cost effectiveness, cost efficiency, and use of evidence-based practices.

Overview Program/Project/Activity Management:

- Funding Source

  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$4,600,000	*
2006	$4,200,000	*
2007	$4,000,000	*
2008	$3,967,000	*
2009	$1,774,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 4:28:03 PM

Strategic Prevention Framework

Partnerships for Success: State and Community Prevention Performance Grant

Substance Abuse and Mental Health Services Administration

CSAP / DSP

Where are we now?

CSAP is implementing the Partnerships for Success program to build on the success of the Strategic Prevention Framework State Incentive Grant (SPF SIG) program. CSAP funded four grantees in FY 2009. The purpose of this program is to improve the health and well being of our nation's communities by providing States and U.S. Territories (collectively referred to as "States") with grant funds and a special incentive to decrease statewide substance abuse rates by meeting or exceeding quantified, statewide, prevention performance targets.

The overall goals of Partnerships for Success are as follows:

- Reduce substance abuse-related problems
- Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking
- Strengthen capacity and infrastructure at the State- and community-levels in support of prevention
- Leverage, redirect, and realign statewide funding streams for prevention

Where do we want to go?

This grant program is designed to provide eligible States, U.S. Territories, and Indian Tribes with grant funds to achieve a quantifiable decline in statewide substance abuse rates, incorporating an incentive award at the beginning of Year 4 to grantees that have reached or exceeded their prevention performance targets. This will enable grantees to maintain a data-driven outcomes-based and public health infrastructure that is used to implement and support all prevention program, policies and practices.

How will we get there?

To address the Partnerships for Success goals, applicants will be required to set, in conjunction with SAMHSA/CSAP, statewide three-year performance targets for substance abuse prevention and will continue to reduce rates after the performance targets are reached. Applicants must also identify and select subrecipient communities that can most effectively collaborate with the State to achieve an overall reduction in statewide substance abuse rates through the implementation of evidence-based programs, policies, and practices. SAMHSA/CSAP intends to offer a key performance incentive (in the form of a program expansion supplement) during Year 4 of the

Partnerships for Success grant period to reward States that have met or exceeded their performance targets.

In order for grantees to be successful in meeting or exceeding their prevention performance targets, CSAP strongly recommends the use of a public health model to address substance abuse problems and to use a performance management approach. The Partnership for Success program is designed with the following milestones:

By the end of the first 6 months

- State has documented a process showing that multiple sources of funding are being leveraged, redirected, and/or incorporated into the State prevention system to support the achievement of the statewide performance target.
- State has funded all subrecipient communities.
- State has ensured that all subrecipient communities have hired Project Director and Staff.

By the end of the first 9 months

- States have approved their subrecipient communities' project Implementation Plans.
- Subrecipient communities are implementing evidence-based programs, policies, and practices identified in their project plans.
- States have completed an Evaluation Plan to assess State, community, and program level data.
- States have completed all milestones as evidenced by the Quarterly Progress Report and the Government Project Officer's (GPO) Site Visit Report.

Within 60 days of the end of Year 1

- States have submitted their Year 1 Evaluation Report, including process data, assessing contributing factors, performance measures, and outcome data showing progress on meeting their agreed upon prevention performance targets.

Within 60 days of the end of Year 2

- States have submitted their Year 2 Evaluation Report, including process data, assessing contributing factors, performance measures, and outcome data, showing progress on meeting their agreed upon prevention performance targets. This report reflects data covering the State, community, and program levels.

Within 60 days of the end of Year 3

- States have submitted their Year 3 Evaluation Report, including process data, assessing contributing factors, performance measures, and outcome data, showing progress on meeting their agreed upon prevention performance targets. This report reflects data covering the State, community, and program levels. Note: The data contained in this Year 3 Evaluation Report will be critical in allowing CSAP to determine whether the Partnerships for Success grantee will have met the eligibility criteria for applying for SAMHSA/CSAP's Program Expansion Supplement, which may become available in Year 4.

Within 60 days of the end of Year 4

- States have submitted their Year 4 Evaluation Report, including process data, assessing contributing factors, performance measures, and outcome data, showing progress on meeting their agreed upon prevention performance targets. This report reflects data covering the State, community, and program levels.

Within 90 days of the end of the grant period

- States have submitted their Year 5 (Final) Evaluation Report, including process data, assessing contributing factors, performance measures, and outcome data showing a final report of overall system changes, changes in outcomes and lessons learned. This report reflects data covering the State, community, and program levels.

Funding Mechanism: Grant

How will we stay on course?

States will be required to establish an evaluation process and provide yearly evaluation reports to CSAP detailing their progress toward meeting and exceeding the performance targets.

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	*	*
2009	$9,200,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 5:56:43 PM

Strategic Prevention Framework

Strategic Prevention Framework State Incentive Grant

Substance Abuse and Mental Health Services Administration

CSAP / DSP

Where are we now?

CSAP implemented the Strategic Prevention Framework (SPF) State Incentive Grant (SIG) program in 2004 beginning with Cohort I and has funded four cohorts including Cohort II in 2005, Cohort III in 2006, and Cohort IV in 2009. To date, CSAP has funded 48 States, 13 Tribes, and 6 U.S. Jurisdictions for a total of 67 grantees. The SPF implements a five-step process known to promote protective factors, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the lifespan.

Where do we want to go?

The major goal of the program is to fund a SPF-SIG grant in all 50 States that have applied for a SPF-SIG. This will enable States to develop and maintain a data-driven outcome based infrastructure that will be used to implement and support all prevention program, policies, and practices. The Strategic Prevention Framework provides an effective prevention process, a direction, and a common set of goals to be adopted and integrated at all levels. Grantees are funded to implement the SPF in partnership with community level organizations in their States, Territories, or Tribes.

How will we get there?

Moving SAMHSA's SPF from vision to practice is a strategic process that States and community stakeholders must undertake in partnership. Through the SPF-SIG cooperative agreement, grantees will provide the requisite leadership, technical support, and monitoring to ensure that identified communities are successful in implementing the five steps of the framework which include 1) profiling population needs, resources, and readiness to address the problems and gaps in service delivery; 2) mobilizing and/or building capacity to address needs; 3) developing a comprehensive strategic plan; 4) implementing evidence-based prevention policies, programs, and practices and infrastructure development activities; and 5) monitoring process, evaluating effectiveness, sustaining effective programs/activities, and improving or replacing those that fail. The SPF SIG program is designed with the following goals:

<u>By the end of the first 4 months</u>:
SPF Project Director and staff hired
SPF Advisory Council meeting on a regular basis
SEOW Workgroup's completed needs assessment
Evidence-Based Practices Workgroup is in place

<u>By the end of the first 9 months</u>:
Approved SPF-SIG Strategic Plan

Approved sub-recipient funding mechanism
Funding of all subrecipients

By the end of the first 18 months:
Completion of subrecipients' comprehensive Strategic Plans
Implementation of subrecipients' programs, policies and practices

By the end of Years 2, 3, 4, and 5:
Submission of State level outcomes
Submission of subrecipient community- and program-level outcomes

Internal Supports
The SPF-SIG project is supported internally by the Center for the Application of Prevention Technology (CAPT). The CAPT serves as an agent of CSAP to support implementation of SAMHSA's SPF by promoting the adoption of best practices to improve State and community substance abuse prevention capacity, working in collaboration with SPF State Incentive Grant projects, their sub-recipients, and other States and jurisdictions to apply evidence-based substance abuse prevention knowledge and technology at the local level; providing training and technical skill development to help States and localities identify and adapt best practices to match individualized community needs; address cultural competence issues; conduct evaluations; better understand prevention fundamentals, including underlying causal factors and how prevention works best in different settings; utilizing new technology to deliver prevention messages; and identifying the most effective delivery methods for communities to promote adoption and sustainability of evidence-based prevention programs, practices, and policies that produce the greatest systems change and positive prevention outcomes.

External Collaborations
SAMHSA/CSAP has an external collaboration with the National Institute on Drug Abuse for the evaluation of SPF-SIG project cohorts 1 and 2. This project gives NIDA a great opportunity to research effective ways of addressing substance abuse problems in States and communities.

Funding Mechanism: Grant

How will we stay on course?

The cross-site evaluation is ongoing through an Interagency Agreement with NIDA. At this point we have baseline data for all cohorts; however we expect to see outcome data with the next report in the spring of 2010.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$57,700,000	*
2006	$86,800,000	*
2007	$86,800,000	*

Fiscal Year	Awarded Amount	Planned Amount
2008	$86,800,000	*
2009	$78,800,000	*
2010	*	*
2011	*	*
2012	*	*

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Strategic Prevention Framework

Substance Abuse Prevention and Treatment Block Grant (SAPT) / Prevention Set-aside

Substance Abuse and Mental Health Services Administration

CSAP / DSP

Where are we now?

The SAPT Block Grant program funds are based on a congressionally-mandated formula that is administered by two of SAMHSA's three Centers, the Center for Substance Abuse Prevention and the Center for Substance Abuse Treatment. The SAPT Block Grant application provides the means for States to comply with the reporting provisions of the Public Health Act (42 USC 300x-21-66), as implemented by the Interim Final Rule (45 CFR Part 96, part XI). The authorizing legislation determines the purpose of the block grant, eligibility for receiving funds, the scope of the program, and how the award amount is determined.

The SAPT Block Grant, the cornerstone of the States' substance-related programs, accounts for 40 percent of public funds expended on substance prevention activities and treatment services. This grant program with funds disbursed to the States, territories, the District of Columbia, and the Red Lake Band of Chippewa Indians, is based on a congressionally-mandated formula in which 20 percent of the total funding is designated for substance abuse prevention. While the SAPT Block Grant provides federal support to substance abuse prevention and treatment nationally, it empowers States to design solutions to specific substance abuse problems that are experienced locally. Statute and regulations place special emphasis on making primary prevention services available to individuals not in need of substance abuse treatment.

The Annual Synar Report is a document which provides the direction for States to comply with the reporting provisions of the Synar Amendment regarding the sale of tobacco products to minors (Section 1926 of the Public Health Service Act), as implemented by the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, part IV). Synar is described in more detail later in this document.

Where do we want to go?

Part of the mission of the Center for Substance Abuse Prevention is to assist States and communities in improving activities and services with funds from the SAPT Block Grant. One strategy CSAP is using to promote increased State accountability for the management of the SAPT Block Grant funds through the uniform application in which States provide detailed data on expenditures.

CSAP is also encouraging all States to incorporate the Strategic Prevention Framework (SPF) process into the substance abuse prevention 20 percent set-aside of the SAPT Block Grant. It is critical for States, U.S. Territories, and Tribes to develop an infrastructure that supports the implementation of the most effective prevention programs, policies, and practices that includes the development of a statewide comprehensive strategic substance abuse prevention plan. CSAP's SPF

process helps States to support an array of activities, thereby, aiding States in building solid foundations for delivering and sustaining effective substance abuse prevention services and reducing substance abuse problems.

Finally, CSAP has identified several recommendations for improving both measures and data quality for this program in order to provide a more accurate representation of program performance. Recommendations include the following: clarify ambiguous definitions and provide additional training to grantees to ensure consistency in reporting across grantees; revise the Block Grant Application System in order to minimize errors and maximize internal consistency; collect additional program data on grantee activities and costs to support a request to the Office of Management and the Budget to revise the calculation of the new cost-efficiency measures; improve data coverage by increasing the number of grantees reporting data and ensuring that data on all participants and activities are reported; and conduct additional analyses to understand potential biases in baseline information in order to ensure that targets are realistic. CSAP is working to implement these recommendations.

How will we get there?

The Web Block Grant Application System (Web BGAS) was developed to facilitate States' completion, submission, and revision to their block grant application. The Web BGAS can be accessed via the Internet at http://bgas.samhsa.gov
States used a variety of sources to establish their estimates of need. Common data sources include but are not limited to data from surveys; NSDUH data; data from State's MIS; census data; school-based surveys; data from State Epidemiology Workgroups' Needs Assessments for States.

CSAP has identified specific outcome measures that became required of block grant recipients for submission in the FY 2008 block grant application. These National Outcome Measures (NOMs) include the following domains: Abstinence from Alcohol and Other Drugs; Employment/Education; Crime and Criminal Justice; Access/Service Capacity; Retention; Social Support/Social Connectedness; Cost-Effectiveness; and the Use of Evidence-Based Practices. These NOMs relate to youth ages 12 to 17 and to adults ages 18 and older.

CSAP requires States to report annually and electronically on five of the NOMs for two domains for youth and adults: the number of persons served by age; the number of persons served by gender; number of persons served by race; number of persons served by ethnicity; and the total number of evidence-based programs and strategies. Archival and State estimates from the National Survey on Drug Use and Health (NSDUH) are pre-populated by CSAP for the States.

Funding Mechanism: Grant

How will we stay on course?

CSAP has long recognized that technical assistance is a key to help States develop and strengthen infrastructure and desired outcomes. The growing complexity of State-level prevention work, SPF implementation, and NOMs requirements often demands that TA include assistance with comprehensive needs assessment, long-term planning, coordinated program service delivery, ongoing follow-up, and outcomes monitoring.

CSAP recognizes technical assistance as a collaborative effort involving both Federal and State communities. Thus, CSAP will continue to work with the NASADAD SAPT Block Grant Application Redesign Working Group, and will continue to provide through the SPFAS enhanced technical

assistance programs involving conferences and workshops, development of training materials and knowledge transfer manuals, on-site consultation, and State System Reviews. Also, CSAP's Project Officers will continue to monitor States, U.S. Territories, and the Red Lake Band of Chippewa Indians Block Grants to provide technical assistance and lead State System Reviews.

Performance Results
During FY 2007, CSAP expended a total of $587,562,098 on 1,033 grantees. The Substance Abuse Prevention and Treatment Block Grant 20 percent set-aside constitutes the largest proportion of these funds ($351,718,200). Classification of Block Grant expenditures by IOM Category indicates that the largest share of prevention expenditures was allocated to universal direct interventions ($46,565,650). An alternative classification by service type indicates that prevention education services had the largest share of Block Grant expenditures ($118,352,094). A total of 4,318,206 persons were served through individual-based interventions. A total of 21,071,218 person-exposures to population-based interventions were reported by the Block Grants.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Substance Abuse Prevention and Treatment (SAPT) Block Grant

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$355,110,000	*
2006	$351,480,000	*
2007	$351,718,000	*
2008	$351,745,000	*
2009	$355,718,000	*
2010	*	*
2011	*	*
2012	*	*

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Strategic Prevention Framework

Synar

Substance Abuse and Mental Health Services Administration

CSAP / DSP

Where are we now?

In July 1992, Congress enacted the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (P.L. 102-321), which includes an amendment (section 1926) aimed at decreasing youth access to tobacco. This amendment, named for its sponsor, Congressman Mike Synar of Oklahoma, requires States (i.e., all States, the District of Columbia, and the 8 U.S. Territories) to enact and enforce laws prohibiting the sale or distribution of tobacco products to individuals under the age of 18. The Amendment was developed in the context of a growing body of evidence about the health problems related to tobacco use by youth, as well as evidence about the ease with which youth could purchase tobacco products through retail sources. The Synar program is a critical component of the success of youth tobacco use prevention efforts.

Synar Legislation: Because it plays a lead Federal role in substance abuse prevention, SAMHSA was charged with implementing the Synar Amendment. In January 1996, SAMHSA issued the Synar Regulation to provide guidance to the States. The regulation requires that States:

- Have in effect a law prohibiting any manufacturer, retailer, or distributor of tobacco products from selling or distributing such products to any individual younger than age 18;
- Enforce this law;
- Conduct annual, unannounced inspections in a way that provide a valid probability sample of tobacco sales outlets accessible to minors;
- Negotiate interim targets and a date to achieve a noncompliance rate of no more than 20 percent (SAMHSA required that each State reduce its retailer violation rate (RVR) to 20 percent or less by FY 2003); and
- Submit an annual report detailing State activities to enforce its law.

Synar Programmatic Requirements: SAMHSA/CSAP is charged with overseeing States' implementation of the Synar requirements and provides technical assistance to States on both the Synar requirements and youth tobacco access issues in general.

Since the inception of the Synar program, SAMHSA/CSAP has worked with States to assist them in complying with and attaining the goals of the Synar Amendment and has issued programmatic requirements and guidance documents to assist States in their efforts. For example, CSAP has provided a great deal of guidance to States regarding the conduct of random, unannounced inspections. Specifically, in conducting their annual Synar surveys States must:

- Develop a sampling frame that includes both over the counter and vending machine locations accessible to youth;
- Ensure that their sampling frame includes, at a minimum, 80 percent of the tobacco outlets in the State (CSAP requires States that use a list frame to conduct and report the results of a coverage study designed to assess the completeness of the sampling frame);

- Design a sampling methodology and implementation plan that are based on sound survey sampling methodology;
- Sample a large enough number of outlets to meet SAMHSA's precision requirement (one-sided 95 percent confidence interval);
- Obtain a completion rate of 90 percent or better;
- Record the actual steps of the survey process in the field and keep records of all sources of sample attrition in the field; and
- Weight the results of the Synar survey to account for unequal probabilities of selection, differences in percentages of eligible outlets between strata or clusters, and other deviations from the intended design.

Penalties for Noncompliance: In addition to setting targets for States, the Synar Amendment established penalties for noncompliance. The penalty for a State is loss of up to 40 percent of its Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. Since these funds account for a large percentage of all State expenditures for substance abuse prevention and treatment, imposition of this penalty could present a severe problem for a State. From FY 1997 to FY 2005, there were 18 instances involving 14 States in which that penalty could have been imposed.

In lieu of this penalty, in every year since 2000, Congress has provided an alternative penalty (Section 214/Section 218/Section 213) mechanism by which a State can avoid the 40 percent reduction in its SAPT Block Grant if the State stipulates that it will spend its own funds to improve compliance with the law. Specifically, under the alternative penalty, a State that fails to meet Synar requirements can avoid the 40 percent penalty against its SAPT Block Grant by taking the following steps:

- Committing additional State funds to ensure compliance with youth tobacco access laws in an amount equal to 1 percent of its current fiscal year's Block Grant for each percentage point by which the State failed to meet the retailer violation target rate for the previous fiscal year;
- Certifying that these additional State funds will be used to supplement and not supplant funds used for tobacco prevention programs and compliance activities in the fiscal year preceding the fiscal year to which the section applies;
- Providing reports to the Secretary of Health and Human Services on all State resources spent in the previous fiscal year and obligated in the current fiscal year for tobacco prevention and compliance activities by program activity.

The alternative penalty also stipulates that SAPT Block Grant funds cannot be withheld from a U.S. Territory that receives less than $1,000,000 in SAPT Block Grant funds for failing to meet the Synar requirements.

Congress has provided the alternative penalty option as part of the Consolidated Appropriations Act each year since 2000 (the alternative penalty option in the 2000 Consolidated Appropriations Act referred to States out of compliance in FY 1999, the alternative penalty option in the 2001 Consolidated Appropriations Act was determined to refer to States out of compliance in both FY 2000 and FY 2001 and thereafter, the year of the Appropriations Act and the year of the penalty option matched.)

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

The Synar program has also contributed to a decline in the percentage of youth smokers who report retail sources as their usual source of tobacco products. Specifically, according to the Youth Risk Behavior Survey (YRBS), in 1995, 38.7 percent of students under the age of 18 who were current smokers reported that they usually got their own cigarettes by buying them in a store or gas station. In 2007, this percentage had dropped to 16.0 percent.

At the same time, tobacco use among youth has been declining. According to the YRBS, the percentage of students reporting current cigarette use dropped from 36.4 percent in 1997 to 20.0 percent in 2007. Obviously, this drop is not attributable to Synar alone, but the Synar requirements have contributed to a culture change in which youth tobacco use is discouraged.

Where do we want to go?

As previously mentioned, the national weighted average retailer violation rate has dramatically fallen since the inception of the Synar program. This reflects not only a substantial change in retailers' sales patterns but also a swift and dramatic change in tobacco enforcement programs, which were nonexistent in most States and jurisdictions prior to the Synar program. While States are held to a retailer violation rate goal of 20 percent or less, because of such significant improvement, CSAP is working with States to voluntarily reach lower retailer violation rates than the 20 percent RVR goal set in regulation.

How will we get there?

SAMHSA/CSAP is charged with overseeing States' implementation of the Synar requirements and provides technical assistance to States on both the Synar requirements and youth tobacco access issues in general. Since the inception of the Synar program, SAMHSA/CSAP has worked with States to assist them in complying with and attaining the goals of the Synar Amendment and has issued programmatic requirements and guidance documents to assist States in their efforts. Historically, Synar efforts, which are managed by Single State Agencies for Alcohol and Drug Abuse, have not been well integrated with broader tobacco control efforts, which are most often managed by State Departments of Health. This has resulted in a missed opportunity for substance abuse prevention professionals and public health professionals to work together toward their common goal of reducing tobacco use. Several States are making progress in better integrating Synar into other State tobacco control efforts and SAMHSA/CSAP is making similar efforts to better integrate Synar into other Federal tobacco control efforts. For example, SAMHSA/CSAP is sponsoring the 2009 National Conference on Tobacco or Health (NCTOH), which will be held June 10-12, 2009 in Phoenix, Arizona. The NCTOH is the premier national conference on tobacco control. Additionally, CSAP is planning to co-locate our Tenth National Synar Conference from June 8-9, 2009. The Synar Workshop will include 2-3 breakout sessions focusing on States that have maintained RVRs below 10 percent and their practices (i.e., regular, statewide enforcement of youth tobacco access laws in which every retailer is inspected at least once per year; regular and ongoing merchant education, laws that include substantial penalties for violations of youth tobacco access laws that are consistently enforced and upheld by the courts). CSAP also is planning to sponsor one Synar representative from each of the States and Territories to attend the entire NCTOH conference and network with their counterparts involved in other facets of tobacco prevention at the State and local levels. Participation in NCTOH will allow State Synar representatives the opportunity to forge collaborations with others in their State involved in tobacco prevention activities, which will likely lead to even lower rates of non-compliance with youth tobacco access laws.

Finally, CSAP will continue to conduct structured on-site system assessments in which each State is assessed not only on Synar regulatory compliance elements (i.e., law enforcement; random, unannounced inspections and valid probability sample; RVR compliance; and reporting), but also

on the Synar compliance support elements that research and our experience has shown to be associated with low RVRs (i.e., State Synar program system organization; State strategic plan for youth tobacco access reduction; merchant education; consistent Statewide enforcement of youth tobacco access laws). Additionally, CSAP will continue to provide technical assistance on all facets of State Synar programming, as requested by States and recommended by CSAP's Project Officers.

Funding Mechanism: Grant

How will we stay on course?

For the Synar program, SAMHSA will assess program performance through monitoring Annual Synar Reports submitted by States.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention, Substance Abuse Prevention and Treatment Block Grant (SAPT) Set-Aside; Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	*	*
2009	*	*
2010	*	*
2011	*	*
2012	*	*

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Strategic Prevention Framework

Center for the Application of Prevention Technologies (CAPT)

Substance Abuse and Mental Health Services Administration

CSAP / DSD

Where are we now?

For the past decade, SAMHSA's five separate contract-support Centers for the Application of Prevention Technologies (CAPTs) have comprised a regional training and technical assistance network to transfer substance abuse prevention knowledge, apply prevention skills, and translate prevention science into practice for planners and practitioners at all levels of the prevention system, at the State and community levels, including schools. In FY 2008, SAMHSA/CSAP consolidated and integrated the five regional CAPT training and technical assistance contracts into a single new contract. The CAPT contract is designed to balance core capacity at the national level to assure centralized direction, coordination, and deployable analytic capabilities, with decentralized assessment, communication, and regional service delivery and expertise tailored to the unique needs of diverse populations and regions.

The CAPT addresses the needs of States, Jurisdictions, and Federally-recognized Tribes and communities for increasingly specialized and intensive technical assistance and advanced workforce training in the technical and analytic skill sets required for data-driven decision making. Utilizing regional experts, the CAPT assists prevention planners and practitioners to conduct needs assessments that yield epidemiological data; build organizational capacity and create key partnerships; plan strategically to achieve prevention outcomes; and select, adapt, implement, and evaluate effective prevention programs and practices. The CAPT serves States and communities supported under the Substance Abuse Prevention and Treatment Block Grant Program and under CSAP's Programs of Regional and National Significance which currently includes 42 grantees of the SPF State Incentive Grant program; approximately 150 Minority Aids Initiative and 12 Methamphetamine Prevention community-based grantees; and approximately 65 State epidemiological workgroups.

CAPTS also support special SAMHSA/CSAP priorities through the delivery of targeted training and technical assistance services as illustrated in three initiatives, summarized below.

Service to Science Initiative
To build evaluation capacity at the community level, SAMHSA/CSAP established the Service to Science Initiative with the explicit long-range goal of increasing the pool of evidence-based interventions available to meet local needs. Through Service to Science, CAPTs provide evaluation training and customized, intensive technical assistance to build the capacity of locally-developed innovative prevention programs to demonstrate and document program outcomes. Preliminary FY 2008 data reveal that CAPTs provided 299 technical assistance services to a total of 573 individuals. Evaluation data further indicate that 94 percent of Service to Science programs reported increased evaluation capacity resulting from the CAPT technical assistance provided.

Minority HIV/AIDS Initiative
In FY 2008, the CAPTs and CSAP planned and delivered two technical assistance meetings for MAI grantees on a range of topics including sustainability, program implementation, and evaluation: 1)

meeting with 144 grantee representatives, 90 percent of respondents reported overall satisfaction with the entire event and 94 percent reported they were likely to apply the information received; and 2) meeting with 180 grantee representatives with 95 percent of respondents reporting overall satisfaction with the entire event and 98 percent reporting that they were likely to apply the information received.

Methamphetamine Prevention Initiative
In FY 2008, CAPTs provided technical assistance to representatives of 12 grantees on a range of topics including the Strategic Prevention Framework, sustainability, and cultural competency. Approximately 90 percent of participants reported satisfaction with the overall meeting, 100 percent reported they had received new information, and 100 percent reported that they were likely to use the information provided.

Where do we want to go?

The goal of the CAPT is to expand capacity, increase effectiveness, and strengthen the performance and accountability of substance abuse prevention services at both the State and community levels. To accomplish this, the CAPT provides specialized and intensive training and technical assistance for the identification, selection, implementation, and evaluation of effective evidence-based programs and practices so they can be applied successfully within diverse contexts of life within communities, States, Tribes, and Jurisdictions. To assure accountability for effective service provision, CSAP requires the CAPT to evaluate the delivery and impact of their services on the programmatic achievements and progress of its clients in reaching benchmarks on implementation of the SPF and accountability measures for achieving targeted improvements in substance abuse prevention outcomes.

Some key objectives of the CAPT contract are to:

- Convene learning communities to assist States and communities to develop technical capacities and competencies to identify, select, and implement appropriate evidence-based programs and practices;
- Translate scientific prevention knowledge into useful practices, tools, and products for substance abuse prevention practitioners at multiple organizational levels in the prevention system;
- Promote the development of the substance abuse prevention workforce by fostering the acquisition of skills, competencies, and knowledge required to implement the SPF successfully at State and community levels;
- Provide training and technical assistance services to CSAP grantee sub-recipient communities by working under the leadership of, and with the key stakeholders in, State prevention systems; and
- Provide "service to science" evaluation technical assistance to enhance the evaluation capacity of innovative field-generated programs to demonstrate more credible evidence of their effectiveness.

How will we get there?

The new national CAPT system will build on the accomplishments of the five previous regional CAPT centers over the past decade to create an integrated CAPT system that provides responsive, tailored, and outcomes-focused technical assistance. Through the CAPT, SAMHSA will continue its

partnership with the United States Department of Education to provide assistance to local education agency grantees supported under its Grants to Reduce Alcohol Abuse Program.

Funding Mechanism: Contract

How will we stay on course?

Data for the full fiscal year 2008 are not yet available; however, results from the first two quarters of the fiscal year demonstrate the productivity, reach, and impact of CAPT efforts to support SAMHSA/CSAP's vision.
In Q1-Q2 of FY 2008, the CAPTs delivered training/technical assistance events:

- 192 total *events*, the majority of which were skill development trainings (70%) and trainings-of-trainers (7%) designed to advance SAMHSA SPF priorities like needs assessment (priority topic in 29 percent of these events), identifying/selecting/implementing evidence-based prevention programs and practices (24%), strategic planning/sustainability (28%), evaluation (31%), cultural competence/diversity (29%), and prevention fundamentals (47%).
- A total of 34,511 *client service hours*, a measure of service delivery taking into account the number of training hours delivered to individuals training participants.
- 1,212 *hours of training* (a summary of the duration of all training events with no reference to the actual number of participants in those events), both on-site and through distance learning to 5,170 *individuals* from all 60 states, territories, and jurisdictions that the CAPTs serve.
- Resulting in consistently high participant *satisfaction* with these training services (97 percent of participants reported satisfaction with the training provided) and intended *application* of knowledge and skills gained (98 percent of participants reported likelihood of content/skill application)
- In Q1-Q2 of FY 2008, the CAPTs provided more than 849 direct capacity-building technical assistance services to 2,722 *individuals* representing 272 *organizations*.
- These services represent 47,180 client service hours, a measure of service delivery taking into account both the number of CAPT staff hours devoted to delivery of each TA service and the number of individual recipients of those services on a range of topics related to identify, select, and implement evidence-based programs, with increasing emphasis on SAMHSA's Strategic Prevention Framework.

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Prevention, Substance Abuse Prevention and Treatment Block Grant (SAPT) Set-Aside; Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$8,400,000	*

Fiscal Year	Awarded Amount	Planned Amount
2008	$14,560,000	*
2009	$11,691,000	*
2010	*	*
2011	*	*
2012	*	*

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Strategic Prevention Framework

Health Communications and Marketing

Substance Abuse and Mental Health Services Administration

CSAP / DSD

Where are we now?

Health marketing involves creating, communicating, and delivering health information and interventions using customer-centered and science-based strategies to protect and promote the health of diverse populations (Centers for Disease Control and Prevention, 2005). An essential part of the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention approach to making substance abuse prevention work is through the strategic use of health communications and social marketing. The CSAP prevention communications effort will augment those strategies now underway by SAMHSA's Health Information Network (SHIN). Healthy People 2010 defines health communications as "the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. The scope of health communications includes disease prevention, health promotion, health care policy, and the business of health care as well as enhancement of the quality of life and health of individuals within the community."

Information dissemination, sometimes referred to simply as "communications," includes public education, social marketing, media advocacy, media literacy, and is a basic prevention strategy CSAP identifies for prevention programs to use to increase protective factors and reduce the impact of risk factors for substance abuse. Effective health communications play a vital role in preventing substance abuse problems. Communications can increase knowledge and awareness of alcohol, tobacco, and drug problems as well as promote strategies to address with these problems.

Where do we want to go?

As CSAP develops its five-year strategic plan in alignment with the White House Office of National Drug Control Policy objective to create a national, evidence-based, community-oriented prevention system for adolescents, the focus for its prevention communications will be sharpened and tailored to the needs of selected target audiences as well as to the prevention field at large.
The ultimate vision is for an enduring national infrastructure of "prevention-prepared communities" offering systems of evidence-based prevention components provided in a coordinated manner during the full course of adolescence and at multiple venues within the community.

One of CSAP's main goals is to develop and disseminate specific prevention messages to communities. The purpose is to use messages that convey to communities that prevention works, that it is cost-efficient, and that through prevention we can change the nation one community at a time.

How will we get there?

The purpose of this contract is to create a communications effort that specifically serves CSAP's grantees and prevention partners and conducts outreach efforts to various niche audiences in need of prevention messages and resources (e.g., ethnic/racial, lesbian/gay/bisexual/transgender, and other vulnerable populations). This contract is designed to advance SAMHSA/CSAP prevention communications to the field as well as to selected target audiences. The contract focuses on program support for CSAP's partnerships/collaborations with Federal, national, and State level entities; content development for CSAP's Web-based health communication efforts; and resource development to meet the needs of selected audiences. Studies have shown that more Americans seek health information on the Internet than from any other source (CDC, 2009).

CSAP will coordinate its prevention communications efforts with SAMHSA's Office of Communications through use of the SAMHSA Strategic Communications Framework planning template. The Strategic Communications Framework is the platform for aligning public health practice with science-based communications and marketing approaches at SAMHSA. Its core is a template for creating communications and marketing plans to advance program goals.

Funding Mechanism: Contract

How will we stay on course?

SAMHSA will assess program performance through monitoring GPRA and evaluation outcomes of the tasks within the contract.

Overview Program/Project/Activity Management:

- Funding Source

Center for Substance Abuse Prevention, Substance Abuse Prevention and Treatment Block Grant (SAPT) Set-Aside; Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	*	*
2009	$1,470,068	*
2010	*	*
2011	*	*
2012	*	*

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Strategic Prevention Framework

Prevention Fellowship Program

Substance Abuse and Mental Health Services Administration

CSAP / DSD

Where are we now?

The Prevention Fellowship Program is a two-year workforce development program designed to provide increasing levels of substance abuse prevention classwork education as well as work experience every year. Fellows work in State offices or other designated locations on various prevention initiatives. First year formal and informal trainings promote the Strategic Prevention Framework (SPF) as the overarching vehicle for planning, development, and delivery of prevention services. In addition, the Prevention Fellowship Program has added a one-year internship component called the Graduate Internship Program for graduate level students interested in prevention data and program evaluation.

Through structured seminars, mentoring, and coaching, Fellows and interns will work to enhance their knowledge, skills, and competencies in all components of the SPF. Upon completion of the program, participants are expected to become stewards of effective prevention practice in their States and community.

Federal and State health systems are being designed to successfully anticipate opportunities and take steps to educate and train workers in the public health fields. This will result in growing and implementing innovations for reducing health disparities in the nation and allowing individuals to access good health care. This program is at the forefront to develop the talent and skills in the prevention workforce and to continue to support the State's National Prevention Network's offices.

Where do we want to go?

The CSAP Fellows Program will develop a highly trained public health workforce of prevention specialists with public health experience, management, and leadership skills necessary to promote the health of populations at the Federal, state, and local levels. The newly-awarded contract proposes to fund approximately 30 Fellows over the four-year period. In addition, the new contract will fund at least 35 graduate interns to work at the state level and in public and behavioral health organizations to build capacity in the prevention field.

The Fellowship Program will provide opportunities for individuals to strengthen and apply knowledge gained through their academic programs and work experience in prevention service programs, sharpen skills, and develop strong networks among a range of other public health professions. To successfully complete the two-year program, Fellows complete a core set of rigorous projects that will allow them to become involved with direct, hands-on prevention service work at the State level. Fellows complete Web-based and face-to-face training in areas such as communication, health education and promotion, epidemiology, social marketing, cultural competency, and other courses relevant for prevention certification. In addition, Fellows will be exposed to diverse areas of public health practice, work with leading professionals in the field, and

have the opportunity to develop critical research, writing, evaluation, and presentation skills under a structured training program.

How will we get there?

The CSAP Fellows program will use the following guiding principles and policies to implement the program.

- Equity and appropriateness of training and learning experiences
- Strategic and sustainable supply, ensuring resources are available to maintain the program until completion
- Building healthy workplaces, non-threatening environments
- Collaborative practice, developing partnerships with other Federal and State Agencies in which prevention in important in public health
- Effective education and training opportunities, appropriate to effective skill building, using innovative tools to engage and deliver effective prevention strategies
- Information and monitoring, using evidence-based practices to develop a common frame of reference in creating unified prevention principles, guiding a developing prevention workforce
- Collection of data on Fellows and staying current in the field of prevention

Funding Mechanism: Contract

How will we stay on course?

SAMHSA will assess program performance through GPRA and National Outcome Measures

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$2,600,000	*
2008	$2,700,000	*
2009	$1,261,000	*
2010	*	*
2011	*	*
2012	*	*

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Strategic Prevention Framework

State Epidemiological Outcome Workgroups (SEOWs)

Substance Abuse and Mental Health Services Administration

CSAP / DSD

Where are we now?

CSAP provides funds to states, territories, and Native American entities to establish epidemiological workgroups. The purpose of these epidemiological workgroups is to integrate data about the nature and distribution of substance use and related consequences into ongoing assessment, planning, and monitoring decisions at State and community levels. Their deliberate focus is on using data to inform and enhance prevention practice. A State Epidemiological Outcome Workgroup (SEOW) is a network of people and organizations that bring analytical and other data competencies to substance abuse prevention. In some cases, SEOWs are part of CSAP's Strategic Prevention Framework State Incentive Grants (SPF SIGs). In areas without SPF SIG funds, CSAP has made funds available to support an SEOW through this separate contract.

Where do we want to go?

CSAP's overall goal is to encourage all SEOWs to use data to inform and enhance substance abuse prevention practice guided by steps of the SPF. Sites currently without SPF SIG initiatives are building data capacity and infrastructure that will serve to strengthen data systems and competencies. These SEOWs are funded to focus on building infrastructure, develop State and community-level epidemiological profiles, and to address data gaps and other data system challenges related to describing, interpreting, and applying epidemiological data findings (including National Outcome Measures) to enhance decisions about enhancing prevention infrastructure and practice.

Audiences to be served by this public health approach include multiple State agency administrators and workers, policymakers, community advocates, and practitioners by assisting them to make data-driven decisions about substance abuse prevention.

How will we get there?

The SEOWs have made considerable progress over the past few years yet much work lies ahead. The new SEOW contract will focus its effort on managing SEOW efforts through the administration of funding, coordination of SEOW activities, analysis of data collected through the program, and providing comprehensive data to the grantees, SAMHSA, and the public to inform and assist in developing plans, policies, and practices to prevent and reduce behaviors related to substance abuse.

Non SPF SIG States are charged with developing State-level substance-related epidemiological profiles and are expected to conduct a thorough analysis of data gaps, complete a community-level substance-related epidemiological profile, and develop dissemination and sustainability plans. Once the epidemiological profiles have been produced, SPF SIG States must further develop ongoing

monitoring and strategic planning systems for substance abuse prevention, so that they can continue to use data to set priorities and allocate resources.

SEOWs involve agencies/organizations and individuals with the requisite data, skills, and/or decision-making authority for using data to guide and improve substance-related prevention. Substance use problems pervade a wide variety of domains (e.g., school, traffic safety, crime, and public health), so numerous types of State and local agencies and organizations are likely to hold relevant data. Membership varies, but each State, Jurisdiction, or Tribal organization typically involves substance abuse agencies, tribal leaders, public health agencies, tobacco control and drug enforcement authorities, criminal justice and law enforcement, education, behavioral health, researchers/statisticians, and others representing the history and cultural diversity issues relevant to the population.

In addition, CSAP codeveloped and coordinated participation of the SEOWs at the Council of State and Territorial Epidemiologists (CSTE) pre-conference workshop in substance abuse epidemiology sponsored by SAMHSA/CSAP. This specifically focused on epidemiological capacity for substance abuse prevention, tribal epidemiology, Jurisdiction technical assistance needs, data gaps, and the future of SEOWs. Collaboration with CSTE continues, and the CDC has attended many of the workshops and provided consultation.

Funding Mechanism: Contract

How will we stay on course?

To assist States with these tasks, CSAP has developed several resources:

- The State Epidemiological Data System (SEDS) presents a preliminary set of constructs and indicators identified as relevant, important, and available for substance use prevention planning. SEDS can be found at http://www.epidcc.samhsa.gov/.
- Collection and analysis of data at state and sub-state levels to assist efforts to promote local data-driven decision making. States are faced with these challenges in their efforts to institutionalize data-based monitoring and data-driven planning for substance abuse prevention, revealing the necessity of careful planning on next steps to develop and improve their substance abuse data systems.
- Administration and coordination of SEOW-related activities. CSAP assists jurisdictions to be skilled in the areas of planning and communication. We also assist them in sharpening of information systems that can efficiently convey data and communication in a variety of directions. As more states begin to recognize the value of adopting an outcomes-based approach to substance abuse prevention, it is anticipated that support for securing these additional elements will continue to grow.

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$6,800,000	*
2006	$4,200,000	*
2007	$4,100,000	*
2008	$667,000	*
2009	$3,874,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/21/2009 10:43:29 AM

Strategic Prevention Framework

U.S. Counties along the Mexican Border Initiative

Substance Abuse and Mental Health Services Administration

CSAP / DSD

Where are we now?

Hispanic/Latinos are the fastest growing group in the United States and represent about 11.7 percent of the U.S. population, and they are expected to double to 24.3 percent by the year 2050. A large part of this growth is an estimated 9.9 million of the total 45 million school-aged children who live in households in which a language other than English is spoken. Two-thirds of these children, six million, speak Spanish. About 1.8 million people live along the United States side of the U.S.-Mexico Border, and approximately one-quarter live below the poverty line which is more than double the national average. Eighty percent of the children live in families where both parents work. The Hispanic/Latino high school dropout rate is 15 percent compared to 5 percent for Caucasians.

Culturally and linguistically appropriate substance abuse prevention services are paramount for populations living along the United States side of the Mexico Border. Research shows that serious drug addiction and alcohol problems are one of the most significant barriers to employment. One study found that as Latino immigrants adapt to the United States, they are exposed to unfavorable drinking norms and significant social stressors, such as unfamiliar language, unfamiliar customs, and ethnic discrimination that provoke increased consumption of alcohol. The Texas School Survey of Substance Abuse found youth in grades 7-12 who live along the U.S. side of the border reported higher levels of cocaine use at a rate of 13.3 percent for lifetime use and 6 percent for past-month use while students who live in non-border counties had a rate of 7.2 percent for lifetime use and 2.5 percent for past month use. Studies have found that depression is an important indicator for the abuse of alcohol and drugs for all populations and not just youth, highlighting the need for programs that promote health and well-being in addition to preventing the use of illicit substances.

The area that comprises the target population is composed of 24 counties that vary from suburban to very rural areas. Along both sides of the 2,000 mile border, 90 percent of the border population is concentrated in 14 sister or twin cities. The history of this area is etched acutely not only within the residents of the specific area but also in the second and third generations of individuals. There are a plethora of cross-cultural issues, not the least of which is the lack of relevant substance abuse prevention materials in Spanish.

Where do we want to go?

The goal of this initiative is infuse the Strategic Prevention Framework (SPF) within the area by adapting the model to be culturally and linguistically appropriate. Multiple learning methods, especially training/technical assistance, are the basis for the SPF infusion process within the target area. Specifically, the initiative follows the SPF process through assessing the nature and magnitude of the substance abuse problems within the counties that are contiguous to the border, building capacity within those counties by developing strategic plans, planning, implementing, and

evaluating the prevention programs, policies, and practices. Ensuring sustainability and having culturally and linguistically appropriate materials is tantamount to this initiative. The primary audience for this initiative will be local prevention providers living and working in all venues (e.g., schools, community centers, workplace, and faith-based organizations) within the contiguous counties and the communities comprising those counties.

How will we get there?

This initiative will:

- Profile population needs, resources, and readiness to address the problems of substance abuse. Build counties' epidemiological capacity to collect, analyze, and interpret epidemiological data relevant to substance abuse prevention, as substance use problems pervade a wide variety of domains (e.g., school, traffic safety, crime, public health). Numerous types of State and local organizations are likely to and should be involved in these efforts.
- Convene an annual meeting with local prevention providers made up of key community representatives as well as organizations that provide health promotion services to the border.
- Review, develop training and technical assistance products, and adapt bilingual (English/Spanish) resources and webinars to enhance SPF capacity to address the specific needs of individuals living within the counties contiguous to border.
- Provide training and technical assistance to support effective evidence-based/science-based substance abuse prevention programs, practices, and policies so that they can be applied successfully within the diverse contexts of life occurring along the U.S. counties along the Mexican border. Such training and technical assistance is coordinated with SAMHSA's ongoing development and dissemination efforts, especially underage drinking prevention, co-occurring disorders, suicide prevention, and working with minority institutions such as universities and faith centers.

Funding Mechanism: Contract

How will we stay on course?

This proposed effort will align itself closely with SAMHSA's National Outcomes Measures related to the SPF. Contract project staff meets monthly with the selected contractors to ensure compliance with contract provisions and to resolve issues that are identified.

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*

Fiscal Year	Awarded Amount	Planned Amount
2007	*	*
2008	$434,922	*
2009	$443,231	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 6:11:17 PM

Strategic Prevention Framework

Data Analysis Coordination and Consolidation Center (DACCC) and Information Technology Infrastructure Contract (ITIC)

Substance Abuse and Mental Health Services Administration

CSAP / DSD / PTAB

Where are we now?

CSAP supports two related contracts to collect and analyze data on program accomplishments.

DACCC Contract

The Data Analysis Coordination and Consolidation Center (DACCC) is CSAP's centralized resource for data-related activities including, but not limited to, substance abuse prevention data quality improvement, program analysis and reporting, staff and grantee training, and measure identification and implementation. During FY 2009, the DACCC worked with two expert panels to review the current National Outcome Measures and make recommendations for potential modifications and improvements. The DACCC provides analysis and findings for three critical annual reports, for quick turnaround queries from the OD, OA, HHS, OMB, Congress and others; for special one-time reports (e.g., the cost benefit of prevention; adolescent predictors of young adult alcohol dependence) that can contribute to the field. The DACCC provides continuous quality improvement for program data. The DACCC provides the capacity to report for all CSAP programs on particular populations served; number, types, and locations of particular activities supported; effectiveness across programs for particular populations; the characteristics and effectiveness across programs of activities relative to national, subpopulation, and geographic area data and trends. Beginning in FY 2009, the DACCC also will support more in-depth cross-site evaluations for the Minority AIDS Initiative program and the SPF SIG (cohorts 3 and 4) program, and will have increased ability to provide training and technical assistance support and materials development on data requirements and other applied data topics. Ultimately, it is anticipated that the DACCC will become a resource for all prevention practitioners (e.g., researchers, policymakers, providers) who require analytic results in various forms such as reports, presentations, and fact sheets.

DITIC Contract

The CSAP Information Technology Infrastructure Contract (DITIC) facilitates building capacity, enhancing effectiveness, and improving accountability by providing a single platform to the public, grantees, CSAP, and SAMHSA in locating, entering, and retrieving prevention-related information, Web tools, and data. The DITIC hosts all of CSAP's training courses, data-related publications, announcements, and serves as CSAP's data warehouse and data mart for viewing, analyses, and downloading purposes. It also provides online tools to grantees to track and submit National Outcome Measures (NOMs) and other program-related performance data electronically. The DITIC ensures that technical assistance is provided to grantees in the use of this system. Quality control standards are implemented for all data processes. SAMHSA or its representatives receive timely and accurate data for analysis and producing various reports.

Where do we want to go?

These two linked contracts:

- Serve as a resource to CSAP, its grantees, and contractors to support the use and submission to CSAP of common valid and reliable data as determined by Federal data reporting requirements. This objective includes the development and/or promotion of common standards, formats, definitions, data collection protocols, and instrument development to assure NOMs, Program Assessment Rating Tool (PART), and Government Performance Results Act (GPRA), as well as other program specific requirements, are met.
- Provide a one-stop shopping systems portal for program data entry, a Web analytic tool for online data analysis and reporting of real-time data, geo-mapping, and other prevention resources.
- Provide CSAP with a mechanism to obtain short turn around, one-time analytic reports as well as regularly scheduled standard reports with which to interpret relevant trends and program accountability for policy and program decisions.
- Serve as a mechanism through which CSAP can identify gaps in needed data.
- Track, monitor, perform secondary analyses, and report on data from other relevant studies and surveys in order to assess CSAP's responsiveness to national needs and to identify emerging issues of importance to substance abuse prevention planning.

How will we get there?

DACCC
We will achieve our goals by continuing current DACCC activities and by performing new cross site evaluation activities as well as current analysis for performance monitoring purposes. The process will involve regular dialogue, input, and feedback from users including, but not limited to, the grantees and program staff. The DACCC also obtains valuable suggestions and input from its steering committee that is composed of representatives from CSAP's various constituencies. It is clear that, given demands for reports to Congress and other more detailed evaluation findings and proof of program effectiveness, quality cross site studies for current and future SPF-SIG, HIV, and STOP Act cohorts are needed. This contract will also continue and expand training support for grantees in data requirements and CSAP staff in the use and interpretation of data submitted by their grantees. CSAP staff use these data to monitor compliance and assess technical assistance needs. With professional development workshops in applied data and evaluation topics, CSAP staff will be better able to understand the data that are submitted, help guide their grantees in improving data quality and compliance, and provide targeted assistance in weak areas identified through DACCC analyses. The DACCC also is providing support in the examination of the most appropriate performance measurement for current substance abuse prevention programs.

DITIC
This contract will continue current DITIC activities, and will perform additional tasks such as upgrading the existing legacy system that will allow states, territories, substance abuse agencies, community-based service providers, and others to quantify and compare the numbers and types of primary substance abuse prevention and early intervention services delivered, providing a Web-based portal where all training and technical assistance requests by the states and contractors will be reviewed, and supporting new discretionary grant program that were awarded in FY 2009. Recently, online data entry is being implemented for grantees to replace paper progress reports.

Funding Mechanism: Contract

How will we stay on course?

The DACCC performs analyses and generates outcomes for other CSAP programs. For example, the DACCC annually produces "The Accountability Report" which contains in great detail, program- and CSAP-wide outcomes for GPRA and NOMs by demographics, over time, and other perspectives. The DACCC also annually produces the "State NOMs Trends Report" which provides, for each state, their performance on each NOM, 1) currently, 2) over time, and 3) compared to the national median. The DACCC also produces other reports such as "The Cost Benefit of Prevention" which will help the field identify effective programs to implement within their resources. Furthermore, the DACCC produces guidance materials, such as the National Outcome Measures Toolkit for each of CSAP's programs, and provides training for CSAP staff and grantees about the data requirements, such as GPRA, and how to meet them. The DACCC obtains feedback and input from CSAP's senior leadership, its external steering committee, CSAP staff, and grantees regarding future directions and modifications of products and priorities. For example, we expect the upcoming year to contain more emphasis on shorter, more user-friendly reports for dissemination.

The DITIC regularly meets with and obtains feedback from grantees, CSAP Project Officers, and senior management on the strengths and weaknesses of the system, as well as recommendations for quality improvements. The DITIC performs regularly scheduled revisions as well as ad hoc enhancements depending on critical need. The DITIC continues to add and refine online management reporting tools for each discretionary grant program, add online data entry functions for newer programs, develop online analytic capacity, and more, depending on need and resource availability. Per staff recommendations, technical assistance tracking function will be added, the ability for management and grantees to view and analyze data in real time, and the states/territories data collection system will be upgraded in the upcoming year. Division training on system use and enhancements is ongoing with Web tutorials always available.

Overview Program/Project/Activity Management:

- Funding Source

  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$6,600,000	*
2008	$5,907,000	*
2009	$6,300,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 3:49:26 PM

Strategic Prevention Framework

National Laboratory Certification Program

Substance Abuse and Mental Health Services Administration

CSAP / DWP

Where are we now?

The purpose of this contract is to provide the Division of Workplace Programs (DWP) with a mechanism to satisfy all the requirements for the National Laboratory Certification Program (NLCP) as required by E.O. 12564 and Section 503 of Public Law 100-71 and specified in the Mandatory Guidelines for Federal Workplace Drug Testing Programs (69 FR 19644, April 13, 2004) (Mandatory Guidelines), and any subsequent revisions. In addition, this program will provide for (1) the scientific and technical guidelines for the testing of hair, sweat, and oral fluid specimens; (2) the scientific and technical guidelines for onsite screening tests for urine and oral fluids at the collection site; and (3) the requirements for the certification of laboratories, and ongoing quality assurance and performance of NLCP-related activities at collection sites, laboratories, and by medical review officers (MROs).

This contract is based on the "Mandatory Guidelines for Federal Workplace Drug Testing Programs," published in the Federal Register on November 25, 2008, with a May 1, 2010 effective date for the changes and additions to program requirements. Additional notices in the Federal Register will need to be published requesting information and assistance from the public concerning the use of alternative drug test specimens such as oral fluid, sweat patch, and hair, as well as Point of Collection Testing Devices. Additional study and analysis will be required for the drug testing science, actual use of additional technologies, collection of specimens, procedures for collection site inspection and quality assurance. Additionally, Medical Review Officer Training and certification procedures used in the evaluation of drug test results using these alternative specimens will need to be developed and implemented prior to the Federal register deadline.

Where do we want to go?

The contractor operates the National Laboratory Certification Program (NLCP) as described in the Mandatory Guidelines and will be conducting special research studies and performance testing evaluations when it is evident or necessary to make policy decisions based on the outcomes of special projects including, but not limited to, the following:

1. New Drug Testing Technology, Instruments, and Analytes

The contractor will gather information on new technologies and new instruments being developed to test for drugs and additional analytes (e.g., MDMA, synthetic opiates) that may or could be included in future modifications to current drug testing programs. For technologies and instruments, the task includes evaluating the technologies and instruments and providing an assessment of their potential applicability to workplace drug testing programs. The applicability of these new technologies shall be addressed by technical working groups in developing technical guidelines for the use of this instrumentation and technologies within the NLCP program.

2. Alternative Specimens for Drug Testing
The contractor will evaluate other types of specimens (e.g., hair, sweat, oral fluid) for possible use in workplace drug testing programs. For alternative specimens and other analytes, the task may include establishing cutoff concentrations, estimating detection windows, and ability to develop and include performance testing samples in the NLCP performance testing (PT) program. The applicability of these alternative matrices and performance evaluations shall include screening and confirmation methods and outcomes of these evaluations.

3. Demographic Analysis
The contractor will establish a process to gather non-negative drug test results to allow demographic analysis and establish a means to evaluate alternative drug testing data and demographic analysis of the data.

4. Drug Testing Specimen Collectors
The Contractor shall develop a quality assurance program to assess the specimen collection process and the compliance of collectors with NLCP requirements. The applicability within the NLCP Program shall be addressed by technical working groups.

5. Medical Review Officers
The Contractor shall develop a quality assurance program to assess the review of drug test results by Medical Review Officers and their compliance with NLCP requirements. The applicability within the NLCP Program shall be addressed by technical working groups.

6. Bibliography of Scientific Journal Articles
The Contractor shall maintain a bibliography and copies of journal articles related to drug testing and alternative matrix testing.

How will we get there?

It is important to note that based on new Federal Employee Drug Testing Program requirements published in the Federal Register on November 25, 2008 and effective May 1, 2010, additional work will need to be done that was not clearly identified in the contract awarded in August 2008, before that notice was published. Many deliverables are required in the current contract that supports this program. Additional notices in the Federal Register will need to be published requesting information and assistance from the public concerning the use of alternative drug test specimens such as oral fluid, sweat patch, and hair, as well as Point of Collection Testing Devices. Additional study and analysis will be required for the drug testing science, actual use of additional technologies, collection of specimens, procedures for collection site inspection, and quality assurance. Additionally, Medical Review Officer training and certification procedures used in the evaluation of drug test results using these alternative specimens will need to be developed and implemented prior to the Federal Register deadline.

The overall program objectives are to develop and implement the changes, through consultation with multiple ad hoc working groups. These working groups will focus primarily in these areas: MS/MS Technical Standard Development, the OMB-cleared Federal Chain of Custody Form, Medical Review Officer Training and Certification Standards, and Drug Test Specimen Collector Training and Collection Site Inspections. These program objectives have been reviewed and assessed based on program objectives and priority of need.

Funding Mechanism: Contract

How will we stay on course?

The Contractor shall continue to operate the National Laboratory Certification Program (NLCP) as described in the Mandatory Guidelines. The Contractor shall independently furnish the necessary services, qualified personnel, material, equipment, and facilities not otherwise provided by the Government to perform the tasks described below. A copy of the Public Law 100-71 (Section 503), Executive Order 12564, the NLCP Laboratory Application Form, the NLCP Laboratory Information Checklist, the NLCP Inspection Checklist, the NLCP Records Audit Checklist, and the NLCP Manual for Laboratories and Inspectors will serve this purpose. These references total more than 350 pages. Additionally, the first three references above can also be found on our Web site (http://www.workplace.samhsa.gov) with the complete Federal Register Notice detailing the requirements of the Mandatory Guidelines for Federal Workplace Drug Testing Programs.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$2,367,941	*
2006	$2,294,176	*
2007	$2,456,857	*
2008	$2,595,718	*
2009	$3,250,621	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 5:41:16 PM

Strategic Prevention Framework

Young Adults in the Workplace (YIW) Program

Substance Abuse and Mental Health Services Administration

CSAP / DWP

Where are we now?

Young adults 16 to 24 years old are at highest risk for substance use in the workplace. This group has been underrepresented in services and programs. These years are risky for this age group as it is a transition point in their lives (e.g., moving out of their homes, getting a first job, attending college, getting married). Approximately 68 percent of young adults are in the workplace, and the workplace is an excellent location to provide prevention and early intervention services/programs. Given the increasing proportion of younger workers in our workplaces, increased national security concerns, and the need for rebuilding infrastructure in the U.S. there continues to be a need for prevention programs based in the workplace. The Young Adult in the Workplace (YIW) program is a multisite collaborative project designed to build a strategic, cooperative alliance among multidisciplinary teams interested in studying workplace-based substance abuse prevention programs for young workers. Six grantees are in Phase II of the service to science program; they are developing process and outcome reports and producing replication guidelines. They have delivered papers at four conferences and are developing materials for public dissemination. Peer-reviewed papers will be produced by each grant and the cross-site evaluation.

Where do we want to go?

Research continues to indicate that becoming an adult is challenging for all young people. The 2000 Census noted that there are more than 27 million young adults in transition (ages 18-24). Over 25 percent of young adults, 18-24, have not completed high school; 68 percent of this group are employees (37 percent full-time) with an average salary of $15,533 and a large percentage without insurance. Approximately 15 percent are 1st generation immigrants. The poverty rate in this group is 30 percent. During the years 18-25, there is much transition: leaving public education, moving out of their home, getting a job, getting married, going to college, becoming a parent. Young people must accomplish much during this time but there is a high risk of substance abuse. Specific jobs have been shown to carry an even higher risk to these young adults, including food and beverage service, construction, transportation, health care delivery, and first responders (e.g., fire, police, health). In addition, high-risk young adults who are transitioning to work such as military veterans, those aging out of orphanages, and those coming out of institutions such as correctional facilities or mental health treatment settings. SAMHSA/CSAP offers the opportunity to build on the success of the YIW programs, community coalitions, and other grantees by enhancing workplace programs available to employees and their families. This grant program received final funding in FY 2008 to support workplaces (private/public), community coalitions, and other organizations in their provision of substance abuse prevention services through strategic partnerships using evidence-based practices, prior NREPP programs, and other well-documented, tailored, and evaluated programs. The grant program is supported by the current cross-site evaluation team contract following the end of Cohort I of the YIW; each grantee will be producing a replication manual.

How will we get there?

There will be a cross-site evaluation completed; successful programs will produce replication manuals and may apply for NREPP status. Products, which can be used for the public, will be adapted by CSAP and provided through the Workplace Resource Center such as http://www.getfit.samhsa.gov, an interactive health/wellness Web site that was made available following the Workplace Managed Care grant program. Toolkits of methodology and evaluation tools such as cost analysis tools for YIW programs, and presentations from major conferences of related work are made available on the Workplace Resource Center.

Funding Mechanism: Grant

How will we stay on course?

The six grant programs in the YIW initiative include models of substance abuse prevention integrated and delivered through health promotion programs, life skills training, and team-based peer-to-peer programs. Program modules include classroom training, eLearning self-directed methods, supported EAP services, interactive gaming methods, peer, and supervisor mentoring, and printed materials. Programs are implemented across six partnering organizations in more than 160 work sites across retail/service, health care, union/trade, work-readiness, and transportation industries. The cross-site infrastructure for the YIW initiative supports three interrelated evaluation efforts: process evaluation, outcome evaluation, and economic evaluation. The evaluation questions are the foundation of the cross-site evaluation and analysis plan and correspond to the three components of the evaluation. The majority of the grantees implemented a group randomized pre- and post-design. All grantees collected at least one baseline and three post-intervention data at 6, 12, and 18 months. This design and data structure created a multilevel or nested phenomenon in which the activities at one level are influenced by those at a higher level. For example, employee behavior is influenced by experience and attitudes of individual employees and by the amount and nature of the intervention that they receive, as well as by work site characteristics and contextual elements such as tolerance and policy. The modeling framework is an extension of the dismantling strategy that permits the tests of hypothesis at the intervention component, work site, and individual levels.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,800,000	*
2006	$1,800,000	*
2007	$1,800,000	*
2008	$1,800,000	*
2009	*	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 5:29:51 PM

Children & Families

Underage Drinking Prevention Public Service Advertising Campaign

Substance Abuse and Mental Health Services Administration

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Where are we now?

The negative consequences of underage drinking are more widespread and serious than previously known. A growing body of research shows that alcohol can change the way the brain works and the way it's wired, and may have consequences reaching far beyond adolescence. Many more dangers of underage drinking are immediate, including alcohol poisoning, sexual and physical assault, and motor vehicle crashes. Underage drinking is a serious problem, with roots deep in our culture. Because of emerging new knowledge about the number of children who drink, how much they drink and what happens when they drink, the Surgeon General issued a Call to Action to Prevent and Reduce Underage Drinking. It explains why underage alcohol use is a major public health and safety issue. As they grow older, the chance that young people will use alcohol grows. Approximately 22.1 percent of 12-14 year olds say they have used alcohol at least once. By age 15-17 alcohol use more than doubles. And by 18 – 20 just over 80 percent have had at least one drink. Rates of death and injury nearly triple between the early teen years and early adult life. Underage drinking contributes to this increase and that's why ending teen alcohol use can help save lives. As part of the Surgeon General's "Call to Action to Prevent and Reduce Underage Drinking," SAMHSA is working with the Ad Council on a Public Service Advertising campaign that seeks to reduce and delay the onset of underage drinking by increasing communication between parents and youth. The campaign's message is that parents need to talk to their children early and often about alcohol and especially before they've started drinking. Parents and viewers are encouraged to visit http://www.stopalcoholabuse.gov to get information about teens and alcohol, as well as tips on how to initiate conversations with their children about underage drinking. Research shows 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. This 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 about alcohol at an early age.

Where do we want to go?

The Underage Drinking Prevention campaign, targeted to parents of children ages 11-15, urges parents to speak with their children about underage drinking in order to delay the onset of and ultimately reduce underage drinking.

How will we get there?

A comprehensive array of public service advertising (TV, Radio, Billboards, Outdoor, Web Banners) and public education materials (Family Guide Brochure and website http://www.stopalcoholabuse.gov) are continually being updated and deployed through appropriate

media channels. A multicultural component of the campaign is currently in development and a new wave of general audience materials are in the early stages of development. The Ad Council works with over 33,000 media companies/properties to place the Public Service Announcements (PSAs) in donated time and space. Whenever possible, the campaign collaborates with local prevention efforts and provides resources and materials as needed. The Underage Drinking Prevention Public Service Advertising Campaign is aligned with CSAP underage drinking prevention efforts as well as the Office of Policy, Planning and Budget. Using the Surgeon General's Call to Action for Preventing and Reducing Underage Drinking as the guide, SAMHSA coordinates Ad Council Campaign activities with the Interagency Coordinating Committee to Prevent Underage Drinking.

Funding Mechanism: Contract

How will we stay on course?

The Ad Council measures donated media support as one aspect of campaign success. According to the latest information available the campaign has received over $111 million in donated media. The Ad Council also conducts periodic tracking surveys to measure the campaign's effectiveness and impact over time on parents and guardians of children aged 10-15. The most recent study conducted in October of 2007 surveyed 660 parents and saw increases since 2006 in the percentage of respondents who were "extremely" concerned about underage child drinking (21% to 27%) as well as the percentage of respondents visiting a website to find out how to speak with their children about underage drinking (12% to 16%). At the same time, the percentage of parents who report that they have talked to their child about underage drinking declined over the three waves of tracking, from 77% to 73% to 66%. The three waves of tracking were conducted in October 2005 (prior to campaign launch), December 2006, and October 2007. These data are critical to understand as the campaign moves into its next phase.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$800,000	*
2006	$800,000	*
2007	$800,000	*
2008	$983,000	*
2009	$1,000,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 5/11/2009 12:46:54 PM

Children & Families

Comprehensive Community Mental Health Services For Children and their Families Program

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

An estimated 4.5 to 6.3 million children and youth in the United States suffer from a serious emotional disturbance and approximately 65 to 80 percent of these children and youth do not receive the specialty mental health services and supports they need. Many of them have mental health challenges that affect their ability to perform successfully in home, school and community settings. In many communities, services for these young people are fragmented, unavailable, and largely ineffective. For the two-thirds of this population who do not receive specialty mental health services, the result is often school failure, involvement with the juvenile justice system, and an inability to meet the developmental milestones necessary to transition to independent adulthood.

Since its inception, the Community Mental Health Services for Children and their Families Program (Short title: Child Mental Health Initiative [CMHI]) has impacted nearly 22% of our nation's 3,177 counties, parishes, boroughs, independent cities, geographical census areas, geographic regions, and the District of Columbia and has served over 88,000 children and youth. National program evaluation data collected over the past 15 years 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 6 months of program participation
- Improvements in school attendance and school achievement
- Reduction in suicide-related behaviors
- Significant reductions in placements in juvenile detention and other secure facilities (resulting in per-child cost savings)
- Decreases in reliance on inpatient care and reduced costs due to fewer days in inpatient care (resulting in per-child cost savings)

Where do we want to go?

The CMHI will continue its efforts to transform children's mental health care by bringing systems of care to scale and by sustaining those systems of care already in place.

How will we get there?

CMHI issues an annual Report to Congress, documenting program performance on numerous program areas including: characteristics of children and families served in system of care;

characteristics of funded grant communities; child and family characteristics at program intake; outcomes for children and families; service experience and satisfaction with services; system-level outcomes and program sustainability; costs of services and supports in systems of care; and special studies on an as needed basis. The CMHI conducts a continuous quality improvement (CQI) process in all of our funded sites (initiated in FY 2005). The CQI Initiative supports the quality and continued improvement of grant communities and ensures that technical assistance needs are identified and delivered to funded grantees based upon data-driven and responsive decision-making.

In addition, a benchmarking initiative is underway to provide a tool that incorporates performance measurement and benchmarks to assess site-level performance and improvement. Specifically, the CQI Progress Report provides data on key performance indicators encompassing the key principles of the CMHI. Those key principles include: family-driven services, individualized services, cultural and linguistic competency, least restrictive service planning, community-base services, interagency collaboration, accessible services, and coordinated collaboration between service providers and partners. The Report focuses on 35 indicators nested within five domains: (1) system level outcomes; (2) child and family outcomes (3) satisfaction of services; (4) family and youth involvement; and (5) cultural and linguistic competency. Based upon the evidence being gathered through process and outcome evaluations and through this CQI process, the CMHI institutes appropriate program modifications in program requirements and activities to ensure a high degree of quality and responsiveness in all aspects of program functioning. The CMHI will also continue to ensure that the program either meets or exceeds all OMB targets for prescribed GPRA indicators.

Funding Mechanism: Cooperative Agreement

How will we stay on course?

In 2002, the CMHI was one of the first Federal programs to be assessed through PART and received a rating of "moderately effective." Since that time, the program has continued to make progress and set ambitious performance targets for each of the program's GPRA indicators. The targets are frequently met or exceeded and the program continually monitors performance on various program performance indicators. The results of the national evaluation are also used regularly and continuously to assess numerous aspects of program accountability and outcome measures as specified above. In addition, the CMHI has:

- Undertaken a comprehensive and ongoing strategy to implement intensive technical assistance activities to work with funded communities to ensure that communities monitor and improve their performance on numerous indicators based upon a rigorous CQI performance improvement process.
- Instituted a Transformation Accountability (TRAC) data collection process at all funded grantee sites that collects data for all of the children's National Outcomes Measures (NOMS), specified by SAMHSA and approved by OMB.
- Evaluated the effectiveness and success of all technical assistance activities provided to funded grantee sites.
- Published and/or presented over 350 papers documenting the results of the CMHI program in numerous venues, including refereed journals, technical reports, conference proceedings, etc.

Center for Mental Health Services - Children's Health Initiative.

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$105,000,000	*
2006	$104,000,000	*
2007	$104,000,000	*
2008	$102,260,000	*
2009	$108,323,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 8:31:32 AM

Children & Families

National Child Traumatic Stress Initiative

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

In a nationally representative sample of 12- to 17-year-old youth, 8 percent reported a lifetime prevalence of sexual assault, 17 percent reported physical assault and 39 percent reported witnessing violence. Many children and youth experience multiple and repeated traumatic events. In fiscal year 2001, in recognition of the serious mental health impact that traumatic events can have on children, adolescents and families, Congress authorized SAMHSA to develop a national grant program, the National Child Traumatic Stress Initiative (NCTSI), to focus on child trauma. The NCTSI has recruited nationally recognized experts in child/adolescent trauma and developed a collaborative network, the National Child Traumatic Stress Network (NCTSN or "Network"), that develops evidence-based clinical interventions and trauma services, including trauma-informed services for systems in which children/adolescents with high rates of trauma exposure are found. Traumatic events may include; physical or sexual assault, natural or man-made disasters, family or community violence, serious motor vehicle or other accidents, and traumatic loss of family members or other significant relationships. Network Treatment and Service Adaptation (TSA) Centers identify, develop, support and improve treatment approaches for different types of child and adolescent traumas. Community Treatment and Services (CTS) Centers provide services to children who have experienced traumatic events and implement and evaluate the effectiveness of trauma treatment and services in community and service system settings.

The NCTSI also supports a national coordinating center, the National Center for Child Traumatic Stress, to provide leadership and to promote collaboration across the Network, and a National Resource Center to disseminate Network-developed resources and intervention products. The Network served 28,878 children in fiscal year 2008 through direct services and of the children receiving ongoing clinical treatment during that period, 69 percent showed improvement in behavioral symptoms associated with their traumatic experiences. In addition, since the inception of the Network, over 800,000 mental health professionals, primary care providers, other professionals in child-serving systems, consumers and members of the public have been trained on the treatment, assessment and/or education of child traumatic stress in approximately 19,000 Network-sponsored sessions and events.

Where do we want to go?

The mission of the NCTSI is to transform mental health care for children and adolescents affected by trauma throughout the country by improving the quality of community-based trauma treatment and services and increasing access to effective trauma-focused interventions.

To achieve this mission the program is focusing on:

- Developing effective interventions to reduce the mental health effects of traumatic experiences of children/adolescents.
- Developing interventions effective in settings in which traumatized children/adolescents typically receive services.
- Developing effective training approaches and provide training in effective trauma treatment and services to large numbers of practitioners.
- Disseminating the most effective trauma treatment and services throughout the country.
- Developing clinical knowledge of children's and adolescents' responses to trauma and recovery, and
- Developing resources on trauma for professionals, consumers and the public.

It is of particular interest that intervention approaches developed within the Network can be readily implemented in the community settings in which children commonly receive services, and that they will contribute to transforming service delivery approaches so that trauma-informed practices and interventions "take root" within local community service systems. While significant progress has been made in the seven years since NCTSN grants were first initiated, there are gaps in the range of existing child trauma interventions and a need to develop and implement additional intervention approaches for areas that are not yet addressed and to deliver these and existing intervention approaches to additional communities.

How will we get there?

The NCTSI has recruited nationally recognized experts in child and adolescent trauma and continues to develop evidence-based clinical interventions and trauma services, including trauma-informed services for systems in which children and adolescents with high rates of trauma exposure are found. For example, over forty empirically supported treatments and promising practices have been developed, adapted and/or disseminated by the NCTSN and additional interventions will be developed. Creating Trauma-Informed Systems The Network has finalized or is in the process of completing training programs or other materials for key child and adolescent serving systems including; mental health, substance abuse, schools, child welfare, law enforcement, first responders, courts, foster care providers and children's advocacy centers. These training products, combined with the consultation and training capacity of the Network, are establishing a trauma-informed workforce that is better prepared to identify traumatized youth and respond to their needs in ways that promote recovery. Resources for the Public and Professionals The Network website, http://NCTSN.org is increasingly accessed by the public and service providers as a source for current and reliable information on all aspects of child trauma. The Network has developed cutting edge training platforms, using Learning Collaboratives and web-based training to reach thousands of professionals throughout the country.

Funding Mechanism: Grant

How will we stay on course?

To help determine the effectiveness of the program and the extent to which it has met its goal of improving treatment and services for children directly or indirectly affected by trauma, SAMHSA has implemented a multi-year, national cross-site evaluation of the NCTSI through a contract with Macro International. The overarching purpose of the cross-site evaluation is to assess the impact of the NCTSI on both access to care and quality of care for children exposed to trauma. The evaluation is comprised of 8 study components, each of which examines a different facet of the Network's activities and impact. The goals of the evaluation include: describing the children and

families served by NCTSN centers and the behavioral and clinical outcomes of children served; assessing child/family satisfaction with services; evaluating the effectiveness of Network-sponsored trainings in expanding knowledge of trauma-informed care; tracking the development, dissemination, and adoption of effective products, treatments, and services; assessing intra-Network collaboration; and studying the Network's national impact on both mental health and non-mental health child-serving fields. Cross-site evaluation findings are shared with grantees twice yearly in the form of Data Profile Reports, in addition to short evaluation briefs, presentations at regional and national meetings, and an annual report to SAMHSA. The current evaluation contract ends in FY 2009. A new contract is expected to be issued to continue the national evaluation process.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	$25,146,735	*
2007	$24,345,723	*
2008	$33,092,000	*
2009	$38,000,000	*
2010	*	*
2011	*	*
2012	*	*

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Children & Families

National Technical Assistance Center for Children's Mental Health

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The National Technical Assistance Center for Children's Mental Health (NTAC) was established at Georgetown University to strengthen the capacity of states, territories, tribes, and communities to transform their mental health systems to meet the diverse and complex needs of children and adolescents with or at risk for serious emotional disturbances and their families. A carefully designed strategic approach to training and technical assistance was established to assist states and other jurisdictions to develop and increase infrastructure capacity to address the challenges and overcome the barriers inherent in systems transformation.

Where do we want to go?

NTAC seeks to assist states, territories, tribes, and communities to build capacity to develop and sustain comprehensive systems of care for children and their families. NTAC utilizes an integrated approach to technical assistance and continues to provide technical assistance at various levels of intensity (universal, targeted, and intensive) through the use of technical assistance strategies to meet identified needs within SAMHSA's priority focus areas. Through its work with state and community mental health officials, NTAC continues to serve as a national resource to support the efforts of states, territories, tribes, and communities to strengthen capacity in the following areas: (1) systems planning; (2) policy development; (3) financial strategy development; (4) improvement of systems of care and services; (5) development of evidence-based/promising practices and dissemination of information. NTAC's specific focus is on state mental health agencies, their partner child-serving agencies, statewide family organizations, and youth leaders. NTAC uses an integrated approach to technical assistance, addressing the priority areas specified in the original cooperative agreement.

How will we get there?

NTAC receives approximately $3M per year in funding through a 5-year cooperative agreement with SAMHSA to provide the training and technical assistance described above. NTAC works with states, territories, tribes, and communities to plan and implement strategies to help improve services and the systems they operate within. NTAC is funded by, and thus works closely with, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Children & Families (ACF). Additionally, NTAC works collaboratively with a large number of state and national agencies and organizations. Some examples of external organizations include American Institutes for Research (AIR), the Federation of Families for Children's Mental Health (FFCMH), the National Association for State Mental Health Program Directors (NASMHPD), National Association of State Directors of Special Education (NASDSE), and a number of other organizations with shared interest in children's mental health.

Funding Mechanism: Cooperative Agreement

How will we stay on course?

The core activities of NTAC are grounded in a solid research base and are continually informed, improved, and sustained by ongoing evaluation. Our approach to research and evaluation includes:

- Effective partnerships: Collaborating with families and youth, communities, local agencies, national organizations, and universities in developing research questions and designing and conducting research projects;
- Innovative evaluation strategies: Moving beyond typical evaluation strategies to continually advance the scope and quality of the Center's evaluation work;
- Applied research: Balancing scientific rigor with practical considerations regarding what is relevant and useful for children, families, communities, providers, and policy makers; and
- Building research and evaluation capacity: Providing technical assistance to non-evaluators to enhance understanding of evaluation and guide development of compelling, data-driven strategies that will help transform, improve and sustain programs.

Measurement topics include:

- Outputs/process outcomes including the implementation of technical assistance strategies focusing on the types and extent of technical assistance provided, the structure and timeliness of content for trainings;
- Utility including the perceived usefulness/effectiveness of training and technical assistance, relevance/quality of materials, satisfaction of recipients;
- Short-term knowledge change including changes in knowledge, attitudes and behavior; and
- Long-term change in practice including changes/improvements in states and communities that are attributed to the technical assistance received.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$3,100,000	*
2006	$2,859,000	*
2007	$2,930,000	*
2008	$2,930,000	*
2009	$2,930,000	*
2010	*	*
2011	*	*
2012	*	*

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Children & Families

Project LAUNCH

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

2008 marked the inauguration of the Center for Mental Health Service's (CMHS) initiative, Linking Actions for Unmet Needs in Children's Health (LAUNCH). The purpose of Project LAUNCH is to promote the wellness of young children, birth to 8 years of age. Through novel approaches to promotion and prevention, Project LAUNCH brings together States/tribes/territories, communities, service providers, and parents to create a unified and integrated service delivery system that meets the needs of young children and their families, and a common vision of wellness and healthy child development. Infrastructure reform at the State/tribal/territorial and local levels, along with workforce development and enhancements to wellness promotion and prevention services, will enable children to reach early developmental milestones, enter school ready to learn, and flourish within their families, schools and communities.

Project LAUNCH awarded six cooperative agreements in 2008 and anticipates awarding 12 in 2009 to fund activities in three major areas: planning, policy reform, systems-building, and coordination among child serving agencies at the State/tribal and local levels; workforce development among providers in child-care, early education, primary care, education and other child-serving domains in order to foster common understandings of child wellness and healthy child development; and expansion of evidence-based prevention and promotion services and practices for young children and their families, including but not limited to mental health consultation, integration of behavioral health and primary care services, developmental assessments, family strengthening activities, and home visitation programs.

Where do we want to go?

The vision of Project LAUNCH is that all young children will be ready for school, learning successfully, and thriving in safe and supportive environments. The initiative draws from a growing body of knowledge that demonstrates that 1) systems should work to promote health and to prevent illness before it occurs; and 2) early childhood is a critical time to put children on the path towards healthy functioning and optimal development. Project LAUNCH seeks to improve outcomes at the individual, family, and community levels by addressing risk factors that can lead to negative outcomes and by promoting protective factors that support resilience and healthy development. This program seeks to:

- develop new or strengthen existing partnerships and collaborations among child-serving systems;
- develop a promotion- and prevention-oriented service system for young children and their families at the State, Tribal, and local levels;

- expand and enhance services that incorporate evidence-based practices and reach greater numbers of children and families; increase community awareness of the issues surrounding young child wellness;
- facilitate changes in the knowledge, attitudes, practice, and behavior of parents, educators, physicians, service providers, and early childhood caregivers to support child wellness;
- increase the number of children screened and referred for appropriate services;
- reduce risk factors and improve protective factors for outcomes related to wellness; and
- increase school readiness among children served.

How will we get there?

After a competitive review of more than 30 applicants, six Project LAUNCH grants were awarded to 5 States (Washington, Rhode Island, Maine, New Mexico, Arizona) and one tribe (Red Cliff Band of Lake Superior Chippewa). Project LAUNCH grantees have been awarded up to $916,000 each for five years in order to build state and local capacity to achieve program goals. Grantees are expected to develop comprehensive plans to support child wellness at the State/Tribal level and bring together key agencies and stakeholders to drive change. Additionally, each grantee will pass on the majority of the funds they receive to support both infrastructure and program development in a chosen locality. Selected localities will create and implement comprehensive and financially sustainable programs, services, and supports for young children and their families. Localities are expected to implement a range of evidence-based programs and practices to support young child wellness, including mental health consultation, integration of primary and behavioral health care, family strengthening programs, parenting skills training, and home visitation.

In order to model collaboration and interagency coordination at the Federal level, CMHS program staff actively participated in the Early Childhood Systems Federal Partners Workgroup with partners from: HRSA, ACF, CDC, ASPE, Dept. of Ed., Dept. of Justice, Head Start Child Care Bureau, SAMHSA's Center for Substance Abuse Prevention as well as several other agencies within the Department of Health and Human Services (DHHS), including the Office of the Assistant Secretary for Planning and Evaluation.

The Project LAUNCH Steering Committee coordinates program activities with other DHHS grant programs and provides expertise and direction to Project LAUNCH. Project LAUNCH has also entered into an intra-agency agreement with the Administration for Children and Families (Office of Planning, Research and Evaluation) for oversight and management of a national cross-site evaluation.

Funding Mechanism: Grant

How will we stay on course?

Project LAUNCH grantees will be required to conduct an assessment of the program on the State, tribal and territorial levels as well as the local level. The assessment will analyze: 1) the effectiveness of grant funded interventions; 2) the costs of implementing the program across the various populations served; 3) the quality of implementation of evidence-based programs and practices (process evaluation); and 4) the strength of State, territorial, tribal and local partnerships. Furthermore, grantees are required to participate in a national cross-site evaluation, which will be designed to capture national as well as site-based data on program indicators and outcomes. All sites will participate in training on the cross-site instrument protocol, data collection, and data management procedures, and other evaluation-related activities at the time the program

is initiated, and at annual intervals for the duration of the grant period.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	$7,369,000	*
2009	$20,000,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 11:33:52 AM

Children & Families

Safe Schools/Healthy Students

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Safe Schools/Healthy Students (SS/HS) Initiative has been making a difference in schools across America since 1999. Every year, more communities join the effort to build healthy, safe environments that give young people a more promising future. The idea behind the SS/HS Initiative is simple—people can accomplish more when they work together. Within each community, agencies and organizations serve the same youth, so they share a common interest in promoting healthy childhood development and preventing violence and substance abuse. The Initiative allows local educational agencies (LEAs) to partner with their local mental health, law enforcement, and juvenile justice agencies to apply for Federal funds to support a comprehensive, coordinated plan of activities, programs, and services. These plans are intended to develop an infrastructure for safe, healthy, drug-free schools and communities that will continue long after the grants have ended.
The SS/HS Initiative signifies collaboration on the Federal level as well. The U.S. Departments of Education, Health and Human Services, and Justice are partners in the Initiative, which integrates research and best practices from the fields of education, justice, mental health, and social services. A Cross-Site Evaluation of the 1999, 2000, and 2001 cohorts found reductions in:

- classroom bullying (5%),
- classroom fighting (8%),
- verbal abuse of teachers by a student (11%),
- teachers feeling threatened by a student (21%)
- middle school students witnessing violence at school (student bullying/fighting) (6%),
- any alcohol use during the past 30 days (11%),
- cigarette use on school property during the past 30 days (19%), and
- feeling unsafe at school (7%).

High school students reported significant reductions in their use of alcohol (10%) and tobacco (13%) during the past 30 days. They also reported a significant reduction (6%) in feeling unsafe at school.

Where do we want to go?

The SS/HS Initiative draws on the best practices of education, justice, law enforcement, social and mental health services to encourage applicants to use a community-focused, collaborative approach to develop SS/HS comprehensive plans with a continuum of activities, curricula, programs, and services. The SS/HS Initiative identifies four local agencies—education, mental health, law enforcement, and juvenile justice—to provide leadership and management to the educational collaboration and to support the vision of the SS/HS program. The LEA's, along with their collaborative partners implement an integrated, comprehensive, community-wide plan

designed to create safe, respectful, and drug-free school environments and to promote prosocial skills and healthy childhood development. Plans must focus activities, curricula, programs, and services in a manner that responds to the community's existing needs, gaps, or weaknesses.

How will we get there?

To date, the SS/HS Federal partners have provided more than $1.5 billion in funding and other resources to 336 communities across the Nation. Most recently, in July 2008, 60 new 4-year SS/HS grants were awarded to local education agencies in 29 states. Just under $75 million is expected to be awarded each year, for four years from SAMHSA. In addition, nearly $80 million is matched by funds from the Department of Education. As a condition of funding, each grantee's comprehensive strategy must address the following five elements:

- Element One—SafeSchool Environments and Violence Prevention Activities;
- Element Two—Alcohol, Tobacco, and Other Drug Prevention Activities;
- Element Three—Student Behavioral, Social, and Emotional Supports;
- Element Four—Mental Health Services; and
- Element Five—Early Childhood Social and Emotional Learning Programs.

Grantees are required to collect individual level performance measures to help determine whether they are making progress in achieving their stated objectives. The following six Government Performance and Results Act (GPRA) measures must be included in their annual performance report and final performance reports:

- Percentage of students who did not go to school on 1 or more days during the past 30 days because they felt unsafe at school or on their way to and from school.
- Percentage of students who have been in a physical fight on school property in the 12 months prior to the survey.
- Percentage of students who report current (30-day) marijuana use.
- Percentage of students who report current (30-day) alcohol use. Number of students receiving school-based mental health services.
- Percentage of mental health referrals for students that result in mental health services being provided in the community.

In addition, SAMHSA funds the NationalCenter for Mental Health Promotion and Youth Violence Prevention which provides training and technical assistance in areas in which SSHS grantees work, including strategic planning, coalition building/partnership development, program assessment, evaluation, sustainability strategies and cultural competence. They do this by providing one-on-one consultation with experts in the field, by mentor sites, and/or by offering web-based resources. Finally, SAMHSA funds a SS/HS Communications Team to provide training and technical assistance in communications and social marketing to all SS/HS grantees. This team of communications and marketing professionals help SS/HS grant sites promote their programs and services, plan and conduct social marketing campaigns, and use communications to support their ongoing sustainability efforts.

Funding Mechanism: Grant

How will we stay on course?

SS/HS has a contract to conduct a national evaluation for the FY 2005 through 2008 cohorts. The evaluation focuses on the collection, analysis, and interpretation of cross-site data related to the

processes and outcomes of the efforts of SS/HS grantees. Methods include both quantitative and qualitative strategies aimed at understanding the outcomes of safe schools policies, collaborations among partners, and use of evidence-based programs, as well as the more distal outcomes of improved learning environment, reduced violence and aggression, reduced substance abuse, and enhance social an emotional competence.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$78,738,000	*
2006	$80,913,000	*
2007	$80,670,000	*
2008	$82,802,000	*
2009	$84,320,000	*
2010	*	*
2011	*	*
2012	*	*

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Children & Families

Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence

Substance Abuse and Mental Health Services Administration

CSAP / DSD

Where are we now?

SAMHSA created the Fetal Alcohol Spectrum Disorder (FASD) Center for Excellence in 2001. FASD refers to a spectrum of disorders such as Fetal Alcohol Syndrome (FAS), Alcohol-Related Neurodevelopment Disorder (ARND), and Alcohol-Related Birth Defects (ARBD). These disorders are caused by a woman's use of alcohol during pregnancy, and are the leading known cause of mental retardation and birth defects in the U.S. and Canada. Each year, at least 40,000 children are born with an FASD in the U.S. alone, and our estimated national costs related to FASD exceed $6 billion. Symptoms of FASD include growth deficiencies and neurological damage, effects which are irreversible and lifelong. Effective education, prevention, and treatment strategies can greatly reduce and even eliminate FASD. Section 519D of the Children's Health Act of 2000 provides six mandates (42 USC 290bb-25d) defining the work to be done by the various centers for excellence:

1. Study adaptations of innovative clinical interventions and service delivery improvement strategies for children and adults with an FASD and their families.
2. Identify communities with exemplary comprehensive systems of care for such individuals so that they can provide technical assistance (TA) to other communities attempting to set up such systems of care.
3. Provide TA to communities that do not have a comprehensive system of care for such individuals and their families.
4. Provide training to community leaders, mental health and substance abuse professionals, families, law enforcement personnel, judges, health professionals, persons working in financial assistance programs, social service personnel, child welfare professionals, and other service providers on the implications of FASD and early identification of and referral for such conditions.
5. Develop innovative techniques for preventing alcohol use by women in childbearing years.
6. Perform other functions, to the extent authorized by the Secretary after consideration of recommendations made by the National Task Force on Fetal Alcohol Syndrome.

Where do we want to go?

The objectives of this initiative are to:

- Increase community awareness about FASD;
- Increase capacity to improve screening for/documentation of alcohol consumption among pregnant women and encourage referral to and participation in substance abuse treatment;
- Improve screening, diagnosis, intervention, and referrals to sustainable services in order to increase functioning and quality of life for individuals and their families affected by FASD; and

- Improve coordination of supports for individuals with an FASD.

How will we get there?

The FASD Center for Excellence is funded through a contract to meet its objectives through a five-part strategy of products and services:

1. **Training and technical assistance** designed to increase care capacity among individuals, programs, agencies, systems, and States
2. **Information dissemination**, including the development of an official Web site that acts as a primary resource on the issue of FASD, a call center to respond to training requests and other public inquiries, print and multimedia products for audiences ranging from consumers and educators to caregivers and policymakers, and an ongoing survey of the literature and the field in order to identify gaps and trends in the field, synthesize findings, and develop materials about FASD for health and social service professionals, communities, States, and tribal organizations
3. **Capacity building** through subcontracts with programs and agencies across the country who are formalizing and implementing promising interventions and treatment practices
4. **Partnerships** with states, local communities, and Federal agencies such as the Centers for Disease Control and Prevention (CDC) and the Interagency Coordinating Committee on Fetal Alcohol Syndrome (ICCFAS) of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and other organizations in order to provide support for program development and capacity building
5. **Building infrastructure and collaboration** by convening national meetings and summits on FASD, and also establishing and supporting organizations devoted to improved services for those affected by FASD, such as the Birth Mothers Network (BMN) and the National Association of FASD State Coordinators (NAFSC)

Funding Mechanism: Contract

How will we stay on course?

- **Measuring substantial change in State responsiveness to FASD**.
- Continuing to **review FASD-related interventions and practices** to identify those that are appropriate to be reviewed for the National Registry of Evidence-Based Programs and Practices (NREPP), SAMHSA's searchable database of interventions for the prevention and treatment of mental and substance use disorders.
- Continuing to **fund State and community prevention and treatment projects**, to screen and provide brief interventions for women at risk of an alcohol-exposed pregnancy or screened, diagnosed, and referred individuals with FASD for interventions.
- Continuing to **develop and provide training sessions** to diverse audiences throughout the United States.
- Expanding and updating the **Web-enabled, searchable database** containing more than 9,000 records of FASD literature, publications, posters, public service announcements (PSAs), and other materials.

- Funding Source
Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	$9,821,000	*
2009	$9,821,000	*
2010	*	*
2011	*	*
2012	*	*

- Contact:

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Last Update: 10/8/2009 4:08:34 PM

Children & Families

Interagency Working Group on Youth Programs (http://FindYouthInfo.gov)

Substance Abuse and Mental Health Services Administration

CSAP / DSD

Where are we now?

The Interagency Working Group on Youth Programs (Working Group) was established to improve the coordination and effectiveness of youth programs and to promote achievement of positive results for at-risk youth. The members of the interagency working group are from the following agencies: Department of Health and Human Services (Chair), Department of Justice (Vice-Chair), Corporation for National and Community Services, Office of National Drug Control Policy, Department of Agriculture, Department of Commerce, Department of Defense, Department of Education, Department of Housing and Urban Development, Department of Interior, Department of Labor, and Department of Transportation. One charge of the Working Group includes creating a Federal Interagency Web site on Youth that builds on past efforts. In addition, the Working Group is responsible for promoting enhanced collaboration at the Federal, State, and local level, as well as with community and faith-based organizations, schools, families, and communities; and identifying and disseminating strategies and practices that support youth and have been shown to be effective. The Working Group convened meetings in May 2008. In June 2008, the Working Group launched a monthly meeting schedule. In addition to its full meetings, the Working Group continues to work on tasks through conference calls, e-mail communications, task-focused meetings, and subgroup efforts. A contract was awarded on August 1, 2008 to KIT Solutions, LLC by SAMHSA for the development of the Web site, provide training and technical assistance to select users of the Web site, and assist in developing a marketing plan. SAMHSA was selected by the Working Group to perform this task because of its expertise in issuing Web development contracts. The contract will provide the Web site expertise and capacity to enable the Working Group to accomplish its goals and responsibilities.

Where do we want to go?

This project will involve creating a Federal Interagency Web Site on Youth, http://FindYouthInfo.gov. Included in the system was the development of a calendar of Federally-hosted announcements or events, including conferences, webinars, and other publicly accessible meetings. The content will assist the Web site's primary audience (youth-serving organizations and partnerships/coalitions at the community, state, and national levels, including schools) as well as secondary audiences (such as Federal Project Officers, state, and local public agency officials, and other stakeholders with an interest in supporting youth) in forming strategic partnerships to better serve and support youth in their communities and states.

How will we get there?

The launch of the new Web site will include the development and execution of a training and technical assistance plan for users who wish to learn how to maximize the features of http://FindYouthInfo.gov. A marketing plan will be developed and executed to promote the new and

enhanced Web site. This marketing plan will include an understanding of the primary and secondary users/audiences for http://FindYouthInfo.gov, as well as potential new categories of users. The Working Group also seeks to encourage youth-serving Federal and state agencies, communities, grantees, and organizations to adopt high standards for assessing program results, so that the most effective practices can be identified and replicated, and ineffective or duplicative programs can be eliminated or reformed. The Working Group will work to improve the Program Tool feature to promote high standards for assessing program results, including the use of rigorous impact evaluations, and to work toward a common understanding about program assessment and evaluation. The new http://FindYouthInfo.gov will not only include a searchable directory and will also link to Federally-hosted model program and evidence-based program directories. By providing one-stop access to these Federal directories, the new Web site will help users find evidence-based programs to consider replicating in their communities. SAMHSA's Immediate Office of the Administrator and CSAP are supporting HHS leadership in this effort.

Funding Mechanism: Contract

How will we stay on course?

The Interagency Working Group on Youth Programs will provide oversight and guidance. SAMHSA participation is contingent on continued funding from Interagency Working Group agencies. Estimated annual expenditure for all components of the Interagency Working Group on Youth Programs is approximately $1,600,000.

Overview Program/Project/Activity Management:

- Funding Source
  SAMHSA's financial contribution to the overall effort is 100,000.

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	$100,000	*
2009	$100,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 5:47:21 PM

Children & Families

National Underage Drinking Prevention Public Service Campaign

Substance Abuse and Mental Health Services Administration

CSAP / DSD

Where are we now?

Youth who begin drinking before the age of 15 are seven times more likely to develop alcohol problems as compared to those who wait until 21. Each additional year of delayed drinking onset reduces the probability of alcohol dependence by 14 percent. Students diagnosed with alcohol abuse were found to be four times more likely to experience major depression than those without an alcohol problem (NIAAA, 1997). Alcohol use is linked with youthful death by drowning, fire, suicide, and homicide. In particular, alcohol use among youth has been associated with considering, planning, attempting, and completing suicide (NIAAA, 1997 and 2000). SAMHSA recognizes that addressing underage drinking is a priority goal in the improvement of prevention services and the reduction of future substance abuse.

The purpose of this contract is to continue a national underage drinking prevention campaign in concurrence with the direction of the United States Congress and in consultation with the industry, advocates, and other interested parties for an underage drinking prevention public service campaign directed at parents. The campaign will target educational efforts to parents of children aged 9 to 15. It will identify and promulgate research-based public heath messages and activities, and support national and local media efforts to reduce underage drinking. A workgroup that includes representatives of the private and public sectors, including representatives from the industry and advocacy organizations working in the prevention of underage drinking, will advise the process and participate in a mutually acceptable, comprehensive public service campaign over the period of this contract.

Where do we want to go?

The goal of the National Underage Drinking Prevention Public Service Campaign directed at parents is to delay the onset of underage drinking and reduce underage drinking by increasing communication between parents and youth concerning alcohol issues and by encouraging parents to get others involved in the effort to prevent underage drinking. The National Underage Drinking Prevention Public Service Campaign will be designed to improve parents' awareness, understanding, and behavior around the importance of communication concerning the harms associated with underage drinking. The campaign will target parents in all parts of the nation and will include ethnically and racially diverse populations and rural populations.

How will we get there?

SAMHSA/CSAP working in collaboration with the Interagency Coordinating Committee to Prevent Underage Drinking, CSAP's Drug Free Communities Grantees, the newly awarded STOP Act grantees, and community-based coalitions across the Nation will expand the National Underage

Drinking Prevention Public Service Campaign to increase specific actions to be taken by parents and adults to reduce underage drinking and decrease adult conduct that facilitate underage drinking.

Funding Mechanism: Contract

How will we stay on course?

For the underage drinking prevention initiatives, SAMHSA/CSAP will assess program performance through monitoring GPRA and National Outcome Measures.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	*	*
2009	$1,098,642	*
2010	*	*
2011	*	*
2012	*	*

- Contact:

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Last Update: 10/8/2009 3:07:30 PM

Children & Families

Underage Drinking Prevention Education Initiatives

Substance Abuse and Mental Health Services Administration

CSAP / DSD

Where are we now?

Although alcohol is an illegal substance for persons under the age of 21, there are more than 10 million drinkers between the ages of 12 and 20. Children can establish their attitudes and expectations about alcohol as early as age 6. Alcohol advertising and family attitudes and use patterns affect these attitudes and expectations. To help prevent underage drinking, children and their parents/caregivers need age appropriate information about the physical and social consequences of alcohol consumption. This contract continues the Agency and Center's efforts in underage drinking prevention that supports children and their families by providing effective and appropriate prevention programs, activities, and strategies. In addition, it supports States and their communities by providing a mechanism to introduce training to get the community organized, build capacity, and plan for sustainability around the prevention of underage alcohol use. Approximately $17 million in funds over 5 years support more than 50 million families, their children, and other youth-serving organizations through technical assistance, guidance, suggested activities, information about promising approaches, and materials and tools that help activists and other concerned members of the community organize around underage drinking issues. The current contract became effective September 15, 2009.

Where do we want to go?

The Underage Drinking Prevention Education Initiatives contract will continue to expand on objectives set forth in the previous underage drinking prevention contract: 1) foster changes in American society that facilitate healthy adolescent development, and help prevent and reduce underage drinking; 2) engage parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences; 3) promote an understanding of underage alcohol consumption in the context of human development and maturation that takes into account individual adolescent characteristics as well as environmental, ethnic, cultural, and gender differences; and 4) work to improve public health surveillance on underage drinking and on population-based risk factors for underage drinking.

How will we get there?

In 2010, this contract will support a national forum to bring together States from the Governor’s level to begin a dialogue around State plans for addressing the underage drinking issue in each State. In addition, funds will be provided to support national town hall meetings to mobilize States and their communities, families, and youth with the opportunity to engage in discussion on the seriousness of underage drinking as a public health issue and the strategies needed to reduce and prevent youth alcohol use. The contract will work with the STOP Act Grantees to continue the synergy that was created through previous town hall meetings and the National Forum

in implementing appropriate activities and strategies to prevent underage drinking and to implement the strategies addressed in the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking.

Funding Mechanism: Contract

How will we stay on course?

For the underage drinking prevention initiatives, SAMHSA/CSAP will assess program performance through monitoring GPRA and National Outcome Measures.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,000,000	*
2006	$3,600,000	*
2007	$1,600,000	*
2008	$2,740,000	*
2009	$3,239,000	*
2010	*	*
2011	*	*
2012	*	*

- Contact:

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Last Update: 10/8/2009 2:57:27 PM

Mental Health System Transformation

Community Mental Health Services Block Grant

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Community Mental Health Services Block Grant (MHBG) is the largest single federal funding stream dedicated to improving mental health service systems across the country and helps support a public mental health system that serves 6 million persons per year. The MHBG was established in 1981 under Sections 1911-1920 of the Public Health Service (PHS) Act to provide comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance. The objectives outlined in statute are to: carry out the State plan for the fiscal year involved; evaluate programs and services carried out under the plan; and planning, administration, and educational activities related to providing services under the plan.

In 1982, the MHBG was administered by the National Institute of Mental Health (NIMH). In 1992, SAMHSA and CMHS were created under the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act, Public Law (P.L.) 102-321, which mandates oversight of the MHBG. The MHBG statute requires states to submit an annual comprehensive community-based mental health plan due by September 1 of each year to establish goals, objectives, and performance targets for their system and an annual implementation report due December 1 of each year to report on their achievement in these areas. Since FY 2007, an online automated system has been available for these submissions and to support the peer review process and ongoing oversight and review by the Project Officers.

States are also required to establish an independent Mental Health Planning Council, with mandated membership of state agencies, consumers, and family. The council reviews and advises on the mental health plan developed by the State Mental Health Agency, advocates on behalf of those in need, and monitors, reviews, and evaluates the allocation and adequacy of mental health services within the State. In 2003, States were asked to begin reporting data through the Uniform Reporting System on the number and characteristics of persons served using specific outcome measures (National Outcome Measures – NOMS) which increase program accountability.

Where do we want to go?

The goal of the CMHS MHBG is continued transformation of the public mental health system toward an integrated, community based, recovery focused and consumer driven system of service delivery. This goal is being pursued by continuing refinement of the CMHS MHBG Plan Guidance to direct States toward use of the concepts outlined above with planning, program implementation, and reinforcement of these concepts through on-site monitoring reviews and peer review of the MHBG Plans and Implementation Reports.

How will we get there?

The MHBG provides a flexible funding source to support infrastructure, service delivery, planning, and evaluation activities by the states toward development of a comprehensive community-based mental health service delivery system. The program also identifies needs and provides technical assistance to the states in a broad range of areas. The program provides statutory oversight of the states use of MHBG funds and encourages transformation through review of Plans and Implementation Reports and on-site monitoring reviews. The MHBG also requires collection and submission of data on 10 National Outcome Measures, including an efficiency measure, to assure accountability and efficiency of program operations. State Mental Health Planning Councils which are mandated by Statute to collaborate in the development of the MHBG Plan, advocate for mental health services, and monitor and evaluate state mental health services.

Funding Mechanism: Grant

How will we stay on course?

The Mental Health Block Grant underwent a performance assessment in 2003. The assessment cited clear purpose and need, effective performance measures, and sound management as strong attributes of the program. As a result of the performance assessment, the program conducted an independent evaluation.

The independent evaluation study of the program has been completed and a draft report is under review for tentative publication in late 2009. A pilot on the collection of client level data across all states for National Outcome Measures is also being conducted. A standardized data protocol for use in test data submission has been developed and a test data submission has been received by all states. The second submission will be received in September which will allow analysis of the client level data for measurement of the National Outcome Measures. A final report on the pilot will be completed by the end of the year which will summarize the extent to which client level outcome data could be reported as well as what resources would be needed to roll out client level data collection and reporting to all states.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Mental Health Block Grant

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$432,756,000	*
2006	$427,974,000	*
2007	$428,256,000	*
2008	$420,774,000	*
2009	$420,774,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/21/2009 11:34:34 AM

Mental Health System Transformation

Federal Partner Senior Workgroup (FPSWG) on Mental Health Transformation

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Federal Partnership on Mental Health is the alliance of Federal agencies forwarding the mental health agenda across the nation. Those agencies are: Department of Agriculture, Department of Defense, Department of Education, Department of Health and Human Services (Administration on Aging, Administration for Children and Families, Agency for Healthcare Research and Quality, Office of the Assistant Secretary for Planning and Evaluation, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health [including National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, and National Institute of Mental Health], Office for Civil Rights, Office on Disability, Office of Public Health and Science, Office of Personnel Management, and Substance Abuse and Mental Health Services Administration); as well as Housing and Urban Development, Department of Justice, Department of Labor, Social Security Administration, Department of Transportation, and Department of Veterans Affairs. The partnership develops concrete strategies, connects a transformed vision of a mental health system to the local, state, and national levels, and ensures that services are recovery-focused, consumer-oriented, and evidence-based. The first Federal Action Agenda was created in 2005 and involved 70 action steps. From these action steps the partners devised a more manageable way of monitoring critical areas, including creating 14 priority workgroups. The top five priority workgroups were: Suicide Prevention, Primary Care and Mental Health Integration, Financing Issues, Employment and Transition, and Disaster and Emergency Response (which was a result of Hurricanes Katrina, Rita and Wilma As a result of the current wars in Afghanistan and Iraq imposing more mental health issues and those veterans having difficulty accessing mental heath care, a sixth priority workgroup on the Reintegration of Returning Veterans and Their Families was created. The ongoing workgroups are:

- Consumer and Family Driven Care/Youth Guided Care
- Criminal/Juvenile Justice
- Homelessness and Housing
- Information Technology
- Public Education
- Research Activities
- State System Transformation
- Workforce Issues
- Federal National Partnership (FNP) for Transforming Child and Family Mental health and Substance Abuse Prevention and Treatment.

Some of the Federal Partner Initiatives completed are:

- Transforming Mental Health Care in America: The Federal Action Agenda – A Living Agenda (July 2008)
- Suicide Prevention Compendium of Federal activities
- Suicide Prevention Toolkits
- Compendium of Primary Care and Mental Health Integration
- Carter Center and Moorehouse University School of Medicines Center for Primary Care meeting entited "Making It Real: Integrating Primary Care and Behavioral Health in Community Based Settings
- Report on Reimbursement of Mental Health Services in Primary Care Settings

Where do we want to go?

The Federal Government has the opportunity to create positive change in transforming the mental health system by promoting shared responsibility for change at the Federal, state and local levels, and in the private sector. Cooperatively, we can create services that move the role of consumers and their families far beyond simply participating in the system…. they become the reason for the system. It is a bold and powerful idea that required dramatic change from the status quo. It required us to change the way we conceive, plan, finance and deliver mental health services. We want every consumer to have the opportunity for recovery.

How will we get there?

This unprecedented collaboration is reshaping the role the Federal government in implementing the call for a fundamental transformation of mental health services in America. It is breaking down the silos and creating an effective communication between Federal agencies, States and local agencies as well as the private sector. This work is improving our services to those with mental illness and their families, reflecting our commitment to make every segment of the nation's health care system reflect the essentiality of mental health for all Americans.

Funding Mechanism: Other

How will we stay on course?

Overview Program/Project/Activity Management:
- Funding Source
  Mental Health Systems Transformation

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	*	*
2009	*	*

Fiscal Year	Awarded Amount	Planned Amount
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 12:15:39 PM

Mental Health System Transformation

Mental Health Transformation State Incentive Grant

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Mental Health Transformation State Incentive Grant Program (MHTSIG) supports an array of infrastructure and service delivery improvement activities to help grantees - i.e., States, Territories, the District of Columbia, and/or federally recognized American Indian/Alaska Native Tribes or Tribal Organizations -¬ build a solid foundation for delivering and sustaining effective mental health and related services. These grants are unique in that they support new and expanded planning and development to promote transformation to systems explicitly designed to foster recovery and meet the multiple needs of consumers. The MHTSIG program was created to address the broad systemic change needed by State systems to respond to the needs of mental health consumers and families. The MHTSIG program supports State efforts to completely redesign how mental health services are delivered, with a focus on recovery from mental illness as the primary goal.

In the first year of the grant cycle, each grantee completed a needs assessment and resource inventory of their State system. This assessment included all agencies and organizations that offer mental health services and supports. The information was then used to build a Comprehensive Mental Health Plan (CMHP), which guides each grantee's transformation efforts. The grantee is responsible for updating their CMHP at the beginning of each fiscal year.

Where do we want to go?

MHTSIG grantees will create new and expanded planning and development to promote transformation to State systems explicitly designed to foster recovery and meet the multiple needs of consumers by considering the perspective of consumers, youth and family members. Transformation of the mental health system occurs only through the close collaboration of all systems that serve people with mental illnesses. The ultimate goal of the MHTSIG is to foster consumer independence and the ability to live, work, learn, and participate fully in their communities.

How will we get there?

In September 2005, SAMHSA awarded Mental Health Transformation State Incentive Grants to seven States: Connecticut, Maryland, New Mexico, Ohio, Oklahoma, Texas, and Washington. The following year, grants were awarded to two additional states: Hawaii and Missouri. Each State receives between $2.1 million and $2.7 million per year for 5 years. An independent evaluation of the MHTSIG program is being conducted. The evaluation will determine the extent to which the program achieves its goals within the grant period of transforming mental health systems and facilitating consumer recovery and resilience. It will also provide information regarding transformation activities that are effective and ineffective, and will document factors that

contribute to successful transformation in order to inform current and future transformation efforts of other States. SAMHSA is also funding a technical assistance center to coordinate and provide technical assistance to the MHTSIG grantees, including the exchange of knowledge and resources (listserv, website, conference calls, etc.), preparation of reports, site visits and onsite direct technical assistance.

Funding Mechanism: Grant

How will we stay on course?

The MHTSIG grantees are required to report performance data regarding infrastructure indicators on an annual basis. Indicators include the following:

- Percentage of policy changes completed as a consequence of the CMHP;
- Number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the CMHP;
- Percentage of financing policy changes completed as a consequence of the CMHP;
- Number of organizational changes completed as a consequence of the CMHP;
- Number of organizations that regularly obtain and analyze data relevant to the goals of the CMHP;
- Number of consumers and family members that are members of statewide consumer-and family-run networks, and;
- Number of programs that are implementing practices consistent with the CMHP.

Overview Program/Project/Activity Management:

- Funding Source

  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$19,840,000	*
2006	$26,012,000	*
2007	$26,003,000	*
2008	$26,012,000	*
2009	$26,012,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 10:13:38 AM

Mental Health System Transformation

National Technical Assistance Centers on Consumer/Peer-Run Programs

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Funded since 1992 the National Technical Assistance Centers on Consumer/Peer-Run Programs (TACs) directly facilitates SAMHSA's mission and vision of promoting recovery so individuals with mental illnesses live a full and rewarding life in the community. These centers transform mental health systems by fostering a recovery-oriented, consumer and family driven system of care. These approaches maximize consumer self-determination and recovery by assisting people to decrease their dependence on expensive social services and avoid inappropriate use of inpatient hospitalization. The TACs along with the Statewide Consumer Network Program are unique in that only consumer or consumer supporter organizations are eligible to apply and are directly funded for the purpose of strengthening the capacity of consumers/consumer supporters to assist in the transformation of the mental health system.

The TACs promote consumer participation in all aspects of policy and practice. They promote skills development for consumers with an emphasis on leadership, business management, accountability, evaluation skills and financial sustainability. They strengthen consumer organizations and leadership in communities and improve collaboration among consumers, families, advocates, providers, administrators, including coalitions to transform community mental health services and supports. The TACs increase opportunities for knowledge application and field- based skill building of self-management/self-help approaches. They increase consumer participation in all aspects of mental health transformation, including: planning, development, evaluation and policy formation.

The three consumer technical assistance centers rotate the hosting of the annual Alternatives Conference. The purpose of these conferences is to provide a national forum for consumers to meet, to exchange information and ideas, and to provide and receive technical assistance on peer-operated services along with other relevant topics such as peer support, consumer-operated services, self-help, protection and advocacy issues, empowerment and recovery.

Where do we want to go?

Consumer and family-driven approaches to transform mental healthcare in this nation are imperative. The TAC's are a fundamental means for SAMHSA to provide leadership to meet this need. Such approaches should be expanded to include the promotion of the following:

- support of employment programs and opportunities;
- the use of specially trained consumer college students to promote mental health and provide support on campuses;

- the use of Medicaid waivers at the state level for the hiring of peer supports for the provision of services;
- the integration of primary health and mental health with an emphasis on support of the SAMHSA/CMHS 10X10 campaign to reduce the public health crisis of early mortality experienced by mental health consumers;
- the use of asset development plans – which can be used to obtain further education, housing or operate individual businesses;
- expand consumer choice and control over home and community-based services to foster greater independence;
- the use and financial funding of community-based crisis services operated and run by consumers; and services for older adults, returning veterans and the criminal and juvenile justice system.

How will we get there?

In September 2007, 5 grants were awarded to the following national consumer and consumer supporter organizations: National Empowerment Technical Assistance Center (NETAC) , Mental Health Association of Southeastern Pennsylvania's National Mental Health Consumers' Self-Help Clearinghouse (NMHCSHC); Depression and Bipolar Support Alliance's `Peers Helping Peers'; Mental Health America (MHA) National Mental Health Association Consumer Supporter Technical Assistance Center (NCSTAC) National Alliance for the Mentally Illnesses NAMI Support, Technical Assistance, and Resource Center (STAR). The five TACs are funded for three years at a total of $1.8 million per year. This includes the annual funding of the Alternatives Conference which is hosted by one of the three Consumer TACs on a rotating basis .

Funding Mechanism: Grant

How will we stay on course?

SAMHSA will assess program performance through data drawn from relevant national outcome measures for infrastructure. The infrastructure measures will be extracted from the following domains: policy development; workforce development (number trained and level of satisfaction with training – CMHS training satisfaction form under development); financing organizational restructuring; accountability; types/targets of practices; and cost efficiency.

Overview Program/Project/Activity Management:
- Funding Source
  Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,984,000	*
2006	$1,961,000	*
2007	$1,961,000	*
2008	$1,927,000	*
2009	$1,927,000	*
2010	*	*

Fiscal Year	Awarded Amount	Planned Amount
2011	*	*
2012	*	*

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Last Update: 10/21/2009 11:41:17 AM

Mental Health System Transformation

Refugee Mental Health

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Since 1995, the Refugee Mental Health Program (RMHP) has been funded through an intra-agency agreement (IAA) with the Administration for Children & Families (ACF), Office of Refugee Resettlement (ORR) to provide refugee mental health consultation and technical assistance to ORR and other Federal, State, or local agencies. The IAA provides funding for one full-time Senior Public Health Advisor.

Where do we want to go?

The objectives of RMHP are:

- To facilitate collaboration among refugee service providers and public and private mental health providers, organizations, and systems.
- To provide technical assistance and consultation on refugee mental and behavioral health and well-being to ORR and refugee service provider organizations or agencies.
- To respond to emergencies of refugee admissions and other unique refugee- related assignments from the Office of the Director, ORR.

How will we get there?

To satisfy its goals, the RMHP Senior Public Health Advisor provides onsite and distance consultation and technical assistance; refugee community assessments; program development; dissemination of technical assistance documents; development and provision of workshops and training programs for resettlement staff, mental health personnel, or other providers; monitoring, technical assistance, and evaluation of torture treatment centers; and special missions as assigned by the ORR Director. Although ORR is funding the RMHP IAA through FY 09, determination by SAMHSA and ACF as to whether the IAA will funded beyond FY 09 has not been made..

Funding Mechanism: Other

How will we stay on course?

Performance outcome has been based on positive ORR customer satisfaction. Since 1995, RMHP has been funded through an intra-agency agreement with the Office of Refugee Resettlement, Administration for Children and Families, U.S. Department of Health and Human Servicesl.

Overview Program/Project/Activity Management:

- Funding Source
  Interagency Agreement with Administration for Children and Families (ACF)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$317,868	*
2006	$339,187	*
2007	$234,591	*
2008	$239,135	*
2009	$232,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 11:35:40 AM

Mental Health System Transformation

Services in Supportive Housing

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Services in Supportive Housing (SSH) program of CMHS was created to help end chronic homelessness by funding services for individuals and families experiencing homelessness while living with severe mental illness or a co-occurring mental and substance abuse disorder. The goal of the SSH is to provide treatment and support services to individuals and families in coordination with permanent supportive housing programs and resources. Services supported under the SSH funding include, but are not limited to, such program activities as outreach and engagement, case management, mental health and substance abuse treatment, and assistance in obtaining benefits. The SSH program focuses its attention on the provision of services in participants' housing facility as opposed to within various community-level settings. In this regard, special attention is paid to the type, dose and quality of services provided that seek to enhance the level of functioning and extended housing stability of program participants. The following (required) services are provided to participants in SSH funded programs: outreach and engagement; assertive community treatment or intensive case management; services to support housing retention; independent living skills (e.g., budgeting and financial education); motivational interventions; crisis care; assistance in obtaining income support and entitlements; mental health treatment; including treatment for trauma and post traumatic stress; substance abuse treatment; integrated/coordinated treatment for co-occurring disorders; medications management; and self-help programs. The following services are encouraged (allowable) under this program: discharge planning, employment, education and training, support services (including child care, family support, and parental skills training), services for children of homeless families, transportation, and psychosocial rehabilitation

Where do we want to go?

CMHS believe the SSH program to be an efficient tool for services and supports its existence and possible expansion. The following SSH program measures are of interest to CMHS: mental illness symptomatology, employment/education, crime and criminal justice, stability in housing, social support/social connectedness, access – number of persons served by age, gender, race, and ethnicity, rate of readmission to psychiatric hospitals. Data on the above measures are being collected at 3 points: baseline, 6 months and discharge. SAMHSA also expects data to be collected on the perception of care, cost effectiveness, and the use of evidence-based practices.

How will we get there?

There are 14 grantees in the SSH program. The first cohort of 9 grantees was awarded in FY 2007. They are located in New York, Missouri, Massachusetts, California, Oregon, Alaska and Washington, D.C. Three of these grantees are former grantees under the Collaborative Initiative to Help End Chronic Homelessness. In FY 2008 five additional grants were funded and are located in California, Florida, Georgia, West Virginia and Minnesota.

Funding Mechanism: Grant

How will we stay on course?

SSH grantees are also expected to report on the following evaluation elements:

- Outcome Questions: What was the effect of intervention on participants? What program/contextual factors were associated with outcomes? What individual factors were associated with outcomes? How durable were the effects?
- Process Questions: How closely did implementation match the plan? What types of deviation from the plan occurred? What led to the deviations? What effect did the deviations have on the planned intervention and performance assessment? Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$3,900,000	*
2008	$6,253,000	*
2009	$27,279,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 12:33:14 PM

Mental Health System Transformation

Statewide Consumer Network Grant Program

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Statewide Consumer Network Grant program builds on the work of the Community Support Program (CSP) which promotes the development of systems of care that help adults with serious mental illness recover, live independently and productively in the community, and avoid inappropriate use of inpatient services. This program promotes the use of consumers as agents of transformation to enhance State capacity and infrastructure to be consumer-driven and targeted toward recovery and resiliency. To date, over 50 consumer organizations have been recipients of a grant, providing training and tools in the development of individualized mental health plans, understanding the need and use of accountability and evaluation measures, and many self-help skills. Using these strategies, grantees provide the guidance and foresight into changing the present system to a recovery-oriented system for all peers. The Statewide Consumer Network Grant Program is unique in that consumer organizations are directly funded to enhance infrastructure development and implement the values of community support initiatives by promoting the consumer voice in policy, planning and program development activities in tandem with the National Consumer Technical Assistance Centers Grant Program.

Where do we want to go?

Statewide Consumer Networks are encouraged to work in partnership with their states' Mental Health Transformation State Incentive Grant programs and other transformation initiatives toward achieving common statewide consumer network goals. The program is designed to ensure that consumers are the catalysts for mental health and related system change in their State by strengthening coalitions among consumers, policymakers and service providers by expanding infrastructure development in the following activities.

- Improvement of community services to include creating individualized plans of care
- Developing anti-stigma initiatives
- Interacting with the criminal justice system
- Supporting employment programs
- Developing supports for returning veterans
- Improvement of cultural competence issues which include rights protection; responsiveness to diverse needs of racial and ethnic minorities
- Outreach to rural, minority, transition age youth and young adults, and older adult populations
- Policy development to improve and support establishment of standards of care
- Alternatives to seclusion and restraint
- Development/revision of credentialing, licensure, or accreditation requirements
- Tele-health education and other on-line supports, including the creation of personal recovery pages.

By leveraging their partnerships and expertise with other state and local initiatives, the Statewide Consumer Networks will enhance their sustainability planning to ensure they remain catalysts for systems improvement in planning, policy development and quality improvement.

How will we get there?

In October 2007, 20 grants were awarded to consumer organizations in the following states: Alaska, California, Connecticut, Georgia, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New York, Ohio, Oklahoma, Oregon, South Carolina, Texas, Vermont, and Virginia. The awards totaled almost $4.2 million over three years to help consumer organizations around the country work with policymakers and service providers to improve services for persons living with serious mental illnesses. Grantees sustained involvement in policy, planning and service delivery decision-making roles in FY 06 to FY 07, and increased consumer involvement by 16% from the previous year. Grantees will continue to receive targeted technical assistance and training to strengthen leadership, capacity building and other infrastructure development activity as well broaden collaboration and coordination of programmatic activities with the National Consumer Technical Assistance Centers Grant Program.

Funding Mechanism: Grant

How will we stay on course?

SAMHSA will access program performance through data drawn from relevant national outcome measures for infrastructure. The infrastructure measures will be extracted from the following domains: policy development; workforce development (number trained and level of satisfaction with training – CMHS training satisfaction form under development); financing organizational restructuring; accountability; types/targets of practices; and cost efficiency.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,500,000	*
2006	$1,500,000	*
2007	$1,500,000	*
2008	$1,531,000	*
2009	$2,531,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 12:36:08 PM

Mental Health System Transformation

Statewide Family Networks (SFN) Grant Program

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Statewide Family Network (SFN) Program is intended to ensure self-sufficient, empowered networks and family and youth leaders that will effectively participate in State and local mental health services planning and health care reform activities related to improving community based, family driven services for children and adolescents with serious emotional disturbances and their families. Families know what works for them, and it makes sense that they drive service delivery decisions. For programs, agencies, and systems to provide family-driven care, there must be a paradigm shift, and there must be administrative support to change behaviors and relationships. Developing, promoting, and supporting a commonly accepted definition of family-driven is a necessary step to view the decision making process differently; to act and interact in new ways; to feel comfortable with shared responsibility for decision making; and to own and believe in family-driven as the right way of working together.

Where do we want to go?

Although significant progress has been made over the past decade, continued support ensures that families are the catalysts for transforming the mental health and related systems in their State by strengthening coalitions and collaborative partnerships among and between family members, youth, policymakers, service providers and communities. The goals of Statewide Family Network Grants are to: 1) strengthen organizational relationships; 2) foster leadership and business management skills among families of children and adolescents with serious emotional disturbance; and 3) identify and address the technical assistance needs of children and adolescents with serious emotional disturbances and their families. To achieve this goal, the program assists family members around the country to work with policy makers and service providers to improve services for children and adolescents with serious emotional disturbances and their families. These goals are addressed though individual peer support and assistance which includes the provision of individualized information, referral to services, emotional support, and assistance in circumstances of crisis. The programs are valuable in accessing services, assisting in public agency meetings and hearings, outreaching to underrepresented populations, ensuring system transformation where SFNs are actively involved in policy development to support needed service system improvements. These activities may include rate-setting activities, establishment of standards of care, development/revision of credentialing, licensure, or accreditation requirements, and the dissemination of information about mental health disorders, services, systems, and other topics to groups of individuals.

How will we get there?

The Statewide Family Network Program builds on the work of the Child, Adolescent and Services Systems Program (CASSP), which helped to establish a child and family focus in programs serving children and adolescents with serious emotional disturbances around the country. The Statewide

Family Network Program is designed to facilitate a family-driven approach for transforming the mental health and related systems, recognizing that family members are the best and most effective change agents The SFN Grantee Program has a National Technical Assistance Center that works collaboratively with other partners to provide technical assistance, training, and resource dissemination to assist the SFNs to meet their mission and vision through program sustainability and leadership. This is accomplished by creating learning opportunities for staff, boards, leadership, and volunteers, disseminating resources to build capacity, assisting leaders with resources and training to enhance their capacity to serve as system transformation change agents. Last fiscal year, the National Center provided technical assistance to 46 states and their partners through 1622 encounters.

Funding Mechanism: Grant

How will we stay on course?

All SFN grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results Act (GPRA). During the federal fiscal year 2006-07 GPRA data was collected as specified by the Government Performance and Results Act for this program. The program provided data in response to the number of youth and family members served by Statewide Family Networks and the number of youth and family members from Statewide Family Networks participating on policy, planning and service delivery decision-making groups. The Networks reported a variety of services that assisted a very large number of family members and youth, serving an estimated 10,589 unduplicated youth and family members per site, for an estimated total of 391,782 unduplicated youth and family members. This count is an estimate based on the data reported from 38 of the Networks. The Networks also reported that youth and family members held 4,921 seats on numerous policy, planning and service delivery decision-making groups in FY 2006-07, an increase from 4,096 seats in FY 2005-06. The data for FY 07-08 is currently under analysis.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$3,341,000	*
2006	$3,352,000	*
2007	$3,332,000	*
2008	$3,274,000	*
2009	$3,705,000	*
2010	*	*
2011	*	*
2012	*	*

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Mental Health System Transformation

Transformation Transfer Initiative (TTI)

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

In a continued effort to assist States in transforming their mental health systems of care, SAMHSA and CMHS developed the Transformation Transfer Initiative (TTI). The TTI provides, on a competitive basis, modest funding awards to States, the District of Columbia, and the Territories not currently participating in the Mental Health Transformation State Incentive Grant (MHTSIG) program, or not having already received a TTI award in a previous year. (For additional information on MHTSIG, refer to the separate program summary.) The TTI relates to all of CMHS' programs in line with the CMHS Block Grant. TTI provides awards to States and Territories to support an array of infrastructure and service delivery improvement activities that are used to build a solid foundation for delivering and sustaining effective mental health and related services and new and expanded planning and development to promote transformation to systems that foster recovery and meet the multiple needs of consumers.

For FY 2009, CMHS will award TTI grants of $221,000 to 11 States or Territories. This funding is flexible in that it may be used to identify, adopt, and strengthen transformation initiatives and activities that can be implemented in the State, either through a new initiative or expansion of one already underway. The focus is on one or multiple phases of system change in the public mental health system of the State or Territory. This initiative was designed to complement the MHTSIG program with its inclusion of planning and infrastructure activities. Service initiatives may also be included for consideration under the TTI. More than 70% of the annual and total funding for the TTI Task Order goes directly to the States as awards in order to provide States with an additional resource to plan for, implement and report on transformative activities and their outcomes. The TTI provides ongoing technical assistance to the selected States to support their initiatives.

Where do we want to go?

The TTI is a means to continue the transformation of mental health care within the public mental health systems of States and Territories. This transformation effort began with the Mental Health Transformation State Incentive Grant (MHTSIG) program that offered significantly larger awards (over a 5-year period) to 11 States to support fundamental planning and infrastructure change. When it was clear that it would not be feasible (financially) to offer this opportunity to all the States and Territories as originally intended, the TTI was envisioned and crafted to facilitate (on a smaller scale) the transformation efforts of the remaining States over a 5-year period, while making use of the lessons learned from the original MHTSIG States.

How will we get there?

The TTI was developed utilizing the principles of the Community Mental Health Services (CMHS) Block Grant and other smaller CMHS initiatives that maximize and facilitate system change by

offering funding flexibility to the States, encouraging the leveraging of State and other funds, as well as building upon intrastate collaborations. This initiative also makes the most of a peer-to-peer network of MHTSIG and previous TTI States to provide technical assistance through sharing knowledge and experience gained from peer-to-peer support, informed planning and organizational principles that proved most successful in similar initiatives. Each grantee is required in their application to indicate the outcomes that are to be achieved and how they will be measured. The contractor for ITT issues requests for applications to all the eligible States and Territories (those not awarded T-SIG or TTI awards previously). Reviews of the applications are executed by the contractor and recommendations for selection are made to CMHS. Applications for the TTI are judged on the following criteria: Transformation readiness, demonstrated by examples of transformation initiatives already underway using State funds, CMHS Block Grant funds, other identified public or private resources; Existing multi-agency collaboration on transformation initiatives; Proposed initiatives rooted in systems change with the greatest quality impact; Identification of other State resources and infrastructure that allow for leveraging the TTI award funds for the proposed initiative; Consumer involvement/collaboration in the development, selection and review of the project proposal; and Realistic timeframes, concrete activities, and measurable outcomes for the proposed initiative. Awards are made and cooperative agreements are executed between the contractor and awardees.

The TTI in the previous fiscal year (FY08) was a modification of the National Association of State Mental Health Program Directors (NASMHPD) contract with SAMHSA/CMHS for technical assistance to the States (provided by the National Technical Assistance Center). For FY09 the TTI was successfully competed as an independent task order and awarded to NASMHPD. In FY08, 11 awards were made, each for $105,000. For FY09, 11 additional states are to receive awards, each for $221,000. The current contract is with NASMHPD for 5 years (base year/4 option years); the base year is for $3,090,000 per year for a total of $15,450,000. Seventy percent of this task order goes directly to the States and Territories. The planned end date for the task order is 09/29/13.

Funding Mechanism: Contract

How will we stay on course?

Each of the pilot TTI States developed specific outcome measures to track the success of their initiatives. From information included in the draft Final Report, outcome measures appear to have been successfully achieved.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	$3,080,000	*
2009	$3,090,000	*
2010	*	*

Fiscal Year	Awarded Amount	Planned Amount
2011	*	*
2012	*	*

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Last Update: 10/21/2009 11:12:27 AM

Mental Health System Transformation

Trauma-Informed Care

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The number of people in public mental health services with histories of violence and trauma (over 80 to 90%), and the lack of training for existing providers to effectively serve trauma survivors, led to the creation of CMHS' National Center for Trauma-Informed Care (NCTIC). Trauma-informed care (TIC) is a services delivery organization that is based on the assumption that everyone seeking public mental health services is a trauma survivor. Thus, unlike traditional services, trauma-informed care is focused on trauma as the key central issue to improving program efficacy and promoting health and recovery. NCTIC's purpose is to provide training, education and technical assistance, and consultation to assist states and community programs in the implementation of TIC. To date, requests for NCTIC consultation have far exceeded response capacity. In the past year, over 250 programs have been served directly. Currently, over 45 State Mental Health Authorities have established TIC within their state systems. Interest in trauma-informed care in the consumer/survivor communities has grown rapidly, not only in the service delivery end of peer support, but also in the role of peers in effecting trauma-informed systems change. Numerous requests for consultation also come, not only from mental health services, but from human service organizations across the public health spectrum. Current plans involve testing and further refining of knowledge about effective models for implementing trauma-informed care and integrating perspectives and voices of consumers/survivors in the organizational implementation process across the range of human services delivery systems.

Where do we want to go?

The core focus for NCTIC FY09 activities are: (1) provision of strategic technical assistance support to all State mental health authorities/systems (including executive, regulatory, advisory) in the implementation of TIC; and (2) provision of technical assistance support to consumer/survivors and peer groups (coalition-building, strategic partnership, planning, and peer support) to establish leadership in developing, monitoring, and evaluating TIC implementation into each state's transformation goals and objectives. At present, a number of Mental Health Transformation State Incentive Grantees have initiated TIC implementation. To meet this challenge, TIC knowledge is organized in a variety of ways, at different levels of complexity, to meet different needs of various target audiences and mesh with different learning styles and capabilities of stakeholders using the most cost effective approaches that yield the most successful results. TIC organizational change information will be systematically presented in a TIC Implementation Handbook. A series of "TIC Organizational Change Practicum" are planned for teams demonstrating readiness for change at the state and local level.

How will we get there?

An implementation agenda of TIC programming in support of transformation of mental health systems and organizations for FY09 includes five (5) different types of strategic activities: (1)

screening for TIC evidence-based findings and best practices; (2) synthesizing TIC knowledge into targeted communication and TA for various types of users; (3) organizing facilitated learning about TIC through TA and organizational consultation and follow-through; (4) building and strengthening existing networks and infrastructure for TIC implementation; and (5) using new TIC knowledge emerging from current activities to help shape future agendas.

Funding Mechanism: Contract

How will we stay on course?

NCTIC uses a series of accountability measures to assess program performance, including: the target number of state systems and local community programs to be served, the number of requests for NCTIC assistance (training, technical assistance, and ongoing TIC consultation), the number of requests deemed "actionable" for TIC implementation, the number of actionable TIC implementations completed, and the total estimate of providers and consumers served through each request.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$650,000	*
2006	$635,000	*
2007	$650,000	*
2008	$650,000	*
2009	$750,000	*
2010	*	*
2011	*	*
2012	*	*

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Mental Health System Transformation

Wellness / 10 by 10 Campaign

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

SAMHSA-supported studies have shown that Americans with mental illnesses die an estimated 25 years earlier than the general population. This alarming rate of early mortality is due to a variety of causative factors such as the following: a high prevalence of co-morbid chronic diseases including cardio-vascular illnesses; hypertension and diabetes; smoking; obesity; poverty; social isolation; lack of access to quality medical care; and others. These factors are complicated by the lack of integration of primary care with mental health care; lack of emphasis on prevention, mental health promotion, and consumer self-management; and negative public attitudes toward people with mental illnesses. In response to this public health crisis, in September of 2007, CMHS/SAMHSA convened a National Wellness Summit where the agency launched the "10 by 10 Campaign" to reduce early mortality by 10 years over the next 10-year time period. The focus of the Campaign is on providing education and awareness to treatment providers, consumers, administrators and researchers on how to achieve this goal. A Web site has been launched and a monthly Wellness Update of resources, research findings, and other information has been published. The Web site can be accessed at the following address: http://www.bu.edu/cpr/resources/wellness-summit/index.html. CMHS also sponsored a NASMHPD Medical Directors meeting to identify protocols and performance measures for mental health care facilities to better identify primary health concerns of consumers served.

Where do we want to go?

In FY 2009, CMHS proposes to expand its Wellness efforts by initiating a comprehensive educational program over the next five years. Target audiences and specific objectives include the following:

- For mental heath consumers, the objective is to acquire skills to better self-manage their own healthcare including prevention and promotion activities, smoking cessation, exercise, nutrition, etc.
- For mental health treatment providers, the objective is to improve their ability to monitor the physical health of those they serve and to work more effectively with primary care providers.
- For primary health providers, the objective is to improve their skills and knowledge when working with mental health consumers to better meet their physical healthcare needs.
- For program administrators and State and local officials, the objective is to acquire knowledge on how to implement effective practices and policies to improve the holistic outcomes of consumers served.
- For researchers, the objective is to increase their ability to identify effective practices to reduce early mortality and to improve surveillance of co-morbidity and mortality.

How will we get there?

Products will include a range of multi-media informational materials to meet the above objectives. These will range from specialized self-care and health promotion materials for consumers to data depositories for research findings. A series of trainings – via interactive Web-based audio-net presentations – will target the audiences listed above to assist with the adoption of needed practice and policy innovations. An annual Wellness Summit meeting will gather key stakeholders to chart progress, share learnings, and plan new initiatives. There are a range of public and private partners including but not limited to NASMHPD, provider and consumer organizations, HRSA, CMS, AHRQ, NIMH, managed behavioral health organizations, and many others. There are several compelling forces to motivate these groups to collaborate on the 10 X 10 Campaign ranging from ethical/moral considerations (to reduce early death) to financial (facilitating preventive care to reduce the cost burden of chronic diseases).

Funding Mechanism: Contract

How will we stay on course?

The reduction of early mortality experienced by consumers will be the major outcome to determine success. Other measures will include public outreach efforts, promotion of campaign materials to increase public awareness, and satisfaction and outcomes of trainings.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$100,000	*
2008	$50,000	*
2009	$350,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 9:57:41 AM

Suicide Prevention

Suicide Prevention Public Service Advertising Campaign

Substance Abuse and Mental Health Services Administration

OC

Where are we now?

Suicide prevention is a national public health priority. Currently, suicide is the 11th leading cause of death among all age groups in the United States, accounting for more than 30,000 deaths annually. Consequently, governments at the Federal, State, and local levels have sought to develop effective approaches to reduce suicide and the associated costs and consequences that burden society.

Where do we want to go?

As part of a national effort to reduce suicide, the Substance Abuse and Mental Health Services Administration (SAMHSA) is supporting a national public education campaign. This SAMHSA project done in collaboration with the Ad Council is developing a suicide prevention campaign targeting youth 15-20.

How will we get there?

This campaign is in the early stages of development - steps taken to date include: 1) Convening a Suicide Expert Panel (December 2006), 2) Participating in an Attempt Survivor Panel (January 2007), 3) Development of a Research Proposal (January 2007), and 4) Reconvening Expert Panel (11/7/08). SAMHSA's Office of Communications (OC) is working with the Center for Mental Health Services (CMHS) to ensure agency programs are aligned and support the National Strategy for Suicide Prevention: Goals and Objectives for Action, 2001. SAMHSA is collaborating with the Ad Council, DDB New York (Creative, pro-bono Agency), Inspire USA (providing research data and learnings from similar campaign conducted in Australia.)

Funding Mechanism: Contract

How will we stay on course?

Donated media and tracking studies will be used to gauge success of the public service advertising campaign.

Overview Program/Project/Activity Management:

- Funding Source
  Program Reserve

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$769,614	*
2008	$0	*
2009	*	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 5/11/2009 12:57:07 PM

Suicide Prevention

AI/AN Suicide Prevention

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

A decade ago, the Office of Technology Assessment noted that American Indian and Alaska Native (AI/AN) youth have more serious mental health problems than the general U.S. population, and limited access to mental health services in their home communities. More recent studies have found AI/AN youth to have suicide rates 2.4 times that of the U.S. population, with a suicide death rate among Alaska Natives 4.6 times higher than for all U.S. races. Suicide in Indian country too often affects entire communities, as young people may take their lives in clusters. For example, during a one month period in 2009, six young Native American youths died by suicide. Developing effective strategies for suicide and violence prevention in Indian country is an urgent public health need. In 2005, SAMHSA funded Native Aspirations, a training and technical assistance project that provides resources for tribal communities to mobilize existing social and educational resources to implement comprehensive and collaborative community-driven prevention plans that will reduce violence, bullying, and suicide among American Indian/Alaska Native youth. The project enhances pro-social and help-seeking behaviors among Native youth and their families, increases protective factors, and decreases risk factors that contribute to youth violence, bullying, and suicide. Since 2005, 25 sites have received services from the Native Aspirations program. Eight more sites are expected to be selected over the next five years.

Where do we want to go?

The purpose of Native Aspirations is to enhance pro-social and help-seeking behaviors among Native youth and their families and increase protective factors and decrease risk factors contributing to youth violence, bullying, and suicide. Communities receiving services include children, youth and their families living on American Indian tribal reservations and in Alaska Native villages. It is the mission of this program to reach as many native communities, individuals and families as possible and provide the most up-to-date and relevant services available to accomplish the program's goals as described above.

How will we get there?

For each of its communities, Native Aspirations:

- Conducts an introductory site visit to discuss the project's benefits, obligations, and activities, and to assist in establishing a project oversight panel.
- Conducts community readiness training to help the community develop and implement prevention programming that integrates culture and resources.
- Offers to conduct a Gathering of Native Americans (GONA) event onsite, providing a safe place to share, heal, and plan for action, offering hope and a positive start to communities.
- Conducts an onsite Community Mobilization and Planning (CMP) event with as many stakeholders as possible, such as tribal leaders, elders, youth, key service providers, and

representatives of local schools. The CMP enhances cross-collaboration with Indian Health Service, State, and National efforts, as well as community prevention efforts.
- Developed a guide titled: To Live To See The Great Day That Dawns: Preventing Suicide by American Indians and Alaskan Native Youth and Young Adults. This lays the groundwork for comprehensive community prevention planning.
- Provides financial support including the costs of bringing evidence-, practice-, and culture-based interventions and consultation to the communities.
- Provides ongoing technical assistance to facilitate the communities' implementation of their CMP.
- Passes a tribal/village resolution or executive order of support.
- Names a lead contact person and lead agency.
- Establishes a panel to oversee the planning, implementation, and evaluation of the project.
- Provides infrastructure to support the project.

Funding Mechanism: Contract

How will we stay on course?

Native Aspirations Communities are required to undergo a program assessment that requires communities to review and revise their plan for performance, conduct a needs assessment, evaluate community engagement, and monitor and evaluate the implementation of a Community Prevention Plan, among other assessments. Performance Results:

- NA1 (the first cohort) served 9 communities (58,980 Tribal members in 6 communities and 1,955 Alaska Natives in 3 villages).
- In NA1 communities, community readiness scores rose 36 percent, enabling suicide prevention programs to be implemented. The three communities least ready to implement programs improved up to 50–80 percent.
- NA2 (the second cohort) served 16 additional communities (88,490 Tribal members in 5 communities and 741 Alaska Natives in 2 villages).
- NA3 (the third cohort) served 9 additional communities (52,264 Tribal members).

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,000,000	*
2006	$795,000	*
2007	$2,200,000	*
2008	$2,918,000	*
2009	$2,944,000	*
2010	*	*
2011	*	*

Fiscal Year	Awarded Amount	Planned Amount
2012	*	*

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Last Update: 10/21/2009 11:46:15 AM

Suicide Prevention

Garrett Lee Smith Campus Suicide Prevention Grant Program

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Approximately 12.5 million college students attend more than 3,400 schools in the United States (Brindis & Reyes, 1997). The American College Health Association found that 61 percent of college students reported feeling hopeless; 45 percent said they felt so depressed they could barely function; and 9 percent felt suicidal. Forty-four percent of students surveyed at 4-year colleges reported drinking heavily during a two week period (Wechsler, Lee, Kuo, & Lee, 2000). These problems have significant implications for students' lives, academic performance, and behavior. In addition to the increased need for mental health services on college campus, there is an increasing need to prevent suicides. An estimated 1,088 suicides occur among college students each year (National Mental Health Association [NMHA] & The Jed Foundation [JED], 2002).
The complex problem of suicide and suicidal behaviors on campuses demands a multifaceted, collaborative, and coordinated response. A prevention program cannot rely solely on campus counselors or community mental health centers. Where campus resources alone are insufficient to provide prevention, intervention, and treatment services, the planning process needs to include agencies and helping institutions from the broader community. In 2005, Congress passed the Garrett Lee Smith Suicide Prevention Act (GLS) in memory of Garrett Smith, son of Senator Gordon Smith who died by suicide while at college.

The purpose of the Campus Suicide Prevention Grants Program is to provide funding to support grants to institutions of higher education to enhance services for students with mental and behavioral health problems, such as depression, substance abuse, and suicide attempts which can lead to school failure. Since 2005, 72 grantees have been funded and served as cohorts I and II of this grant program. In FY 2008, Congress provided funding to 16 additional grantees to serve as cohort III. To date, the Campus Suicide Prevention Program has made great strides in its efforts. In 2008 alone, 681,425 students were exposed to mental health and suicide awareness campaigns on college campuses. Additionally, 74% of students surveyed on grantee campuses are aware of at least one place to refer a suicidal peer, faculty who had participated in suicide prevention activities were significantly more aware of suicide risk and prevention, and students who had been exposed to suicide prevention materials have demonstrated significantly greater awareness of suicide risk and prevention.

Where do we want to go?

The purpose of the GLS Campus Suicide Prevention Grant program is to increase protective factors that promote mental health on college campuses, reduce risk factors for suicide among students, reduce suicides and suicide attempts among students and reduce school academic failures. The long-term goals of this program are to:

- Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention;
- Advance mental health with the same urgency as physical health;
- Improve access to quality care that is culturally competent; and
- Improve access to quality care in rural and geographically remote areas.

How will we get there?

All grantees are required to match Federal funding received to fund the program. Campuses build a public health infrastructure for their overall suicide prevention efforts through one or more of the following activities:

- Training students and campus personnel to respond effectively and make appropriate referrals for students in crisis or at risk for mental health problems and suicide.
- Creating a networking infrastructure to link the institution with mental health providers from the broader community if comprehensive services do not exist on campus.
- Providing educational seminars for students and campus personnel—for example, preventing suicide, identifying risk and protective factors, promoting help seeking, and reducing the stigma of seeking mental health care.
- Operating local hotlines or promoting the National Suicide Prevention Lifeline (1-800-273-TALK).
- Providing informational materials for campus personnel, students, and students' families to increase awareness of mental and behavioral health issues.

Funding Mechanism: Grant

How will we stay on course?

Grantees will be required to report performance on infrastructure development and will be required to assess their projects annually. This local evaluation will be designed to help determine whether grantees are achieving the goals, objectives, and outcomes of the project and whether adjustments need to be made to the project. The local annual project evaluation of process, outcomes, and activities will include consulting with interested families and students. The evaluations will be designed to provide regular feedback to the project that can translate into informed decision-making and ongoing project improvement. The following are examples of outcome and process questions that will be utilized in the local evaluations:
Outcome Questions

- What was the effect of training on participants?
- What program/contextual factors were associated with outcomes?

Process Questions

- How closely did implementation match the plan?
- What types of deviation from the plan occurred?
- What led to the deviations?
- What effect did the deviations have on the planned training and performance assessment?

- Who provided (program staff) what prevention services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

All grantees will also be required to participate in a cross site evaluation. To support implementation of the cross-site evaluation, grantees will receive training and technical assistance from the suicide prevention evaluation contractor. The cross-site evaluation will entail participating in training events, completing data reports/inventories, data entry, applying for and receiving Institutional Review Board clearance, respondent identification, and utilizing a Web-based database.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,500,000	*
2006	$4,945,000	*
2007	$4,950,000	*
2008	$4,913,000	*
2009	$4,975,000	*
2010	*	*
2011	*	*
2012	*	*

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Suicide Prevention

National Suicide Prevention Lifeline

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Suicide takes the lives of more than 32,000 Americans every year and is the 11th leading cause of death in this country. Although suicide prevention hotlines have been providing crisis intervention and referral services in this country for 40 years, their reach does not extend to all areas of the country. Historically, hotlines are diverse, with some also offering face-to-face client services in the context of hospitals or community mental health centers, while others are stand-alone, hotline-only organizations. Some hotlines are primarily staffed by trained, lay volunteers who are supervised by clinical staff, while others are staffed entirely by licensed mental health professionals. Whether hotlines are certified or licensed depends on their structure and the laws and regulations within their States. The National Suicide Prevention Lifeline is a network of independent, certified telephone crisis services located across the United States linked by several national, toll-free numbers (primarily 1-800-273-TALK/8255). Persons in emotional distress or suicidal crisis can access the Lifeline network 24/7 from any location and be connected to the crisis center geographically closest to them. Funding to link the crisis centers into the national network is provided by CMHS; the crisis centers themselves are independently funded. Networking on this scale provides the opportunity to increase access to services, enhance counselor training, develop and disseminate best-practices (including risk assessment and emergency response) protocols, and implement data collection standards to permit the evaluation of client- and community-centered outcomes that have not been previously pursued. As of April 2009, the Lifeline's network included 139 crisis centers in 48 States. Until the crisis centers in the remaining States join the Lifeline network, crisis centers from neighboring States provide coverage. Lifeline has also celebrated the following accomplishments:

- Responded to 513,298 calls in 2008.
- Partnered with the Department of Veterans Affairs to use 1-800-273-TALK to link veterans to a specialized VA-staffed call center and to more than 150 Suicide Prevention Coordinators in VA Medical Centers across the country. Approximately 300 callers use the service daily.
- Evaluated hotline services with a team from Columbia and Rutgers Universities. Results were published in the June 2007 issue of Suicide and Life-Threatening Behavior.
- Developed suicide risk assessment standards for crisis centers to ensure proper identification and risk assessment of suicidal callers. One hundred percent of the crisis centers are implementing the standards. Currently developing guidelines for intervention with callers at imminent risk.
- Developed and disseminated educational materials to raise awareness of suicide prevention and to promote Lifeline nationally, including 500,000 wallet cards with suicide warning signs.
- Collaborating with social networking Web sites in promoting Lifeline among younger populations. Users who mention "suicide" in their posting to http://Help.com receive a response from Lifeline.
- Launched Lifeline Caller in Summer 2008 to raise awareness and provide a space for sharing of stories of hope and recovery.

- Conducted a two-day action summit May 2009 to develop plans for using new media for suicide prevention, intervention and postvention by educating and supporting new media users.
- Facilitated a one-day roundtable discussion with suicide attempt survivors to gain information about the most effective methods to reach and serve them.
- Established a Native American initiative to build relationships with Tribes, and crisis centers serving American Indian tribes in Montana, Wyoming, North Dakota, South Dakota and Minnesota.
- A Spanish language sub-network was established to provide help to the Spanish-speaking community.

Where do we want to go?

The National Suicide Prevention Lifeline seeks to increase and improve access to crisis programs for those in need, improve client follow-through with intervention plans, encourage a consistent and clinically accepted approach to interventions by hotline workers, and use response protocols and data collection standards to permit the evaluation of client- and community-centered outcomes not previously pursued. Although the Lifeline strives to make services and assistance available to everyone in need, its primary target populations are people at high risk for suicidal behaviors, suicide attempt survivors, veterans, people concerned about loved ones at risk for suicide, and Native Americans/Alaska Natives.

How will we get there?

Section 520A of Public Health Service Act authorizes Lifeline's activities to prevent suicide within the public health model. Congress has appropriated funding for a national suicide prevention hotline since 2001. In FY 2008, SAMHSA funded six networked crisis centers in a new National Suicide Prevention Lifeline Crisis Center Followup Grant Program. The purpose of this 3-year program is to promote systematic follow-up of suicidal persons who call the Lifeline in an effort to develop, document, and evaluate best practices to ensure that suicidal people are able to access the life-saving services they deserve. Collaborating agencies and organizations include the Department of Veterans Affairs (VA). The VA contracts with Lifeline to manage the VA Suicide Prevention Hotline infrastructure, provides related services and works closely with SAMHSA in co-marketing the Hotline. The American College of Emergency Physicians distributes consensus suicide warning signs and materials for suicide attempt survivors and their families to more than 5,000 emergency departments across the country.

Funding Mechanism: Grant

How will we stay on course?

As noted, independent evaluators from Columbia University are conducting an ongoing evaluation of the Lifeline network. Results from the evaluation will be analyzed and integrated into the system for quality improvement. Evaluators are currently designing the evaluation protocol for the Crisis Center Follow up Grant Program.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$2,200,000	*
2006	$2,600,000	*
2007	$2,900,000	*
2008	$5,080,000	*
2009	$5,522,000	*
2010	*	*
2011	*	*
2012	*	*

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Suicide Prevention

State and Tribal Youth Suicide Program

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Suicide is the third leading cause of death for children and youth between the ages of 15 and 24. According to SAMHSA's latest National Survey on Drug Use and Health, in the last year, an estimated 900,000 youth nationwide made a plan to commit suicide during their worst or most recent episode of major depression; 712,000 attempted suicide during such an episode. From 1952 to 1995, the rate of suicide among children and young adults tripled. From 1980 to 1997, the rate of suicide among youth age 10 to 14 increased 109 percent. More recent studies have found American Indian/Alaskan Native youth to have suicide rates 2.4 times that of the U.S. population, with a suicide death rate among Alaska Natives 4.6 times higher than for all U.S. races.

The National Strategy for Suicide Prevention states, "Suicide prevention is a complex problem. It intersects public health (especially injury prevention), mental health, and substance abuse. It requires commitment from education, justice, and social services, and it requires the commitment of various private sector groups.…" Authorized under the 2005 Garrett Lee Smith Memorial Act, the State/Tribal Youth Suicide Prevention and Early Intervention Program builds on the foundation of earlier SAMHSA suicide prevention efforts to support states and tribes in developing and implementing statewide and tribal youth suicide prevention and early intervention strategies grounded in public-private partnerships. Since the program's inception, 61 states, tribes and tribal organizations have been awarded 3-year grants to implement prevention activities in a diverse range of settings, including schools, foster care and juvenile justice. Primary program activities include direct prevention services such as gatekeeper training, public awareness campaigns, engaging caregivers, voluntary screening of youth at risk for suicide and follow-up with youth who have attempted suicide.

Preliminary data gathered from the Garrett Lee Smith (GLS) State & Tribal cross-site evaluation indicate:

- 176,855 individuals have been trained in youth suicide prevention by the GLS grantees cumulative through September 2008.
- 13,618 youth have been screened through GLS-supported activities cumulative through September 2008.
- 2,220 youth screened positive for suicide risk and 98 percent of those youth were referred for additional services including: mental health assessment, tutoring/academic counseling, crisis hotline, psychiatric hospitalization, emergency room or mobile crisis units, and substance use assessment or treatment.

While a cross-site evaluation is in its preliminary stages, anecdotal information from the first cohort of grantees discloses significant early accomplishments.

- Gatekeeper Training: In 6 months, one site conducted 63 gatekeeper trainings, with nearly 1,600 participants. Their goal is to train more than 14,000 people, including child welfare

and juvenile justice staff, foster parents, educators, nurses in regional health departments and college faculty and students. Another grantee reported that requests for trainings at one site have increased by nearly 50 percent and that nearly 1,000 school and college personnel and another 2,280 students and adults have received gatekeeper training.
- Public Awareness: Over 15,000 people attended suicide prevention presentations at meetings of school boards, civic organizations, faith-based groups, and other community organizations.
- School Projects: Another grantee reports that five schools developed collaborations with local crisis agencies to participate in the program; representatives of each of the schools received gatekeeper training.
- Collaborations: One grantee developed a state youth suicide prevention task force that includes representatives from six tribal nations; two urban Indian agencies; faith-based organizations; law enforcement; public health, schools, and universities; mental health, general health, and substance abuse treatment providers; and suicide prevention advocates, families and survivors.
- Follow-up of youth suicide attempters: One grantee provides an Emergency Department intervention with youth who have attempted suicide, as well as an in-home follow-up of youth attempters. Both interventions are utilizing programs currently in the National Registry of Evidence-based Practices and Programs that they are adapting for use with an American Indian population.

Where do we want to go?

The State and Tribal youth Suicide Prevention program seeks to reduce youth suicide and suicide attempts and continually evaluate and improve current youth suicide early intervention and prevention efforts.

How will we get there?

To accomplish the State and Tribal Youth Suicide Prevention program's goals grantees are expected to complete the following activities:

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

Funding Mechanism: Grant

How will we stay on course?

The State and Tribal Youth Suicide Prevention program staff, along with partners at the Suicide Prevention Resource Center and Macro International, provide continuous technical assistance to grantees through regular phone and email communication, and site visits to grantee locations. In addition, grantees are expected to continuously collect and report data about their local evaluation activities, and are required to participate in the cross-site evaluation conducted by Macro International Incorporated.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$6,924,000	*
2006	$17,820,000	*
2007	$20,835,000	*
2008	$32,394,000	*
2009	$32,394,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 12:46:06 PM

Suicide Prevention

Suicide Prevention Assessment and Resource Kit (SPARK)

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Reports by the Institute of Medicine and the World Health Organization reveal the magnitude and impact of suicide, citing it as the cause of death for more than 30,000 Americans and more than 1 million persons worldwide each year. These reports, as well as the President's New Freedom Commission on Mental Health report and the U.S. Department of Health and Human Services' National Strategy for Suicide Prevention, call for intensified efforts to reduce the loss of life and suffering related to suicide. The priority populations targeted in this contract reflect significant areas of national concern for suicide prevention. For youth aged 10-24, suicide is the third leading cause of death (CDC, 2005). A rise in youth suicide in 2004 has increased the already substantial concern nationally regarding the tragedy of youth suicide (CDC, 2004). Suicide among veterans has also been an area of significant concern, with as many as 5,000 veterans per year dying by suicide, according to the Department of Veteran's Affairs Office of the Inspector General (VA, 2007). This means that 15% of all suicides in the United States annually are attributable to veterans. While there has been an increasing focus on preventing suicide in youth in the past several years with the passage and funding of the Garrett Lee Smith Memorial Act, much less attention has been given to preventing suicide among those in mid-life or among older adults. Yet, more suicides occur among those in midlife than among any other age group, with these rates increasing. Suicide among those aged 45-54 increased by 20% from 1999 to 2004 (CDC, 2008). The highest rates of suicide have historically been among older adults, with the death rate of those over 75 remaining the highest of any age group.

When looking at the settings in which targeted populations can best be reached for suicide prevention and mental health promotion activities, schools and primary health care settings are important for youth. Primary health care settings are also significant for reaching those at risk throughout the lifespan. Studies have estimated that approximately 45% of all those who die by suicide have seen a primary health care clinician in the month before their suicide. In addition, many who are at risk have been seen in hospital Emergency Departments. For those in midlife, the workplace is a major untapped resource for suicide prevention activities, and for older adults, senior living communities are important additional venues for suicide prevention.

The Suicide Prevention Branch (SPB) supports an array of initiatives designed to increase public and professional awareness of suicide as a preventable public health problem and to enhance the ability of stakeholders in the community to promote prevention and intervention. The Branch's suicide prevention initiatives have grown significantly over the past few years, from a budget of $6 million that supported two programs in 2001, to its current budget of $36 million, which supports seven major programs. Each program in the SPB portfolio advances the National Strategy for Suicide Prevention. The overall objective of this contract is to develop, test and disseminate tools to be used in varied service settings for mental health promotion, suicide prevention, and early intervention with populations at high risk for suicide.

Where do we want to go?

The SPARK seeks to: 1) identify best practices including awareness materials, educational and training programs, protocols, and policies with populations (youth, veterans, middle-aged individuals and older adults) at high risk for suicide; 2) incorporate lessons learned from the best practices into a toolkit, with components tailored for specific at-risk groups within specific settings; and 3) increase the capacity of schools, veterans service organizations, primary care professionals, employee assistance programs and senior living communities to implement suicide prevention and early intervention programming in their respective settings.

How will we get there?

In Years 1 and 2 of the contract, a toolkit will be developed for Older Adults in senior living communities and Youth in school settings through a contract that was awarded on August 28, 2008. Data will be collected to determine the use and utility of the SPARK, and the actual or potential impact on organizations' and professionals' capacity to meet the needs of the at-risk target populations. A web-based survey will be utilized to capture participant responses. This contract will add to the suicide prevention initiatives supported by the Suicide Prevention Branch. It is anticipated that depending on available funding, a total of five toolkits will be developed with each component targeting one of the specific targeted populations identified earlier.

Funding Mechanism: Contract

How will we stay on course?

This SPARK contract is newly funded and it is expected that these funds will support the development of evidence-based toolkits for several populations at-risk for suicide. Materials in the toolkit will be a combination of summaries of state-of-the-art knowledge, easy-to-use tools and educational materials created by the contractor.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	$1,916,000	*
2009	*	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 12:07:32 PM

Suicide Prevention

Suicide Prevention Resource Center

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Suicide Prevention Resource Center (SPRC) was established in 2001 and then authorized in 2005 to be part of the Garrett Lee Smith Memorial Act (GLSMA), which was passed by Congress in memory of the son of United States Senator Gordon Smith, who died by suicide while at college. The SPRC plays a critical role in advancing a comprehensive, coordinated, and innovative national suicide prevention effort as outlined in the National Strategy for Suicide Prevention:Goals and Objectives for Action (NSSP) and Achieving the Promise: Transforming Mental Health Care in America. This program promotes implementation of the National Strategy for Suicide Prevention and enhances the Nation's mental health infrastructure by providing States, tribes, government agencies, private organizations, colleges and universities, and suicide survivor and mental health consumer groups with access to the science and experience that can support their efforts to develop programs, implement interventions, and promote policies to prevent suicide.

The Center provides customized technical assistance and information support to SAMHSA's State/Tribal Youth Suicide Prevention and Early Intervention Program; Campus Suicide Prevention grantees funded under the GLSMA; and to state, territorial and tribal suicide prevention coordinators and coalition members. Additionally, SPRC furnishes suicide prevention support through telephone and email (877-GET-SPRC and info@sprc.org), connecting visitors to prevention specialists who provide individual consultation and reach out to a variety of coalitions working in communities, states, territories, and tribes across the entire nation.

The latest annual assessment found that, among other accomplishments, the Suicide Prevention Resource Center:

- provided 473 episodes of technical assistance services to grantees and state and tribal coordinators and coalitions;
- responded to 177 additional requests for information and referrals;
- added 8 suicide prevention programs to the SPRC/AFSP Best Practices Registry;
- delivered community core competency training 11 times to a total of 282 people in 9 states;
- delivered the Assessing and Managing Suicide risk core competency training for mental health clinicians 66 times to 3259 participants;
- added 178 resources to the SPRC suicide prevention on-line library and added 481 items to its physical library;
- developed 7 new products;
- sent a weekly e-mail newsletter to 2100 subscribers and received more than 377,800 website visits;
- released, with the National Association of State Mental Health Program Directors, the report, *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority*, and developed *Suicide Prevention in Juvenile Correctional Facilities: A Curriculum for State Agency Directors;*
- served about 12,600 unique visitors to its Web site each month, or 151,000 per year;

- conducted regional planning meetings with all 50 States to promote comprehensive suicide prevention planning in State and local systems; and,
- developed and piloted a training curriculum for physicians on discharge planning for emergency room doctors following treatment for a suicide attempt patient.

Where do we want to go?

The overarching goals of the SPRC are: 1) enhance the size and capacity of the suicide prevention workforce; 2) create a national network of communities of practice by connecting regional, State, and local networks, organizations, and practitioners engaged in suicide prevention; 3) create and disseminate resources; 4) support mechanisms for implementing the public health approach to suicide prevention; 5) broaden participation in suicide prevention activities and integrate suicide prevention into existing activities and programs; and 6) continue to advance the goals and objectives of the National Strategy for Suicide Prevention.

How will we get there?

To accomplish its goals, the SPRC:

- Provides technical assistance to grantees of the Garrett Lee Smith Suicide Prevention Program;
- Develops and implements training on suicide prevention products, materials services, and health promotion strategies to enhance and promote effective suicide prevention and early intervention;
- Assists States, territories, and tribes in their efforts to plan for the development, implementation, and evaluation of suicide prevention programs;
- Collects and disseminates information on best practices of suicide prevention; and
- Supports the field of suicide prevention by developing and providing access to needed resources for suicide prevention activities.

Funding Mechanism: Grant

How will we stay on course?

SPRC will efficiently and effectively manage resources toward accomplishing project goals. They will track and evaluate their work to ensure compliance with project goals using the following tools:

- Technical assistance service database—tracks individual clients, organizations, and episodes of technical assistance and informational services provided to clients and organizations;
- Regular Budget Review; and Assessment of technical assistance episodes to determine satisfaction of key stakeholders with SPRC's services and produced a report which was sent to SAMHSA.

The SPRC communicates regularly with SAMHSA. SPRC meets weekly with project officers as requested to review progress, set priorities and make decisions about issues related to SPRC's work. SPRC also began meeting biweekly with the SAMHSA communications contractor and

communicates regularly with the cross-site evaluation team and with Lifeline. SPRC also seeks guidance from the steering committee on SPRC activities, progress and the direction of work.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$2,976,000	*
2006	$3,954,000	*
2007	$3,960,000	*
2008	$4,913,000	*
2009	$4,957,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 11:45:55 AM

Homelessness

Projects for Assistance in Transition from Homelessness (PATH)

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

In 1990, the Stewart B. McKinney Homeless Assistance Amendments Act authorized creation of Projects for Assistance in Transition from Homelessness (PATH), a formula grant program designed to address the needs of individuals with serious mental illness (SMI) who are experiencing homelessness, are at risk of homelessness, or experiencing a co-occurring SMI and substance use disorders. PATH connects individuals who otherwise would not receive services to critical services and resources to assist in their recovery. PATH funds community-based outreach, mental health, substance abuse, case management, and other supportive services, as well as a limited set of housing services in over 480 programs from all 50 states, the District of Columbia, Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, and the Northern Mariana Islands.

In an average week, an estimated 637,000 adults are homeless in America. Of these, approximately 20 - 25% have serious mental illnesses. Through outreach alone, PATH contacted over 142,000 individuals in 2007 and enrolled more than 82,000 individuals in PATH services. Of those enrolled, 64% were first contacted on the streets or in shelters, 9% were veterans, 58% experienced a co-occurring substance abuse disorder in addition to a serious mental illness, and 58% were literally homeless with almost 20% having been homeless for over a year.

Where do we want to go?

Over the next two years, the PATH program will initiate efforts to transform its data systems. In addition, the program will continue to provide what makes PATH so unique – conducting literal outreach to those individuals with serious mental illness who are experiencing homelessness – individuals who would otherwise go without recovery-oriented services. Efforts will focus on PATH program outcome measures to ensure that the program meets new OMB targets, which will support the viability of the program at the Federal level. In addition, PATH will work to redesign the data system to provide real outcomes for consumers while still providing State and Federal data to ensure program accountability and sustainability. Through these efforts, we will improve our ability to evaluate the PATH program and services at the local and national levels.

How will we get there?

Definitions have been developed for PATH eligibility and enrollment which will result in providing consistency across states and territories, improving methods to increase eligibility determinations on the streets by non-clinical staff, and reducing barriers to enrollment. Collaboration with other Federal agencies, national organizations and state and local partnerships will be imperative for making a difference in the lives of the individuals served. CMHS will work to encourage the ongoing development of these partnerships, as well as look for new opportunities. PATH has an ongoing

partnership with the Department of Housing and Urban Development (HUD) to develop reporting definitions and to identify outcomes and outputs for PATH and HUD outreach services. CMHS will continue to work collaboratively with the Veterans Administration on the national, state, and local levels to address the needs of veterans on our streets and to be prepared for the expected surge of veterans from the current conflicts. An increase is expected in the level of physical, emotional, and cognitive disability for returning veterans who will experience homelessness. PATH providers and State contacts will continue to work to ensure that services are coordinated and available to veterans experiencing homelessness. At the State and local levels, CMHS will work with grantees in local and regional planning efforts to end homelessness, as well as with primary care professionals to increase the focus on integrating mental health and primary care.

The new PATH Web site will be a vehicle for improved communication among PATH providers nationwide and will increase our ability to exchange ideas, best practices, and tools to improve workforce skills and knowledge. The Homelessness Resource Center Web site, which hosts the PATH Web site, has tools and communication methods that reach out to a younger audience in order to sustain our workforce.

Funding Mechanism: Grant

How will we stay on course?

PATH underwent a performance assessment in 2002. The assessment cited strong clear purpose, appropriate design, and progress toward performance goals as strong attributes of the program. As a result of the performance assessment, the program is collaborating with the Department of Housing and Urban Development on performance measures, conducting an independent evaluation, and evaluating its technical assistance component.

In addition, PATH will take the following actions:

- Embark on a long-term strategy to implement intensive technical assistance activities to work with the States on strategies and best practices for increasing their performance on the PATH national outcome measures;
- Launch initiatives with Federal partners to send a unified message to the states encouraging mutual outreach and increasing coverage in their communities; and
- Evaluate the SSI/SSDI Outreach, Access and Recovery (SOAR) technical assistance initiative.

Overview Program/Project/Activity Management:
- Funding Source
Center for Mental Health Services - Projects for Assistance in Transition from Homelessness (PATH)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$54,809,000	*
2006	$54,223,000	*

Fiscal Year	Awarded Amount	Planned Amount
2007	$54,261,000	*
2008	$54,313,000	*
2009	$59,687,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/21/2009 11:51:36 AM

Homelessness

Development of Comprehensive Drug / Alcohol and Mental Health Treatment Systems for Persons Who are Homeless (Treatment for Homeless)

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

In the United States, as many as 750,000 persons are homeless at any point in time. Individuals who experience substance use disorders or prolonged psychiatric disability are greatly overrepresented among the population living in shelters and on the streets. Approximately one-third of Americans who are homeless have serious mental disorders, substance use disorders, or both, and these disorders often co-occur with other health problems.

CSAT initiated the Treatment for Homeless program (also known as "Grants for the Benefit of Homeless Individuals") in 2001 to enable local communities to expand and strengthen treatment services for persons who are homeless who also have substance use disorders, mental disorders, or co-occurring substance use and mental disorders. The purpose of the program is to help homeless persons find stable housing and provide them with treatment services for alcohol, substance use disorders, and co-occurring disorders. The primary goal is to link treatment services with housing programs and other services (e.g., primary care).

From 2001-2003, the program awarded grants for a three-year period. Beginning in 2004, SAMSHA extended the grant period to 5 years to help communities develop more stable systems. Through FY 2008, SAMHSA awarded 162 grants, with 112 active grants as of October 2008. Grantees may receive up to $400,000 annually for up to five years. The Center for Substance Abuse Treatment funded all grants awarded in 2001-2002. Beginning in FY 2003, The Center for Mental Health Services (CMHS) also provided funding for this program. CMHS funds support ten of the current 112 grants.

In 2006, within the Treatment for Homeless program, SAMHSA set aside funds to award grants specifically to serve persons who are chronically homeless – that is, unaccompanied homeless individuals with a substance use disorder, mental disorder, or co-occurring substance use and mental disorder, who have either been continuously homeless for a year or more or have had at least four episodes of homelessness in the past three years. Nine of 23 grants awarded in FY 2006 were awarded specifically to serve this population.

Similarly, in 2008, SAMHSA expanded the program to provide services in supportive housing (SSH) grants and set aside funds for this purpose. SSH supports services for clients already in housing that is permanent, affordable, and linked to health, mental health, employment, and other support services that provide homeless consumers with long-term, community-based housing options. This approach combines housing assistance and intensive individualized support services to chronically homeless individuals with substance use disorders, mental disorders, or co-occurring substance use and mental disorders. Twelve of the 25 Treatment for Homeless grants awarded in 2008 were for services in supportive housing.

The Treatment for Homeless and SSH grants are complementary approaches that provide a comprehensive response and support the implementation of effective, evidence-based practices. The combination of the two approaches allows SAMHSA to support communities in reaching their homeless populations in need of services for substance use and mental health disorders wherever they are found, whether in supportive housing or other community-based settings.

Where do we want to go?

The Treatment for Homeless program contributes to the reduction of homelessness in the United States by enabling communities to develop effective treatment systems for homeless persons who also have substance abuse disorders, mental disorders, or co-occurring disorders. Grantees must use funds to provide:

- Direct treatment services;
- Outreach and other strategies to increase participation in, and access to, treatment services to the target population;
- Case management or other linkage strategies to connect clients with and retain clients in housing and other necessary services; and
- "Wrap-around" and recovery support services designed to improve access to and retention in services and to continue treatment gains.

Grantees may also use funds to provide:

- Education, screening, and counseling for hepatitis, HIV/AIDS and other sexually transmitted infections;
- Trauma-informed services, including assessment and interventions for emotional, sexual, and physical abuse; and
- Employment readiness, training, and placement.

How will we get there?

SAMHSA will continue to support the Treatment for Homeless program. In FY 2009, SAMHSA anticipates funding up to 33 new awards, of which approximately 13 will be specifically for the provision of services in supportive housing. The President's budget request for FY 2010 includes approximately $9.8 million for 24 new awards. SAMHSA supports its grantees through a variety of technical assistance resources, including on-site training and other assistance, online and printed informational materials, a website, and annual grantee meetings.

SAMHSA works with other Federal agencies such as Health Resources and Services Administration, the Department of Housing and Urban Development, and the Department of Veterans Affairs in developing its homeless programs and in providing assistance to grantees.

Funding Mechanism: Multiple

How will we stay on course?

SAMHSA holds Treatment for Homeless grantees accountable for meeting performance targets, including:

- Target number of clients served;
- Number of enrolled clients who receive follow-up interviews at six months post-admission; and
- Grantee success in achieving outcomes in accord with SAMHSA National Outcome Measures, which include: increased abstinence from use of illegal drugs and alcohol, improved housing stability, and increased employment.

Grantees are also required to use evidenced-based practices to serve clients.

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$32,300,000	*
2006	$34,500,000	*
2007	$34,800,000	*
2008	$42,500,000	*
2009	$42,750,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 6/11/2009 4:04:02 PM

Older Adults

Older Adults Targeted Capacity Expansion Program

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Almost 20 percent of older adults experience specific mental disorders that are not part of "normal" aging. With the aging of the baby-boomer generation, the number of older adults with mental illness is expected to double to 15 million in the next 30 years. The suicide rate for older persons is 50 percent higher than all other age groups. Mental illness in older persons is often more difficult to diagnose and treat than in younger persons because of higher co-morbidity with other physical diseases and conditions. Unrecognized or untreated, mental illness and alcohol and drug misuse and abuse, can be severely impairing and costly.

The purpose of the Older Adults Targeted Capacity Expansion (TCE) Grant Program is to help communities provide direct services and build the necessary infrastructure to support expanded services for meeting the diverse mental health needs of older persons. The target population of older adults is defined as persons 60 years and older who are at risk for or are experiencing mental health problems. Concerned about the need to provide evidence-based care to address the mental health needs of older adults, in 2002, SAMHSA provided $3.6 million in funding to the Older Adults TCE grant program. Nine programs were funded for FY 2002-2005 at approximately $400,000 per year. In 2005, a second cohort of grantees was funded at $4.4 million per year for FY 2005-2008, which provided funding for 11 sites throughout the country at approximately $400,000 per year for three years.

These programs have served older adults from diverse backgrounds throughout the country including: Latino elders in urban and rural areas; Native American older adults; seniors who are Holocaust survivors and their families; and gay, lesbian, bisexual and transgender older adults. Several programs have addressed identification and engagement of older adults into mental health services by training over 5,000 community members to recognize and refer older adults in need of mental health intervention. A peer support training program was developed to address the need for culturally and linguistically appropriate services for Vietnamese elders with a history of trauma and refugee experiences. An innovative program used a community garden to engage seniors into a program which significantly decreased symptoms of depression and diabetes.

Where do we want to go?

Managing care for older adults is more compassionate, effective, and less costly when services are delivered in a proactive manner through outreach, integrated primary care and referral to specialized mental health care when appropriate. The objectives of the program are to demonstrate the efficacy of implementing evidence-based practices to identify, engage and treat older adults with mental health disorders. A specified portion of grant funds must be used for infrastructure development which is intended to address system transformation and sustainability of programs.

How will we get there?

After competitive grant review, in September 2008, ten additional programs were awarded up to $415,000 per year for three years to continue to implement evidence based demonstration programs and practices to address the mental health needs of older adults in a diverse variety of settings and locations. A technical assistance program helps grantees to implement evidence based practices, infrastructure development and program sustainability.

Funding Mechanism: Grant

How will we stay on course?

SAMHSA assesses the Older Adults TCE Program performance through TRAC ("Transformation Accountability," a Web-based database system for capturing program performance data), which includes accountability and outcome measures. Accountability measures include the target for number of clients served. Outcome measures include the following: clients' functioning, stability in housing, employment and education, crime and criminal justice status, perception of care, and retention in treatment.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$4,960,000	*
2006	$4,903,000	*
2007	$4,900,000	*
2008	$4,814,000	*
2009	$4,814,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 9:34:59 AM

Older Adults

Substance Abuse Prevention Older Americans Technical Assistance Center

Substance Abuse and Mental Health Services Administration

CSAP / DSD / PTAB

Where are we now?

This activity supports SAMHSA's Matrix area focus on older Americans and CSAP's priority area for older adults. CSAP awarded a new contract in FY 2009 supporting the Substance Abuse Prevention Older Americans Technical Assistance Center, a Service-to-Science initiative to:

- Increase the number of substance abuse prevention evidence-based practices (EBP) for older Americans by modifying EBPs from other sources.
- Complete the Evidence-Based Implementation Curricula for Older Americans initiated under a prior CSAP contract.

Currently there are few evidence-based substance abuse prevention programs for older Americans (prescription/illicit misuse and abuse, and alcohol in combination with medications). By working with the program developers of existing evidence-based community/health programs, CSAP will test to assess the program's effectiveness when adding a substance abuse prevention component. Another crucial part of this initiative is to complete Evidence-Based Implementation Curricula for Older Americans. This online curriculum will guide users through the steps needed to successfully implement an evidence-based program to prevent substance misuse/abuse in older Americans.

The first Substance Abuse and Mental Health Services Administration's Older Americans Technical Assistance Center mission (which ended in FY 2008) was designed to enhance the quality of life and promote the physical and mental well-being of older Americans by reducing the risk for and incidence of substance abuse/misuse and mental health issues later in life. Through partnerships with State and Federal agencies and health and social service providers, the Center served as a national repository to disseminate information, training, and direct assistance in the prevention and intervention of substance abuse/misuse and mental health disorders.

SAMHSA is dedicated to the prevention and treatment of substance abuse/misuse and mental health disorders within the older adult population. SAMHSA's Office of Applied Studies had recently released two studies showing that older Americans are binge drinking and that illicit drug use among "baby-boomers," including the abuse and misuse of prescription medication, is on the rise. The significant impact of these disorders on the health and functioning of older people, their families, and communities and the associated increases in health care use and costs demonstrate a critical need for the identification, organization, dissemination, and implementation of evidence-based substance abuse prevention and intervention programs in this area.

Where do we want to go?

CSAP will work with states/communities and health and social service providers by providing technical support through SAMHSA's contract mechanism. The success of the base year contract will determine how to best provide technical assistance around implementation and evaluation of evidence-based practices for older Americans and how to finish the curriculum portion for the "Guide for Implementing Evidence-Based Practices to Prevent Substance Abuse and Mental Health Problems among Older Adults," started under the original Substance Abuse and Mental Health Older Americans Technical Assistance Center. In addition, this contract will provide technical assistance to existing geriatric health promotion programs to increase the number of evidence-based programs that focus on substance abuse prevention for older Americans.

How will we get there?

The contract will identify, create, and implant effective strategies for substance abuse prevention among older adults. The products and services will be finalizing the curriculum around evidence-based practices implementation and evaluation for Older Americans along with a technical assistance plan.

Collaborators for this effort will be the Administration on Aging and the National Council on the Aging and this proposed effort will work closely with SAMHSA sister centers that have done work around evidence-based practices for Older Americans. CSAP also anticipates working with the CDC on this effort.

Funding Mechanism: Contract

How will we stay on course?

This proposed effort will align itself closely with SAMHSA's National Outcomes Measures related to older Americans. Contract project staff will meet weekly with the selected contractors to ensure compliance with contract provisions and to resolve issues that are identified.

Overview Program/Project/Activity Management:

- Funding Source

  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$300,000	*
2006	$300,000	*
2007	$700,000	*
2008	$0	*
2009	$400,000	*
2010	*	*
2011	*	*
2012	*	*

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HIV/AIDS & Hepatitis

HIV/AIDS Related Mental Health Services in Minority Communities

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Mental health complications (psychiatric/psychological/psychosocial) frequently are not diagnosed or addressed either at the time of diagnosis with HIV/AIDS or through the course of the HIV/AIDS disease process. As the incidence of HIV/AIDS increases among people of color, the need for mental health treatment goes up as well. 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. The primary focus of the program is to provide specific HIV-related mental health treatment for individuals who are HIV positive, many of whom have a DSM diagnosis. Each project incorporates the provision of culturally competent services to promote mental health and prevent mental and behavioral disorders, and link the client to family members, dependents, parents or partners that are included within the care plan for the primary consumer. Provision or linkages to a comprehensive array of services is required, including case management and primary care services. The projects include 16 grantees across a variety of settings nationally – AIDS service organizations, mental health clinics, primary care settings, substance abuse treatment and academic health settings, each expanding mental health care in minority communities. In the initial 2 years of the current cohort (2006-2010) approximately 70% of the consumers are African American and 30% are Hispanic; approximately 2,000 individuals have been engaged in mental health services.

Where do we want to go?

Mental Health HIV Services Collaborative MHHSC grantees expand access to care and provision of mental health services to persons with HIV/AIDS and mental health disorders improving the outcomes for service recipients and individuals with HIV/AIDS who frequently otherwise cannot access these services. Expanded care assists individuals to adhere to complex chronic HIV/AIDS care regimens and to have meaningful lives in the community, reduce depression and anxiety, and encourage positive behavioral changes. Consumer involvement assures relevance and acceptability of services. The increased number of HIV-related mental health service providers in communities of color serve more individuals, educate individuals about mental health and early intervention, and link individuals to comprehensive care helping meet unmet health needs.

How will we get there?

Services required to achieve outcomes include:

- Culturally, linguistically competent HIV/AIDS-related mental health services;
- Mental health assessment, treatment, and support services that are provided both in clinical venues, as well as in "non-traditional" settings such as in the home or in other culturally-

defined arenas in which support may be given (e.g. places of worship, markets, schools, cultural centers, or other places where people gather);
- Case management services to coordinate the provision of comprehensive HIV/AIDS and related mental health care;
- Psychiatry services with HIV/AIDS-related expertise, including evaluation, consultation, psychotherapy, and psychopharmacology;
- Establishment/maintenance of Consumer Advisory Boards (CAB) that are representative of the target population, to offer meaningful guidance to project activities;
- Linkages with other community providers who may serve the target population, such as substance abuse treatment centers, primary and specialty care clinicians, public health centers. Providers are strongly encouraged to provide HIV rapid testing or by linkage to another provider.

An independent cross-site evaluation is being conducted and is designed to add to the body of knowledge about community-based organizations offering mental heath services to people of color living with HIV/AIDS. Reports from the evaluation will help those organizations expand and improve their capacity to provide high quality culturally competent mental health services. These efforts will offer support to services provision in communities of color relative to health challenges. Technical assistance is provided by CMHS across the range of topics to refine provision of care, linkages, partnerships, CAB development and sustaining services.

Funding Mechanism: Cooperative Agreement

How will we stay on course?

Grantees report on the SAMHSA-defined key priority areas relating to mental health (GPRA domains): functioning, employment, education, crime and criminal justice, stability in housing, retention in care, social connectedness, and consumer perception of care to reflect the achievement of performance targets. CMHS is utilizing a web-based GPRA data collection and reporting system called Transformation Accountability (TRAC). Grantees submit their GPRA data electronically using the TRAC system, including data at baseline (i.e., the client's entry into the project), periodic reassessments and at discharge. Data is produced in real time reports. TRAC entry began in 2007. Over 2,000 clients have been served, and of which 70% are African American and 30% are Hispanic consumers

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$9,300,000	*
2006	$9,300,000	*
2007	$9,300,000	*
2008	$9,300,000	*
2009	$9,300,000	*
2010	*	*

Fiscal Year	Awarded Amount	Planned Amount
2011	*	*
2012	*	*

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Last Update: 10/9/2009 12:19:29 PM

HIV/AIDS & Hepatitis

Minority AIDS Initiative (MAI)

Substance Abuse and Mental Health Services Administration

CSAP/DCP/CGPDB

Where are we now?

The Minority AIDS Initiative (MAI) was created in FY 1999 when the Congressional Black Caucus initiated a partnership with the Department of Health and Human Services (HHS) to significantly increase the national response to the HIV/AIDS epidemic in racial and ethnic minority communities. The purpose and mission of the MAI is to increase the access of racial and ethnic minority communities to HIV prevention at the forefront of the HIV/AIDS epidemic providing prevention, care, and treatment services. The primary focus of this program is to address the HIV/AIDS crisis facing racial and ethnic minorities by identifying strategies that specifically target the highest-risk and hardest-to-serve populations, which for the past two decades have eluded more traditional HIV/AIDS prevention, treatment, and education efforts.

SAMHSA's MAI Initiative focuses on the role that substance abuse plays in the spread of HIV transmission and provides services to meet three overarching goals: (1) increase the access of racial and ethnic minority communities to HIV prevention, care, and treatment services; (2) implement strategies and activities specifically targeted to the highest risk and hardest-to-serve populations; and (3) establish collaboration for affected populations and communities across the United States. CSAP operates a program as part of SAMHSA's MAI Initiative which addresses the prevention of the risk behaviors associated with substance abuse and HIV transmission including HIV screening and testing for sub-populations at greatest risk for HIV transmission. CSAP's grant program is designated as the Minority Substance Abuse/HIV Prevention Initiative. The stated purpose of this program is to enhance and expand substance abuse prevention services in conjunction with HIV/AIDS services in African American, Latino/Hispanic, and/or other racial and ethnic communities highly affected by the twin epidemics of substance abuse and HIV/AIDS. In FY 2009, CSAP funded five new cooperative agreements and continued funding 135 grants under the Minority Substance Abuse/HIV Prevention Initiative.

Where do we want to go?

CSAP will continue to work to implement the Minority AIDS Initiative created in FY 1999 by the Congressional Black Caucus to significantly increase the national response to the HIV/AIDS epidemic in racial and ethnic minority communities. CSAP's program management experiences has indicated that implementing the Strategic Prevention Framework (SPF) is an important element in accomplishing this goal. Moving SAMHSA's SPF from vision to practice is a strategic process that community key stakeholders must undertake in partnership with multiple agencies and levels of government. CSAP envisions the adaptation of the SPF as a required expectation for 135 grantee organizations in 26 states to carry out the five steps. CSAP will work to infuse the purpose of MAI goals to increase access of substance abuse and testing to at-risk racial and ethnic minority communities to reduce substance abuse and HIV rates and make referrals to care and treatment service.

How will we get there?

While grantees have substantial flexibility in designing their grant projects, all are required to base their projects on the five steps of the SPF to build state-of-the-science Substance Abuse and HIV/AIDS prevention capacity for their targeted at-risk racial/ethnic minority populations. CSAP proposes to mandate HIV testing requirement of grantees in all future Request for Announcements applications to detect early diagnosis of HIV disease of at-risk minority populations and make referrals for support care and treatment.
CSAP has created a data system to capture valuable information on grantee profiles of the types and kinds of evidence-based prevention practices being implemented across the U.S. CSAP has provided many data training and technical assistance sessions to its grantees and Project Officers in face-to-face trainings and webinars. This type of strategic planning continues to move the field toward excellence in bringing grantees online to improve timely data reporting submission and by monitoring grantees' performance.

Funding Mechanism: Cooperative Agreement

How will we stay on course?

The SAMHSA/CSAP Substance Abuse and HIV Program is anticipating that as the funding for the Cohort 6 five-year initiative ends on September 30, 2010, more robust, measurable outcomes will become available to inform future planning efforts on substance abuse and HIV prevention activities. Grantees must evaluate their projects and are required to develop an evaluation plan that must include both process and outcome measures. In addition, grantees are using two online reporting data submissions. Grantees are required to report on SAMHSA's National Outcome Measures (NOMS) to assess individual and/or community level changes as appropriate to each grantee's project.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS); HHS Secretary's Reserve

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$39,800,000	*
2006	$39,400,000	*
2007	$39,400,000	*
2008	$39,300,000	*
2009	$41,400,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 4:20:39 PM

HIV/AIDS & Hepatitis

Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

The first cases of AIDS were reported in the U.S in 1981. Since then approximately 1.7 million people are estimated to have been infected with HIV in this country, and more than 1.1 million are estimated to be living with HIV/AIDS today. Racial and ethnic minorities have been disproportionately affected by HIV/AIDS, and represent the majority of new AIDS cases (70%), new HIV infections (54%), people living with HIV/AIDS (65%), and AIDS deaths (72%) (CDC, 2006).

To address the disproportionate impact of HIV/AIDS on ethnic and racial minority groups, the Minority AIDS Initiative (MAI) was created in 1999 and resulted in a $166 million appropriation which was distributed across eight Federal agencies, including SAMHSA. With MAI funds, the Center for Substance Abuse Treatment has awarded a total of $550 million (since 1999) through the Targeted Capacity Expansion for HIV (TCE/HIV) program. The purpose of the TCE/HIV program is to enhance and expand substance abuse treatment, outreach, and pretreatment services in conjunction with HIV/AIDS services for African American, Latino/Hispanic, and/or other racial or ethnic communities affected by the twin epidemics of substance abuse and HIV/AIDS. Target populations include women and their children, adolescents and youth, injection drug and other illicit drug users, men who have sex with men, and individuals who have been released from prisons and jails.

From 2000 to November 2008, CSAT's TCE/HIV program served approximately 115,800 individuals. Of these individuals, approximately 56% were males, 43% females and 1% transgender individuals; and about 76% were between the ages of 25 and 54 years. Approximately 27% identified themselves as Hispanic/Latino in ethnicity; 54% as non-Hispanic Blacks, 20% white, 2.9% Asian, Native Hawaiian or Pacific Islander, and 2.7% as American Indian.

Where do we want to go?

TCE/HIV grants are funded to increase access and availability of treatment or outreach services to a larger number of clients or improve the quality and/or intensity of services by adding state-of-the-art treatment approaches, or adding a new service to address emerging trends or unmet needs. TCE/HIV grantees are expected to use their grant funds to provide quality and timely services within a comprehensive, integrated, creative and community-based system of care for substance abuse and HIV/AIDS. TCE/HIV grantees are also expected to provide referrals for sexually transmitted diseases, tuberculosis, and hepatitis B and C treatment by developing linkages with organizations with experience in providing services to ethnic and racial communities.

The TCE/HIV and HIV Outreach projects demonstrate that they are an effective and integral part of a network of substance abuse treatment services providers. Outreach and pretreatment programs provide pretreatment services to clients which includes referrals and facilitation of entry into substance abuse treatment. Services are verified and tracked at the required 6-month intervals. Pretreatment services include brief interventions such as providing literature and other materials to support behavior change, facilitating access to drug treatment, HIV/AIDS testing and counseling services, plus other medical and social services available in the local community.

How will we get there?

In FY 2008, SAMHSA awarded 50 new TCE/HIV grants totaling approximately $21 million a year for five years ($105 million over 5 years). Combined with 76 continuing projects, the CSAT portfolio of TCE/HIV grants now consists of a total of 126 projects. For FY 2009, CSAT expects to award approximately seven new grants. Average awards range from approximately $450,000 per year for substance abuse treatment services to approximately $350,000 a year for outreach and pretreatment services. Grantees are community- and faith-based organizations, state and local governments, federally recognized American Indian/Alaska Native tribes and tribal organizations, urban Indian organizations, and public or private universities and colleges. An evaluation of the new cohort will be conducted by an independent contractor to identify best practice delivery models, cost effectiveness, process and outcome measures, and implementation barriers.

To identify new cases of HIV and refer them to care, recent grantees are required to offer all program participants rapid HIV testing and complete HIV rapid testing for a minimum of 80% of participants who do not know their HIV status. CSAT is working closely with the Centers for Disease Control and Prevention through a Memorandum of Agreement to develop a web-based rapid testing guide for use in substance abuse treatment settings.

CSAT has developed collaborations with other federal agencies including the Health Resource and Services Administration and the National Institute of Drug Abuse (NIH) to coordinate efforts to address treatment and behavioral risk factors for HIV/AIDS among high risk groups.

Funding Mechanism: Multiple

How will we stay on course?

The currently active grants have served 16,243 clients as of April 27, 2009. Outcomes from intake to 6 month follow-up are as follows:

- Clients reporting no substance use have increased 53.0%
- Clients reporting no arrests have increased 5.2%
- Clients reporting being employed have increased 54.1%
- Clients reporting being socially connected have increased 1.8%
- Clients reporting being housed have increased 22.8%

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$63,300,000	*
2006	$63,100,000	*
2007	$62,500,000	*
2008	$63,130,000	*
2009	$66,000,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 6/11/2009 4:24:35 PM

Criminal & Juvenile Justice

Jail Diversion Initiative

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Approximately 800,000 persons with serious mental illness are admitted annually to U.S. jails. Moreover, among these admissions, 72 percent also meet criteria for co-occurring substance use disorders. As community-based mental health services have failed to keep pace with demand, law enforcement departments and jails have become de facto service providers to persons with co-occurring disorders. Over the past two decades, jail diversion programs have emerged as a viable and humane solution to the criminalization and inappropriate criminal detention of individuals with mental disorders.

CMHS developed two programs to address this issue. In FY 2002, 34 grants were awarded under the Targeted Capacity Expansion (TCE) Grants for Jail Diversion Program. All of the grantees participated in a multi-site evaluation. Evaluation results and other data have been used to demonstrate improvements from implementing jail diversion to both public health and pubic safety and reductions in cost to the community. As a result, three of every four projects are sustained when grant funding ends.

A significant finding has been the pervasiveness of trauma exposure and trauma related disorders among program divertees (91.1% have experienced physical and/or sexual abuse during their lives). In FY 2007, CMHS reoriented the program to focus on people with trauma related disorders (PTSD, depression, and anxiety disorders) and revised the name to the Jail Diversion and Trauma Recovery Program-Priority to Veterans program. The reoriented program supports local implementation and statewide expansion of trauma-integrated jail diversion programs to reach individuals with PTSD and trauma related disorders. Veterans were prioritized due to higher incidence of these disorders. This program requires states to pilot test a program in one or two communities to divert veterans and others with PTSD to comprehensive, trauma integrated treatment and recovery supports. Six five-year grants were funded in 2008 under 520a of the Public Health Service Act, as amended.

Where do we want to go?

CMHS anticipates releasing a new Jail Diversion and Trauma Recovery RFA and making additional awards in 2009.The National Center for Trauma Informed Care provides trauma-related technical assistance. SAMHSA/CMHS has a strong collaborative relationship with the Bureau of Justice Assistance (BJA) and other Department of Justice partners. CMHS and BJA partners meet quarterly. CMHS also collaborates with the Veterans Health Administration in the review of grants and contracts and developing technical assistance.

How will we get there?

Funding Mechanism: Grant

How will we stay on course?

CMHS will continue to assess program performance through a variety of measures including functioning, employment, housing stability, criminal justice contact and social connectedness.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$6,900,000	*
2006	$6,800,000	*
2007	$6,800,000	*
2008	$6,684,000	*
2009	$6,684,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 10:49:47 AM

Criminal & Juvenile Justice

Adult, Juvenile and Family Treatment Drug Courts

Substance Abuse and Mental Health Services Administration

CSAT

Where are we now?

According to SAMHSA's National Survey on Drug Use and Health only 10 percent of individuals who need treatment for a drug or alcohol use problem receive treatment at a specialty facility. This disparity is also consistent for criminal justice populations. Approximately 10 percent of individuals in need of substance abuse treatment within the criminal justice system actually receive it as part of their justice system supervision.

Recognizing the need to enhance or expand treatment services for people who were involved in the criminal justice system, Treatment Drug Court funding began in 2002 to Adult, Juvenile, and Family drug courts and treatment providers. In 2005 and 2006, funding was offered to Juvenile and Family drug courts and treatment providers. In 2008, funding was available for individual Adult Treatment Drug Courts only; a total of 20 new grants were awarded. For FY 2009, CSAT expects to award approximately 39 new Adult Treatment Drug Court grants.

Where do we want to go?

A major goal of the program is to improve treatment outcomes for individuals involved in treatment drug courts. Treatment Drug Court grantees use their grant funds to enhance or expand treatment and recovery support services for individuals involved in drug courts.

The objectives of the program are to expand substance abuse treatment capacity by increasing the number of clients served, and/or enhancing the treatment services offered to participants not only with clinical treatment, but also including recovery support services such as childcare, transportation, and mentoring.

How will we get there?

In September 2008, after a competitive grant review of more than 80 applications, 20 new 3-year Adult Treatment Drug Court grants were awarded to individual adult drug courts in the following states: California, Florida, Georgia, Illinois, Kentucky, Maine, Missouri, Chippewa Cree Tribe in Montana, Ohio, Pennsylvania, and Virginia.

Each project receives up to $300,000 per year to help expand and/or enhance treatment and recovery support services to clients involved in the drug court.

An independent cross-site evaluation of the Adult Treatment Drug Court program is being conducted. The evaluation will assess the effectiveness of the enhancement and expansion of

treatment services provided to the drug court participants. Funding for the evaluation is estimated to be $1.2 million per year for three years.

The President's Budget for FY 2010 calls for a significant increase in the SAMHSA Treatment Drug Court budget line with approximately $35 million in new grant funding proposed. Early planning for the new SAMHSA/CSAT Treatment Drug Court programming includes recommendations for funding new Adult, Juvenile, and Family Treatment Drug Court grants, with a focus on "Methamphetamine and the Family" in the Family Treatment Drug Court category.

Funding Mechanism: Multiple

How will we stay on course?

SAMHSA will assess program performance through accountability measures as well as through outcome measures. Accountability measures include but are not limited to:

- Target number of clients to be screened
- Target number of clients receiving treatment services
- Target number of clients receiving discharge and/or follow up interviews

The currently active grants have served 2,833 clients as of April 27, 2009. Outcomes from intake to 6 month follow-up are as follows:

- Clients reporting no substance use have increased 56.7%
- Clients reporting no arrests have increased 9.4%
- Clients reporting being employed have increased 16.7%
- Clients reporting being socially connected have increased 3.7%
- Clients reporting being housed have decreased 1.6%

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$10,500,000	*
2006	$10,100,000	*
2007	$10,200,000	*
2008	$10,132,000	*
2009	$23,882,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 6/1/2009 5:11:33 PM

Criminal & Juvenile Justice

Offender Reentry Program

Substance Abuse and Mental Health Services Administration

CSAT/DSI

Where are we now?

According to SAMHSA's National Survey on Drug Use and Health only 10 percent of individuals who need treatment for a drug or alcohol use problem receive treatment at a specialty facility. This disparity is also consistent for criminal justice populations as approximately 10 percent of individuals in need of substance abuse treatment within the criminal justice system actually receive it as part of their justice system supervision. A 2007 study by NIDA's Criminal Justice Drug Abuse Treatment Study indicates that offenders have a much higher rate of psycho-social dysfunction including substance use disorders than the general population. In fact, youth in the juvenile justice system have almost four times the rate of substance use disorders than the general juvenile population in the United States (NSDUH, 2007).

Recognizing the need to enhance and expand treatment services for individuals involved in the justice system who are returning to the community after being incarcerated in a correctional system, "offender reentry" funding began in 2004 with the announcement of the CSAT Young Offender Reentry Program (YORP). The YORP program provided funding for the purpose of expanding and enhancing substance abuse treatment and related reentry services in agencies that provided supervision of and services to sentenced juvenile and young adult offenders returning to the community from incarceration for criminal/juvenile offenses. In 2005, funding was provided for an additional cohort of YORP grants.

Funding amounts for the YORP program were as follows: FY 2004, $4.7 million; FY 2005, $11.1 million; FY 2006, $10.4 million; FY 2007, $10.4 million; and FY 2008, $4.1 million.

In FY 2009, to further address the critical issue of substance-involved offenders returning to communities from prison/jail, SAMHSA announced a new Offender Reentry Program (ORP). The purpose of this program is to expand and enhance substance abuse treatment and related recovery and reentry services to sentenced juvenile and adult offenders returning to the community from incarceration for criminal/juvenile offenses. Applicants are expected to form stakeholder partnerships that will plan, develop and provide a transition from incarceration to community-based substance abuse treatment and related reentry services for the targeted populations. Because reentry transition must begin in the correctional or juvenile facility before release, limited funding may be used for certain activities in institutional correctional settings in addition to the expected community-based services. SAMHSA anticipates awarding up to 21 new ORP grants in September, 2009.

Where do we want to go?

A major goal of the program is to improve treatment outcomes for individuals involved in the justice system who are returning from prison/jail to their respective communities. ORP grantees

will use their funds to enhance or expand treatment and recovery support services for these individuals.

Grantees must provide a coordinated, multi-system approach designed to combine transition planning (screening and assessment of substance abuse and coordination of continued care from institution to community) in the correctional institution with effective community-based treatment, recovery and reentry-related services in order to break the cycle of criminal behavior, alcohol and/or drug use, and incarceration or other penalties. SAMHSA/CSAT is seeking applications that will include a stakeholder partnership of institutional corrections officials with community corrections and community-based services in order to plan, develop, and implement a continuum of care services from the correctional institution (prison/jail/detention center) to the community setting.

A long-term goal of this program is to build sustainable systems of care for juveniles and adults needing substance abuse treatment and recovery support services as they return to the community from incarceration. The objectives of the program include the expansion of substance abuse treatment capacity by increasing the number of clients served, and/or enhancing the treatment services offered to participants not only by providing clinical treatment, but also reentry recovery support services such as childcare, transportation, and mentoring. By providing these services, the program will reduce the health and social costs of substance abuse and dependence to the public, and increase the safety of America's citizens by reducing substance abuse related crime and violence.

How will we get there?

In September 2009, after a competitive grant review, CSAT anticipates awarding up to 21 3-year ORP grants to offender reentry projects across the nation. Each project will receive up to $400,000 per year to help expand and/or enhance treatment and recovery support services to substance-involved individuals who are sentenced to incarceration and returning to their communities. Applicants must propose to serve one of two specific offender population categories:

Juvenile Offenders: Those offenders, 14 years up to 18 years old, under the jurisdiction of the juvenile justice system who have been sentenced to incarceration. (In those State jurisdictions where juvenile justice supervision extends beyond 18 years of age, those "juveniles" are eligible to be served in this category.)

Adult Offenders: Those offenders, 18 years of age and older, under the jurisdiction of the criminal justice system who have been sentenced to incarceration as adults.

In addition, the offender (juvenile or adult) must meet the following criteria to receive services funded under this grant program:

- Be assessed as substance-using/abusing or diagnosed as having a substance abuse disorder;
- Have been sentenced by the criminal or juvenile justice system to incarceration (prison/jail/detention centers);
- Be within four months of scheduled release to the community in order to receive services in the correctional/detention setting ; and
- Upon immediate release from the correctional facility to the community be referred to community-based treatment.

In addition, grantees are also encouraged to provide HIV rapid preliminary antibody testing as part of their treatment regimen.

The President's Budget for FY 2010 calls for approximately $19.4 million in funding for "Ex-Offender Reentry" programming. Early planning for the program included recommendations for funding up to 30 new offender reentry grants, including juvenile and adult populations as well as potential funding for developing linkages with parole and probation agencies.

Funding Mechanism: Multiple

How will we stay on course?

SAMHSA will assess program performance through accountability measures as well as through outcome measures. Accountability measures include (but are not limited to) the following:

- Numbers of clients to be screened
- Numbers of clients receiving treatment services
- Numbers of clients receiving discharge and/or follow up interviews

GPRA client-level data will be collected to measure the percentage of increase or decrease in outcomes for the following areas: substance use, arrests, employment, social connectedness, and being housed.

Overview Program/Project/Activity Management:
- Funding Source
Center for Substance Abuse Treatment – Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	*	*
2009	*	*
2010	*	*
2011	*	*
2012	*	*

- Contact:

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Workforce Development

Psychiatric Leadership Development Program

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The transformation of mental health services to recovery-oriented services requires medical leadership. Working with the National Council of Community Mental Health Organizations, CMHS designed and funded this project to demonstrate the utility of increasing the capabilities of the medical leadership in community mental health centers. The goals include increasing leadership skills among public service psychiatrists, improving quality in care provision, and recruiting, retaining and retooling the next generation of practitioners. The first cohort of 15 fellows entered the program last April, chosen from over 45 applicants. Johns Hopkins University (JHU) has provided the lead faculty person which has engaged a number of other JHU faculty members as well as leading community psychiatrists from all over the county. A year long curriculum, involving several meetings, didactics, and experiential learning is in active evolution.

Where do we want to go?

It is clear that the level of leadership available in the psychiatric profession pales before the work of transformation. We will need a cadre of committed, talented and capable psychiatric leaders at all levels to accomplish these tasks. This program, if it continues and expands, could make a substantial contribution to the need for effective psychiatric leadership across the country. The Office of Medical Affairs, along with other elements in CMHS, is actively engaged in multiple efforts to encourage psychiatry and psychiatrists to engage in the transformation of mental health services.

How will we get there?

The Psychiatric Leadership Development Program (PLDP) has two primary deliverables. The first is the trained cohort of fellows who will continue their work in the field. The second is a curriculum and a process that is geared toward leadership development among medical directors. The National Council, the American Psychiatric Association and the American Association of Community Psychiatrists have all been supportive of the PLDP.

Funding Mechanism: Purchase Order

How will we stay on course?

We can stay the course by supporting the PLDP while encouraging it to seek additional non-Federal revenue schemes to supplement and gradually minimize CMHS support. However, to maintain some input, it would be useful for CMHS to consider some element of ongoing support. It is clear however; that there is demand in the field for such an effort, that the project is feasible, and that participants and faculty are actively engaged.

Overview Program/Project/Activity Management:

- Funding Source

  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	$99,000	*
2007	$99,000	*
2008	$99,000	*
2009	$99,000	*
2010	*	*
2011	*	*
2012	*	*

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Workforce Development

SAMHSA Minority Fellowship Program (MFP)

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The mental health and substance abuse needs of racial and ethnic minority communities within the United States have been historically underserved by trained practitioners who are sensitive to cultural issues or equipped with the language skills that impact effective service delivery. In 1974, the National Institute of Mental Health (NIMH) established the Minority Fellowship Program (MFP) to enhance services to minority communities through specialized training of mental health professionals in psychiatry, nursing, social work and psychology. In 1992, the Substance Abuse and Mental Health Services Administration (SAMHSA) was established and the MFP was transferred from NIMH to the Center for Mental Health Services (CMHS) in SAMHSA. While NIMH continues to offer an MFP program, the NIH program is research focused and provides funds only to the American Psychological Association. SAMHSA's MFP focused on the clinical/treatment component of Mental Health and historically funded Health Professional Organizations (American Nurses Association [ANA], American Psychological Association [APA], Council on Social Work Education [CSWE], and American Psychiatric Association [APA]) as a means of enhancing the Mental Health workforce. Eligibility for this grant was expanded by Congress in FY 2006 to include a fifth professional association, the American Association of Marriage and Family Therapy.

The mission of the SAMHSA MFP is to support doctoral level students in the fields represented by eligible applicants for the purpose of increasing the number of culturally competent behavioral health professionals who teach, administer, conduct services research and provide direct mental health/substance abuse services to underserved populations, especially within the public and private non-profit sectors. The current cohort of MFP Grantees recently completed applications for a 3-year project period (FY08-FY10). The average amount of funding for FY08 MFP grants is $767,000. Based on information from FY08 grant applications there are an average of 22 fellows per grant with a total of 110 doctoral level fellows sponsored for FY08.

Where do we want to go?

Efforts are underway to evaluate the implementation and outcomes of the SAMHSA Minority Fellowship programs operated by the four eligible grantee organizations (ANA, APA, ApA, and CSWE) from 1992 until 2007. In addition, efforts will focus on improving the program by coordinating efforts across the current five grantee organizations and developing a more efficient and effective data infrastructure to enhance reporting and demonstrate the program impacts.

How will we get there?

An independent evaluation of the MFP is being conducted by the Human Services Research Institute which is currently waiting OMB approval of an evaluation protocol which will be used to gather information from all relevant stakeholders. The resulting data will identify the historical

context in which the MFP has operated, the processes and activities established by SAMHSA and by the grantees to implement the MFP, perceptions about how well the SAMHSA MFP is performing, and assessment of the ability of the program to achieve particular goals under its purview. Additionally, in FY 2008, CMHS sponsored the development of a MFP Coordination Center (MFP CC). The Coordinating Center will enhance the effectiveness of the MFP program by:

- developing and coordinating a multi-discipline workgroup to address findings of the MFP evaluation;
- analyzing grantee reporting methods and systems and how they may be strengthened;
- fostering multi-disciplined approaches to recruitment and retention of program participants, participant tracking and mental health curriculum development;
- addressing multi-disciplined approaches to improving the placement of MFP participants in mental health and substance use underserved areas; and
- increasing program participant familiarity with National Outcome Measures for mental health.

Funding Mechanism: Grant

How will we stay on course?

Based on preliminary evaluation data, since its inception in 1993, the SAMHSA MFP programs have sponsored approximately 600 Fellows (through 2006). To date, within the four SAMHSA supported MFP programs funded 1993-2006, 64% of fellows have completed their psychiatric residency or obtained their doctoral degree.

Overview Program/Project/Activity Management:
- Funding Source
Center for Mental Health Services, Center for Substance Abuse Prevention, and Center for Substance Abuse Treatment - Minority Fellowship Program (MFP)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$4,200,000	*
2008	$3,800,000	*
2009	$4,400,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 10:03:13 AM

Science and Services / Evidence-Based Practice

SAMHSA's Health Information Network

Substance Abuse and Mental Health Services Administration

OC

Where are we now?

The SAMHSA Health Information Network (SHIN) includes the National Clearinghouse for Alcohol and Drug Information (NCADI) and the National Mental Health Information Center (NMHIC). SHIN connects the behavioral health workforce and the general public to the latest information on the prevention and treatment of mental and substance use disorders by promoting SAMHSA resources, fulfilling publication requests, and responding to inquiries from professionals and the general public. Each of SAMHSA's priority areas, as discussed in the SAMHSA matrix, is covered by SHIN. SHIN received 654,464 inquiries in Fiscal Year (FY) 2008, averaging 54,539 inquiries per month. Table 1 shows the approximate number of publications we have in active inventory for each of the matrix priority areas. Note that not all publications fit into matrix categories, and that some publications fit into more than one. There were a total of 1,318 active publications in inventory as of October 2008. Table 1. Approximate Number of Active Publications per Matrix Priority, October 2008 Co-occurring Disorders 56; Substance Abuse Treatment Capacity 516; Seclusion and Restraint 2; Strategic Prevention Framework Initiative 80; Children and Families 270; Suicide Prevention 234; Homelessness 10; Older Adults 38; HIV/AIDS Hepatitis 12; Criminal and Juvenile Justice 32; Workforce Development 26; Disaster Readiness 42.

Where do we want to go?

The principal purpose of SHIN is to provide readily accessible information to the provider community, the patient and family member community, and the general public on mental and addictive disorders. Since the SHIN contract was awarded, the Office of Communications has focused on developing and implementing a new strategic plan with extensive executive leadership team input and feedback; developing and implementing an eNetwork for mass communications promoting SAMHSA programs and products; organizing and staffing the SHIN Contact Center, Resource Center, and SAMHSA library; implementing a new consolidated "one SAMHSA" 24/7 telephone operation in a new Contact Center configuration; and developing and implementing a Knowledge Management System (KMS) that integrates a new consolidated backend database system and warehouse that can track and report on SHIN activity including, but not limited to, incoming inquiries from both phone and web, fulfillment of orders, trends in ordering, and publication inventory and usage. One of the priorities for this year is marketing SHIN to SAMHSA staff. Hopefully, this effort will result in SAMHSA staff utilizing the resources of SHIN to a greater extent. We also are hopeful that we can align our program plans to be in concert with the National Survey on Drug Use and Health, so that the areas of greatest concentration of substance use and mental health issues are where SHIN resources are being utilized.

How will we get there?

Over the remaining 2½ years of the current SHIN contract, OC has set plans in motion to significantly expand and diversify the target audiences for SAMHSA and build continuous feedback

loops to gather target audiences' needs and monitor trends. To reach these goals, we are moving on multiple fronts, including using KMS to capture target audience demographic information more efficiently, inventory and call data, media activity, and state-specific data. We are building a user-friendly Web interface for KMS to provide quick and reliable access to SAMHSA inventory, content, and reports. We are positioning the exhibits program to collect quantitative and anecdotal data at conferences and exploring exhibit opportunities at nontraditional venues to reach untapped audiences. On the interactive front, we are rolling out plans to promote the SAMHSA eNetwork service to more than 25 Federal agencies. We are setting up to execute search engine optimization and blogging activities to capture new SAMHSA audiences. On a parallel track, we are continuing to interface with the SAMHSA program staff to assess their needs. We want to educate the program staff on the data available through SHIN to help them create timely and targeted content and products, including developing a process for filling topical gap demands in inventory. Lastly, we will provide monthly reports to Center Directors that will inform SAMHSA stakeholders on the utilization of their products, identify consumer demand, and inform budget decisions regarding material development and reproduction. As part of the contract, SAMHSA has an Interagency Agreement (IA) with the Office of National Drug Control Policy (ONDCP) for SHIN information specialists to answer the ONDCP toll-free lines, take publication orders, and send mail from the SHIN warehouse. We also have an IA with the Office for Women's Health (OWH) where SHIN will be responsible for the distribution and evaluation of the utilization of OWH publications. There is considerable potential for developing partnerships with other agencies. The three NIH institutes that deal with mental health and substance abuse (National Institute on Drug Abuse, National Institute of Mental Health, and National Institute on Alcohol Abuse and Alcoholism) are obvious potential partners. Beyond that, there are the Veterans Administration and Department of Defense, two other agencies dealing extensively with mental health and substance abuse issues among their constituencies. Lastly, there are potential opportunities with the Department of Education and its programs dealing with substance abuse and mental health issues in the schools and the Department of Housing and Urban Development and its homeless program.

Funding Mechanism: Contract

How will we stay on course?

There are currently no Program Assessment Rating Tool (PART) Scores or Government Performance Results Act (GPRA) outcome measures for SHIN. Nonetheless, GPRA outcome measures are under development as part of the performance measurement section of the SHIN Strategic Plan. SHIN keeps its customers at the center of all planning and design by conducting research to discover their needs and information-seeking habits. SHIN has been continually gathering feedback from its internal customers - SAMHSA staff members such as center and division directors and persons reponsible for overseeing SAMHSA publications, campaigns, and grantees. This feedback has informed the development of SHIN's marketing and outreach, taxonomy, Web site design, and data reporting format and content. Surveys and analyses have encompassed both internal and external SAMHSA customers, including various types of professional and nonprofessional NCADI and NMHIC customers. The data gathered by these efforts inform further research and the development of customer-centric planning tools.

Overview Program/Project/Activity Management:

- Funding Source

Center for Mental Health Services, Center for Substance Abuse Prevention, and Center for Substance Abuse Treatment - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	$9,629,671	*
2007	$16,552,682	*
2008	$16,320,000	*
2009	$17,355,535	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 5/11/2009 12:21:36 PM

Science and Services / Evidence-Based Practice

National Registry of Evidence-based Programs and Practices (NREPP)

Substance Abuse and Mental Health Services Administration

OPPB

Where are we now?

Recent seminal reports (i.e., The Surgeon General's Report on Mental Health, the Institute of Medicine's Crossing the Quality Chasm, and Improving the Quality of Health Care for Mental and Substance Use Conditions, and the President's New Freedom Commission Report Achieving the Promise: Transforming Mental Health Care in America) have documented the challenges that exist in closing the "research to practice gap," or promoting broader use in routine clinical and community-based settings those services that science has demonstrated to be effective in preventing and/or treating mental and substance use disorders. In addition, there are increasing expectations from purchasers that mental health and substance abuse providers be able to demonstrate the effectiveness (through scientific means) of the services that they provide. Moreover, the growing emphasis on the use of comparative effectiveness research as a strategy for both enhancing the quality of services provided, as well as ensuring more efficient use of health care funds, has contributed to the advancement of systems that can identify and objectively – and systematically – evaluate the evidence to support the use of particular interventions. As a result of these trends, more attention is currently being paid within HHS and its agencies to assessing and demonstrating the "evidence-base" for specific services, and in developing systems that will identify, evaluate and provide relevant information about interventions to assist both purchasers and the general public in making informed decisions about the selection and use of evidence-based services.

Where do we want to go?

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The purpose of this registry is to assist the public (including: service agency administrators and workers, policymakers, service recipients or potential recipients, educators, parents and families, researchers, and community advocates) in identifying approaches to preventing and treating mental and/or substance use disorders that have been scientifically tested and that can be readily disseminated to the field. NREPP is one way that SAMHSA is working to improve access to information on tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field. With NREPP, stakeholders can begin to determine whether a particular intervention may meet their unique needs.

How will we get there?

NREPP publishes a report called an intervention summary on its Web site (http://www.nrepp.samhsa.gov) for every intervention it reviews. Each intervention summary includes: descriptive information about the intervention and its targeted outcomes; Quality of

Research and Readiness for Dissemination ratings; a list of studies and materials submitted for review; and contact information for the intervention developer. NREPP is a cross-cutting contract - each of SAMHSA's three Centers provides annual funding for NREPP, and a new 5-year contract to support this system was recently awarded in July 2009.

A number of discretionary grant programs within SAMHSA have included language encouraging selected grantees to submit their final evaluation report to the NREPP contractor for possible review and inclusion in NREPP. Relevant NIH Institutes – including NIMH, NIDA, and NIAAA – are supportive of NREPP, and have worked with both SAMHSA staff and NREPP contractor staff to: (1) identify potential interventions for NREPP review; (2) encourage select program developers to submit their intervention for NREPP review; and (3) identify and encourage selected researchers to serve as NREPP reviewers.

Funding Mechanism: Contract

How will we stay on course?

The NREPP system and Web site was launched in March 2007. Information on approximately 150 interventions is currently available, and new intervention summaries are continually being added as reviews are completed (at a rate of 3-6 per month). Moreover, new interventions to address service needs and gaps are submitted for review each year in response to an annual Federal Register notice.

Overview Program/Project/Activity Management:
- Funding Source
  SAMHSA, National Registry of Evidence-based Programs and Practices (NREPP)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,700,000	*
2006	$1,295,000	*
2007	$1,495,000	*
2008	$1,587,000	*
2009	$2,087,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 1:42:39 PM

Science and Services / Evidence-Based Practice

Evidence-Based Practice KITS

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Evidence-Based Practice KITs (EBP KITs), a product of the Center for Mental Health Services (CMHS), provide resources to States, communities, administrators, practitioners, consumers of mental health care, and their family members to implement mental health practices that work. CMHS is developing a system in which research is translated into evidence-based interventions quickly and improvements are made in the quality of care that consumers receive. A primary objective for producing the toolkit series is to provide cutting-edge science-based information to the field. In September, 2000, a contract was awarded to produce EBP KITs that would provide guiding materials to help States and communities implement the following practices: 1) Assertive Community Treatment (ACT); 2) Supported Employment; 3) Integrated Treatment for Co-occurring Disorders; 4) Family Psychoeducation; 5) Illness Management and Recovery (IMR); and 6) Medication Management. In September, 2002, a second contract was awarded to pilot test the use of the KITs in eight States and 55 communities.

Where do we want to go?

CMHS will create a series of EBP KITs that provides information, tools, and resources to help States, communities, and organizations select, implement, and evaluate evidence-based and promising practices. Included in each KIT are the following components: a summary of the scientific evidence for the effectiveness of the practice; materials to introduce the practice to a wide variety of stakeholders, including consumers and family members; training and evaluation tools; and information for State mental health authorities and program administrators to help them set up systems to support the practice. The quality of the content of KITs delivered to date is excellent and CMHS is expanding the series to include additional practices of importance to the mental health field.

How will we get there?

In addition, CMHS awarded a contract to produce additional EBP KITs to address the following practices of importance to the mental health services field: supportive housing, services for older adults, consumer-operated services, services for children, and mental health promotion services.

Funding Mechanism: Contract

How will we stay on course?

A team of CMHS and contract staff meets monthly to review the status of each KIT. Without unforeseen delays, all KITs in progress should be completed in 2009. CMHS staff meets periodically with staff from the SAMHSA Office of Communications to help facilitate the publications clearance

planning and process.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	*	*
2009	$500,000	*
2010	*	*
2011	*	*
2012	*	*

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Data for Performance Measurement & Management

National Outcome Measures Website: Policy Analysis, Performance Management, and Public Reporting

Substance Abuse and Mental Health Services Administration

OPPB

Where are we now?

Annual products supporting evidence-based policy decisions in setting budget priorities include:

NOMS Program Priority Area Reports for Children and Families, Co-Occurring Disorders, Seclusion and Restraint, Suicide, Mental Health Transformation, Substance Abuse Treatment Capacity, Criminal and Juvenile Justice, HIV/AIDS and Hepatitis, Homelessness, Older Adults, Strategic Prevention Framework produced in collaboration with all three Centers and matrix leaders.

An annual assessment of each States capacity to deliver substance abuse treatment services is produced by compiling and mapping State Funding, behavioral health manpower, and population based estimates of treatment seeking and admission data to the sub-State level of analysis produced in collaboration with CSAT.

Products supporting performance measurement and management of SAMHSA programs include empirical analysis of potential performance measures such as candidate measures for measuring treatment efficiency. In addition other Federal data programs are assessed for policy relevant data such as the recently completed "National Youth Surveys: Comparison of Surveys and Potential Mental Health and Substance Abuse Analyses".

Products supporting the transparency of SAMHSA's performance management efforts include the National Outcome Measures Web-site with an "Annual Report of Performance Management Accomplishments" released concurrent with appropriations hearings. The is produced in collaboration with all three Centers and the Office of Applied Studies. An analysis of the Federal Budget to identify potential partners, overlaps, and gaps is produced for each Center Director.

Where do we want to go?

We want to increase Center Director and IOA directed analyses to support their decision making. In general we want to increase the availability of data analyses to support executive management decisions by expanding the analyses of SAMHSA resource and prevalence data and acquiring resource and prevalence data from other Federal agencies to refine a more complete National picture of behavioral health problems and service resources. We want to assess SAMHSA performance measures for validity, reliability, and sensitivity to improve our performance measurement capability. Annually update the SAMHSA NOMs website with detailed performance outcome data for discretionary and block grant programs to enhance transparency of program outcomes and identify the bases for priorities.

How will we get there?

In August 2008 SAMHSA entered into a 5 year contract to support the NOMs/ State Profile Website, annually update the report for each priority area, and acquire and analyze data from other Federal data sets relevant to behavioral health in the United States for executive management of the Agency. We will continue to meet quarterly with Agency leadership to review available analyses and determine future collaborations.

Funding Mechanism: Contract

How will we stay on course?

SAMSHA uses focus groups of internal and external stake holders to assess satisfaction with material published on the website.

Overview Program/Project/Activity Management:
- Funding Source

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$245,000	*
2008	$338,592	*
2009	$400,313	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 1:33:35 PM

Data for Performance Measurement & Management

Drug Abuse Warning Network (DAWN)

Substance Abuse and Mental Health Services Administration

OAS

Where are we now?

DAWN is used to monitor trends in drug misuse and abuse; identify the emergence of new substances and drug combinations; assess health hazards associated with drug abuse; and estimate the impact of drug misuse and abuse on the Nation's health care system.

Annually, DAWN produces estimates of drug-related visits to hospital emergency departments for the Nation as a whole and for selected metropolitan areas. DAWN also publishes annual profiles of drug-related deaths submitted by medical examiners and coroners in selected metropolitan areas and selected States.

Where do we want to go?

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

How will we get there?

DAWN is a major component of the Nation's capacity to monitor trends in the morbidity and mortality associated with drug misuse and abuse. It is used by national, State, and local professionals to monitor trends in the health hazards associated with substance abuse and to identify emerging trends and changing patterns of drug abuse. DAWN offers data of value to policymakers, law enforcement, pharmacologists, and health professionals.

The data are used by the White House Office of National Drug Control Policy to monitor national trends; the Drug Enforcement Administration for surveillance, diversion control, and intelligence;

and the Food and Drug Administration and pharmaceutical industry for post-marketing surveillance of prescription and over-the-counter pharmaceuticals, for active monitoring of adverse events associated with medications that are new or old, and for assessing the abuse potential for labeling and scheduling decisions. State and local professionals, including law enforcement and the Community Epidemiology Work Group, use DAWN to assess changes in local trends and patterns of drug use. SAMHSA itself uses DAWN to target program resources to areas of greatest need and to monitor adverse events associated with buprenorphine treatment for opiate addiction. The redesign of DAWN began in 2003 and was fully in place in 2004.

There are two contracts awarded under the IDIQ mechanism that provide support for DAWN, one for data collection and one for data analysis. The analytic contract was awarded to RTI International (Contract No. 280-03-2600) on 4/28/2005 for a period of four years. The data operations contract (Contract No. 283-08-024) was awarded to Westat on 2/21/2002 for a period of seven years.

Funding Mechanism: Contract

How will we stay on course?

As with other large national surveys, DAWN faces the challenges of providing high quality, timely data within tight frames. Additionally, DAWN faces the challenge of ensuring that it remains within budgetary constraints. To address these challenges, DAWN staff continuously monitoring data collection and analytic activities and seek input from DAWN constituents on how to best utilize the resources available. Using this input and implementing economic measures, DAWN will continue to provide these essential data to SAMHSA, to DAWN data users, and to policy and program developers who require insight into the adverse effects of drug use, misuse and abuse.

Overview Program/Project/Activity Management:

- Funding Source
  Substance Abuse Prevention and Treatment (SAPT) Block Grant Set-a-Side

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$17,000,000	*
2006	$17,000,000	*
2007	$17,000,000	*
2008	$17,000,000	*
2009	$19,000,000	*
2010	*	*
2011	*	*
2012	*	*

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Data for Performance Measurement & Management

Drug and Alcohol Services Information System (DASIS)

Substance Abuse and Mental Health Services Administration

OAS

Where are we now?

The Drug and Alcohol Services Information System (DASIS) is an integrated data system maintained by the Office of Applied Studies. The purpose of DASIS is to provide useful information to policymakers, agency administrators and program managers, academic researchers, and the members of the public seeking treatment for themselves or others.

DASIS supports SAMHSA's mission by providing high quality data on the characteristics of the treatment system and admission to the system in order to inform policy and program decision-making. In addition DASIS supports the overall objective of SAMHSA's Data Strategy to provide timely, comprehensive, relevant, and accurate data to guide and performance monitoring. Data from this project are also used to track national trends, a key component of SAMHSA's Strategic Plan. The Drug and Alcohol Services Information System (DASIS) is the only source of comprehensive national data on the services available for substance abuse treatment, on the characteristics of the national treatment system, and on the numbers and general characteristics of people who are admitted to treatment.

DASIS contains three data sets, which are maintained with the cooperation and support of the States: 1) The Inventory of Substance Abuse Treatment (I-SATS) a master list of all specialty substance abuse treatment programs known to SAMHSA. It serves as the list frame for the annual National Survey of Substance Abuse Treatment Services and as a sampling frame for other special surveys of treatment providers and their clients. 2) The National Survey of Substance Abuse Treatment Services (N-SSATS) an annual census of all facilities listed on the I-SATS, which collects information on the location, organization, structure, services, and utilization of substance abuse treatment facilities in the United States. Data are used for program administration and policy analysis, and to compile and update the National Directory of Drug and Alcohol Abuse Treatment Programs and the online Substance Abuse Treatment Facility Locator. 3) The Treatment Episode Data Set (TEDS) a standard set of variables describing the demographic and drug use characteristics of individuals admitted to treatment, primarily by providers receiving public funding. TEDS consists of an admissions and a discharge data set, which can be linked to provide information on treatment episodes. In 2006, new data elements were added to the TEDS discharge data set so that comparisons of client status at admission and at discharge can be made on several critical dimensions, including substance use, living arrangements, employment status, and criminal justice involvement.

The DASIS data sets offer the opportunity to identify treatment programs, characterize services, enumerate persons in treatment, describe the general characteristics of people admitted to treatment, determine the proportion of those admitted that complete treatment and measure length of stay in treatment. In doing so, DASIS data sets satisfy the mandates of Section 505 of the Public Health Service Act (42 U.S.C. 290aa-4) which require the annual collection of information on these subjects. The N-SSATS and its predecessors have been in place for nearly two decades, allowing analysis of change over time in the structure, composition, and use of treatment

services. The TEDS has data on admissions since 1992, making it possible to monitor changing patterns in the drugs that lead people into treatment and to assess trends in age, gender, and race/ethnicity among admissions to treatment.

In addition to its core components (I-SATS, N-SSATS, and TEDS), the DASIS project supports two other SAMHSA initiatives, the State Outcomes Measurement and Management System (SOMMS) and National Outcome Measures (NOMs). The SOMMS uses DASIS data to assess the performance of State treatment systems funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant which is administered by the Center for Substance Abuse Treatment (CSAT). The NOMS are the specific measures used to assess performance and are based on data from both TEDS and N-SSATS. The NOMS are used by CSAT and the Office of Policy, Planning, and Budget (OPPB) to assess SAPT Block Grant performance for purposes of performance management and reporting on GPRA and PART measures.

DASIS is conducted in collaboration with State substance abuse agencies. States help maintain the facility inventory, assist with some aspects of the annual facility survey, and are the source of the data submitted to TEDS. States receive funding through the DASIS contract to support these activities in the form of two kinds of subcontracts to the DASIS contract. The DASIS State Agreements are subcontracts that disperse $3.9 million dollars annually to States to offset some of the costs of their participation in DASIS. The SOMMS State Subcontracts provide payments of $150,000 per State per year to those States that submit data to TEDS that meet certain specified quality standards. These data are used in the calculation of the following substance abuse treatment NOMs:

- Percent of discharges from treatment abstinent at discharge
- Percent of discharges with stable living arrangement at discharge
- Percent of discharges employed or in school at discharge
- Percent of discharges with no arrests in the 30 days prior to discharge
- Length of stay in treatment

Where do we want to go?

Three goals for the project are to expand the analysis of the data, to redesign the N-SSATS to better meet the needs for data on behavioral health treatment services, and to promote the completeness and quality of the data submitted by States to the TEDS. The purpose of DASIS is to provide useful information to policymakers, agency administrators and program managers, academic researchers, and the members of the public seeking treatment for themselves or others. N-SSATS has two objectives: (1) to provide statistical information on the location, scope, utilization, and availability or treatment services; and (2) to provide information to persons looking for treatment on where to find treatment programs with services that meet their specific treatment needs. Both objectives require up-to-date comprehensive information. The purpose of TEDS is to provide information that can be used to monitor trends in treatment admissions and to assess the performance of the treatment system by examining treatment completion rates, length of stay in treatment and client status at discharge. Both N-SSATS and TEDS can be used to study treatment resources and utilization at the national, State, and community level.

How will we get there?

DASIS products include a variety of published data reports, web-based tables and summaries, the National Directory of Drug and Alcohol Abuse Treatment Programs and the online Substance Abuse Treatment Facility Locator. All DASIS reports can be accessed at

http://www.oas.samhsa.gov/dasis.htm. DASIS data are collected under a contract which will expire in December, 2009. In order to continue DASIS activities, a new contract will be awarded in early FY 2010. The new contract will continue to emphasize quality, completeness and timeliness of data submissions for all DASIS components. Additionally, technical assistance to the States will be continued to ensure that they receive appropriate assistance in meeting quality and timeliness standards.

Funding Mechanism: Contract

How will we stay on course?

DASIS is associated with the GPRA goal entitled: "SAPT Block Grant Set-aside: National Surveys (Accountability)," which specifies that DASIS data are to be available fifteen months after the end of data collection. (Refer to the following web page for additional information: http://www.samhsa.gov/Budget/FY2008/SAMHSA08CongrJust.pdf, page PD-41, or 171 of 188). This goal continues to be met each year. Data collection ends in October and the national findings report is completed in October/November of the following year.

Overview Program/Project/Activity Management:

- Funding Source
  Substance Abuse Prevention and Treatment (SAPT) Block Grant Set-a-Side

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	$6,294,959	*
2007	$9,296,259	*
2008	$9,243,334	*
2009	$11,743,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 1:47:10 PM

Data for Performance Measurement & Management

National Survey on Drug Use and Health (NSDUH)

Substance Abuse and Mental Health Services Administration

OAS

Where are we now?

The National Survey on Drug Use and Health (NSDUH) is an ongoing survey of the civilian, non-institutionalized population, aged 12 years or older in the United States. Since 1971, the NSDUH has provided estimates of the incidence and prevalence of substance abuse in the United States. The survey is mandated by The Public Health Service Act, Section 505 (42 U.S.C. 290aa-4), which requires the annual collection of National incidence and prevalence of the various forms of mental illness and substance abuse. This program supports SAMHSA's mission by providing high quality data to inform decision-making. In addition it supports SAMHSA's Data Strategy overall objective to provide timely, comprehensive, relevant, and accurate data that can guide and improve policymaking, program development, and performance monitoring. Data from this project are also used to track national trends, a key component of SAMHSA's Strategic Plan.

Each year, the survey collects data from approximately 67,500 respondents. Respondents are interviewed face-to-face in their homes, and the questionnaire obtains detailed information on substance use, mental health, service utilization, demographics, employment and income, and risk and protective factors associated with substance use and mental disorders. The survey addresses the need for information on the nature and extent of substance use and abuse and mental health problems in the general population, including the number and characteristics of persons using alcohol, tobacco, and illicit drugs and in need of treatment for mental and substance use disorders. The survey is designed to provide estimates at the national, regional, and State levels. The NSDUH is the only continuous survey that provides both national and State measures of substance use and mental disorders in the general population. Each year, national results are made available about 8 months following the close of data collection. State results are made available about 15 months following the close of data collection. Periodic reports provide data for substate areas.

Where do we want to go?

Two goals for NSDUH are to expand the analysis of the data and to redesign the survey to better meet the needs of policymakers, researchers, and other users of these data. The redesign will balance data and information needs with budget limitations, as the survey currently costs about $50 million per year, which is more than the amount budgeted for the project in FY07, FY08, or FY09. Carryover funds from prior year budgets have allowed the project to continue without major reduction in scope until FY2011; therefore, a redesign is planned for 2012. A major purpose for the survey is tracking trends in substance use and abuse in the U.S. The NSDUH also offers the opportunity for in-depth analysis on a wide variety of policy issues, such as treatment need and access to treatment services; patterns of substance use among special populations of interest, such as racial/ethnic minorities, pregnant women, welfare recipients, and the unemployed; and relationships of substance use with other conditions, such as mental illness, criminal behavior, and dropping out of school. Such research results in more efficient prevention interventions and

treatment services. The NSDUH data facilitates the evaluation of SAMHSA programs and makes it possible to direct Federal funds to areas with severe or unique problems. Because of its State and substate-level capability, the data can be used to assess the impact of differing laws, programs and policies across States and counties.

How will we get there?

Much of the NSDUH work is done under contract. Currently, there are two contracts active, one to conduct the 2005-2009 surveys, and one to conduct the 2010 and 2011 surveys. These contracts are with RTI International, with an estimated cost of $50 million per year. Within these contracts, developmental work and testing for the redesign is in progress. A new contract to conduct the 2012-2016 surveys will be awarded in FY 2010. In addition, SAMHSA is consulting with data users in SAMHSA, at NIH, CDC, FDA, DOJ, ONDCP, States, and university researchers to assess data needs to guide the redesign. To expand the analysis of NSDUH data, SAMHSA's Office of Applied Studies (OAS), which is responsible for managing the project, has been conducting presentations and workshops with SAMHSA staff and with staff from other agencies, to increase staff understanding of the capabilities of the data and how it could be useful to their work. SAMHSA is also exploring ways to make microdata files more widely available to researchers, through specialized web-based software and by designating agents who would be allowed access to restricted-use NSDUH data files. Interagency agreements with NIH and CDC may be arranged to facilitate more analysis to meet those agencies' specific data needs. Expansion of OAS analytic capability, through increases in staff and analytic contract budgets, will also be pursued to improve the survey output.

Funding Mechanism: Contract

How will we stay on course?

NSDUH is associated with the GPRA goal titled: "SAPT Block Grant Set-aside: National Surveys (Accountability)," which specifies that NSDUH data are to be available eight months after the end of data collection. (For further information, refer to the following Web page:http://www.samhsa.gov/Budget/FY2008/SAMHSA08CongrJust.pdf, page PD-41, or 171 of 188). This goal continues to be met each year since data collection ends in late December and the national findings report is completed at the end of August, in time for release during the National Alcohol & Drug Addiction Recovery Month activities held in September. The Substance Abuse Prevention and Treatment (SAPT) Block Grant provides funding to States by use of a formula, in order to plan, carry out, and evaluate activities to prevent and treat substance abuse. To facilitate improvements to the SAPT Block Grant program, as required by a previous performance evaluation, the NSDUH is being used (along with data from other sources) to provide data for the National Outcome Measures (NOMs). The implementation of NOMs data collection and measurement, which is a SAMHSA performance-based management process, involves tracking a set of key outcome measures at the National and State levels annually. NOMs data cover 10 domains for all discretionary and block grant formula grant programs with client-level outcomes. A primary purpose for NOMs is to create a basic national data set to measure the performance of systems administered by State substance abuse and mental health agencies. For further information, including descriptions of domains and measures, refer to the following Web page: http://www.nationaloutcomemeasures.samhsa.gov/.

Overview Program/Project/Activity Management:

- Funding Source
  Substance Abuse Prevention and Treatment (SAPT) Block Grant Set-a-Side

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$56,284,000	*
2006	$44,860,000	*
2007	$40,528,000	*
2008	$44,050,000	*
2009	$45,000,000	*
2010	*	*
2011	*	*
2012	*	*

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Data for Performance Measurement & Management

Substance Abuse and Mental Health Data Archive (SAMHDA)

Substance Abuse and Mental Health Services Administration

OAS

Where are we now?

Since 1995, the Substance Abuse and Mental Health Data Archive (SAMHDA) has supported SAMHSA's mission by making high quality national and specialized data available to all segments of the public to inform decision-making. SAMHDA is administered by the Office of Applied Studies (OAS). The purpose of SAMHDA is to disseminate OAS public-use datasets such as Treatment Episode Dataset (TEDS), National Survey of Substance Abuse Treatment Services (N-SSATS) and National Survey on Drug Use and Health (NSDUH), as well as to provide access to other data sets on substance abuse and mental health for use by analysts and policy makers in order to promote data-driven scientific decision making.
SAMHDA promotes and supports the responsible use of the nation's preeminent substance abuse and mental health research data for better public understanding of these issues. SAMHDA is committed to using innovative methods to optimize data utility for diverse audiences. SAMHDA provides free, ready access to comprehensive research data in a variety of formats and promotes the sharing of these data among researchers, academics, policymakers, service providers, and others. The goal is to increase the use of the data to promote the most accurate understanding and assessment of substance abuse and mental health problems and the impact of related treatment systems.

SAMHDA supports the overall objective of SAMHSA's Data Strategy to provide timely, comprehensive, relevant, and accurate data that can guide and improve policymaking, program development, and performance monitoring. Specifically, the mission of SAMHDA reflects the following two objectives in the SAMHDA Data Strategy Plan: – Objective 1.2: Improve ease of access and user interface with SAMHSA public datasets – Objective 1.4: Increase dissemination of SAMHSA data and analyses, targeting the markets critical to promoting SAMHSA's priorities for the field.

SAMHDA data include the U.S. general and special populations, annual series, and designs that produce nationally representative estimates. Some of the data acquired and archived under SAMHDA have never before been publicly distributed. The archive is intended to ensure that data are in a user friendly format. All data may be downloaded from the Web site and most studies are available for use with our online data analysis system. This system allows users to conduct analyses ranging from cross-tabulation to regression without downloading data or relying on other software. Another feature, Quick Tables, provides the ability to select variables from drop down menus to produce cross-tabulations and graphs that may be customized and cut and pasted into documents. Online tutorials, user guides, and FAQs provide assistance to users, and SAMHDA staff offer user support through email and a toll-free helpline. SAMHDA also conducts disclosure analyses and applies best practices to providing public-use data with the highest quality disclosure protection. Each collection includes survey instruments (when provided), a bibliography of related literature, and related Web site links. An important feature of the project is a variable-level search, which includes all metadata (i.e., question text, variable and value labels) and allows multi-term searching.

Where do we want to go?

The goal of the project is to continue to provide and increase widespread access to mental health and substance abuse data to federal, state and local governments and policymakers as well as to mental health and substance use researchers.

How will we get there?

There are over 100 datasets archived at SAMHDA. Over the past year the archive has had a monthly average of 178,000 Web page hits, 14,000 data downloads, and 19,000 online analyses page views. User interest has increased greatly over the last 10 years. Over the last two years there has been almost a 25 percent increase in online analysis page views and 150 percent increase in monthly page hits. The program will continue to maintain and increase its monthly Web page hits, data downloads and online analysis page views. In addition, it will continue to acquire additional datasets for distribution to users. It will develop additional modes of access of data through enhancement of the online analysis system, quick tables and flash maps.

This program is funded through a contract. The contract period is from May 1st, 2005 to April 30th, 2010. The archive is housed at the Inter-university Consortium for Political and Social Research (ICPSR), Institute for Social Research, University of Michigan. The total contract costs are about $900,000 per year. This project coordinates with the Division of Population Surveys (NSDUH) as well as with the Division of Facility Surveys (TEDS and N-SSATS). In addition, it coordinates with the OAS Publications and Data Dissemination (PADD) team. SAMHDA provides support to other agencies producing substance abuse and mental health data, e.g., the Monitoring the Future Survey (MTF) is sponsored by the National Institute on Drug Abuse (NIDA).

Funding Mechanism: Contract

How will we stay on course?

We will continue to monitor web statistics to ensure usage of data, to ensure minimal down times and maximum availability, to provide help to analysts, to provide new ways of accessing data, and to update the citations page. We will also continue to accept new data sets in standard series (e.g., NSDUH, TEDS) and to seek out data sets from other sources to include when they meet our criteria related to topic, research value, quality, and cost.

Overview Program/Project/Activity Management:

- Funding Source
  Substance Abuse Prevention and Treatment (SAPT) Block Grant Set-a-Side

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$800,079	*
2006	$825,350	*
2007	$851,383	*

Fiscal Year	Awarded Amount	Planned Amount
2008	$851,000	*
2009	$851,000	*
2010	*	*
2011	*	*
2012	*	*

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Data for Performance Measurement & Management

Data Infrastructure Grants (DIG)

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Following the reauthorization of SAMHSA under the Children's Act of 2000 (PL106 310), Congress called on SAMHSA to collaborate with the states on developing outcome and performance accountability for the Block Grant programs. SAMHSA identified ten National Outcome Measures (NOMS) required for outcome and performance reporting. In 2002, the Center for Mental Health Services (CMHS) funded the Mental Health Data Infrastructure Grant (DIG) Program to begin developing and collecting NOMS measures within the Uniform Reporting System (URS), for consumers served within the State Mental Health Authorities (SMHAs). The overall goal was to enable the States to develop the infrastructure needed to support uniform data reporting across State Mental Health Agencies and across multiple local agencies. The primary objectives of the DIG Grant have been (1) to collaborate with States on state testing, developing, and refining of uniform outcome measures, focusing on the NOMS, and (2) to support development of data infrastructure within states for reporting outcome measures.

The DIG is supported by a State Data Infrastructure Coordinating Center (SDICC) which collects and reports state data, works with grantees to address reporting, refine measures, and further develop URS and NOMS measures, identifies technical assistance and evaluates data on URS for uniformity of reporting, use in state planning, and significance. The future of the SAMHSA/CMHS State mental health data reporting program continues to evolve with current implementation of a State Client Level Data Pilot involving nine States, testing the feasibility of implementing client level reporting in the States.

Where do we want to go?

The goal of DIG grant activities is for 100% of reporting of the URS and NOMS by all states. As states improve on reporting capability, there is interest in moving forward in areas such as: 1) assessment and improvement in data quality of state reporting; 2) refinement of the URS and NOMs by piloting of existing and new outcome measures; 3) continuing current ties to the Centers for Disease Control (CDC) Intra-agency agreement to support further work on mental health surveillance in the state;, 4) increase in collaboration with MHBG planners to tie data planning to mental health programs, for example strengthening data analysis capacity of MHBG Planning Councils, and strengthening benchmarking capabilities in the states; 5) continued work with the Pacific Jurisdictions in developing measures that reflect cultural competence;, 6) maintaining a knowledge base among the DIG grantees on significant federal initiatives such as electronic health records; and 7) providing technical assistance to states in data infrastructure development and technology. Additionally, the feasibility of all states reporting client level data for the NOMS continues to be assessed through the current pilot project.

How will we get there?

Individual DIG grants are awarded to 54 Grantees for FY07, FY08, and FY09. An annual total of $7 million is awarded with individual grants funded at $142,200 for States and $71,100 for U.S. Territories. The Client Level Data Pilot Project is funded through FY 08 with a projected completion date of Fall 2009. Fifty Four SMHAs are funded through CMHS DIG Grants to provide performance measures to meet requirements of the MHBG. The DIG program works with State MHBG Planners who are included in monthly DIG conference calls and participate in the DIG Annual Meeting to strengthen collaboration in reporting of NOMs through the Block Grant. State MHBG Planners and data representatives also attend the Annual Mental Health Block Grant Conference.

Funding Mechanism: Grant

How will we stay on course?

The program has demonstrated continued improvement in reporting of NOMs performance measures reported to the MHBG program and the Office of Management and Budget. This has met the GPRA expectations of increased number of reporting of NOMs by States. Additionally, an independent evaluation of the MHBG Program, including data reporting, is currently being conducted by an independent contractor.

This program has resulted in meeting the Mental Health Block Grant (MHBG) requirements for state and national reporting of the NOMs. By 2007, 85% of all State DIG Grantees were able to report on 8 of the 10 National Outcome Measures. Fifty States, the District of Columbia, and the 8 U.S. Territories are reporting on the same performance measures for 6,121,641 consumers served annually in public mental health systems throughout the nation. States report more broadly on 21 reporting tables that focus on utilization and outcome, and a survey is implemented in all states reporting consumer perception of outcome and treatment. In addition to reporting on the NOMs, emphasis has been placed upon the importance of use of data for decision making and policy development within state systems.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Mental Health Block Grant Set-Aside

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$7,446,899	*
2008	$7,920,000	*
2009	$7,691,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 8:41:33 AM

Reducing Stigma & Discrimination & Other Barriers to Services

Campaign for Mental Health Recovery

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The 1999 U.S. Surgeon General's mental health report identified "stigma" as the greatest barrier to recovery for people with mental health problems. In response, SAMHSA convened a national symposium in March 2000 to develop a strategic plan to address this key issue. As a result of the meeting, SAMHSA implemented two major recommendations, the formation of a national technical assistance center on prejudice and discrimination called the Resource Center to Promote Acceptance, Dignity, and Social Inclusion also known as the ADS Center and the Elimination of Barriers Initiative a Social Marketing Demonstration program. The program is designed to test public education messages and develop an evidence-base for a national campaign to promote social inclusion and recovery for individuals with mental illnesses. In December 2006, SAMHSA launched the Campaign for Mental Health Recovery (CMHR). The CMHR consists of a comprehensive social marketing campaign with an interactive website and multi-media educational materials; the Voice Awards program; the ADS Center; the CMHR State Awards program; and the CMHR State Partnership Network.
The first phase of the social marketing campaign for the CMHR is entitled "What a Difference a Friend Makes" http://whatadifference.samhsa.gov/ that targets young adults 18-25and includes television, radio, print, outdoor, and interactive web-based public service announcements. Since the launch of these materials, the Campaign has received over $60 million in donated media and gone through extensive evaluation that has confirmed its effectiveness.

The Voice Awards http://whatadifference.samhsa.gov/voiceawards/ began in 2006 and is held annually to honor writers and producers of film and television productions who create respectful and accurate portrayals of individuals with mental illnesses. The Voice Awards also recognize consumer leaders who have made outstanding contributions to their communities to promote social inclusion.

The ADS Center http://www.stopstigma.samhsa.gov/ is a national technical assistance center to provide support for State and local efforts to foster social inclusion via a 1-800 number.
Callers receive assistance on how to design, implement, and evaluate an evidence-based program to reduce prejudice and discrimination; a database of current research; bi-monthly web-based teleconferences on how to identify and successfully respond to various forms of prejudice and discrimination.

The CMHR State Awards program provides support for State and community organizations to promote the campaign; and the CMHR State Partnership Network serves as an identified resource for the CMHR at the State and local level.

Where do we want to go?

CMHS is in the process of developing the next two phases of the social marketing campaign that will build on the existing "What a Difference a Friend Makes" theme. The second phase will target young adult multicultural audiences including Latino Americans, African Americans, Asian Americans, and American Indians and is expected to launch in early 2009. The third phase targets young adult audiences using an expanded, comprehensive, interactive-based strategy that takes advantage of the synergy of the existing theme with the social networking phenomenon on the internet. Several other pressing public education needs that SAMHSA has begun to address include:

- The impact of trauma on mental health. This is important given the needs of returning military service personnel and their families;
- The employment of people with mental illnesses. In particular, there is a need to target employers to encourage them hire and retain consumers; and
- Wellness for people with mental illnesses. This is needed to address the high rates of co-morbidity and early mortality – estimated at 25 years – experienced by consumers.

How will we get there?

Research has identified three effective means for countering prejudice and discrimination associated with mental illness: public education campaigns, reward strategies, and interpersonal contact approaches. The CMHR will continue to employ a comprehensive strategy that includes all three:

- a proven effective, ongoing, social marketing campaign that educates the public and encourages them to act;
- an awards program that addresses influential media portrayals of people with mental health problems;
- continual support to State and community organizations that specifically uses interpersonal contact approaches to impact attitudes, beliefs, and behavior.

The CMHR will continue to develop TV, radio, print, outdoor, and interactive public service announcements with supporting materials and a campaign infrastructure; the Voice Awards program to impact the entertainment industry; and a nationally-recognized technical assistance center that provides extensive support, creates multiple educational services and products, and promotes the CMHR through an extensive grassroots outreach component. This comprehensive, evidenced-based approach, along with consistency of messaging and exposure of materials over time, provides the best opportunity to reduce prejudice and discrimination associated with mental illnesses.

Funding Mechanism: Contract

How will we stay on course?

Since the CMHR was launched in December 2006, the "What a Difference a Friend Makes" campaign has received over $60 million dollars in donated media and ranks in the top 5 for Ad Council campaigns (out of approximately 60 national campaigns) for radio advertising. The Campaign has also scored highly for website engagement and interactive media. Nearly 700,000 campaign brochures have been distributed making it one of the most highly requested items from SAMHSA. The CMHR has a myriad of media monitoring and tracking results that demonstrates its

effective reach. SAMHSA partnered with NIMH to conduct a study of the CMHR materials and found them to have a positive impact on attitudes, beliefs, and behavior of the target audience. In addition, a pre-post survey was also conducted to assess awareness of the materials and impact on attitudes with positive results. The CMHR also conducted a survey of PSA directors nationwide to assess the favorability of the campaign again with positive results. Lastly, CMHR focus group testing and message checks have shown that the messaging and materials are effective. The Voice Awards have steadily grown over the first 3 years of the program. Each year has seen an increase in sponsored partnerships by major mental health organizations; growing recognition and support of the event in the entertainment industry; and increased media attention and national awareness. The resources of the ADS Center have been used by hundreds of thousands of Americans since its inception. The technical assistance program has responded to approximately 20,000 calls and emails. The research database maintains over 2,000 articles online. Over 6,000 people have participated in ADS Center web-based audio trainings and more have accessed the archived trainings on the website. The ADS Center also produces web casts that can be accessed online. All of these programs have excellent performance records for timely and quality deliverables and have scored highly on their annual performance evaluations.

Overview Program/Project/Activity Management:

- Funding Source

  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$678,000	*
2006	$383,259	*
2007	$1,873,340	*
2008	$1,895,236	*
2009	$2,003,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 11:09:43 AM

Cultural Competency / Eliminating Disparities

Indian Country Methamphetamine Initiative

Substance Abuse and Mental Health Services Administration

IOA

Where are we now?

In 2006, methamphetamine abuse and production were identified as a problem by Tribes through Tribal Round Table sessions, the Department of Health and Human Services (HHS) Regional Tribal Consultations, and numerous tribal community gatherings with the Office of Minority Health (OMH), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Indian Health Service (IHS), and the Department of Justice (DOJ). The current picture of methamphetamine use, especially among young people, is heavily weighted towards States where American Indian/Alaska Native (AI/AN) people live. In response to this problem, the federal partners came together with the National Institutes of Health (NIH) and created the Indian Country Methamphetamine Initiative (ICMI).

There are now 10 Tribes and 5 national Tribal organizations involved with the ICMI project. The Tribes are the Chippewa-Cree Tribe, the Choctaw Nation, the Crow Nation, Gila River Indian Community, the Navajo Nation, the Northern Arapaho Tribe, the Salt River Pima-Maricopa Indian Community, the San Carlos Apache Nation, the Winnebago Tribe, and the Yakama Nation. The national organizations are National Congress of American Indians (NCAI) that serves as the program lead for national media outreach, the Association of American Indian Physicians (AAIP) that subcontracts with One Sky Center, Inc., Northwest Portland Area Indian Health Board (NPAIHB), and United South and Eastern Tribes, Inc (USET) for a national evaluation and the creation of a national survey pilot. Three agencies, NIH, OMH, and SAMHSA provide funding for this Initiative. IHS, BIA, and DOl provide technical assistance relevant to their areas of expertise. SAMHSA's national role in this Initiative involves direct coordination with the Tribes, providing training and technical assistance to Tribal members, and building reporting and evaluation capacity of the Tribes.

Where do we want to go?

These ongoing activities are designed to address the overarching goal of promoting safe and healthy Indian communities through multiple strategies in multiple sectors. With a focus on community improvement and development, the ICMI stakeholders have developed an information and outreach campaign and a culturally-specific methamphetamine use education toolkit that has been sent to every Tribe. The other national Tribal organizations are working with the Tribes to document and evaluate promising practices. Locally, every Tribe has a multi-disciplinary team/partnership that has a unique and locally-informed approach to problem-solving, delivering promising practices and increasing awareness. As a result of this local approach, an additional $1 million has been provided to the Tribes from HHS to address HIV/AIDS and an additional $1.9 million has been provided to the Tribes from the Corporation for National and Community Service to develop youth-led service learning projects.

Tribal College/University Initiative

In partnership with the Office of HIV/AIDS Policy, IHS, Office of Women's Health, Centers for Disease Control and Prevention, and the Health Resources and Services Administration, SAMHSA has implemented a Tribal College HIV Prevention Initiative with seven Tribal Colleges and Universities that are affiliated with the ICMI Tribes to include Salish Kootenai College in Montana, Wind River Tribal College in Wyoming, Dine College in Arizona, Little Big Hom College in Montana, Little Priest Tribal College in Nebraska, Navajo Technical College in New Mexico, and Stone Child College in Montana. This project supports students as peer educators to conduct campus awareness activities that focus on HIV/AIDS, substance abuse, and hepatitis prevention. Students through their educational activities also encourage students to get tested for HIV to "know their status." This past year over 1,581 students were tested for HIV and ofthose tested, 1,199 of these students were first-time testers. In addition, over 1,423 students participated in peer-led education and awareness sessions.

How will we get there?

Qualitatively, the tribal partners are reporting on progress, local collaborations, and outcomes as per their individual plans. OMH is the federal lead in supporting an overall evaluation component of the program. This product is in development and will include uniform qualitative and quantitative measures. Additionally, OMH is directing the national partners in the development, distribution, analysis, and reporting of a national methamphetamine prevalence and impact survey.

Funding Mechanism: Contract

How will we stay on course?

Overview Program/Project/Activity Management:

- Funding Source
  Inter Agency Agreements with other federal partners and contracts.

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	$389,000	*
2009	*	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/28/2009 6:06:09 PM

Cultural Competency/Eliminating Disparities

Internal SAMHSA Tribal Issues Work Group

Substance Abuse and Mental Health Services Administration

IOA

Where are we now?

In 2008, the internal SAMHSA Tribal Issues Work Group (TIWG) was reactivated to help address the Cross-Cutting Principal of Culturally Competency/Eliminating Disparities. The TIWG is an internal, voluntary group comprised of SAMHSA employees from each Center/Office who have an interest in service to American Indian/Alaska Native (AI/AN) communities. The TIWG meets monthly to discuss ongoing efforts to strengthen and support the SAMHSA Tribal Agenda.

In April 2008, the TIWG hosted an all-SAMHSA roll-out of the "Culture Card: A Guide to Build Cultural Awareness, American Indian and Alaska Native." The "Culture Card" is a pocket size fold-out informational document. The roll-out event included a traditional opening, drumming and food sampling. The agenda also included an interactive presentation on federal-tribal relations by the TIWG members. Over 200 federal employees attended the event and received a "Culture Card" to reference in their work with AI/AN communities.

At the request of SAMHSA Project Officers and recommendation of the SAMHSA Tribal Technical Advisory Committee, the TIWG developed an AI/AN Cultural Competency Project Officers' Retreat. The retreat was designed to provide guidance on how to effectively work with AI/AN communities including a format that is similar to the Gathering of Native Americans format used by the SAMHSA Native Aspirations suicide prevention contract. The TIWG collaborated with SAMHSACenter for Substance Abuse Prevention's Native American Center for Excellence (NACE) to develop the retreat agenda and activities. In November 2008, over 60 Project Officers were part of the retreat. The TIWG and NACE will again collaborate to provide follow-up training in 2009. In August 2009, over 45 SAMHSA Project Officers participated in introductory and intermediate courses.

The TIWG hosted a Pow Wow and Storytelling event in honor of National American Indian Heritage Month in November 2008 for SAMHSA employees. This event also included two panels to discuss cultural significance of dancing, singing, drumming and feasting among AI/AN communities. In recognition of National American Indian Heritage Month in November 2009, the TIWG will host an agency-wide event to focus on SAMHSA AI/AN grantees.

Where do we want to go?

There is an existing Federal online course "Working Effectively with Tribal Governments" that would be a starting point for employees who do not have any experience working with and serving AI/AN communities. The training was developed by the White House Office Intergovernmental Affairs' Indian Affairs Executive Working Group and was rolled out in November 2007. At a minimum, the TIWG recommends SAMHSA Project Officers be required to take the online training. As an eventual goal, the TIWG would like to develop a certified mandatory AI/AN training for all SAMHSA Project Officers who work with AI/AN grantees. Utilizing feedback from the AI/AN Cultural Competency

Project Officers' Retreat, the TIWG in collaboration with the NACE will pursue certification of the training module so that Project Officers can obtain CEU credits. The purpose of this training is to ensure that Project Officers are familiar with the AI/AN communities that their grants serve as well as understand the unique legal relationship between the federal government and the Tribes.

How will we get there?

The TIWG, CSAP/NACE and Senior Advisor for Tribal Affairs will continue to work in collaboration to evaluate the Project Officer's training needs. The next step will be determining how to proceed with certifying the materials and possibly offering to all interested SAMHSA employees.

Funding Mechanism: Contract

How will we stay on course?

Support for the TIWG activities will be incorporated into existing contracts.

Overview Program/Project/Activity Management:

- Funding Source
  To be determined

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	*	*
2009	*	*
2010	*	*
2011	*	*
2012	*	*

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Cultural Competency / Eliminating Disparities

SAMHSA Tribal Technical Advisory Committee (STTAC)

Substance Abuse and Mental Health Services Administration

IOA

Where are we now?

The revised 2007 SAMHSA Tribal Consultation Policy, Section X (B), SAMHSA Tribal Technical Advisory Committee (STTAC) established the STTAC to address the then existing SAMHSA Cross-Cutting Principals of (1) Reducing Stigma and Discrimination & Other Barriers to Service; (2) Cultural Competency/Eliminating Disparities; and (3) Rural & Other Specific Settings. The STTAC supports the SAMHSA Tribal Agenda, specifically to improve Tribal Consultation and implementation of the revised Tribal Consultation Policy. The STTAC was established in the revised approved March 2007 SAMHSA Tribal Consultation Policy (SAMHSA/TCP). The SAMHSA/TCP calls for a 14 member committee representing 12 specific areas of Indian Country and 2 National tribal organizations. The 12 area members must be currently elected tribal leaders thereby the STTAC exempt from the Federal Advisory Committee Act and its stringent legal requirements. The SAMHSA Senior Advisor for Tribal Affairs within the Office of the Administrator serves as the STTAC Executive Director.

The purpose of the STTAC is to provide guidance to the Administrator on issues affecting Indian Country including: reducing barriers to accessing SAMHSA grants; boosting federal cultural competency; and rural conditions limiting Tribal access. The STTAC held its inaugural two day meeting in February 2008 at the SAMHSA building in Rockville, MD. The agenda included one-day to develop their charter and one day to familiarize them with SAMHSA structure. The STTAC held its second two-day meeting in August 2008 in Billings, MT, at the SAMHSA sponsored "Federal Interdepartmental Tribal Justice, Safety and Wellness Government-to-Government Consultation, Training and Technical Assistance" session. The agenda included a day of STTAC discussions and one day of participation in tribal consultation roundtable discussions. The STTAC held its third meeting in Rockville, MD, January 21-22, 2009. The most recent offsite STTAC meeting was held Tulsa, OK, as part of the "Tribal Justice, Safety and Wellness" session #9.

Where do we want to go?

The STTAC is required by SAMHSA policy and their charter to convene face-to-face two times a year. The goal is to annually have a full committee at the begining of the year at the SAMHSA offices in Rockville, MD and to hold the second meeting in Indian Country. The STTAC formed three subcommittees to develop position papers on: (1) State-Tribal relations; (2) Services; and (3) Policy Development, e.g. SAMHSA reauthorization. These subcommittees will be meeting telephonically to develop their papers. The STTAC would like their position papers conveyed to the new Administration.

How will we get there?

The Senior Advisor for Tribal Affairs serves as the STTAC Executive Director. The Executive Director will need to work with the co-chairs and leads for each subcommittee to organize teleconferences and to develop position papers. Under the Services subcommittee, the STTAC has encouraged SAMHSA to boost cultural competency among our Project Officers whose portfolios include serving American Indian/Alaska Native (AI/AN) communities. The training is expected to help the Project Officers understand the government-to-government relationship with Tribes and the AI/AN culture.

The AI/AN Cultural Competency Project Officers' Retreats were held November 6 and 13, 2008 to address this STTAC suggestion. The Senior Advisor for Tribal Affairs in coordination with the internal SAMHSA Tribal Issues Work Group and the CSAP Native American Center for Excellence developed, implemented and evaluated the retreat. In 2009, a second set of Cultural Competency trainings were offered to SAMHSA Project Officers. The STTAC has encouraged SAMHSA to continue to support the "Federal Interdepartmental Tribal Justice, Safety and Wellness Government-to-Government Consultation, Training and Technical Assistance" sessions. Specifically, the STTAC would encourage the consultation with Tribes to be more prominent at these sessions in the field to capture more Tribal leadership input along with discussions with State leadership.

Funding Mechanism: Contract

How will we stay on course?

The Executive Director will work with the Co-chairs to help the subcommittees meet their goal of developing tribally-driven position papers. The Tribal Coordinator who is supervised by the Senior Advisor for Tribal Affairs, will work with SAMHSA's internal Tribal Issues Work Group (TIWG) to implement AI/AN specific Project Officer's trainings in the future. The TIWG and SAMHSA's Center for Substance Abuse Prevention are collaborating on providing the follow-up training in 2010 for all SAMHSA employees.

The STTAC has identified 3 priority areas to focus on for the next two years: 1) State-Tribal Relations-- pilot program with discussions between Tribes and States (MT, NM and AZ) to determine how these States work with their respective Tribes. 2) Recommendations for Policy Development-- meetings to receive updates on SAMHSA reauthorization so STTAC can report current/accurate information back to their respective regions/constituents; and promoting consultation with Tribes as part of the federal interdepartmental Tribal Justice, Safety & Wellness sessions. SAMHSA will work with the National Congress of American Indians to promote Tribal Consultation; and 3) Services Promoting Tribal Issues—continuing education and training of SAMHSA staff and other interested federal agencies on Tribal issues including a Government Project Officers' training.

Overview Program/Project/Activity Management:

- Funding Source
  The STTAC is funded through SAMHSA contracts.

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*

Fiscal Year	Awarded Amount	Planned Amount
2007	*	*
2008	*	*
2009	*	*
2010	*	*
2011	*	*
2012	*	*

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Cultural Competency / Eliminating Disparities

Tribal Training and TA (T / TA)

Substance Abuse and Mental Health Services Administration

IOA

Where are we now?

The strategy that SAMHSA has taken to the very complex problems, issues and challenges in Indian Country is one of partnership. Through partnerships, SAMHSA has addressed training and technical assistance as demonstrated through the Tribal Justice, Safety and Wellness sessions; through partnership SAMHSA has addressed meth abuse through the HHS Indian Country Methamphetamine Initiative (ICMI)-Public Health; and through partnership is expanding its outreach, education, stigma reduction, prevention, treatment, capacity building for Native Americans and Alaska Natives at risk for substance use and HIV/AIDS. The need for those at the federal level to continue engaging Tribal leaders, organizations and communities is clear. No one agency can solve the many issues of concern related to public health and public safety for Indian Country alone.

In 2006, Tribal Leaders and other tribal members emphasized the need to improve tribal capacity and infrastructure through tribal training and technical assistance (TT&TA) to tribal communities. The Department of Justice, Bureau of Justice Assistance/Office of Justice Programs responded to their stated needs by making available a series of four TT&TA sessions organized across the country, beginning in December 2006 and concluding in August 2007. In order to make these sessions as useful as possible, BJA/OJP invited other DOJ agencies and other Federal agencies to join them in conducting the TT&TA series. DHHS/SAMHSA became the first Federal partner of DOJ to work on solving the many issues of concern, especially methamphetamine use and suicide prevention.

HHS/SAMHSA and DOJ/BJA/OJP held the first session in a series of four in Palm Springs, CA with over 200 participants. The trainings offered general session topics on public safety and health for Indian Country; public safety challenges and priorities in Indian Country; AI/AN barriers to accessing Federal resources; and additional topics on federal grants application submissions and the grants management process including http://grants.gov training and Tribal best practices. Sessions on issues of concern included topics such as methamphetamine use, sex offender registry, Amber alert, suicide prevention and effective multi-jurisdictional partnerships and strategies. The three other sessions were held in 2007: (March), Prior Lake, MN with 450 participants; (June), Shelton, WA with 375 participants; and (late July/early August), Phoenix, AZ with 650 participants.

Due to the success of the four initial sessions, three additional trainings were offered in 2007-2008. To date, nine successful sessions have taken place with Session #7 held in Billings, MT and attended by over 1,000 participants; and session #8 held in Palm Springs, CA with 200 participants. The Federal partners, who include: the Department of Health and Human Services (HHS) through its Substance Abuse and Mental Health Services Administration (SAMHSA), Indian Health Service (IHS), and the Office of Minority Health (OMH) in the office of the Secretary; the Department of Justice (DOJ) through its Office of Justice Programs (OJP), Community Oriented Policing Services (COPS), Native American Issues Subcommittee (NAIS) in the Executive Office of U.S. Attorneys (EQUSA), Office of Tribal Justice (OTJ) and Office of Violence Against Women

(OVW); U.S. Department of the Interior (DOI), Bureau of Indian Affairs (BIA); U.S. Department of Housing and Urban Development (HUD) through its Native American Programs (ONAP); the Small Business Administration (SBA); and The Corporation for National and Community Service (CNCS) are committed to working together to enhance Tribal justice, safety, public health, safe housing and economic development in Tribal communities.

Session #9, held in Tulsa, OK, topics included panel discussions and workshops on the American Recovery and Reinvestment Act of 2009; health care reform; tribal data systems, reporting and information sharing; Inspector General audit compliance; and the Indian Country Methamphetamine Initiative, among others. In addition, DOJ held a pre-conference session on the Sex Offender Registration and Notification Act and an evaluation session on the Tribal Justice, Safety, and Wellness sessions. The conference also featured a full-day pre-conference grant writing skills enhancement workshop and a pre-session meeting on State-Tribal Relations hosted by SAMHSA.

Session #1: December 5-62006 (Palm Springs, CA)
Session #2: March 27-29, 2007 (Prior Lake, MN)
Session #3: June 4-6, 2007 (Shelton, WA)
Session #4: July 29-August 1, 2007: Phoenix, AZ
Session #5: November 27-30, 2007 (Santa Ana Pueblo, NM)
Session #6: March 5-7, 2008: (Washington, DC)
Session #7: August 18-22, 2008, Billings, MT
Session #8: December 8-13, 2008, Palm Springs, CA
Session #9: August 10-14, 2009, Tulsa, OK

For background information on Tribal Justice, Safety and Wellness Sessions 1 thru 9, please follow this web link: http://www.tribaljusticeandsafety.gov

Where do we want to go?

In follow up to the 2006 HHS final Grants Barriers Report which studied barriers to grants access for American Indian and Alaska Native Tribes accessing DHHS discretionary grants, the study offered strategies for improving access. In response to the study, SAMHSA took the following steps:

- Established a policy that made Tribes eligible to apply for all SAMHSA grants;
- Implemented a new tribal agenda that began with the highest priority to make revisions to its existing Tribal Consultation Policy (TCP) and establish a SAMHSA Tribal Technical Advisory Committee (STTAC);
- Convened an internal workgroup to develop strategies to remove barriers by reviewing the language used in our Requests for Applications (RFAs).
- Convened a Tribal Grants Review Team to get Tribes direct input and participation in the barriers removal process; and
- Became a federal partner of Tribal Justice, Safety and Wellness that was established to help improve tribal capacity and infrastructure through tribal trainings and technical assistance.

The need for those at the federal level to continue engaging Tribal leaders, organizations and communities is clear. No one agency can solve the many issues of concern related to public health and public safety for Indian Country alone. These Tribal Justice, Safety and Wellness Government-to-Government Consultation Training and Technical Assistance Sessions have provided many opportunities for Tribal leaders to learn about SAMHSA's Grant Programs as well as important information regarding grants administration, financial management, tips for successful grant writing, overviews on various federal funding sources and information on Tribal Drug Courts.

Also, as a result of Sessions 1 thru 9, a document entitled: Interdepartmental Tribal Justice, Safety & Wellness Government-to-Government Consultation Matrix: Prioritization of Proposed Solutions has been developed where tribal leaders have identified a broad range of issues and challenges in Indian Country.

Until the goal is reached, which is to find solutions to the challenges and concerns that have been identified in this document, SAMHSA should continue its participation in the Tribal Justice, Safety & Wellness Government-to-Government Consultation, tribal trainings and technical assistance sessions.

How will we get there?

The continuation of the Government-to-Government relationship using Consultation is the manner in which SAMHSA operates to insure that the Government-to-Government relationship is respected and is the standard way that the Federal Government relates to and operates with Tribes. It is expected that Tribal Consultation will lead to collaborative efforts and relationships, intergovernmental coordination, and support of Tribal self-determination that supports local ingenuity and local solutions that result in tangible benefits in Tribal communities.

Funding Mechanism: Multiple

How will we stay on course?

Efforts will be sustained through the SAMHSA TCP that provides guidance for working effectively with Indian Tribes to maximize access to services, programs and resources within SAMHSA.

The TCP acknowledges and affirms common goals with other HHS Divisions, Indian Tribes, Tribal Organizations, Indian Organizations and Native Organizations to: 1) eliminate health and human services disparities faced by AI/AN; 2) maximize access to substance abuse and mental health services; and 3) achieve health equity for all AI/AN people and communities.

Overview Program/Project/Activity Management:
- Funding Source
  IAA with other federal and non-federal programs/agencies and direct congressional appropriations

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$100,000	*
2008	$200,000	*

Fiscal Year	Awarded Amount	Planned Amount
2009	$200,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/28/2009 5:50:35 PM

Cultural Competency / Eliminating Disparities

Circles of Care Grant Program

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Circles of Care (COC) program is a 3-year discretionary infrastructure grant program for American Indian/Alaska Native (AI/AN) organizations administered by the Child, Adolescent and Family Branch of the Center for Mental Health Services. The COC program was created in 1998, in response to the collective vision of a large number of AI/AN tribal members, service providers, advocates, researchers, and federal agency representatives. Primary goals of the program include: (1) planning for the development of a community-based system of care model for children with serious emotional disturbance and their families, and (2) the development of local capacity and infrastructure to assist tribal communities with obtaining funding and resources to implement their model system of care. The COC program promotes the system of care approach, which is based on the principles of family-driven and youth-guided care that is provided in a culturally competent manner through community-based, coordinated and collaborative interagency partnerships. This grant program distinguishes itself by being the only SAMHSA grant that is designed solely for AI/AN communities. Eligible entities are federally recognized Indian tribes, state recognized Indian tribes, and tribal organizations including urban Indian organizations and Tribal Colleges and Universities. In the first three cohorts for the grant program, a total of 23 AI/AN tribes, tribal organizations and urban Indian programs received funding. The fourth cohort of 8 grantees is being funded from FY08 through FY10.

Where do we want to go?

To meet the goals and objectives of the grant program and individual community goals, the Circles of Care grantees are expected to engage tribal and State service agency administrators and direct service workers from multiple child service agencies including primary care, mental health, substance abuse, juvenile justice, child welfare, education and other service organizations. As a community-based program, grantees are also expected to engage youth, families, community leaders and advocates, traditional healers and elders, tribal elected officials and other concerned citizens. To impact larger scale policy change, grantees are also expected to engage State and tribal level policy makers and federal agency policy makers where appropriate.

During the first year of the project, the grantees engage in the following activities:

- conduct an in-depth analysis of the existing infrastructure of the local child serving system to identify policy;
- service gaps and potential resources;
- facilitate culturally respectful strategic planning activities engaging community members, key stakeholders, youth, elders, spiritual advisors and tribal leaders to identify outcome expectations and measures;
- implement consensus building to develop a culturally relevant logic model for an integrated system of care through family-driven and youth-guided approaches; and

- utilize culturally appropriate social marketing techniques to broaden the awareness of behavioral health and reinforce commitments from system partners.

During years two and three of the project, the grantees engage in the following activities:

- formalize interagency commitments;
- reinforce the role of community leaders, members, youth and families in decision-making;
- develop policies, corresponding funding streams and other strategies for implementation and sustainability of the model system of care;
- identify evidence-based practices that may be culturally relevant in the community;
- identify the role of traditional healing practices in the community, especially if there are indications that such integration will reduce disparities in mental health care;
- conduct trainings to expand service capacity;
- confirm performance measures for system assessment; and
- complete the feasibility assessment and process evaluation, leading to adoption of the model.

How will we get there?

Each grantee produces several key documents through a series of community-based activities over the course of the grant:

1. Local definition of "Severe Emotional Disturbance,"
2. Current Service System Assessment,
3. Community Needs Assessment,
4. Local Outcome Measures for infrastructure development,
5. Participation in Cross-Site Evaluation,
6. Process Evaluation,
7. Feasibility Study of Model System of Care, and finally
8. Model System of Care.

COC is a positive example of SAMHSA's Tribal Agenda goal to increase tribal access to SAMHSA grants. Most COC grantees have also been successful in securing additional SAMHSA grants, as a direct result of their work in this program. The COC grant program is closely aligned with the Center for Mental Health Service's Child Mental Health Initiative Cooperative Agreement, also known as the Systems of Care program. In addition to the funding, grantees receive community and program development technical assistance through an Interagency Agreement with the Indian Health Service who contracts with the National Indian Child Welfare Association. Evaluation technical assistance and a cross-site evaluation are provided by the National Center on American Indian and Alaska Native Research at the University of Colorado Health Sciences Center.

Funding Mechanism: Grant

How will we stay on course?

Each grantee evaluate their own local outcomes based on the activities described above and in most cases protocols are approved by local Institutional Review Boards. Outcome measures/domains for the cross-site evaluation are negotiated through a consensus building process with the grantees and the evaluation technical assistance providers. The overall focus of the evaluation is to document the impact of grant activities on the two overall goals of the

program: (1) planning for the development of a community-based system of care model for children with serious emotional disturbance and their families, and (2) the development of local capacity and infrastructure to assist tribal communities obtain funding and resources to implement their model system of care.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$3,000,000	*
2006	$3,000,000	*
2007	$3,000,000	*
2008	$2,948,000	*
2009	$2,948,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 8:11:09 AM

Cultural Competency / Eliminating Disparities

Eliminating Mental Health Disparities (EMHD)

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The Center for Mental Health Services (CMHS) is undertaking a major initiative to eliminate disparities in mental health services. This effort to eliminate disparities in mental health services includes a focus on racial and ethnic groups, along with disparities created by gender, gender expression, sexual orientation, disability, religion, socio-economic status, geography (e.g., rural, remote and frontier services), language, immigration status and family composition. The overall goal of this project is to develop and implement strategies that will facilitate the elimination of disparities across the life span.

Where do we want to go?

The Eliminating Mental Health Disparities (EMHD) Workgroup serves as a vehicle for CMHS, in conjunction and collaboration with the SAMHSA Cultural Competence/Eliminating Disparities (CCED) Workgroup, to develop and implement strategies to facilitate the elimination of disparities across the life span at the federal, state and local levels. The specific tasks coordinated by EMHD will ensure that services and supports are accessible and culturally and linguistically competent to meet the mental health needs of a culturally, racially and ethnically diverse population. The CMHS EMHD internal workgroup guides this initiative and includes representatives from across program areas. In addition, SAMHSA created the CCED Workgroup to provide guidance across all three centers as part of its broad efforts to eliminate disparities.

A product of the CCED workgroup is the development of a National Network for Eliminating Disparities (NNED). The EMHD initiative is an important component of SAMHSA's effort to establish a National Network, and to create activities that will contribute to the goal of eliminating disparities in behavioral health care. To effectively accomplish the activities associated with this project, EMHD will leverage the support and involvement of federal partners, national, state and local organizations, and agencies and other community groups to plan, develop and implement the tasks. These groups will assist by providing input into the development and implementation of activities in this project. Input will also be obtained to ensure coordination and collaboration, and to include expertise from individuals and groups that are committed to eliminating disparities across the life span.

How will we get there?

Human Resources Research Organization (HumRRO) has been contracted by the Office of Personnel Management (OPM) through an interagency agreement with SAMHSA to carry out the various tasks that will be required to accomplish this effort. This contract began in 2005, and will continue until the funding is exhausted. As this HumRRO contract comes to a close, which is

planned for mid 2009, the recently awarded AFYA contract has begun, which is a one year contract with 4 option years.
For the AFYA contract, HumRRO is serving as a primary subcontractor, so there will be fluidity and continuity among the tasks:

- Collaborate with the SAMHSA Cultural Competence/Eliminating Disparities (CCED) Initiative and the National Network for Eliminating Disparities (NNED) in the Creation of an External Workgroup on Mental Health Services Disparities
- Convene External Workgroup and Ad hoc Committees
- Convene Planning Meeting of the Federal Partners and Primary Contractors
- Enhance ability of the Center for Mental Health Services to increase knowledge of and opportunities for culturally competent behavioral health care for American Indian and Alaska Native populations
- Develop a database of consultants who can provide expertise and technical assistance on behalf of SAMHSA on issues of Latino mental health
- Develop an outline for a training curriculum targeted to mental health providers working in Cambodian-American communities
- Documenting the Mental Health Needs of AfricanAmericanCollege Students
- NNED Community Defined Evidence Project (CDEP)
- Expand Efforts to Promote the Use of Technology to Improve Access to Mental Health Services for Native American Veterans and Rural Communities
- Coordinate a consultative session and the development of a toolkit on integrating behavioral health and primary health care services for racially and ethnically diverse communities
- Facilitate the Implementation of Specialized Curriculum and Training on CLC in Children's Mental Health
- Expand Efforts to Increase Workforce of Color by Increasing Commitment to Universities
- Implement and evaluate training curriculum to providers working with Asian American, Native Hawaiian and Pacific Islander children, youth and families
- Convene Roundtable to Identify Best Practices in the Cultural Adaptation of Evidence-based Practices and the Systematic Development of Practice-based Evidence
- Reducing Mental Health Disparities in Minority Older Adults: A Research Agenda to Improve Culturally Responsive Services
- Utilize Public Education, Social Marketing and Awareness to Reduce Stigma and Increase Access to Mental Health Services
- Building Cultural Competency among Service Providers Working with Youth who are Homeless and Lesbian, Gay, Bisexual, and Transgender
- Convene a Policy Summit to Improve States' Capacity to Eliminate Mental Health Disparities
- Collaborate with the SAMHSA Cultural Competence/Eliminating Disparities (CCED) Initiative and the National Network for Eliminating Disparities (NNED)
- Support a Self-Assessment Initiative of the Center for Mental Health Services (CMHS)
- Promote the Use of Translation and Interpretation Services and Produce Deliverables in More than One Language NAMBHA—National Alliance of Multi-Ethnic Behavioral Health Associations NLBHA—National Latino Behavioral Health Association NAAPIMHA—National Asian American Pacific Islander Mental Health Association FNBHA—First Nations Behavioral Health Association NLC—National Leadership Council on African American Mental Health NNED—National Network to Eliminate Disparities UCDHSC—University of ColoradoDenverHealthSciencesCenter NCCBH—National Council for Community Behavioral Health National Technical Assistance Center for Children's Mental Health at GeorgetownUniversity AIR—American Institutes for Research USF—University of SouthFlorida, Research and TrainingCenter, Department of Child and Family Studies National Federation of Families for Children's Mental Health APA—American Psychological Association Vanguard Communication HRC—HomelessResourceCenter Sebastian Lantos, LLC HumRRO—Human Resources Research Organization AFYA, Inc.

Funding Mechanism: Interagency Agreement

How will we stay on course?

This activity does not have GPRA scores or PART outcomes because the mechanism is a contract. For each task within the overall contract, deliverables are requested that must be provided by the agreed upon date in order to receive payment. These deliverables include a wide range of products, from convening meetings and conference calls to Web site and toolkit development.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$1,000,000	*
2006	$1,890,000	*
2007	$947,000	*
2008	$913,000	*
2009	$885,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 8:59:15 AM

Cultural Competency / Eliminating Disparities

Native American Center for Excellence (NACE)

Substance Abuse and Mental Health Services Administration

CSAP / DSD / PTAB

Where are we now?

NACE supports outreach activities to tribal nations and organizations to enable these entities to apply for SAMHSA and other Federal agency grants and to have a clear understanding of the need for coordinating prevention funding, establishing and implementing policies and evidence-based programs, strategic planning, and developing infrastructure. The Center supports Native American tribes and tribal organizations and provides technical assistance to these communities to develop and implement their outreach activities. NACE has made several major accomplishments since SAMHSA has had this contract, including the formation of an Expert Panel of American Indian and Alaskan Native members, development of a Web site, creation of an environmental scan report and routine updates of that information, as well as the facilitation of several intensive trainings. Presentations, trainings, and conferences that NACE has facilitated include:

- Community Capacity Building Trainings for the Indian Country Methamphetamine Initiative
- Service to Science Academies for Native American Prevention Programs in 2008 and another academy in 2009
- Strategic Prevention Framework Webinars
- SAMHSA Project Officer Trainings in 2008 and another in 2009
- Multiple onsite trainings in Native Communities throughout the U.S.
- A gathering of "who's who" of researchers and evaluators in Indian Country at the American Indian and Alaskan Native Evaluation Summit in 2009
- Multiple national conference presentations including CADCA and the IHS/SAMHSA Behavioral Health Conference
- NACE and Native Aspirations SAMHSA-Funded Project Presentations
- Curriculum development to address the need in Indian Country to prepare for prevention certification

In addition, the NACE Web site and environmental scan report were created to collect and disseminate information on both cultural- and evidence-based prevention and intervention strategies for the public, grantees, and grantors. The Web site and report remain important resources in meeting NACE's role to collect and disseminate knowledge.

Where do we want to go?

SAMHSA's objectives for the NACE contract are to prevent/reduce substance abuse and its related consequences among Native Communities from coast to coast in both rural/village and urban settings. Towards this end, NACE has developed and actively supports training and technical assistance to build learning communities of tribal members, content experts, and other stakeholders. In addition, NACE continues to build content expertise and knowledge dissemination in five 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. Lastly, NACE supports SAMHSA's efforts to expand eligibility to grant programs to federally-approved Tribal organizations through technical assistance and developing linkages between Native communities as mentors in this effort.
CSAP proposes to implement the recently-funded contract to accomplish the above goals. The contract focuses on several target audiences under its activities, including Tribal nations and organizations, health and social service providers, State level organizations, community and faith-based providers, and selected Programs of Regional and National Significance (PRNS).

How will we get there?

This contract will primarily utilize training and technical assistance to reach our objectives.

Technical Assistance
NACE will provide six to ten teleconference and/or Web-based technical assistance sessions per year to Native American prevention programs. NACE will also provide technical assistance to tribal State Incentive Grant (SIG) grantees implementing the Strategic Prevention Framework (SPF). Assistance will also be provided to community sub-recipients. In addition, using the Service to Science model, NACE will provide evaluation technical assistance to a minimum of five additional Native American prevention programs, practices, or policies each year.

Training
NACE will provide five one-day trainings per year. Two of the five are train-the-trainer events for SAMHSA's technical assistance centers, and three of the five are hosted for Native American prevention programs at regional or national events. In addition, NACE co-facilitated the Service to Science (STS) Academies, which are designed to enhance the capacity of Native American programs to improve their documentation of outcomes and evaluation designs. NACE also developed Curriculum trainings to assist successful testing for prevention certification. The NACE Web site and online resource database will secure access for tribal SPF-SIG grantees, NACE Expert Panel, and others. The target audience for the Web site are Native American children/youth, families, communities, schools, and tribal leaders.

Expert Panel
The Expert Panel will provide advice and guidance to SAMHSA and the NACE team on how best to develop, plan, communicate, and disseminate information on a range of issues related to substance abuse prevention and related services for Native Americans. Its 13 members are Native American or Alaskan Native and have distinguished backgrounds in social services, public health, behavioral health, higher education, and cultural practices and are geographically diverse. A SAMHSA representative is also a member of the Expert Panel.

NACE Web Site
The NACE Web site will serve as a clearinghouse for state-of-the-art Native American prevention information. It will provide training curricula and modules, PowerPoint presentations, research, reports, prevention program listings, and a searchable resource library. The Web site will be a public access resource. It will also include specific forums for NACE target audiences including the SPF-SIG grantees, Expert Panel members, Indian Country Methamphetamine Initiative grantees, and Service to Science participants.

Environmental Scan
A review of literature, from public and private data sources, was conducted regarding substance abuse and related disorders and health issues for Native Americans. The scan identified emerging issues, issues of immediate need, and gaps in the areas of substance abuse prevention and related issues.

Internal Related Program / Projects / Activities
NACE will be the content and delivery collaborator with the Tribal Issues Work Group in trainings of SAMHSA employees. NACE will continue to be aligned with SAMHSA objectives to improve SAMHSA's presence and training/technical provision to Indian Country.

Funding Mechanism: Contract

How will we stay on course?

Since the beginning of this contract, NACE has convened the NACE Expert Panel in multiple focus groups to gather qualitative information on Native American substance abuse prevention. The Expert Panel is also contacted regularly by NACE throughout the year through e-mail and phone calls to address specific topics and direction. In addition, the NACE Environmental Scan continues to provide guidance with routine updates that are collected and added throughout the year and reviewed by Expert Panel members for accuracy. The most common themes from that data source define the training and technical assistance path for NACE and guide the development of five "building blocks" of excellence (youth, families, schools, community, and tribal leaders/policy) that NACE continues to develop for the American Indian and Alaska Native populations.

Overview Program/Project/Activity Management:
- Funding Source
  Center for Substance Abuse Prevention - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	$1,300,000	*
2008	$1,100,000	*
2009	$1,000,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/8/2009 4:42:07 PM

Financing Strategies & Cost-Effectiveness

Financing Strategies and Cost-Effectiveness

Substance Abuse and Mental Health Services Administration

OPPB

Where are we now?

The nation is facing a continued and unsustainable escalation in health care costs. This growth coincides with a recent and significant down-turn in the national economy and, a continuation in historical trends that show shrinking expenditures for mental health and substance use disorders in comparison with overall health care. In addition, mental and substance use prevention and treatment services are not well understood by an influential number of policy makers in the public and private sectors who will be charged with making difficult decisions about allocating scarce health care resources. This environment creates circumstances under which mental/substance use services could be given astonishingly little consideration in the national health reform dialogue despite their potential for very large cost savings to the overall health and other publicly funded systems. For example, when mental/substance use disorders go untreated or under treated, they complicate medical treatments and place increasing medical, social and economic burden on individuals, families, and communities, as well as the entire health care and social welfare system. Depression and other mental illnesses that go untreated are expensive. They can slow recovery from serious physical illnesses and mask the symptoms of other illnesses. The societal costs of delayed mental health care or undiagnosed mental illnesses are estimated at more than $100 billion annually.

Where do we want to go?

The financing of mental health and substance abuse services faces significant issues over the coming years. In addition to dealing with a patchwork of state and federal funding, there are many different stakeholders all of whom want a voice in the future of these funding issues. The vision for the Financing Center of Excellence (COE) is to provide SAMHSA with the strategy, data, messages, materials and partners to bring SAMHSA "to the table" and meaningfully include mental/substance use disorders financing issues in the national healthcare dialogue. The COE will provide SAMHSA with access to leading experts, innovative insights, and tools and solutions for assessing and leveraging existing and new funding so as to sustain and grow mental/substance use disorders service delivery. The COE will serve as a national network to generate and share existing and emerging financing issues and ideas, and will support SAMHSA in becoming an articulate, persuasive and consistent voice, providing leadership to address today's financing dilemmas. SAMHSA's leadership will support other federal partners, consumers and their families, providers, States, researchers, legislators and others with the knowledge they need to take action.

How will we get there?

The Financing COE will realize its commitment to establishing strong financing expertise by supporting the development of innovative, efficient and effective mental health and substance use financing policy at the national, state, and local level. To serve as a repository for information that stakeholders and partners can utilize to advance the national conversation on mental/substance

use disorders financing issues, the COE will sponsor several initiatives focused on: monitoring public and private mental health and substance use treatment systems and synthesizing major trends and advances in service delivery financing; analyzing potential and real changes in mental/substance use disorders financing alternatives and the effects of these changes on delivery systems and consumers; and convening experts to identify mechanisms to foster sustainable improvements in the financing of mental/substance use disorders delivery systems which result in better health outcomes. These activities will complement and draw-upon Center-level financing activities related to Medicaid and Medicare funding, private insurance, and evidence based practices, among others. An internal SAMHSA "investor group" with representatives from across the agency guides the work of the COE. To date, a number of activities and products have been completed to advance these stated goals. Some of these include:

- website was launched with information about mental and substance use disorder prevention and treatment financing issue and data, including a list of relevant data sets;
- news pulse is distributed on a weekly basis summarizing national and state news and Congressional legislative activity;
- regular staff contact with the Centers for Medicare and Medicaid has increased and improved intra-agency collaboration; and
- briefings on the new parity legislation were delivered to leadership in SAMHSA and the Office of the Secretary, resulting in a SAMHSA leadership role within the HHS parity work group.

Other parity items include fact sheets and research of state parity laws;

- compendium of research studies on the cost effectiveness of prevention and treatment for mental and substance use disorders;
- a glossary of terms of art used in the industry and how mental and substance use disorders fit with the chronic condition concept; and
- a primer on Screening and Brief Intervention and research on Medicare uptake of SBI codes.

Funding Mechanism: Contract

How will we stay on course?

The nature of the COE may change over time as strategic priorities for SAMHSA and the incoming administration direct the issues that will rise to the forefront of healthcare (specifically mental/substance use) financing. Environmental scans of current topics and new solutions will help the COE stay on top of new developments in the field. These issues can be then researched further and new insights uncovered through data analysis and additional input from our network of stakeholders. As we disseminate this information through our website and other electronic communication, the COE will increasingly serve as an authoritative information repository for those looking to analyze the trends and understand the new developments in the field of mental/substance use disorders financing.

Overview Program/Project/Activity Management:
- Funding Source
  Program Reserve

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	$1,331,724	*
2009	$1,161,959	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/21/2009 12:21:45 PM

Disaster Readiness & Response

Disaster Readiness & Response

Substance Abuse and Mental Health Services Administration

OPPB

Where are we now?

Within SAMHSA, Disaster Readiness and Response is a cross-cutting management principle. SAMHSA's primary role in Disaster Readiness and Emergency Response focuses on the provision of Technical assistance and consultation. Policy, operations, command and control for emergency readiness and response are vested in the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR). Each OPDIV has an emergency coordinator as the single point of contact for ASPR, other OPDIVS and other Federal departments. In SAMHSA, the emergency coordinator is located in the Office of Policy, Planning and Budget (OPPB). ASPR assigns tasks to OPDIVs for developing plans and protocols and, during a disaster, delegates mission assignments for response and recovery. Although the behavioral health consequences of disasters are gaining national attention through the issuance of Homeland Security Presidential Directive 21, the National Response Framework and several studies conducted by the Government Accountability Office, SAMHSA does not have a specific authorization (neither legislative nor by delegation) for emergency response or a dedicated line appropriation for emergency response activities. Much of the funding in this area is external to SAMHSA, so SAMHSA resources are leveraged to integrate behavioral health with other disaster preparedness and response activities. The SAMHSA Emergency Coordinator works with other parts of HHS and external Agencies, such as the Federal Emergency Management Agency (FEMA) and the Department of Education, to coordinate disaster behavioral health and SAMHSA activities. Within SAMHSA response activities and pursuant to existing legal authorities and Homeland Security Presidential Directives, SAMHSA developed the SAMHSA Emergency Response Field Operating Guide (SERFOG). This National Incident Management System (NIMS) compliant plan guides SAMHSA incident operations in the management of an emergency event. As part of the HHS Pandemic Influenza Implementation Plan, SAMHSA developed a conceptual plan that is under revision to exist as a operational plan to continue critical programmatic and funding activities in the event of pandemic influenza requiring the use of social distancing as a worker protection strategy. SAMHSA operates two programs related to disasters response. The first is in conjunction with Federal Emergency Management Agency (FEMA) operates through Interagency Agreements between the two parties. This assistance is provided to disaster affected areas triggered by Presidential Disaster Declarations. SAMHSA also operates a small program called SAMHSA's Emergency Response Grant allowing the agency the ability to provide small assistance in events that don't rise to Presidential Declarations.

Where do we want to go?

Disaster Readiness and Response/Technical Assistance and Consultation. SAMHSA strives to educate policymakers, State/local government, grantees, media representatives, and community-based organizations through technical assistance and consultation about the behavioral health effects of disasters and emergencies and promote planning and preparedness activities to mitigate these affects in the general population. Additionally, SAMHSA serves as a spokesperson for our constituencies within local, State and Federal planning and response efforts to ensure that the special needs of consumers are appropriately addressed.

How will we get there?

SAMHSA works with Federal, State and local agencies to assist them in preparation for and response to disasters. Through partnership with FEMA, SAMHSA conducts preparatory national trainings and conferences. SAMHSA also holds seats on multiple disaster related committees and workgroups, and provides consultation and comment on all disaster related plans and policies at the departmental level. SAMHSA staff is required to take courses necessary for NIMS compliance. The SAMHSA Disaster Technical Assistance Center (DTAC) serves as a central repository for disaster behavioral information and resources, and supports SAMHSA efforts in the development and dissemination of new products. The SAMHSA DTAC Website is http://mentalhealth.samhsa.gov/dtac . OPPB has a dedicated FTE for the Emergency Coordinator, and a partial FTE for an alternate. Throughout SAMHSA, there is staff working in other areas at SAMHSA that also spend a portion of their time on Disaster Readiness and Response, supporting a variety of cross-Agency workgroups. SAMHSA currently maintains several cross-Agency workgroups in support of Disaster Readiness and Response: SERFOG Workgroup, Pandemic Influenza Planning Workgroup, and the SAMHSA Continuity of Operations Plan Workgroup. From these workgroups, SAMHSA has produced several internal policy and procedural documents, including the SERFOG, the SAMHSA NIMS Implementation Plan, the SAMHSA Pandemic Influenza Plan, and the SAMHSA COOP. External Collaborators include: ASPR and other OPDIVs within HHS; Department of Education, Department of Homeland Security, Department of Justice, and the Department of Defense. Outside the Federal government: State/local/tribal governments, American Red Cross, professional associations.

Funding Mechanism: Other

How will we stay on course?

SAMHSA stays on course in disaster and readiness issues through environmental surveillance, compliance with external directives and frameworks and worker protection efforts. Continue to plan and implement at least one staff training and/or exercise annually regarding SAMHSA disaster response including NIMS. Long Term: To integrate behavioral health into the public health emergency response, promote population resilience and prevent adverse substance abuse and mental health consequences through pre-event, event and post-event services and other activities. Overview Program/Project/Activity Management: SAMHSA is active in the following areas: (a) liaison with other emergency response organizations to provide technical assistance and consult on the behavioral aspects of disaster response; (b) assisting disaster affected areas and agencies through the provision of technical assistance and consultation; (c) provision and oversight of funding through FEMA/SAMHSA Crisis Counseling and Training Grants, and SAMHSA Emergency Response Grants; (d) the creation and publication of resources, guides and other informational dissemination tools; (e) creating and assuring internal planning is functional, up to date and compliant with directives and guides.

Overview Program/Project/Activity Management:
- Funding Source
  Program Reserve

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	*	*
2009	$165,000	*
2010	*	*
2011	*	*
2012	*	*

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Last Update: 10/9/2009 11:19:39 AM

Disaster Readiness & Response

Disaster Technical Assistance Center

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

Prior to September 11, 2001, most Presidentially declared disasters had been natural disasters such as tornados, hurricanes, floods, and earthquakes. States and communities had very limited experience developing or implementing plans to address large-scale terrorist events. Very few States had developed formal plans to address unusual threats such as bioterrorist incidents, which may have significant behavioral health consequences. The Substance Abuse and Mental Health Services (SAMHSA) Disaster Technical Assistance Center (DTAC) supports SAMHSA's efforts to prepare States, Territories, local entities, and tribal governments to prepare and deliver an effective all-hazards behavioral health response. Services include a wide range of technical assistance activities and products. These activities and products promote both the development of plans and the expansion of organizational and community capacities to deliver effective behavioral health services.

One of the goals of SAMHSA DTAC is to promote well integrated behavioral health services with traditional public health and disaster recovery efforts. SAMHSA DTAC provides consultation to review disaster plans, compiles research on "new" threats and planning methodologies, and brokers knowledge and support from experts in the field. Technical assistance and consultation is SAMHSA's primary role in disaster readiness and emergency response. A primary focus of SAMHSA's objectives in this area is to ensure that States and U.S. Territories are prepared to provide outreach and crisis counseling services in response to all hazards, including terrorism.

The primary mission of SAMHSA DTAC is to ensure that States and U.S. Territories develop viable all-hazards disaster preparedness plans that take into consideration various Federal resources and funding streams, such as the Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program and SAMHSA'S Emergency Response Grant Program. Over the past six years there has been significant national improvement in all-hazards disaster behavioral health preparedness. Due to multiple avenues of Federal funding and the direct technical assistance provided by SAMHSA DTAC, nearly all States and U.S. Territories have created plans, developed response capacity and established disaster behavioral health infrastructure.

Where do we want to go?

SAMHSA DTAC promotes and provides support for emergency preparedness across the nation so that when a disaster strikes, the nation and localities are prepared to handle the mental health and substance abuse issues that arise in its aftermath. It is SAMHSA DTAC's hope that in the future, the nation will be well-prepared to plan for and handle large-scale disasters.

Through technical assistance and consultation, SAMHSA strives to educate policymakers, State and local government agencies, grantees, media representatives, and community-based organizations

about the behavioral health effects of disasters and emergencies. In turn, this promotes planning and preparedness activities to mitigate these affects in the general population. Part of SAMHSA DTAC's mission is to support and initiate public awareness efforts so that the nation is prepared for large-scale disasters. Additionally, SAMHSA serves as a spokesperson for constituencies within local, State, and Federal planning and response efforts to ensure that the special needs of consumers are appropriately addressed.

How will we get there?

SAMHSA DTAC serves as a central repository for disaster behavioral information and resources, and supports SAMHSA efforts in the development and dissemination of new products. SAMHSA works with State and local agencies to help them prepare for disasters that can strike at anytime. To accomplish this mission, SAMHSA DTAC offers speedy response to technical assistance requests. As a resource center, SAMHSA DTAC maintains electronic and hardcopy materials on emergency mental health and substance abuse issues for various audiences, training resources, and initiation and facilitation of meetings and workgroups focused on emergency and disaster mental health and substance abuse topics.

SAMHSA DTAC supports SAMHSA's partnership with FEMA to provide national trainings and conferences, and has supported the Agency's effort to achieve compliance with the National Incident Management System (NIMS) by providing technical assistance to Federal staff completing training courses related to NIMS. SAMHSA DTAC currently participates in several cross-Agency workgroups in support of disaster readiness and response. Among those workgroups is the SAMHSA

DTAC Workgroup, which is comprised of representatives from all three SAMHSACenters as well as SAMHSA's Emergency Coordinator. SAMHSA DTAC was also involved in the Federal Workgroup on Disaster, which included representatives from over 20 Federal agencies. External agencies that are assisting in achieving SAMHSA DTAC's mission includeState/local/tribal governments; local providers; and professional associations, including the NationalCenter for Posttraumatic Stress Disorder, the NationalCenter for Child Traumatic Stress, the National Association of State Mental Health Program Directors, and the National Association of State Alcohol and Drug Abuse Directors.

Funding Mechanism: Contract

How will we stay on course?

SAMHSA DTAC continuously obtains feedback from State and U.S. territory stakeholders and consultants about the quality and availability of technical assistance and resources provided by the Center. The center also measures its progress and effectiveness by thoroughly evaluating the quality, thoroughness, and efficacy of State and U.S. Territory disaster behavior health plans and the effect DTAC services and assistance has had on those plans.

Overview Program/Project/Activity Management:

- Funding Source
  Center for Mental Health Services - Programs of Regional and National Significance (PRNS)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$0	*
2006	$0	*
2007	$0	*
2008	$204,000	*
2009	$1,054,000	*
2010	*	*
2011	*	*
2012	*	*

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Disaster Readiness & Response

FEMA Crisis Counseling Program

Substance Abuse and Mental Health Services Administration

CMHS

Where are we now?

The mission of the FEMA Crisis Counseling Program (CCP) is to assist individuals and communities in recovering from the devastating effects of natural and human-caused disasters. The CCP was implemented as a supplemental assistance program available to the United States and its Territories, by the Federal Emergency Management Agency (FEMA). Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 1974, authorizes FEMA to fund mental health assistance and training activities in Presidentially-declared disaster areas. Through a longstanding interagency agreement with FEMA, SAMHSA administers the CCP, providing technical assistance, program guidance, and oversight. For over 25 years, the CCP has supported short term interventions with individuals and groups experiencing psychological sequelae to large scale disasters.

Interventions are focused on assisting disaster survivors in understanding their current situation and reactions, mitigating additional stress, assisting survivors in reviewing their options, promoting the use of or development of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies that may help survivors with their tangible needs. Crisis counselors are also trained to identify and refer those in need of more intensive mental health or substance abuse services to existing community resources. The program also promotes community resilience through public and group educational activities. The CCP is guided by the following key principles:

- Strengths-based — CCP services promote resilience, empowerment, and recovery.
- Anonymous — Crisis counselors do not classify, label, or diagnose people; no records or case files are kept.
- Outreach-oriented — Crisis counselors deliver services in the communities rather than wait for survivors to seek their assistance.
- Conducted in nontraditional settings — Crisis counselors make contact in homes and communities, not in clinical or office settings.
- Designed to strengthen existing community support systems — The CCP supplements, but does not supplant or replace, existing community systems.

Where do we want to go?

The objectives of the CCP include the following:

- Reach large numbers of people affected by disasters through face-to-face outreach to shelters, homes, and other locations.

- Assess the emotional needs of survivors and make referrals to traditional behavioral health services when necessary.
- Identify tangible needs and link survivors to community resources and disaster relief services.
- Provide emotional support, education, basic crisis counseling, and connection to family and community support systems.
- Train and educate CCP staff and other community partners about disaster reactions, appropriate interventions, and CCP services.
- Develop partnerships with local disaster and other organizations.
- Work with local stakeholders to promote community resilience and recovery.
- Collect and evaluate data to ensure quality services and justify program efforts.
- Leave behind a permanent legacy of improved coping skills, educational and resource materials, and enhanced community linkages.

How will we get there?

The mission of the CCP is to assist individuals and communities in recovering from the often devastating effects of natural and human-caused disasters. The CCP provides the following services to achieve its mission:

- Individual crisis counseling: Helps survivors understand their reactions, improve coping strategies, review their options, and connect with other individuals and agencies that may assist them.
- Basic supportive or educational contact: General support and information on resources and services available to disaster survivors.
- Group crisis counseling: Group sessions led by trained crisis counselors who offer skills to help survivors cope with their situations and reactions.
- Public education: Information and education about typical reactions, helpful coping strategies, and available disaster-related resources.
- Community networking and support: Relationship building with community resource organizations, faith-based groups, and local agencies.
- Assessment, referral, and resource linkage: Adult and child needs assessment and referral to additional disaster relief services or mental health or substance abuse treatment.
- Development and distribution of educational materials: Flyers, brochures, tip sheets, educational materials, and Web site information developed and distributed by CCP staff.
- Media and public service announcements: Media activities and public messaging in partnership with local media outlets, State and local governments, charitable organizations, or other community brokers.

Funding Mechanism: Grant

How will we stay on course?

The CCP continuously performs program evaluations, solicits stakeholder feedback, and performs cross-site evaluations of grants. By utilizing these evaluation techniques, the CCP program strives to improve its services on a continual basis.

Overview Program/Project/Activity Management:
- Funding Source

Center for Mental Health Services - Federal Emergency Management Agency (FEMA)

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	$13,640,668	*
2006	$59,642,394	*
2007	$36,717,080	*
2008	$38,667,953	*
2009	$41,900,000	*
2010	*	*
2011	*	*
2012	*	*

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Other

Materials Development and Media Support (MDMS)

Substance Abuse and Mental Health Services Administration

OC

Where are we now?

The SAMHSA Office of Communications supports SAMHSA's efforts to achieve its mission, by combining sound public health practices with science-based communications and marketing approaches. The Office does this by working with SAMHSA's leadership and program offices to create and support communications goals/objectives related to SAMHSA's mission; identify target audiences for action to reach these goals and objectives; determine how best to meet the needs of target audiences, through market research and other varied approaches; and evaluate activities, both for process improvement and performance management. In addition, SAMHSA is responsible for establishing and strengthening constituency outreach communications and facilitating activities to further improve the agency's public and professional communications, information/public education and other marketing-related activities. The MDMS activity includes services such as media outreach/support and publications support, including writing, reviewing and editing materials to be disseminated to SAMHSA's various constituencies including, but not limited to individual members of the general public, national and local affiliates of national organizations relevant to SAMHSA's vision and mission, local communities and community organizations, state and/or tribal governments, and National and state Congressional/legislative committees and their staffs. This is a one-year contract with four option years.

Where do we want to go?

The project is designed to educate service providers, consumers, policy makers, the media, SAMHSA staff and the general public about SAMHSA, its work, programs and products as well as new developments in mental health services, addiction treatment and substance abuse prevention.

How will we get there?

Writing, editing, and general publication and editorial review assistance, media-related assistance, media tracking, analysis and research, electronic press release distribution, media mailing list, and communications training. Use of a close collaboration with SAMHSA's Health Information Network is an important component of this contract as SHIN will provide the warehouse, distribution, contact center, website and marketing support for all activities. In addition, the Strategic Communications Framework is the platform for aligning public health practice with science-based communications and marketing approaches and will help advance SAMHSA's program goals.

Funding Mechanism: Contract

How will we stay on course?

Special communications initiatives and media campaigns will have an evaluative component to measure and determine campaign effectiveness, progress and overall performance.

Overview Program/Project/Activity Management:
- Funding Source
  Program Reserve

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*
2008	$822,876	*
2009	$1,210,491	*
2010	*	*
2011	*	*
2012	*	*

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Other

SAMHSA Web Program

Substance Abuse and Mental Health Services Administration

OC

Where are we now?

SAMHSA's Web program is almost completely decentralized and funded at the discretion of the Center and Office budgets. Web priorities are not currently managed centrally. This fact, combined with SAMHSA's diverse mission, has led to a current count of 85 Web sites, and roughly a half million Web pages.
At a high level, the main audiences for SAMHSA's Web sites are:

- People who currently have, or are looking to apply for, a SAMHSA Grant
- People who work in the substance abuse & mental health prevention & treatment fields
- People doing research in the areas of substance abuse & mental health
- People seeking information and/or help for substance abuse or mental health-related issues

There are 3 top-level Web sites:

1. http://www.samhsa.gov (main agency Web site)
2. http://Ncadi.samhsa.gov (part of the publications clearinghouse Web site substance abuse-focused, and will be merging with #3 under SHIN, see below for details)
3. http://Mentalhealth.samhsa.gov (part of the publications clearinghouse Web site mental health-focused, and will be merging with #2 under SHIN, see below for details)

SAMHSA's other Web sites generally fall into one of the following categories:

- Topic-specific (topics targeted at a specific audience such as underage drinking, mental health stigma, recovery, or homelessness)
    - The majority of SAMHSA's Web sites fall into this category
- Grants-supporting (Technical Assistance Centers, Centers for Excellence, etc.)
- Data and Statistics (e.g., the National Survey on Drug Use and Health, and the
- Drug Abuse Warning Network)
- Organizational/Informational Web sites (e.g., the Center for Substance Abuse Prevention, SAMHSA's Newsletter)

Where do we want to go?

Objectives:

- SAMHSA will have an agency-level Web program with defined governance, content ownership, site management, and clearance functions and responsibilities across all Web sites and related Internet-based services
- SAMHSA's Web presence will be centered on our customers and their needs (task-focused), so that our various customers can quickly and easily accomplish their desired tasks on SAMHSA's Web sites
- The program will be supported by quantitative and qualitative performance data that demonstrates the effectiveness of SAMHSA's Web sites supporting SAMHSA's mission
- SAMHSA's Web sites will be recognized by our customers, stakeholders and peer agencies as best in class

Goals:

- No obsolete, inaccurate, duplicate, or irrelevant content
- All SAMHSA Web sites will have a Site Plan and Content Management Plan which identifies the content owner(s), review and update schedules, and protocols for new content approval.
- All SAMHSA Web sites managers will have data that demonstrates that they are serving their target customers' most important tasks & used
- Overall agency costs for developing, hosting, maintaining, and managing SAMHSA's Web sites and content will be documented, controlled, and strategically aligned to meet our goals & objectives

How will we get there?

1) We have formed a partnership of sponsors, including members of SAMHSA's Office of Communications, Division of Technology Resources, and Office of Policy, Planning, and Budget.

2) The partnership has developed a Web Strategy Report, which defines a set of activities for developing an agency-wide Web strategy at SAMHSA, with the goal of creating a Web Program to directly support the agency in meeting its mission.

3) We anticipate the following activity in the next year:

- Sponsor an Agency-wide Web Content Cleanup.
- All Web sites will be managed according to their Site Plan and Content Management plan.
- Improve the Performance of the SAMHSA Search Engine.
- Innovate the Mental Health Service Locator.
- Continue and increase Accessibility Compliance Support.
- Upgrade the SAMHSA Home Page with new content, features, and design.
- Coordinate/leverage existing initiatives:
    - SAMHSA Health Information Network (SHIN) Knowledge Management project (covered in #3 below, and a separate brief on SHIN)
        - Taxonomy
        - Metadata standards
        - Content Typing
        - User Personas
        - Initial Usability Testing
    - Process improvement effort on the Communications Product Lifecycle Process

4) SAMHSA does not have a defined agency-level Web program at this time. This activity is currently handled at the program level. The Office of Communications has engaged in various

activities to raise awareness, including publicizing the results of our Web inventory project, and inviting Web usability expert Gerry McGovern to speak at SAMHSA.

5) The SAMHSA Health Information Network (SHIN) Knowledge Management project (discussed in a separate brief), is a separately funded effort to improve SAMHSA's publication distribution & call center around the same customer-centered and data-driven principles that will govern SAMHSA's Web presence. This project is also being run out of the Office of Communications, with the same staff that is working on SAMHSA's Web program. Therefore, the work on that project (taxonomy, metadata standards, etc.) will be leveraged as much as possible for SAMHSA's overall Web program. The process improvement effort on the Communications Product Lifecycle Process (a Lean Six-Sigma approach) is a project aiming to improve the efficiency and quality of communications products (Web, print, and media), and the process that governs their approval (from inception to release). Again, the same Web program staff is involved in this effort. Our goal is to use the outcome from this effort (delivered in Spring 2009) to implement new processes in support of the Web program objectives & goals. The implementation of the program kicks off in October 2009.

6) External collaborators include the HHS Web Council (made up of all representative agencies at HHS), and the Federal Web Managers group (Federal government-wide). Web strategy lessons-learned, best practices and other input and assistance has been and will continue to be sought from these groups.

Funding Mechanism: Other

How will we stay on course?

1 – Outcomes associated with SAMHSA's Web program are currently managed at the program level.
2 - Overview *Program/Project/Activity Management*:

- - Funding Source
    - Funding is currently managed at the program-level, from the Centers.

3 – Rich Morey, Web Communications Manager, SAMHSA Office of Communications, rich.morey@samhsa.hhs.gov, 240-276-2131

Overview Program/Project/Activity Management:
- Funding Source
Center for Mental Health Services, Center for Substance Abuse Prevention, and Center for Substance Abuse Treatment

- Program/Project/Activity Funding

Note: * denotes an empty cell

Fiscal Year	Awarded Amount	Planned Amount
2005	*	*
2006	*	*
2007	*	*

Fiscal Year	Awarded Amount	Planned Amount
2008	*	*
2009	*	*
2010	*	*
2011	*	*
2012	*	*

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