DEPARTMENT of HEALTH and HUMAN SERVICES

FISCAL YEAR 2011

Substance Abuse and Mental Health Services Administration

Justification of Estimates for Appropriations Committees

Online Performance Appendix

Page Intentionally Left Blank

INTRODUCTION

The FY 2011 Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2011 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Summary of Performance and Financial Information Report. These documents are available at http://www.hhs.gov/budget/docbudget.htm.

The FY 2011 Congressional Justification and accompanying Online Performance Appendix contains the updated FY 2009 Annual Performance Report and FY 2011 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Citizens' Report summarizes key past and planned performance and financial information.

Page Intentionally Left Blank

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the FY 2011 Online Performance Appendix for the Substance Abuse and Mental Health Services Administration (SAMHSA). The report represents the monitoring and management of SAMHSA programs in the area of substance abuse prevention, substance abuse treatment, and mental health services programs.

This justification and accompanying Online Performance Appendix includes a more direct link between the budget discussion and program performance. Performance measurement and reporting at SAMHSA provide a comprehensive set of outcomes in 31 major areas enabling SAMHSA to share with stakeholders its progress toward achieving three strategic goals:

- Measure and report performance
- Increase service availability
- Improve service quality

SAMHSA, with its many partners, has a shared vision for what needs to be accomplished. SAMHSA has established a performance framework for linking agency-wide goals with program priorities and targeting resources to meet the needs of those with substance abuse and mental illness and their families. Through ongoing performance measurement and management, SAMHSA can monitor its progress and achievements and strive for continued improvement.

The Online Performance Appendix includes the most recent performance data for our largest and most well-known programs. This year some of SAMHSA's programs have reported data reflecting substantially lower achievement than previous years' trends. SAMHSA believes these results may have been impacted by the current economic situation and anticipate many of these data to return to previous trends in coming months and years. As a result, SAMHSA has not revised targets for subsequent years based on FY 2009 data. We hope to see improvement as the economic climate continues to improve, but will continue to monitor these performance measures to ensure effectiveness of SAMHSA programs.

In the FY 2011 Online Performance Appendix, SAMHSA has expanded the display of its performance tables to include targets for FY 2012. As many of SAMHSA's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, the performance tables throughout the two documents includes targets for the year impacted by the FY 2011 funding proposed here.

To the best of my knowledge, the performance data reported by SAMHSA for inclusion in the FY 2011 Online Performance Appendix is accurate, complete, and reliable.

//s//
Pamela S. Hyde, J.D.

Administrator

****Page Intentionally Left Blank****

TABLE OF CONTENTS

Introduction 2
Message from the Administrator 4

Summary of Performance Targets and Results 14
Table 1: Summary of Targets and Results for SAMHSA 14

Performance Detail 16
Mental Health Programs of Regional and National Significance (PRNS) 16
Suicide Prevention 16
Table 2: Reduce the number of suicide deaths 16
Table 3: Increase the number of students exposed to mental health and suicide awareness campaigns on college campuses 16
Table 4: Increase the total number individuals trained in youth suicide prevention 17
Table 5: Increase the total number of youth screened 17
Table 6: Increase the number of calls answered by the suicide hotline 17
Table 7: Data Source and Validation 18

Safe Schools/Healthy Students 20
Table 8: Increase the number of children served 20
Table 9: Decrease the percentage of middle school students who have been in a physical fight on school property 20
Table 10: Decrease the percentage of high school students who have been in a physical fight on school property 21
Table 11: Decrease the percentage of middle school students who report current substance use 21
Table 12: Decrease the percentage of high school students who report current substance use 22
Table 13: Increase the percentage of students attending school 22
Table 14: Increase the percentage of students who receive mental health services 23
Table 15: Percentage of grantees that provided screening and/or assessments that is coordinated among two or more agencies or shared across agencies 23
Table 16: Percentage of grantees that provide training of school personnel on mental health topics 24
Table 17: Data Source and Validation 24

National Child Traumatic Stress Initiative 25
Table 18: Increase the estimated number of children and adolescents receiving trauma-informed services 25
Table 19: Improve percentage showing clinically significant improvement 26
Table 20: Dollars spent per person served 26
Table 21: Increase the unduplicated count of the number of children and adolescents receiving trauma-informed services 27
Table 22: Increase the number of child-serving professionals trained in providing trauma-informed services 27
Table 23: Data Source and Validation 28
Table 24: Data Source and Validation (continued) 29

Mental Health Services – Homelessness Programs 31
Table 25: Increase the number of clients served 31
Table 26: Increase the percentage of adults receiving services who report improved functioning 31
Table 27: Increase the percentage of adults receiving services who were currently employed 32
Table 28: Increase the percentage of adults receiving services who had no/reduced involvement with the criminal justice system 32

Table 29: Increase the percentage of adults receiving services who had a permanent place to live in the community 32
Table 30: Increase the percentage of adults receiving services who had improved social support 33
Table 31: Increase the percentage of adults receiving services who report positively about perception of care 33
Table 32: Data Source and Validation 33

Mental Health System Transformation Grants'' 34
Table 33: Increase the number of policy changes completed as a consequence of the Comprehensive Mental Health Plan (CMHP) 34
Table 34: Number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the CMHP 35
Table 35: Increase the number of financing policy changes completed as a consequence of the CMHP 35
Table 36: Increase the number of organizational changes completed as a consequence of the CMHP 36
Table 37: Increase the number of organizations that regularly obtain and analyze data relevant to the goals of the CMHP 36
Table 38: Increase the number of consumers and family members that are members of Statewide consumer- and family-run networks 36
Table 39: Increase the number of programs implementing practices consistent with the CMHP 37
Table 40: Data Source and Validation 37

Other Mental Health Capacity Activities 38
Table 41: Rate of consumers reporting positively about perception of care 38
Table 42: Increase the percentage of clients receiving services who report improved functioning 39
Table 43: Percentage of people in the United States with serious mental illnesses in need of services from the public mental health system, who receive services from the public mental health system 39
Table 44: Number of evidence based practices implemented 39
Table 45: Number of Adults: percentage of population coverage for each 40
Table 46: Number of Children: percentage of population coverage for each 40
Table 47: Data Source and Validation 41

Mental Health PRNS - Science and Service Activities' 42
Table 48: Number of people trained by CMHS Science and Service Programs 42
Table 49: Percentage of those trained by the program who report they were very satisfied with training 43
Table 50: Data Source and Validation 43

Children's Mental Health Services 44
Table 51: Increase the percent of funded sites that will exceed a 30 percent improvement in behavioral and emotional symptoms among children receiving services for 6 months 44
Table 52: Increase percentage of children attending school 80% or more of time after 12 months 45
Table 53: Increase percentage with no law enforcement contacts at 6 months 45
Table 54: Decrease average days of inpatient facilities among children served in systems of care at 6 months 46
Table 55: Percent of systems of care that are sustained 5 years post Federal funding 46
Table 56: Increase number of children receiving services 47
Table 57: Increase total savings for in-hospital patient care costs per 1,000 children served 47
Table 58: Data Source and Validation 48
Table 59: Data Source and Validation (continued) 49

Protection & Advocacy ... 51
Table 60: Increase percentage of complaints of alleged abuse not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as result of PAIMI involvement ... 51
Table 61: Increase percentage of complaints of alleged neglect substantiated not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement ... 52
Table 62: Increase percentage of complaints of alleged rights violations substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, or elimination of other barriers to personal decision-making, as a result of PAIMI involvement ... 52
Table 63: Percent of interventions on behalf of groups of PAIMI-eligible individuals that were concluded successfully ... 53
Table 64: Increase in the number of people served by the PAIMI program ... 53
Table 65: Ratio of persons served/impacted per activity/intervention ... 54
Table 66: Cost per 1,000 individuals served/impacted ... 54
Table 67: The number attending public education/constituency training and public awareness activities ... 55
Table 68: Data Source and Validation ... 55

Projects to Assist in the Transition from Homelessness (PATH) ... 57
Table 69: Increase the percentage of enrolled homeless persons who receive community mental health services ... 57
Table 70: Increase number of homeless persons contacted ... 58
Table 71: Increase percentage of contacted homeless persons with serious mental illness who become enrolled in services ... 58
Table 72: Average Federal cost of enrolling a homeless person with serious mental illness in services ... 59
Table 73: Provide training for PATH providers on SSI/SSDI Outreach, Access, Recovery to ensure eligible homeless clients are receiving benefits ... 59
Table 74: Data Source and Validation ... 59

Mental Health Block Grant ... 61
Table 75: Reduce rate of adult readmissions to State psychiatric hospitals within 30 days ... 61
Table 76: Reduce rate of adult readmissions to State psychiatric hospitals within 180 days ... 62
Table 77: Reduce rate of child/adolescent readmissions to State psychiatric hospitals within 30 days ... 62
Table 78: Reduce rate of child/adolescent readmissions to State psychiatric hospitals within 180 days ... 63
Table 79: Number of evidence based practices implemented ... 63
Table 80: Adult: Percentage of adult population coverage for each ... 64
Table 81: Children: Percentage of population coverage for each ... 64
Table 82: Increase rate of consumers reporting positively about outcomes ... 65
Table 83: Increase rate of family members reporting positively about outcomes ... 65
Table 84: Number of persons receiving evidence-based practices per $10,000 of mental health block grant dollars spent ... 66
Table 85: Increase number of people served by the public mental health system ... 66
Table 86: Data Source and Validation ... 67

Substance Abuse Prevention PRNS ... 69
Strategic Prevention Framework State Incentive Grants ... 69
Table 87: 30-day use of alcohol among youth age 12-17 ... 69
Table 88: 30-day use of other illicit drugs age 12 and up ... 69
Table 89: Percent of SPF SIG States showing a decrease in state level estimate of percent of survey respondents (age 12-20) who report 30-day use of alcohol ... 69

Table 90: Percent of SPF SIG States showing a decrease in state level estimate of percent of survey respondents (age 21 and up) who report 30-day use of alcohol 70
Table 91: Percent of SPF SIG states showing a decrease in state level estimates of survey respondents (age 12-17) who report 30-day use of other illicit drugs 70
Table 92: Percent of SPF SIG states showing a decrease in state level estimates of survey respondents (age 18 and up) who report 30-day use of other illicit drugs 71
Table 93: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who rate the risk of substance abuse as moderate or great 71
Table 94: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 18 and up) who rate the risk of substance abuse as moderate or great 72
Table 95: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who somewhat disapprove or strongly disapprove of substance use. . 72
Table 96: Number of evidence-based policies, practices, and strategies implemented 73
Table 97: Percent of grantee states that have performed needs assessments 73
Table 98: Percent of grantee States that have submitted State plans 74
Table 99: Percent of grantee States with approved plans 74
Table 100: Data Source and Validation 75

Partnerships for Success 77
Table 101: Increase the number of sub-recipient communities funded through the Partnerships for Success grants 77
Table 102: Increase the number of communities who report an increase in prevention activities that are supported by collaboration and leveraging of funding streams 77
Table 103: Increase the number of EBPs implemented by sub-recipient communities 77
Table 104: Increase the number of sub-recipient communities that improved on one or more targeted NOMs indicators 78
Table 105: Data Source and Validation 78

Minority AIDS Initiative: Substance Abuse Prevention, HIV Prevention and Hepatitis Prevention for Minorities and Minorities Re-entering Communities Post-Incarceration....... 79
Table 106: Percent of program participants (age 12-17) that rate the risk of substance abuse as moderate or great 79
Table 107: Percent of program participants (age 18 and up) that rate the risk of substance abuse as moderate or great 79
Table 108: Percent of participants (age 12-20) who used alcohol at pre-test who report a decrease in use of alcohol at post-test 80
Table 109: Percent of participants (age 21 and up) who used alcohol at pre-test who report a decrease in use of alcohol at post-test 80
Table 110: Percent of participants (age 12-20) who report no alcohol use at pre-test who remain non-users at post-test 80
Table 111: Percent of participants (age 21 and up) who report no alcohol use at pre-test who remain non-users at post-test 81
Table 112: Percent of participants (age 12-17) who used illicit drugs at pre-test who report a decrease in 30-day use at post-test 81
Table 113: Percent of participants (age 18 and up) who used illicit drugs at pre-test who report a decrease in 30-day use at post-test 81
Table 114: Percent of participants (age 12-17) who report no illicit drug use at pre-test who remain non-users at post-test 82
Table 115: Percent of participants (age 18 and up) who report no illicit drug use at pre-test who remain non-users at post-test 82
Table 116: Percent of program participants (age 12-17) who somewhat disapprove or strongly disapprove of substance use 82
Table 117: Number of evidence-based policies, practices, and strategies implemented by HIV program grantees 83
Table 118: Number of individuals exposed to substance abuse/hepatitis education services 83

Table 119: Cost per participant improved on one or more measures between pre-test and post-test ... 84
Table 120: Data Source and Validation ... 84
Table 121: Data Source and Validation (continued) ... 85

Sober Truth on Preventing Underage Drinking ... 87
Table 122: Percentage of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades ... 87
Table 123: Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades ... 87
Table 124: Percentage of coalitions that report improvement in youth perception of parental disapproval on the use of alcohol in at least two grades ... 88
Table 125: Data Source and Validation ... 88

Prevention PRNS - Science and Service Activities ... 89
Table 126: Number of people provided technical assistance Services ... 89
Table 127: Percentage of technical assistance (TA) recipients who reported that they are very satisfied with the TA received ... 90
Table 128: Percentage of TA recipients who reported that their ability to provide effective services improved a great deal ... 90
Table 129: Percentage of TA recipients who reported that the TA recommendations have been fully implemented ... 90
Table 130: Number of persons receiving prevention information directly ... 91
Table 131: Number of persons receiving prevention information indirectly from advertising, broadcast, or website ... 91
Table 132: Data Source and Validation ... 92

Substance Abuse Treatment PRNS ... 94
Access to Recovery ... 94
Table 133: Increase the number of clients gaining access to treatment ... 94
Table 134: Increase the percentage of adults receiving services who had no past month substance use ... 94
Table 135: Increase the percentage of adults receiving services who had improved family and living conditions ... 95
Table 136: Increase the percentage of adults receiving services who had no/reduced involvement with the criminal justice system ... 95
Table 137: Increase the percentage of adults receiving services who had improved social support ... 96
Table 138: Increase the percentage of adults receiving services who were currently employed or engaged in productive activities ... 96
Table 139: Cost per client served ... 97
Table 140: Data Source and Validation ... 97

Screening, Brief Intervention and Referral to Treatment (SBIRT) ... 98
Table 141: Increase the number of clients served ... 98
Table 142: Increase the percentage of clients receiving services who had no past month substance use ... 99
Table 143: Data Source and Validation ... 99

Juvenile and Adult Drug Courts ... 100
Table 144: Juvenile: Percentage of clients that complete treatment ... 100
Table 145: Juvenile: Increase percentage of clients receiving services who were currently employed or engaged in productive activities ... 100
Table 146: Juvenile: Increase percentage of clients receiving services who had a permanent place to live in the community ... 101

Table 147: Juvenile: Increase percentage of clients receiving services who had no involvement with the criminal justice system 101
Table 148: Juvenile: Increase percentage of clients receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social consequences 102
Table 149: Juvenile: Increase percentage of clients receiving services who had no past month substance use 102
Table 150: Juvenile: Percent of drug court participants who exhibit a reduction in substance use while in the drug court program 102
Table 151: Juvenile: Reduce cost-per-client served 103
Table 152: Juvenile: Increase number of clients served 103
Table 153: Adult: Percentage of clients that complete treatment 104
Table 154: Adult: Increase percentage of clients receiving services who were currently employed or engaged in productive activities 104
Table 155: Adult: Increase percentage of clients receiving services who had a permanent place to live in the community 105
Table 156: Adult: Increase percentage of clients receiving services who had no involvement with the criminal justice system 105
Table 157: Adult: Increase percentage of clients receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences 105
Table 158: Adult: Increase percentage of clients receiving services who had no past month substance use 106
Table 159: Adult: Percent of drug court participants who exhibit a reduction in substance use while in the drug court program. 106
Table 160: Adult: Reduce cost-per-client served 106
Table 161: Adult: Increase number of clients served 107
Table 162: Data Source and Validation 107

Ex-Offender Re-Entry Program 109
Table 163: Number of clients served 109
Table 164: Percentage of clients who had no past month substance use 109
Table 165: Data Source and Validation 109

Grants for the Benefit of Homeless Individuals 110
Table 166: Increase percentage of adults receiving services who had no past month substance use 110
Table 167: Increase the number of clients served 110
Table 168: Increase percentage of adults receiving services who were currently employed or engaged in productive activities 111
Table 169: Increase percentage of adults receiving services who had a permanent place to live in the community 111
Table 170: Increase percentage of adults receiving services who had no involvement with the criminal justice system 111
Table 171: Increase percentage of adults receiving services who had improved social support 112
Table 172: Data Source and Validation 112

Treatment PRNS - Other Capacity 113
Table 173: Increase percentage of adults receiving services who had no past month substance use 113
Table 174: Increase the number of clients served 113
Table 175: Increase percentage of adults receiving services who were currently employed or engaged in productive activities 114
Table 176: Increase percentage of adults receiving services who had a permanent place to live in the community 114
Table 177: Increase percentage of adults receiving services who had no involvement with the criminal justice system 115

Table 178: Increase percentage of adults receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences 115
Table 179: Increase the percentage of grantees in appropriate cost bands 116
Table 180: Data Source and Validation 116

Treatment PRNS - Science and Service 117
Table 181: Report implementing improvements in treatment methods on the basis of information and training provided by the program 117
Table 182: Increase the number of individuals trained per year 118
Table 183: Increase the percentage of drug treatment professionals trained by the program who would rate the quality of the events as good, very good, or excellent 118
Table 184: Increase the percentage of drug treatment professionals trained by the program who shared any of the information from the events with others 119
Table 185: Increase the percentage of grantees in appropriate cost bands 119
Table 186: Data Source and Validation 120

Substance Abuse Prevention and Treatment Block Grant (SAPTBG) 121
Treatment Activities 121
Table 187: Number of admissions to substance abuse treatment programs receiving public funding 121
Table 188: Increase the percentage of States and Territories that express satisfaction with Technical Assistance provided 121
Table 189: Increase the percentage of States in appropriate cost bands 122
Table 190: Percentage of clients reporting abstinence from drug use at discharge 122
Table 191: Percentage of clients reporting abstinence from alcohol at discharge 123
Table 192: Percentage of clients reporting being employed/in school at discharge 123
Table 193: Percentage of clients reporting no involvement with the Criminal Justice System 124
Table 194: Data Source and Validation 124

Prevention Set-Aside .....
Synar Amendment Implementation Activities 126
Table 195: Increase number of States (including Puerto Rico) whose retail sales violations is at or below 20% 126
Table 196: Number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% 126
Table 197: Data Source and Validation 127
Figure 1: States Reporting Retailer Violation Rates At or Below 20% and Below 10% 129
Other Set-Aside Activities 130
Table 198: Number of evidence-based policies, practices, and strategies implemented 130
Table 199: Percent of program costs spent on evidence-based practices (EBP) 130
Table 200: Number of participants served in prevention programs 131
Table 201: Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17) 131
Table 202: Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 18+) 132
Table 203: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 12-20) 132
Table 204: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 21+) 133
Table 205: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 12-17) 133
Table 206: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 18+) 134
Table 207: Data Source and Validation 134
Table 208: Data Source and Validation (continued) 135

SAPTBG - National Surveys ... 137
Table 209: Availability and timeliness of data for the National Survey on Drug Use and Health 137
Table 210: Availability and timeliness of data for the Drug Abuse Warning Network ... 137
Table 211: Availability and timeliness of data for the Drug and Alcohol Services Information System ... 138
Table 212: Data Source and Validation ... 138

Cross-Center Initiatives ... 139
Mental Health/Substance Abuse SBIRT ... 139
Table 213: Increase the number of individuals screened for mental disorders and substance use disorders ... 139
Table 214: Increase the number of individuals receiving a brief intervention for MH and/or SUD 139
Table 215: Increase number of individuals assessed and referred for specialty MH and/or SA treatment ... 139
Table 216: Increase the percentage of individuals receiving mental health and/or substance abuse treatment services who report improved functioning ... 139
Table 217: Data Source and Validation ... 140

Co-Occurring State Incentive Grants ... 141
Table 218: Increase the number of persons with co-occurring disorders served ... 141
Table 219: Increase the percentage of treatment programs that screen for co-occurring disorders ... 141
Table 220: Increase the percentage of treatment programs that assess for co-occurring disorders ... 141
Table 221: Increase the percentage of treatment programs that treat co-occurring disorders through collaborative, consultative, and integrated models of care ... 142
Table 222: Data Source and Validation ... 142

SAMHSA's Health Information Network ... 143
Table 223: Total number of SAMHSA knowledge products disseminated ... 143
Table 224: Total number of individuals referred for treatment resources ... 143
Table 225: Data Source and Validation ... 144

Overview of Performance ... 146
Strategic Plan ... 149

SAMHSA Linkages to HHS Strategic Plan ... 150
Table 226: SAMHSA linkages with Goal 1 Health Care ... 150
Table 227: SAMHSA linkages with Goal 2 Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness ... 150
Table 228: SAMHSA linkages with Goal 3 Human Services ... 151
Table 229: SAMHSA linkages with Goal 4 Scientific Research and Development ... 151

Additional Items ... 152
Full Cost Table ... 152
Table 230: SAMHSA program full cost associated with HHS Goal 1 Health Care ... 152
Table 231: SAMHSA program full cost associated with HHS Goal 2 Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness ... 152
Table 232: SAMHSA program full cost associated with HHS Gal 3 Human Services ... 153
Table 233: SAMHSA program full cost associated with HHS Goal 4 Scientific Research and Development ... 153
Evaluations Included in HHS Evaluations Database for FY 2009 ... 154

SUMMARY OF PERFORMANCE TARGETS AND RESULTS

Table 1: Summary of Targets and Results for SAMHSA[1,2]

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2006	99	96	97%	61	64%
2007	141	138	98%	96	70%
2008	164	156	95%	106	68%
2009	170	90	53%	53	59%
2010	168	N/A	N/A	N/A	N/A
2011	171	N/A	N/A	N/A	N/A
2012	190	N/A	N/A	N/A	N/A

[1] As of Program Performance Tracking System (PPTS) Report run 1/22/10.

[2] During FY 2009, the method for calculating the Summary of Measures Table was revised. As a result of this change, the number of total targets and other calculations for SAMHSA performance measures have changed somewhat from those previously published in the FY 2010 President's Budget.

Page Intentionally Left Blank

PERFORMANCE DETAIL

MACRO PROGRAM: MENTAL HEALTH PROGRAMS OF REGIONAL AND NATIONAL SIGNIFICANCE

PROGRAM: SUICIDE PREVENTION

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

FY	Target	Result
2012	30,584	Apr 30, 2015
2011	30,684	Apr 30, 2014
2010	30,684	Apr 30, 2013
2009	30,784	Apr 30, 2012
2008	30,984	Apr 30, 2011
2007	31,084	Apr 30, 2010
2006	N/A	33,300 (Historical Actual)

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

FY	Target	Result
2012	739,615	Dec 31, 2012
2011	681,425	Dec 31, 2011
2010	681,425	Dec 31, 2010
2009	662,774	1,037,974 (Target Exceeded)
2008	662,774	681,425 (Target Exceeded)
2007	Set Baseline	662,774 (Baseline)

Table 4: Measure 2.3.59: Increase the total number individuals trained in youth suicide prevention[3] (Outcome)

FY	Target	Result
2012	36,202	Dec 31, 2012
2011	35,371	Dec 31, 2011
2010	35,371	Dec 31, 2010
2009	29,323	83,724 (Target Exceeded)
2008	97,742	101,669 (Target Exceeded)
2007	Set Baseline	75,186 (Baseline)

Table 5: Measure 2.3.60: Increase the total number of youth screened[4] (Output)

FY	Target	Result
2012	3,360	Dec 31, 2012
2011	3,360	Dec 31, 2011
2010	3,360	Dec 31, 2010
2009	3,360	27,132 (Target Exceeded)
2008	Set Baseline	3,182 (Baseline)

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

FY	Target	Result
2012	666,158	Dec 31, 2012
2011	555,132	Dec 31, 2011
2010	555,132	Dec 31, 2010
2009	538,963	619,813 (Target Exceeded)
2008	Set Baseline	513,298 (Baseline)

---

[3] This measure has been revised for the FY 2011 President's Budget. Previously the measure was cumulative. It has been revised to report its data annually. As a result, targets for FY 2009 and 2010 were adjusted and data provided here may appear to differ from those previously published in the FY 2010 President's Budget.

[4] This measure has been revised for the FY 2011 President's Budget. Previously the measure was cumulative. It has been revised to report its data annually. As a result, targets for FY 2009 and 2010 were adjusted and data provided here may appear to differ from those previously published in the FY 2010 President's Budget.

Table 7: Data Source and Validation for Performance Measures for Suicide Prevention Programs

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

Agency Program, Measure 2.3.57 - 2.3.61

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

SAMHSA's Suicide Prevention portfolio includes campus, State, and tribal activities related to the Garrett Lee Smith Memorial Act, as well as the Suicide Prevention Hotline, Suicide Prevention Resource Center and an American Indian/Alaska Native Suicide Prevention Initiative.

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

Measure 2.3.58 is a key performance output measure for the program. Suicide prevention efforts are measured by the number of students who are exposed to mental health and suicide awareness campaigns on grantee college campuses. Since the baseline was set in 2007, performance for this measure has exceeded the targets set for the last two years. In FY 2009, 356,549 additional students were exposed to mental health and suicide awareness campaigns on college campuses compared to the previous year. The number of individuals trained (2.3.59) is also an important indicator of program penetration as well as increased suicidal awareness. Since 2005, the program has trained 423,680 mental health professionals, teachers, police officers, social service providers, advocates, coaches, and other individuals who frequently interact with youth.

Two output measures were added in FY 2008: Increase the Total Number of Youth Screened (2.3.60), and Increase the Number of Calls Answered by the Suicide Hotline (2.3.61). Baselines for both measures were captured in FY 2008 and both were exceeded in 2009. All targets for which data were available were exceeded for this program in 2009. Ambitious targets for all measures were set for FY 2010, FY 2011, and FY 2012.

PROGRAM: SAFE SCHOOLS/HEALTHY STUDENTS

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

FY	Target	Result
2012	2,328,500	Dec 31, 2012
2011	2,328,500	Dec 31, 2011
2010	2,328,500	Dec 31, 2010
2009	2,328,500	3,154,305 (Target Exceeded)
2008	1,062,963	2,328,500 (Target Exceeded)
2007	1,062,963	1,845,110 (Target Exceeded)
2006	Set Baseline	1,062,963 (Baseline)

Table 9: Measure 3.2.05: Decrease the percentage of **middle school** students who have been in a physical fight on school property[5] (Outcome)

FY	Target	Result
2012	34%	Dec 31, 2012
2011	34%	Dec 31, 2011
2010	34%	Dec 31, 2010
2009	34.4%	23.8% (Target Exceeded)
2008	36%	34.4% (Target Exceeded)
2007	30%	36.6% (Target Not Met)
2006	Set Baseline	30.8% (Baseline)

[5] Successful result is below target

Table 10: Measure 3.2.06: Decrease the percentage of **high school** students who have been in a physical fight on school property[6] (Outcome)

FY	Target	Result
2012	23%	Dec 31, 2012
2011	23%	Dec 31, 2011
2010	23%	Dec 31, 2010
2009	23.7%	16.1% (Target Exceeded)
2008	29%	23.7% (Target Exceeded)
2007	24%	29.8% (Target Not Met)
2006	Set Baseline	24.2% (Baseline)

Table 11: Measure 3.2.07: Decrease the percentage of **middle school** students who report current substance use[7] (Outcome)

FY	Target	Result
2012	13%	Dec 31, 2012
2011	13%	Dec 31, 2011
2010	13%	Dec 31, 2010
2009	13.7%	13.3% (Target Exceeded)
2008	16%	13.7% (Target Exceeded)
2007	16%	16% (Target Met)
2006	Set Baseline	16.9% (Baseline)

[6] Successful result is below target

[7] Successful result is below target

Table 12: Measure 3.2.08: Decrease the percentage of **high school** students who report current substance use[8] (Outcome)

FY	Target	Result
2012	33%	Dec 31, 2012
2011	33%	Dec 31, 2011
2010	33%	Dec 31, 2010
2009	33%	31.1% (Target Exceeded)
2008	35%	33% (Target Exceeded)
2007	35%	35% (Target Met)
2006	Set Baseline	35.3% (Baseline)

Table 13: Measure 3.2.09: Increase the percentage of students attending school[9] (Outcome)

FY	Target	Result
2010	Discontinued	N/A
2009	93%	94.5% (Target Exceeded)
2008	93%	93% (Target Met)
2007	93%	95.1% (Target Exceeded)
2006	Set Baseline	92.6% (Baseline)

[8] Successful result is below target

[9] Measure 3.2.09 will be retired from public reporting in FY 2010. Please see explanation in the narrative for this program.

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

FY	Target	Result
2012	66%	Dec 31, 2012
2011	66%	Dec 31, 2011
2010	66%	Dec 31, 2010
2009	66%	74.4% (Target Exceeded)
2008	46%	66% (Target Exceeded)
2007	46%	46% (Target Met)
2006	Set Baseline	45.5% (Baseline)

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

FY	Target	Result
2012	69%	Dec 31, 2012
2011	69%	Dec 31, 2011
2010	69%	Dec 31, 2010
2009	68.1%	73.9% (Target Exceeded)
2008	67.1%	62.4% (Target Not Met)
2007	Set Baseline	66.1% (Baseline)

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

FY	Target	Result
2012	67%	Dec 31, 2012
2011	67%	Dec 31, 2011
2010	67%	Dec 31, 2010
2009	66.4%	73.9% (Target Exceeded)
2008	65.4%	64% (Target Not Met)
2007	Set Baseline	64.4% (Baseline)

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

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

Agency Program 1.2, Measure 3.2.04 - 3.2.22

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

Since the baseline was set in 2006, the performance targets for measure 3.2.05, number of

children served, have consistently been exceeded. Since the targets were set more grants were awarded than had been anticipated and the resulting number of children served was significantly higher than the targets. The significant increase in 2009 can be attributed to the fact that the 2008 cohort became fully operational in its violence prevention activities in 2009.

In addition, all targets for student outcomes were exceeded in FY 2009. This excellent performance can be attributed in part to the capacity of the larger than usual 2005 cohort of 40 grantees were at their peak in providing violence prevention services. GPRA measures are defined as follows: Violent incidents (3.2.06) are defined by the percentage of students that have experienced violence at least once in the past 12 months as measured by a student survey item. This percentage has decreased from 2006 to 2009 by 23% for middle school students and 33% for high school students. Substance use (3.2.07) is defined as the percentage of students that report having used alcohol in the past 30 days, which has also decreased over 20% over the same time period. For the "Increase mental health services to students and families (3.2.10)" measure, the definition of mental health services is determined by the grantee with guidance from their project officer. This measure represents the percentage of students that receive services following a mental health referral and has increased nearly 30% since 2006.

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

PROGRAM: NATIONAL CHILD TRAUMATIC STRESS INITIATIVE (NCTSI)

Table 18: Measure 3.2.01: Increase the estimated number of children and adolescents receiving trauma-informed services[10] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	29,000	Dec 31, 2010
2009	16,955	25,143 (Target Exceeded)
2008	33,910	28,878 (Target Not Met)
2007	33,910	31,446 (Target Not Met)
2006	39,600	33,910 (Target Not Met)

[10] Measure 3.2.01 will be retired from public reporting in FY 2010. Please see explanation in the narrative for this program.

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

FY	Target	Result
2012	69%	Dec 31, 2012
2011	69%	Dec 31, 2011
2010	69%	Dec 31, 2010
2009	69%	76% (Target Exceeded)
2008	37%	69% (Target Exceeded)
2007	37%	56% (Target Exceeded)
2006	37%	35% (Target Not Met)

Table 20: Measure 3.2.03: Dollars spent per person served[11,12] (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	$718	Dec 31, 2010
2009	$718	$1511 (Target Not Met)
2008	$774	$948 (Target Not Met)
2007	$480	$774 (Target Not Met)
2006	$493	$741 (Target Not Met)

[11] Successful result is below target.

[12] Measure 3.2.03 will be retired from public reporting in FY 2010. Please see explanation in the narrative for this program.

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

FY	Target	Result
2012	3,217	Dec 31, 2012
2011	3,217	Dec 31, 2011
2010	3,217	Dec 31, 2010
2009	2,925	1,922 (Target Not Met but Improved)
2008	Set Baseline	975 (Baseline)

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

FY	Target	Result
2012	100,800	Dec 31, 2012
2011	100,800	Dec 31, 2011
2010	100,800	Dec 31, 2010
2009	96,000	95,186 (Target Not Met but Improved)
2008	Set Baseline	91,517 (Baseline)

Table 23: Data Source and Validation for Performance Measures for National Child Traumatic Stress Initiative - NCTSI

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

Table 24: Data Source and Validation for Performance Measures for National Child Traumatic Stress Initiative - NCTSI (continued)

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

Agency Program 1.3, Measure 3.2.01 - 3.2.24

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

The National Traumatic Stress Network (NCTSN) is a nationwide collaborative network of organizations involved in the evaluation, treatment, and support of children and their families impacted by traumatic stress. The Network includes three components: (A) the National Center for Child Traumatic Stress (NCCTS, Category 1), (B) Intervention Development and Evaluation Centers (Category 2), and (C) Community Treatment and Services Centers (Category 3). The NCTSN is currently comprised of 59 funded Centers.

The trend for measure 3.2.01, the estimated number of children receiving services, shows a decrease of 26% from 2006 to 2009. This downward trend is primarily due to the relatively large number of established NCTSN centers that provided direct services from the FY 2003 Cohort that were no longer funded as of FY 2007 (14 Category 3 centers). Although there were several new centers added during FY 2007 (15 sites total, 10 Category 3 sites and 5 Category 2 sites), during 2008 (8 sites total, 8 Category 3 sites) and 2009 (36 sites total, 1 Category 1 site, 9 Category 2 sites, and 26 Category 3 sites), this decrease in number of children served also reflects: (A) start-up time needed to establish direct services at these new sites, (B) a change in focus of previously funded sites from providing direct clinical services to training, and (C) the actual number of new centers providing direct clinical services. It should also be noted that this number does not include the more than four thousand children and families served by formerly funded centers that mobilized to respond to natural disasters including Hurricanes Gustav and Ike. Currently, this measure is an estimate of clients served based on quarterly reports from grantees. As this does not allow for a true unduplicated count, SAMHSA will be retiring this measure in FY 2011. The NCTSI began using a web-based GPRA data collection system called Transformation Accountability (TRAC) System in FY 2008 which ensures the capture of an unduplicated count of children served. In FY 2008, the baseline for this new measure (3.2.23) was 975. This result is significantly lower than the estimated number served in measure 3.2.01 due to the fact that not all grantees are fully utilizing the TRAC system. This is the result of factors such as delays in human subjects review at some sites and various staffing/budget constraints. Although the result for 2009 was an increase of nearly 1,000 children served over 2008, the target was not met. SAMHSA expects compliance to continue to improve considerably over time as we are providing additional technical assistance and working aggressively with grantees to improve compliance with TRAC.

The target for improving children's outcomes was exceeded considerably again in FY 2009 and has nearly doubled since 2006. Clinically significant improvement is demonstrated as an improvement of a standard deviation or more (10-15+) on at least one of the three standardized assessment measures given to children. The program examined this result, and it appears to be a result of the maturation of the grant program.

The NCTSN efficiency measure (3.2.03, dollars spent per person served) is calculated by dividing the total dollar amount awarded to grantees by the number who received direct services from those grantees. As discussed above, the number of children served decreased in FY 2009 due to fluctuations in the grant cycle, and more importantly, that direct service provision may not be a grantee's primary strategy for increasing access of children and their families to trauma-

informed interventions. Since this measure is calculated using the current estimated client count, SAMHSA intends to retire it in FY 2011 and replace it with a cost per improved client measure which would include an unduplicated count of number served (3.2.23) in the denominator.

PROGRAM: MENTAL HEALTH SERVICES – HOMELESSNESS PROGRAMS[13]

Table 25: Measure 3.4.01: Increase the number of clients served (Output)

FY	Target	Result
2012	2,784	Dec 31, 2012
2011	2,262	Dec 31, 2011
2010	2,223	Dec 31, 2010
2009	2,145	878 (Target Not Met)
2008	Set Baseline	548 (Baseline)

Table 26: Measure 3.4.02: Increase the percentage of adults receiving services who report improved functioning (Outcome)

FY	Target	Result
2012	68.4	Dec 31, 2012
2011	68.4	Dec 31, 2011
2010	68.4	Dec 31, 2010
2009	68.4	54.8 (Target Not Met)
2008	Set Baseline	68.4 (Baseline)

[13] Prior to FY 2010 president's Budget, Homelessness data was reported in the CMHS Other Capacity table

Table 27: Measure 3.4.03: Increase the percentage of adults receiving services who were currently employed (Outcome)

FY	Target	Result
2012	15.6	Dec 31, 2012
2011	15.6	Dec 31, 2011
2010	15.6	Dec 31, 2010
2009	15.6	9.1 (Target Not Met)
2008	Set Baseline	15.6 (Baseline)

Table 28: Measure 3.4.04: Increase the percentage of adults receiving services who had no/reduced involvement with the criminal justice system (Outcome)

FY	Target	Result
2012	98.2	Dec 31, 2012
2011	98.2	Dec 31, 2011
2010	98.2	Dec 31, 2010
2009	98.2	97.5 (Target Not Met)
2008	Set Baseline	98.2 (Baseline)

Table 29: Measure 3.4.05: Increase the percentage of adults receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2012	60.6	Dec 31, 2012
2011	60.6	Dec 31, 2011
2010	60.6	Dec 31, 2010
2009	60.6	74.2 (Target Exceeded)
2008	Set Baseline	60.6 (Baseline)

Table 30: Measure 3.4.06: Increase the percentage of adults receiving services who had improved social support (Outcome)

FY	Target	Result
2012	78	Oct 31, 2012
2011	78	Oct 31, 2011
2010	78	Oct 31, 2010
2009	78	70 (Target Not Met)
2008	Set Baseline	78 (Baseline)

Table 31: Measure 3.4.07: Increase the percentage of adults receiving services who report positively about perception of care (Outcome)

FY	Target	Result
2012	96.1	Oct 31, 2012
2011	96.1	Oct 31, 2011
2010	96.1	Oct 31, 2010
2009	96.1	94.5 (Target Not Met)
2008	Set Baseline	96.1 (Baseline)

Table 32: Data Source and Validation for Performance Measures for Mental Health Services - Homelessness Programs

Measure	Data Source	Data Validation
3.4.01 3.4.02 3.4.03 3.4.04 3.4.05 3.4.06 3.4.07	Data are collected through standard instruments and submitted through the TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

Agency Program, Measure 3.4.01 - 3.4.07

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

The purpose of Services in Supportive Housing program is to help prevent or reduce chronic homelessness by funding services for individuals and families experiencing chronic homelessness in coordination with existing permanent supportive housing programs and resources. Supportive housing provides consumers with long-term, community-based housing options by providing individuals and families who experience chronic homelessness the appropriate services and treatment needed to stay housed in a permanent setting. This housing approach combines housing assistance and intensive individualized support services to people with serious psychiatric conditions and those with co-occurring mental and substance use disorders. As of December 2009, the Services in Supportive Housing grantees have provided more than 1000 persons with comprehensive and coordinated mental health and related services. More than one-half (54.8 percent) of the individuals served demonstrated improvement in behavioral functioning and represent an 65-85 percent reduction in the usage of high cost services such as hospitalizations and emergency room use.

PROGRAM: MENTAL HEALTH SYSTEM TRANSFORMATION GRANTS[14,15,16]

Table 33: Measure 1.2.10: Increase the number of policy changes completed as a consequence of the Comprehensive Mental Health Plan (CMHP) (Output)

FY	Target	Result
2012	103	Oct 31, 2012
2011	2	Oct 31, 2011
2010	29	Oct 31, 2010
2009	31	191 (Target Exceeded)
2008	69	81 (Target Exceeded)
2007	Set Baseline	82 (Baseline)

[14] Program was formally known as Mental Health State Incentive Grants for Transformation.

[15] This program is still under development and performance measures will be added once the program is finalized. In the interim, targets for FY 2011 and FY 2012 have been included and are subject to change.

[16] FY 2011 targets for this program drop off due to grants coming to a natural end.

Table 34: Measure 1.2.11: Number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the CMHP (Outcome)

FY	Target	Result
2012	4,095	Oct 31, 2012
2011	746	Oct 31, 2011
2010	16,557	Oct 31, 2010
2009	8,218	52,748 (Target Exceeded)
2008	34,629	50,850 (Target Exceeded)
2007	Set Baseline	3,276 (Baseline)

Table 35: Measure 1.2.12: Increase the number of financing policy changes completed as a consequence of the CMHP (Output)

FY	Target	Result
2012	54	Oct 31, 2012
2011	0	Oct 31, 2011
2010	19	Oct 31, 2010
2009	18	47 (Target Exceeded)
2008	29	49 (Target Exceeded)
2007	Set Baseline	43 (Baseline)

Table 36: Measure 1.2.13: Increase the number of organizational changes completed as a consequence of the CMHP (Output)

FY	Target	Result
2012	159	Oct 31, 2012
2011	0	Oct 31, 2011
2010	64	Oct 31, 2010
2009	223	148 (Target Not Met but Improved)
2008	93	127 (Target Exceeded)
2007	Set Baseline	40 (Baseline)

Table 37: Measure 1.2.14: Increase the number of organizations that regularly obtain and analyze data relevant to the goals of the CMHP (Output)

FY	Target	Result
2012	46	Oct 31, 2012
2011	0	Oct 31, 2011
2010	794	Oct 31, 2010
2009	239	6841 (Target Exceeded)
2008	562	102 (Target Not Met but Improved)
2007	Set Baseline	37 (Baseline)

Table 38: Measure 1.2.15: Increase the number of consumers and family members that are members of Statewide consumer- and family-run networks (Outcome)

FY	Target	Result
2012	5,784	Oct 31, 2012
2011	0	Oct 31, 2011
2010	3,510	Oct 31, 2010
2009	15,445	82,113 (Target Exceeded)
2008	4,257	4,627 (Target Exceeded)
2007	Set Baseline	62,411 (Baseline)

Table 39: Measure 1.2.16: Increase the number of programs implementing practices consistent with the CMHP (Outcome)

FY	Target	Result
2012	219	Oct 31, 2012
2011	0	Oct 31, 2011
2010	1,227	Oct 31, 2010
2009	633	1,256 (Target Exceeded)
2008	587	1,238 (Target Exceeded)
2007	Set Baseline	175 (Baseline)

Table 40: Data Source and Validation for Performance Measures for Mental Health System Transformation Grants

Measure	Data Source	Data Validation
1.2.10 1.2.11 1.2.12 1.2.13 1.2.14 1.2.15 1.2.16	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

Agency Program, Measure 1.2.10 - 1.2.16

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

In an effort to reach a larger number of states and communities, the FY 2010 the Mental Health Systems Transformation grant awards will be smaller than the earlier grant awards and allow the grantees the flexibility to identify and address critical system and capacity reform needs in their respective communities. The new grants will build on existing infrastructure by supporting States, counties and local communities in implementing activities such as workforce training, implementation of evidence-based practices, and improving access to quality mental health services. Necessary changes to policies and organizational structures to support improved mental health services will also be supported. In addition, the FY 2010 grants will provide States and communities the opportunity to expand the much needed treatment capacity and allow grantees to identify emerging treatment needs, especially those emerging in the context of the economic crisis.

Performance targets for this program were all exceeded in 2009 except one output measure

(1.2.13) and one outcome measure (1.2.15) where the targets were not met: Measure 1.2.10, number of policy changes completed as a consequence of the CHMP, is an important indicator of the program as policy change provides the framework for mental health system transformation. The number of policy changes has increased each year since the baseline was set in 2007 and the 2009 target was exceeded. Workforce development is another important indicator of infrastructure development. Measure 1.2.11, the number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the CHMP, has increased significantly each year since baseline; targets have been exceeded each year. Measure 1.2.15, Increase the number of consumers and family members that are members of statewide consumer- and family-run networks is another important outcome and an indicator of mental health transformation. Ensuring that mental health care is consumer and family driven is a key factor in mental health transformation as evidenced by the level of consumer and family involvement. The target was significantly exceeded in 2009. Finally, measure 1.2.16, increase the number of programs implementing practices consistent with the CHMP is an indicator of the extent to which programs are evidence-based and recovery focused. Outcomes have increased significantly each year over baseline and targets were exceeded.

PROGRAM: MENTAL HEALTH PROGRAMS OF REGIONAL AND NATIONAL SIGNIFICANCE - OTHER MENTAL HEALTH CAPACITY ACTIVITIES[17]

Table 41: Measure 1.2.03: Rate of consumers reporting positively about perception of care (program participants)[18] (Outcome)

FY	Target	Result
2012	98%	Dec 31, 2012
2011	98%	Dec 31, 2011
2010	98%	Dec 31, 2010
2009	98%	95.2% (Target Not Met but Improved)
2008	98%	94.8% (Target Not Met)
2007	Set Baseline	98% (Baseline)[19]

[17] Prior to 2008, includes Jail Diversion, Older Adults, HIV/AIDS, and Services in Supportive Housing programs. Beginning in 2009, data from Services in Supportive Housing will be reported under Homelessness Activities

[18] Measure has been changed with OMB approval from Rate of consumers/family members reporting positively about outcomes (program participants). SAMHSA dropped measure 1.2.04 and change measure 1.2.03 to "Rate of consumers reporting positively about perception of care."

[19] Due to the implementation of the TRAC reporting system midyear FY 2007, data reported for FY 2007 will only contain a partial year.

Table 42: Measure 1.2.05: Increase the percentage of clients receiving services who report improved functioning (Outcome)

FY	Target	Result
2012	54%	Dec 31, 2012
2011	54%	Dec 31, 2011
2010	54%	Dec 31, 2010
2009	54%	52.8% (Target Not Met but Improved)
2008	93%	50.5% (Target Not Met)
2007	Set Baseline	93% (Baseline)[20]

Table 43: Measure 1.2.07: Percentage of people in the United States with serious mental illnesses in need of services from the public mental health system, who receive services from the public mental health system (Outcome)

FY	Target	Result
Out-Year Target	50% (2015)	Dec 31, 2015

Table 44: Measure 1.2.06: Number of evidence based practices (EBPs) implemented (Output)

FY	Target	Result
2012	4.2 per State	Dec 31, 2013
2011	4.2 per State	Dec 31, 2012
2010	4.1 per State	Dec 31, 2011
2009	4 per State	Dec 31, 2010
2008	4 per State	4.2 per State (Target Exceeded)
2007	3.8 per State	4 per State (Target Exceeded)
2006	3.3 per State	3.9 per State (Target Exceeded)

[20] In December 2007, the TRAC reporting capability was incomplete. Once the system was completed, SAMHSA noted that the earlier manual calculation was done incorrectly. The correct formula is now programmed into the reporting system, which should minimize future reporting errors.

Table 45: Measure 1.2.08: Number of Adults: percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice) (Output)

FY	Target	Result
2012	10.5%	Dec 31, 2013
2011	10.5%	Dec 31, 2012
2010	10.5%	Dec 31, 2011
2009	10.8%	Dec 31, 2010
2008	10.8%	8% (Target Not Met)
2007	10.8%	9.4% (Target Not Met)
2006	10.3%	9.5% (Target Not Met)

Table 46: Measure 1.2.09: Number of Children: percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice) (Output)

FY	Target	Result
2012	3.5%	Dec 31, 2013
2011	3.5%	Dec 31, 2012
2010	3.5%	Dec 31, 2011
2009	3.5%	Dec 31, 2010
2008	3.5%	3% (Target Not Met)
2007	2.6%	3.2% (Target Exceeded)
2006	2.3%	2.2% (Target Not Met)

Table 47: Data Source and Validation or Performance Measures for Mental Health Programs of Regional and National Significance - Other Mental Health Capacity Activities

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

Agency Program 1.4, Measure 1.2.03 - 1.2.09

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

Measure 1.2.03 reflects results for participants in the mental health PRNS service programs. Baseline data for consumers has been reported. The target for FY 2008 was missed slightly.

Measure 1.2.05 is to increase the percentage of clients receiving services who report improved functioning. This outcome is comprised of responses to questions about how effectively the consumer is able to deal with daily problems, the ability to control his or her life, the ability to deal with crisis, how well he or she is getting along with family members, how well he or she

handles social situations and at work or school; and if symptoms are bothersome. In December 2007, the TRAC reporting capability was incomplete. Once the system was completed, SAMHSA noted that the earlier manual calculation was done incorrectly which accounts for missing the target by 42.5 percent. The correct formula is now programmed into the reporting system, which should minimize future reporting errors. Subsequent targets will be set accordingly.

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

PROGRAM: MENTAL HEALTH PROGRAMS OF REGIONAL AND NATIONAL SIGNIFICANCE - SCIENCE AND SERVICE ACTIVITIES[21,22]

Table 48: Measure 1.4.06: Number of people trained by CMHS Science and Service Programs (Output)

FY	Target	Result
2012	4,237	Dec 31, 2012
2011	4,237	Dec 31, 2011
2010	4,237	Dec 31, 2010
2009	4,237	3,534 (Target Not Met)
2008	N/A	4,036 (Historical Actual)
2007	N/A	4,852 (Historical Actual)
2006	N/A	4,647 (Historical Actual)

[21] Prior to 2008, includes HIV/AIDS education and Historically Black Colleges and Universities National Resource Center for Substance Abuse and Mental Health. Beginning in 2009, data from Services in Supportive Housing will be reported under Homelessness Activities.

[22] In the FY 2010 President's Budget, it was erroneously noted that Statewide Family/Consumer TA Center contributed to the Science and Services measures. This is not the case and thus has been removed from the list of participating programs.

Table 49: Measure 1.4.07: Percentage of those trained by the program who report they were very satisfied with training (Output)

FY	Target	Result
2012	80%	Dec 31, 2012
2011	80%	Dec 31, 2011
2010	80%	Dec 31, 2010
2009	80%	81.4% (Target Exceeded)
2008	N/A	76% (Historical Actual)
2007	N/A	79% (Historical Actual)
2006	N/A	70% (Historical Actual)

Table 50: Data Source and Validation for Performance Measures for Mental Health Programs of Regional and National Significance - Science and Service Activities

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

Agency Program, Measure 1.4.06 - 1.4.07

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

SAMHSA's Science and Service programs are complements to the Capacity programs. The mental health programs within Science and Service include HIV/AIDS Education, and Historically Black Colleges and Universities (HBCU) Center of Excellence. These programs disseminate best-practices information to grantees and the field, helping to ensure that SAMHSA's Capacity programs build and improve services capacity in the most efficient,

effective and sustainable way possible. The Science and Service programs are also an essential and cost-effective support to building effective capacity in communities that do not receive grant funds from SAMHSA. SAMHSA hopes to include additional data from more of its science and service activities in the future.

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

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

The target for Measure 1.4.06 was not met. The number trained includes the MHCPE HIV/AIDS education training and the Historically Black Colleges and Universities (HBCU) National Resource Center for Substance Abuse and Mental Health training. MHCPE provides the majority of the number trained for this measure and a 12 percent reduction has occurred in the numbers of persons trained face-to-face in the past two years. The program relies heavily on volunteer trainers, and increased demands on their time given current economic conditions for trainers as well as trainees, has resulted in a smaller number trained. Satisfaction with the training remains high as evidenced by the target being exceed in Measure 1.4.07, percentage of those trained by the program who report they were very satisfied with training.

PROGRAM: CHILDREN'S MENTAL HEALTH SERVICES

Table 51: Measure 3.2.11: Increase the percent of funded sites that will exceed a 30 percent improvement in behavioral and emotional symptoms among children receiving services for 6 months[23] (Outcome)

FY	Target	Result
Out-Year Target	60% (2015)	Dec 31, 2015
2010	60%	Dec 31, 2010

23 Long-term measure only. No annual targets have been set.

Table 52: Measure 3.2.12: Increase percentage of children attending school 80% or more of time after 12 months[24] (Outcome)

FY	Target	Result
2012	86.3%	Dec 31, 2012
2011	86.3%	Dec 31, 2011
2010	86.3%	Dec 31, 2010
2009	86.3%	89.2% (Target Exceeded)
2008	84%	86.3% (Target Exceeded)
2007	84%	87% (Target Exceeded)
2006	84%	89.7% (Target Exceeded)

Table 53: Measure 3.2.13: Increase percentage with no law enforcement contacts at 6 months (Outcome)

FY	Target	Result
2012	71.7%	Dec 31, 2012
2011	71.7%	Dec 31, 2011
2010	71.7%	Dec 31, 2010
2009	71.7%	68.9% (Target Not Met)
2008	69%	71.7% (Target Exceeded)
2007	70%	71% (Target Exceeded)
2006	68%	69.3% (Target Exceeded)

[24] This measure has been slightly revised. It was previously reported as “75% or more of the time.” However, the measure has been calculated using an 80% threshold since 2004. Therefore, this revision brings the measure text in line with the calculation.

Table 54: Measure 3.2.14: Decrease average days of inpatient facilities among children served in systems of care at 6 months[25] (Outcome)

FY	Target	Result
2012	-2	Dec 31, 2012
2011	-2	Dec 31, 2011
2010	-2	Dec 31, 2010
2009	-2	-0.12 (Target Not Met)
2008	-2	-1.05 (Target Not Met)
2007	-2	-1.78 (Target Not Met but Improved)
2006	-3.65	-1 (Target Not Met)

Table 55: Measure 3.2.15: Percent of systems of care that are sustained 5 years post Federal funding (Outcome)

FY	Target	Result
Out-Year Target	90% (2013)	Dec 31, 2013
2009	85%	64.1% (Target Not Met)
2008	80%	77.8% (Target Not Met)

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

Table 56: Measure 3.2.16: Increase number of children receiving services (Output)

FY	Target	Result
2012	13,578	Dec 31, 2012
2011	13,051	Dec 31, 2011
2010	13,051	Dec 31, 2010
2009	13,051	10,762 (Target Not Met)
2008	10,000	13,051 (Target Exceeded)
2007	9,120	10,871 (Target Exceeded)
2006	9,120	10,339 (Target Exceeded)

Table 57: Measure 3.2.17: Increase total savings for in-hospital patient care costs per 1,000 children served [26] (Efficiency)

FY	Target	Result
2012	$2,376,000	Dec 31, 2012
2011	$2,376,000	Dec 31, 2011
2010	$2,376,000	Dec 31, 2010
2009	$2,376,000	$160,000 (Target Not Met)
2008	$2,670,000	$1,401,750 (Target Not Met)
2007	$2,670,000	$2,376,000 (Target Not Met but Improved)
2006	Set Baseline	$1,335,000 (Baseline)

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

Table 58: Data Source and Validation for Performance Measures for Children's Mental Health Services

Measure	Data Source	Data Validation
3.2.11	Data on children's outcomes are collected from a multi-site outcome study. Data on clinical outcomes were derived from Reliable Change Index scores (Jacobson & Truax, 1991), calculated from entry into services to six months for the Total Problem scores of the Child Behavior Checklist (CBCL, Achenbach, 2001)	The Reliable Change Index is a standardized method developed by Jacobson and his colleagues to measure change between two data points. The Reliable Change Index has a clear-cut criterion for improvement that has been psychometrically tested and found to be sound (Jacobson & Truax, 1991).
3.2.12	Data on children's attendance are collected from a multi-site outcome study.	Validity analyses were conducted for school attendance and law enforcement contacts. School attendance was found to have a positive relationship with school performance. Children who attended school frequently also had some tendency to receive good grades. The correlation between the two was .313 (p = .000).
3.2.13	Delinquency is reported using a self-report survey	Validity analyses were conducted for school attendance and law enforcement contacts.
3.2.14	The decrease in days of inpatient facilities utilization per child is calculated for a sample of children with complete data on inpatient hospitalization use at both intake and 6 months assessment points. Decrease in inpatient hospitalization days = total number of inpatient days at 6 months – total number of inpatient days at intake. The scale used to assess inpatient-residential treatment is the Living Situations Questionnaire, was adapted from the Restrictiveness of Living Environments Scale and Placement Stability Scale (ROLES) developed by Hawkins and colleagues (1992)	Data are validated by evaluation contractor and subject to project officer review.
3.2.15	Former grantee communities are surveyed 5 years after funding ends	Data are validated by evaluation contractor and subject to project officer review
3.2.16	Grantee reports	Data are validated by evaluation contractor and subject to project officer review

Table 59: Data Source and Validation for Performance Measures for Children's Mental Health Services (continued)

Measure	Data Source	Data Validation
3.2.17	The efficiency measure is computed by calculating the average decrease in days of inpatient facilities utilization per child at six months and multiplying the decrease by the average daily hospitalization charges. The cost savings figure is then converted to a rate per 1,000 children served by the program across all sites. The average daily hospitalization charges = $1,335. National estimates of average daily hospitalization charges were obtained from Health Care Utilization Project Nationwide Inpatient Sample (NIS) 2001	Data are validated b y evaluation contractor and subject to project officer review

Agency Program, Measure 3.2.11 - 3.2.17

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

Measure 3.2.11 is a long-term measure only. No annual targets have been set. The behavioral and emotional functioning of children, youth and families is a key outcome of the Children's Mental Health Initiative (CMHI) program. This long-term indicator reports the percent of funded sites that exceed a 30 percent improvement in behavioral and emotional symptoms for children and youth who have received program services for six months. The baseline obtained for 2001 indicated that 30 percent of funded grantees satisfied the criteria of a 30 percent improvement established for this important long-term outcome indicator. The program seeks to double this percentage to 60 percent of grantee sites. Accordingly, the target set for FY 2010 represents an increase of 100 percent in performance over the baseline obtained when this indicator was initiated. This is a very ambitious increase in target for this CMHI indicator, particularly given that data collected at program entry indicate that some children and youth entering CMHI services are demonstrating more clinically significant behavioral and emotional symptomology in recent years compared to earlier program funding years. There have also been other shifts and changes in populations of focus for some communities funded in FY 2005, FY 2008, and FY 2009 including an emphasis on serving very young children.

The FY 2009 target for increase school attendance among clients of the CMHI program, measure 3.2.12, was set at the level achieved by the program in FY 2008. The FY 2009 target was exceeded by 2.9 percent. Grantees vary in the populations they serve, and those grantees that serve high-risk and/or older children may be less able to achieve these high levels of school attendance. Performance targets for this measure have been exceeded year over year since 2002, except for 2005 where the target was missed by less than one percent. Given that the national average for school attendance is 75%, and this program deals with a population that generally has greater difficulty attending school than children as a whole do, performance for this measure has been excellent.

The target for no law enforcement contact after six months of enrollment in the program among clients in the CMHI program (3.2.13) was increased for FY 2009; however, this target was not met and missed by 2.8 percent. The FY 2009 target was set at the performance level achieved by the program in FY 2008, which was the maximum performance level of the last four years. Since baseline was set in FY 2002, the target has been consistently exceeded though 2008. Given that grantees vary in the populations they target, e.g. those that target high-risk and/or older children, this overall performance demonstrates that the systems of care approach effectively reduces law enforcement contacts.

The FY 2009 target for reduction in hospital days was not achieved for Measure 3.2.14: Decrease average days of inpatient facilities among children served in systems of care at 6 months. Performance of this measure has not met targets over the last four years, which can be partially accounted for by the fact that the number of children hospitalized before they were enrolled in the program differs from year to year resulting in smaller or larger decreases observed. For example, if the average utilization of inpatient hospitalization prior to program intake is relatively low, then decreases in average number of days per child that can be achieved by the program will be low as well. During FY 2009, many funded communities did not enroll children with prior inpatient hospitalization use, and did not have any inpatient use at follow-up. Given these changes in funded communities, SAMHSA will be reviewing its GPRA measures and may be adding new measures in FY 2010.

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

The efficiency measure (3.2.17) reflects per-unit savings in costs. The wording of the measure was changed to better reflect the intent of this measure (total in-patient care cost savings). The FY 2009 target for reduction in costs of inpatient care was not met. Although, one of the main goals of the program is to provide least restrictive services to children and youth served by the grantees, more restrictive services, like inpatient hospitalization, which are also among the most expensive to provide, are sometimes required. This measure is also reflective of the variability of each cohort of grantees' utilization of in-hospital care services. Although alternatives to in-hospital care are used by CMHI systems of care whenever possible, this level of care may be necessary for some children. The FY 2009 result is tied to the reduction to in-hospital days as reported in measure 3.2.14; both of the 2009 targets were not met, due to the fact that many grantees did not serve populations, including very young children, who utilize any inpatient hospitalization services (neither at intake nor at follow-up).

Measure 3.2.15 is a long-term measure to assess sustainability of Federally-funded communities after Federal funding ceases. Former grantee communities are surveyed five years after funding ends. The baseline set in FY 2004 was a result of an assessment of the performance of grantee sites funded in 1994. Since 1994, an additional 123 communities have been funded to provide mental health services for children, youth and their families through the CMHI program. These communities are located throughout the United States and the territories and there is substantial variation in the economic, socio-cultural and other needed resources to ensure that a Federally-funded CMHI grantee community can remain sustained after Federal funding ends. Given the proportion of sites that were able to remain sustained five years after Federal program funding ended for communities funded by CMHI in 1994, 80 percent was set as an ambitious target for performance on this long-term indicator. The annual performance target was increase to 85 percent for FY 2009 and the target was not met.

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

The target of 85 percent was not met, with 64.1 percent of communities funded in 1998 (9 of our 14) achieving sustainability five years past the cessation of federal grant funding. This result may reflect economic conditions affecting the availability of local and State funding within the areas where these communities are located.

The FY 2009 target for the number of children served (3.2.16) was not met. In FY 2008, 16 grantees completed their grant funding cycle and SAMHSA's CMHS awarded 18 new grants. The first year of the grant is a planning year, and grantees do not enroll children in services. In addition, the communities funded in 2003-2004 are towards the end of their funding cycle, when historically, enrollment into services declines. These trends in the currently funded group of grantees are likely to have a significant impact on the number of children and youth served in the CMHI program.

PROGRAM: PROTECTION & ADVOCACY

Table 60: Measure 3.4.08: Increase percentage of complaints of alleged **abuse** not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as result of PAIMI involvement (Outcome)

FY	Target	Result
Out-Year Target	88% (2013)	Jul 31, 2014
2012	84%	Jul 31, 2013
2011	84%	Jul 31, 2012
2010	84%	Jul 31, 2011
2009	84%	Jul 31, 2010
2008	84%	87% (Target Exceeded)
2007	85%	83% (Target Not Met)
2006	84%	84% (Target Met)

Table 61: Measure 3.4.09: Increase percentage of complaints of alleged **neglect** substantiated not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement (Outcome)

FY	Target	Result
Out-Year Target	94% (2013)	Jul 31, 2014
2012	88%	Jul 31, 2013
2011	88%	Jul 31, 2012
2010	88%	Jul 31, 2011
2009	85%	Jul 31, 2010
2008	85%	84% (Target Not Met)
2007	84%	88% (Target Exceeded)
2006	89%	88% (Target Not Met but Improved)

Table 62: Measure 3.4.10: Increase percentage of complaints of alleged **rights violations** substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, or elimination of other barriers to personal decision-making, as a result of PAIMI involvement (Outcome)

FY	Target	Result
Out-Year Target	95% (2013)	Jul 31, 2014
2012	90%	Jul 31, 2013
2011	90%	Jul 31, 2012
2010	90%	Jul 31, 2011
2009	90%	Jul 31, 2010
2008	90%	89% (Target Not Met but Improved)
2007	90%	86% (Target Not Met but Improved)
2006	95%	85% (Target Not Met)

Table 63: Measure 3.4.11: Percent of interventions on behalf of groups of PAIMI-eligible individuals that were concluded successfully (Outcome)

FY	Target	Result
Out-Year Target	95% (2013)	Jul 31, 2014
2012	97%	Jul 31, 2013
2011	97%	Jul 31, 2012
2010	97%	Jul 31, 2011
2009	95%	Jul 31, 2010
2008	95%	97% (Target Exceeded)
2007	95%	97% (Target Exceeded)
2006	Set Baseline	95% (Baseline)

Table 64: Measure 3.4.12: Increase in the number of people served by the PAIMI program (Outcome)

FY	Target	Result
2012	22,325	Jul 31, 2013
2011	22,325	Jul 31, 2012
2010	22,325	Jul 31, 2011
2009	22,325	Jul 31, 2010
2008	22,325	17,468 (Target Not Met)
2007	23,500	18,694 (Target Not Met)
2006	23,500	18,998 (Target Not Met)

Table 65: Measure 3.4.13: Ratio of persons served/impacted per activity/intervention (Outcome)

FY	Target	Result
2012	430	Jul 31, 2013
2011	430	Jul 31, 2012
2010	430	Jul 31, 2011
2009	420	Jul 31, 2010
2008	420	1,177 (Target Exceeded)
2007	420	473 (Target Exceeded)
2006	410	407 (Target Not Met)

Table 66: Measure 3.4.14: Cost per 1,000 individuals served/impacted [27] (Efficiency)

FY	Target	Result
2012	$1,950	Jul 31, 2013
2011	$1,950	Jul 31, 2012
2010	$1,950	Jul 31, 2011
2009	$2,000	Jul 31, 2010
2008	$2,000	$1,886 (Target Exceeded)
2007	$2,000	$1,989 (Target Exceeded)
2006	$2,100	$2,316 (Target Not Met)

[27] Successful result is below target.

Table 67: Measure 3.4.19: The number attending public education/constituency training and public awareness activities (Output)

FY	Target	Result
2012	120,000	Oct 31, 2013
2011	120,000	Oct 31, 2012
2010	120,000	Oct 31, 2011
2009	120,000	Oct 31, 2010
2008	120,000	83,070 (Target Not Met)
2007	Set Baseline	119,423 (Baseline)

Table 68: Data Source and Validation for Performance Measures for Protection and Advocacy for Individuals with Mental Illness (PAIMI) Programs

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

Agency Program, Measure 3.4.08 - 3.4.19

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

Measure 3.4.08 is to increase percentage of complaints of alleged abuse, not withdrawn by the client that resulted in positive change for the client in the safety or welfare of their environment, as a result of PAIMI involvement (same as long-term measure). The FY 2008 target was exceeded by three percent. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Measure 3.4.09 is the percentage of cases of alleged neglect resolved in client's favor. The FY 2008 target was missed by one percent. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Measure 3.4.10 is the percentage of cases of alleged rights violations resolved in client's favor. The FY 2008 target was not met by one percent, but improved by three percent over the 2007 actual. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance. Using what appears to have been an atypical outcome for FY 2004, the targets set for this measure were overly ambitious for FY 2005 and FY 2006 as demonstrated by the actuals for those years. Targets for FY 2009 – 2010 are ambitious at 90 percent compared to the 4-year average of 86 percent.

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

Measure 3.4.12 is to increase in the number of people served by the PAIMI program. The FY 2008 target was not met. This measure is the most volatile because of the number of factors that can influence the outcome. Part of this volatility is inherent in the nature of the PAIMI Program which includes both an individual case and systemic focus. This balance shifts over time from a more individual case emphasis to a more systemic emphasis not only within individual programs but nationally across all programs as well. Also, the case-mix can impact this outcome, as individuals with more complex and extensive needs will require more time and resources which will reduce the total number of persons that can be served. Finally, although the program provides education and outreach, the number of persons served is ultimately determined by the number of persons who seek services which may vary over time. Because of all of these factors, the targets for FY 2009-2010 have been maintained at 22,325, which is still

well above the 4-year average of 21,059.

Both efficiency measures exceeded their targets for FY 2008 (3.4.13 ratio of persons served/impacted per activity/intervention and 3.4.14, Cost per 1,000 individuals served/impacted). These measures demonstrate how the program is able to maximize the number of persons who benefit from the services provided, with emphasis on those services that impact the largest number of individuals and at the least cost.

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

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

PROGRAM: PROJECTS TO ASSIST IN THE TRANSITION FROM HOMELESSNESS

Table 69: Measure 3.4.15: Increase the percentage of enrolled homeless persons who receive community mental health services (Outcome)

FY	Target	Result
Out-Year Target	50% (2013)	Jul 31, 2014
2012	47%	Jul 31, 2013
2011	47%	Jul 31, 2012
2010	47%	Jul 31, 2011
2009	46%	Jul 31, 2010
2008	45%	47% (Target Exceeded)
2007	45%	37% (Target Not Met)
2006	N/A	38% (Historical Actual)

Table 70: Measure 3.4.16: Increase number of homeless persons contacted (Outcome)

FY	Target	Result
2012	195,850	Jul 31, 2013
2011	182,000	Jul 31, 2012
2010	160,000	Jul 31, 2011
2009	151,000	Jul 31, 2010
2008	150,000	134,932 (Target Not Met)
2007	157,500	142,352 (Target Not Met)
2006	157,000	148,655 (Target Not Met)

Table 71: Measure 3.4.17: Increase percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome)

FY	Target	Result
2012	55%	Jul 31, 2013
2011	55%	Jul 31, 2012
2010	55%	Jul 31, 2011
2009	55%	Jul 31, 2010
2008	55%	54% (Target Not Met)
2007	45%	55% (Target Exceeded)[28]
2006	45%	52% (Target Exceeded)[29]

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

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

Table 72: Measure 3.4.18: Average Federal cost of enrolling a homeless person with serious mental illness in services[30] (Efficiency)

FY	Target	Result
2012	$668	Jul 31, 2013
2011	$668	Jul 31, 2012
2010	$668	Jul 31, 2011
2009	$668	Jul 31, 2010
2008	$668	$669 (Target Not Met but Improved)
2007	$668	$674 (Target Not Met)
2006	$668	$623 (Target Exceeded)

Table 73: Measure 3.4.20: Provide training for PATH providers on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits (Output)

FY	Target	Result
2012	5,832	Dec 31, 2012
2011	5,420	Dec 31, 2011
2010	4,927	Dec 31, 2010
2009	4,927	5,104 (Target Exceeded)
2008	Set Baseline	4,927 (Baseline)

Table 74: Data Source and Validation for Performance Measures for Projects to Assist in the Transition from Homelessness (PATH) Programs

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

[30] Successful result is below target.

Agency Program, Measure 3.4.15 - 3.4.20

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

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

In addition, SAMHSA awarded a contract in FY 2008 to begin working with States to utilize the Department of Housing and Urban Development Homeless Management Information System (HMIS) to assist in obtaining individual level outcome data from PATH-funded efforts. In FY 2009, SAMHSA redesigned the PATH Annual Report. It now reflects real consumer outcomes and completes the program's alignment with HMIS data elements.

The number of individuals served is a key measure for SAMHSA programs that fund services. The target for Measure 3.4.16 was not met for FY 2007, which triggered a re-examination of how this measure is calculated. The PATH program now collects data on all persons served using both Federal and match funds. Previously, the program required providers to report on only the proportion of services provided with PATH Federal funds. Our previous analysis of the data indicated that there were inconsistencies in how this formula was applied and that the program was missing critical information on services delivered. Using the Federal-only calculation was an incomplete indicator for performance as the States serve more PATH-eligible consumers than we had reported. As these changes were implemented in FY 2009, the target for Measure 3.4.16 was not met again for FY 2008, but the program expects to meet future targets.

Measure 3.4.17 is an indicator of enrollment of PATH-eligible clients in supportive services other than mental health services. The calculation for this measure was revised to more accurately reflect the true outcome. Prior calculations used the entire number contacted in the calculation. The revised calculation uses only those eligible for services, which explains why the 2007 target was exceeded by 10 percent. The 2008 target was missed by one percent. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance. Eligibility criteria are defined as consumers who are experiencing homelessness or are at imminent risk of homelessness and have serious mental illness including co-occurring substance use disorders.

The target for the PATH efficiency measure (3.4.18) was not met for FY 2008, the 2008 target was missed by one dollar. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance. Performance for this measure FY 2005 through FY 2008 has been excellent. Targets have either been met (2005) or exceeded (2006) and for the most recent two years, they were missed by only six dollars and one dollar respectively. This measure will also

be affected by the proposed change to collect information on all persons served and not just persons served by Federal PATH funds.[31] The current calculation uses the Federal appropriation divided by the number of persons served by Federal PATH funds only. Because the current data only includes the number of persons served with Federal funds, this measure is currently reported as the total cost, including the Federal grant and matching funds, of enrolling a person in services. If programs begin to report information on all persons served including those served with funding from other sources, PATH will be able to accurately capture the Federal cost per person served in addition to the total cost per person served.

Measure 3.4.20 is a measure of a key output of the program: The number of PATH providers trained on Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR). The target for 2009 was exceeded, and 19,220 have been trained since the initiative began. This output is important in that once trained, PATH providers are better able to assist PATH clients in applying for and getting the income benefits for which they are eligible.[32]

PROGRAM: MENTAL HEALTH BLOCK GRANT

Table 75: Measure 2.3.07: Reduce rate of adult readmissions to State psychiatric hospitals within 30 days[33] (Outcome)

FY	Target	Result
2012	9.8%	Sep 30, 2013
2011	9.8%	Sep 30, 2012
2010	9.3%	Sep 30, 2011
2009	8.5%	Sep 30, 2010
2008	8.5%	9.4% (Target Not Met but Improved)
2007	8.7%	9.8% (Target Not Met)
2006	8.3%	9.4% (Target Not Met)

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

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

[33] Successful result is below target.

Table 76: Measure 2.3.08: Reduce rate of adult readmissions to State psychiatric hospitals within 180 days[34] (Outcome)

FY	Target	Result
2012	20%	Sep 30, 2013
2011	20%	Sep 30, 2012
2010	20%	Sep 30, 2011
2009	19%	Sep 30, 2010
2008	19%	21.8% (Target Not Met)
2007	19.1%	20.3% (Target Not Met)
2006	19.2%	19.6% (Target Not Met)

Table 77: Measure 2.3.09: Reduce rate of Child/adolescent readmissions to State psychiatric hospitals within 30 days[35] (Outcome)

FY	Target	Result
2012	6.5%	Sep 30, 2013
2011	6.5%	Sep 30, 2012
2010	6.5%	Sep 30, 2011
2009	5.8%	Sep 30, 2010
2008	5.8%	8.2% (Target Not Met)
2007	5.9%	6.7% (Target Not Met)
2006	6%	6.4% (Target Not Met but Improved)

[34] Successful result is below target.

[35] Successful result is below target.

Table 78: Measure 2.3.10: Reduce rate of Child/adolescent readmissions to State psychiatric hospitals within 180 days[36] (Outcome)

FY	Target	Result
2012	15.3%	Sep 30, 2013
2011	15.3%	Sep 30, 2012
2010	14.5%	Sep 30, 2011
2009	13.9%	Sep 30, 2010
2008	13.9%	17.1% (Target Not Met)
2007	14%	15.3% (Target Not Met)
2006	13.6%	14.2% (Target Not Met but Improved)

Table 79: Measure 2.3.11: Number of evidence based practices (EBPs) implemented[37] (Output)

FY	Target	Result
2012	4.2 per State	Sep 30, 2013
2011	4.2 per State	Sep 30, 2012
2010	4.1 per State	Sep 30, 2011
2009	4.0 per State	Sep 30, 2010
2008	4.0 per State	4.2 per State (Target Exceeded)
2007	4.0 per State	4.0 per State (Target Met)
2006	3.3 per State	3.9 per State (Target Exceeded)

[36] Successful result is below target.

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

Table 80: Measure 2.3.12: Adult: Percentage of adult population coverage for each (reported as percentage of service population receiving any evidence based practice) [38] (Output)

FY	Target	Result
2012	10.5%	Sep 30, 2013
2011	10.5%	Sep 30, 2012
2010	10.5%	Sep 30, 2011
2009	10.5%	Sep 30, 2010
2008	10.5%	8% (Target Not Met)
2007	10.4%	9.4% (Target Not Met)
2006	10.3%	9.5% (Target Not Met)

Table 81: Measure 2.3.13: Children: Percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice) [39] (Output)

FY	Target	Result
2012	3.5%	Sep 30, 2013
2011	3.5%	Sep 30, 2012
2010	3.5%	Sep 30, 2011
2009	3.5%	Sep 30, 2010
2008	3.5%	3% (Target Not Met)
2007	3.4%	3.2% (Target Not Met but Improved)
2006	2.3%	2.2% (Target Not Met)

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

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

Table 82: Measure 2.3.15: Increase rate of consumers (adults) reporting positively about outcomes (Outcome)

FY	Target	Result
2012	72%	Sep 30, 2013
2011	72%	Sep 30, 2012
2010	72%	Sep 30, 2011
2009	72%	Sep 30, 2010
2008	72%	72% (Target Met)
2007	73%	71% (Target Not Met)
2006	74%	71% (Target Not Met)

Table 83: Measure 2.3.16: Increase rate of family members (children/adolescents) reporting positively about outcomes (Outcome)

FY	Target	Result
2012	73%	Sep 30, 2013
2011	73%	Sep 30, 2012
2010	73%	Sep 30, 2011
2009	73%	Sep 30, 2010
2008	73%	64% (Target Not Met)
2007	68%	65% (Target Not Met)
2006	67%	73% (Target Exceeded)

Table 84: Measure 2.3.17: Number of persons receiving evidence-based practices per $10,000 of mental health block grant dollars spent (Efficiency)

FY	Target	Result
2012	7.0	Sep 30, 2013
2011	7.0	Sep 30, 2012
2010	7.0	Sep 30, 2011
2009	6.5	Sep 30, 2010
2008	4.0	6.7 (Target Exceeded)
2007	4.0	6.5 (Target Exceeded)
2006	4.0	5.7 (Target Exceeded)

Table 85: Measure 2.3.14: Increase number of people served by the public mental health system[40] (Output)

FY	Target	Result
2012	6,300,000	Sep 30, 2013
2011	6,300,000	Sep 30, 2012
2010	6,300,000	Sep 30, 2011
2009	6,250,000	Sep 30, 2010
2008	6,200,000	6,332,983 (Target Exceeded)
2007	5,753,633	6,121,641 (Target Exceeded)
2006	5,725,008	5,979,379 (Target Exceeded)

[40] The FY 2010, FY 2011 and FY 2012 targets have been set at 6.3 million persons served (slightly lower than the most recent actual) based on the expectation that the current recession will impact the service delivery systems of the State Mental Health Authorities and may result in fewer persons receiving mental health care nationally.

Table 86: Data Source and Validation for Performance Measures for Mental Health Block Grant

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

Agency Program, Measure 2.3.07 - 2.3.14

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

Measure 2.3.07 is to reduce the rate of readmissions to State psychiatric hospitals for adults within 30 days from their discharge from the hospital. The FY 2008 target was not met. Readmission rates were slightly above target levels. It appears that the initial targets for FY 2003 – FY 2005, which were set from the FY 2002 baseline, may have been too ambitious since the targets have not been met in any of the previous fiscal years. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2007 was increased to 8.7 percent, but this also proved to be too ambitious. FY 2010 targets have been increased to allow time for States to make adjustments to service planning in response to the existing rates.

Measure 2.3.08 is the readmission rate for adults within 180 days from their discharge from the hospital. The FY 2008 target was not met. Readmission rates were slightly above target levels. It appears that the initial targets for FY 2003 – FY 2005, which were set from the FY 2002 baseline, may have been too ambitious since the targets have not been met in any of the previous fiscal years. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2007 was increased to 19.1 percent, but this also proved to be too ambitious. FY 2010, FY 2011 and FY 2012 targets have been increased to allow time for States to make adjustments to service planning in response to the existing rates.

Measure 2.3.09 is the readmission rate for children within 30 days from their discharge from the hospital the FY 2008 target was not met. Readmission rates were slightly above target levels. It appears that since the actuals for FY 2004 and FY 2005 were just above the targets, the targets for FY 2006 and FY 2007 were lowered with the expectation that the rate would continue to fall. Unfortunately, that is not the case since the rates have been increasing. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2010 was increased to 6.5 percent, to allow time for States to make adjustments to service planning in response to the existing rates.

Measure 2.3.10 is the readmission rate for children within 180 days from their discharge from the hospital. The FY 2008 target was not met. It appears that the targets that were set from the FY 2003 baseline may have been too ambitious since the targets have not been met in any of the previous fiscal years. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2007 was increased to 14.0 percent, but this also proved to be too ambitious. FY 2010, FY 2011 and FY 2012 targets have been increased to allow time for States to make adjustments to service planning in response to the existing rates.

Measures 2.3.15 and 2.3.16 reflect the rate of consumers (adults) and family members (children) reporting positively about the outcomes of the services that they received in helping to the problems that brought them into treatment. The target for adults was met; the target for children was slightly missed. Future targets for adults have been reduced on the basis of prior year performance.

The evidence-based practices measures reflect the program's efforts to improve the efficiency and effectiveness of mental health services. The efficiency measure was exceeded (2.3.17). This indicator provides a measure of the number of evidence-based practices (EBPs) implemented per State. The use of EBPs allows mental health providers and programs to more reliably improve services, achieve optimal outcomes and has demonstrated a consistent, positive impact on of the lives of people who have experienced mental health problems. The target was exceeded. For FY 2008, the target for the number of evidence based practices was exceeded (2.3.11). The evidence based practice percentage of coverage for adults (2.3.12) was missed by 2.5% percent and for children (2.3.13) the target was missed by just one-half of one percent. It appears that the program over-estimated the level of progress that states could make in the access of these programs for these populations in the allotted time. Measure 2.3.14 provides a measure of the number of consumers served by the public mental health system. Targets for FY 2007 and FY 2008 were exceeded.

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

MACRO PROGRAM: SUBSTANCE ABUSE PREVENTION PROGRAMS OF REGIONAL AND NATIONAL SIGNIFICANCE

PROGRAM: STRATEGIC PREVENTION FRAMEWORK STATE INCENTIVE GRANTS[41]

Table 87: Measure 2.3.19: 30-day use of alcohol among youth age 12-17 (Outcome)

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

Table 88: Measure 2.3.20: 30-day use of other illicit drugs age 12 and up (Outcome)

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

Table 89: Measure 2.3.21: Percent of SPF SIG States showing a decrease in state level estimate of percent of survey respondents (age 12-20) who report 30-day use of alcohol (Outcome)

FY	Target	Result
2012	55.9%	Aug 31, 2013
2011	50.4%[42]	Aug 31, 2012
2010	50.4%	Aug 31, 2011
2009	50.4%	Aug 31, 2010
2008	51.8%	55.9% (Target Exceeded)
2007	51.8%	47.1% (Target Not Met)
2006	Set Baseline	47.1% (Baseline)

[41] Data have been revised from previously reported. Previously, data collected in a given year were reported as a result for the following year: for example, results reported for 2008 reflected data collected in 2007. In order to achieve consistency throughout SAMHSA, reporting has been revised so that results reported for a given year reflect data actually collected in that year, so that results for 2008 reflect data collected in 2008.

[42] Includes Cohorts 3 & 4. Cohort 4 began the SPF process July 2009.

Table 90: Measure 2.3.22: Percent of SPF SIG States showing a decrease in state level estimate of percent of survey respondents (age 21 and up) who report 30-day use of alcohol (Outcome)

FY	Target	Result
2012	47.1%	Aug 31, 2013
2011	31.4%[43]	Aug 31, 2012
2010	31.4%	Aug 31, 2011
2009	31.4%	Aug 31, 2010
2008	32.3%	47.1% (Target Exceeded)
2007	32.3%	41.2% (Target Exceeded)[44]
2006	Set Baseline	29.4% (Baseline)

Table 91: Measure 2.3.23: Percent of SPF SIG states showing a decrease in state level estimates of survey respondents (age 12-17) who report 30-day use of other illicit drugs (Outcome)

FY	Target	Result
2012	67.6%	Aug 31, 2013
2011	59.8%[45]	Aug 31, 2012
2010	59.8%	Aug 31, 2011
2009	59.8%	Aug 31, 2010
2008	61.5%	67.6% (Target Exceeded)
2007	61.5%	55.9% (Target Not Met)
2006	Set Baseline	55.9% (Baseline)

[43] Includes Cohorts 3& 4. Cohort 4 began the SPF process July 2009.

[44] Data revised from previously reported.

[45] Includes Cohorts 3 & 4. Cohort 4 began the SPF process July 2009.

Table 92: Measure 2.3.24: Percent of SPF SIG states showing a decrease in state level estimates of survey respondents (age 18 and up) who report 30-day use of other illicit drugs (Outcome)

FY	Target	Result
2012	40%	Aug 31, 2013
2011	38.2%[46]	Aug 31, 2012
2010	47.2%	Aug 31, 2011
2009	47.2%	Aug 31, 2010
2008	48.5%	38.2% (Target Not Met but Improved)
2007	48.5%	29.4% (Target Not Met)[47]
2006	Set Baseline	44.1% (Baseline)

Table 93: Measure 2.3.25: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who rate the risk of substance abuse as moderate or great (Outcome)

FY	Target	Result
2012	50%	Aug 31, 2013
2011	47.1%[48]	Aug 31, 2012
2010	78.7%	Aug 31, 2011
2009	78.7%	Aug 31, 2010
2008	80.9%	47.1% (Target Not Met)
2007	80.9%	50% (Target Not Met)
2006	Set Baseline	73.5% (Baseline)

[46] Includes Cohorts 3 & 4. Cohort 4 began the SPF process July 2009.

[47] Data revised from previously reported.

[48] Includes Cohorts 3 & 4. Cohort 4 began the SPF process July 2009.

Table 94: Measure 2.3.26: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 18 and up) who rate the risk of substance abuse as moderate or great (Outcome)

FY	Target	Result
2012	48%	Aug 31, 2013
2011	44.1%[49]	Aug 31, 2012
2010	50.4%	Aug 31, 2011
2009	50.4%	Aug 31, 2010
2008	51.8%	44.1% (Target Not Met but Improved)
2007	51.8%	29.4% (Target Not Met)
2006	Set Baseline	47.1% (Baseline)

Table 95: Measure 2.3.27: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who somewhat disapprove or strongly disapprove of substance use. (Outcome)

FY	Target	Result
2012	80%	Aug 31, 2013
2011	76.5%[50]	Aug 31, 2012
2010	84.9%	Aug 31, 2011
2009	84.9%	Aug 31, 2010
2008	87%	76.5% (Target Not Met but Improved)
2007	87.3%	67.6% (Target Not Met)
2006	Set Baseline	79.4% (Baseline)

[49] Includes Cohorts 3 & 4. Cohort 4 began the SPF process July 2009.

[50] Includes Cohorts 3 & 4. Cohort 4 began the SPF process July 2009.

Table 96: Measure 2.3.28: Number of evidence-based policies, practices, and strategies implemented[51] (Output)

FY	Target	Result
2012	274	Aug 31, 2013
2011	397[52]	Aug 31, 2012
2010	234	Aug 31, 2011
2009	234	Aug 31, 2010
2008	470	731 (Target Exceeded)
2007	470	385 (Target Not Met)
2006	Set Baseline	396 (Baseline)

Table 97: Measure 2.3.29: Percent of grantee states that have performed needs assessments (Output)

FY	Target	Result
2012	100%	Aug 31, 2013
2011	100%	Aug 31, 2012
2010	97%[53]	Aug 31, 2011
2009	100%	100% (Target Met)
2008	100%	100% (Target Met)
2007	100%	100% (Target Met)
2006	100%	92.3% (Target Not Met)

[51] This measure has been revised for the FY 2011 President's Budget. Previously the measure was cumulative. It has been revised to report its data annually. As a result, targets and data provided here may appear to differ from those previously published in the FY 2010 President's Budget.

[52] Includes Cohorts 3 & 4. Cohort 4 began the SPF process July 2009.

[53] Cohort 1: 100%; Cohort 2: 100%; Cohort 3: 94%

Table 98: Measure 2.3.30: Percent of grantee States that have submitted State plans (Output)

FY	Target	Result
2012	100%	Aug 31, 2013
2011	100%	Aug 31, 2012
2010	60%[54]	Aug 31, 2011
2009	95.2%	100% (Target Exceeded)
2008	100%	95.2% (Target Not Met)[55]
2007	85%	96.2% (Target Exceeded)
2006	50%	92.3% (Target Exceeded)

Table 99: Measure 2.3.31: Percent of grantee States with approved plans (Output)

FY	Target	Result
2012	80%	Aug 31, 2013
2011	80%	Aug 31, 2012
2010	54%[56]	Aug 31, 2011
2009	85.7%	100% (Target Exceeded)
2008	100%	85.7% (Target Not Met)[57]
2007	85%	88.5% (Target Exceeded)
2006	25%	69.2% (Target Exceeded)

[54] Cohort 1: 100%; Cohort 2: 100%;Cohort 3: 63%

[55] Includes 100% of Cohort I and 2 and 88% of Cohort 3

[56] Cohort 1: 100%; Cohort 2: 100%; Cohort 3: 63%

[57] Includes 100% of Cohort 1 and 2 and 88% of Cohort 3

Table 100: Data Source and Validation for Performance Measures for Strategic Prevention Framework State Incentive Grants

Measure	Data Source	Data Validation
2.3.19 2.3.20	Long term national measures are obtained from published National Survey on Drug Use and Health reports.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by state grantees to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works with them to insure that data are complete and accurate.
2.3.21	Long term national measures are obtained from published National Survey on Drug Use and Health reports.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by state grantees to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works with them to insure that data are complete and accurate.
2.3.22 2.3.23 2.3.24 2.3.25 2.3.26 2.3.27	Baselines and annual targets for each state are calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Since state-level sample sizes will vary from year-to-year, to ensure sufficient statistical reliability, baselines and annual targets and estimates are calculated by pooling samples from two consecutive years. This year, state-level change is assessed by comparing estimates derived from the 2005/2006 pooled sample with those derived from the 2006/2007 pooled sample.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by state grantees to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works with them to insure that data are complete and accurate.
2.3.28 2.3.29 2.3.30 2.3.31	Output measures are obtained from grantee administrative reports.	Data related to state activities are submitted by state grantees to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with them to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance monitoring. This is expected to be operational in January, 2010.

Agency Program, Measure 2.3.19 - 2.3.31

NOTE: Some data have changed from those previously reported. Previously, data were reported as a result for the following year. For example, results for 2008 reflected data collected in 2007. In order to achieve consistency across SAMHSA, reporting has been revised so that results reflect data actually collected in that year.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

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

The SPF SIG grantees met or exceeded three of their FY 2008 outcome targets. These included 30-day use of alcohol for ages 12-20 and 21 and up, and 30-day use of other illicit drugs for ages 12-17. Grantees also met or exceeded output targets such as the number of evidence-based programs implemented, and measures of successful infrastructure accomplishments. The observed reductions in alcohol and other illicit drug use could be related to the increased numbers of evidence-based programs (EBPs) being implemented.

The SPF SIG program can demonstrate a number of accomplishments. For example, SPF SIG Cohort 1 and 2 data show that, 731 (68.9%) interventions implemented were evidence-based. This number has almost doubled over the past several years. Over 82% of Cohort 1 and 2 communities reporting demonstrated an improvement in their targeted outcomes. Similarly, between 2005/2006 and 2006/2007, SPF SIG states showed greater reductions in underage drinking and youth drug use and greater improvements in perceived risk of use than non-SPF SIG states.

The SPF concept has expanded beyond the current SPF SIG grantee states and territories to other states and territories. For example, 51 states/territories now use SPF or the equivalent for conducting needs assessments, 53 for building state capacity; 53 for planning; 43 for program implementation; and 29 uses SPF or the equivalent for evaluation efforts. Forty-two SPF SIG grants have funded 597 communities for Cohorts 1, 2, and 3.

At the same time, the SPF SIG states failed to meet their targets for other measures. These failures could reflect a variety of methodological and statistical issues, or the targets could be affected by numerous factors external to prevention programs that are outside the control of this program, such as the economy.

Targets for some of the measures are lower in future years because they include both earlier and later cohorts of SPF SIG states. The earlier cohorts will have completed several of the initial

SPF steps, but Cohort 3 was funded in 2006 and will be completing steps 1 and 2, while the latest cohort (Cohort 4), funded July 1, 2009, is at the beginning the SPF process. SAMHSA funded the additional Cohort 4 of SPF SIGs by funding 25 new SPF state, territory, and tribe grantees with an expectation of these SPF SIG grantees having funded their communities within the next 6 to 12 months upon obtaining approval from SAMHSA to do so.

PROGRAM: PARTNERSHIPS FOR SUCCESS

Table 101: Measure 2.3.77: Increase the number of sub-recipient communities funded through the Partnerships for Success grants (Output)

FY	Target	Result
2012	150	Aug 31, 2013
2011	48	Aug 31, 2012
2010	Set Baseline	Aug 31, 2011

Table 102: Measure 2.3.78: Increase the number of communities who report an increase in prevention activities that are supported by collaboration and leveraging of funding streams (Output)

FY	Target	Result
2012	75	Aug 31, 2013
2011	24	Aug 31, 2012
2010	Set Baseline	Aug 31, 2011

Table 103: Measure 2.3.79: Increase the number of EBPs implemented by sub-recipient communities (Output)

FY	Target	Result
2012	300	Aug 31, 2013
2011	96	Aug 31, 2012
2010	Set Baseline	Aug 31, 2011

Table 104: Measure 2.3.80: Increase the number of sub-recipient communities that improved on one or more targeted NOMs indicators (Outcome)

FY	Target	Result
2012	30	Aug 31, 2013
2011	24	Aug 31, 2012
2010	Set Baseline	Aug 31, 2011

Table 105: Data Source and Validation for Performance Measures for Partnerships for Success Grants

Measure	Data Source	Data Validation
2.3.77 2.3.79 2.3.80	Output measures are obtained from grantee administrative reports.	Data related to state activities will be submitted to SAMHSA's data collection and analysis contracts will insure that data are complete and accurate. SAMHSA Project Officers also review the data to ensure accuracy. It is anticipated that this program will eventually be included in the online data entry system available via PMRTS.
2.3.78	Output measures are obtained from grantee administrative reports.	Data related to state activities will be submitted to SAMHSA's data collection and analysis contracts will insure that data are complete and accurate. SAMHSA Project Officers also review the data to ensure accuracy. It is anticipated that this program will eventually be included in the online data entry system available via PMRTS.

Agency Program, Measure 2.3.77 - 2.3.80

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

This new program is designed to provide eligible States, Tribes and U.S. territories with additional funding to extend their strategic prevention framework activities to further reduce state-wide substance abuse rates. They are encouraged to set meaningful performance targets and to leverage and coordinate Federal-state coordinated funding to ensure sufficient impact to meet their performance targets. The program incorporates incentive awards to those who have reached or exceeded these prevention performance targets.

PROGRAM: MINORITY AIDS INITIATIVE: SUBSTANCE ABUSE PREVENTION, HIV PREVENTION AND HEPATITIS PREVENTION FOR MINORITIES AND MINORITIES RE-ENTERING COMMUNITIES POST-INCARCERATION (HIV)[58,59,60]

Table 106: Measure 2.3.35: Percent of program participants (age 12-17) that rate the risk of substance abuse as moderate or great (Outcome)

FY	Target	Result
2012	87%	Aug 31, 2013
2011	87%	Aug 31, 2012
2010	87%	Aug 31, 2011
2009	76.6%	Aug 31, 2010
2008	75.8%	90.1% (Target Exceeded)
2007	89%	87.6% (Target Not Met)
2006	Set Baseline	88.6% (Baseline)

Table 107: Measure 2.3.38: Percent of program participants (age 18 and up) that rate the risk of substance abuse as moderate or great (Outcome)

FY	Target	Result
2012	93%	Aug 31, 2013
2011	93%	Aug 31, 2012
2010	93%	Aug 31, 2011
2009	85.1%	Aug 31, 2010
2008	84.2%	96.5% (Target Exceeded)
2007	Set Baseline	94.4% (Baseline)

[58] Previously, data collected in a given FY were reported in the following year. For example, results for 2008 would reflect data collected in 2007. In order to achieve consistency across SAMHSA, reporting has been revised so that results for a given FY reflect data actually collected in that year, except where otherwise noted.

[59] HIV Cohort 7 serves different population groups so baseline data from this cohort will be established and entered in FY 2010.

[60] The out years of this program are under development and performance measures will be added once the program is finalized. In the interim, targets for FY 2011 and FY 2012 have been included and are subject to change.

Table 108: Measure 2.3.39: Percent of participants (age 12-20) who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease) (Outcome)

FY	Target	Result
2012	76.6%	Aug 31, 2013
2011	76.6%	Aug 31, 2012
2010	76.6%	Aug 31, 2011
2009	76.6%	Aug 31, 2010
2008	75.1%	58.1% (Target Not Met)
2007	Set Baseline	74.4% (Baseline)

Table 109: Measure 2.3.40: Percent of participants (age 21 and up) who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease) (Outcome)

FY	Target	Result
2012	60.8%	Aug 31, 2013
2011	60.8%	Aug 31, 2012
2010	60.8%	Aug 31, 2011
2009	60.8%	Aug 31, 2010
2008	59.6%	60.4% (Target Exceeded)
2007	Set Baseline	59% (Baseline)

Table 110: Measure 2.3.41: Percent of participants (age 12-20) who report no alcohol use at pre-test who remain non-users at post-test (non-user stability) (Outcome)

FY	Target	Result
2012	95.3%	Aug 31, 2013
2011	95.3%	Aug 31, 2012
2010	95.3%	Aug 31, 2011
2009	95.3%	Aug 31, 2010
2008	93.4%	93.7% (Target Exceeded)
2007	Set Baseline	92.5% (Baseline)

Table 111: Measure 2.3.42: Percent of participants (age 21 and up) who report no alcohol use at pre-test who remain non-users at post-test (non-user stability) (Outcome)

FY	Target	Result
2012	92%	Aug 31, 2013
2011	92%	Aug 31, 2012
2010	92%	Aug 31, 2011
2009	92%	Aug 31, 2010
2008	90.2%	90.3% (Target Exceeded)
2007	Set Baseline	89.3% (Baseline)

Table 112: Measure 2.3.43: Percent of participants (age 12-17) who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease) (Outcome)

FY	Target	Result
2012	92.3%	Aug 31, 2013
2011	92.3%	Aug 31, 2012
2010	92.3%	Aug 31, 2011
2009	92.3%	Aug 31, 2010
2008	90.5%	67.3% (Target Not Met)
2007	Set Baseline	89.6% (Baseline)

Table 113: Measure 2.3.44: Percent of participants (age 18 and up) who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease) (Outcome)

FY	Target	Result
2012	70.6%	Aug 31, 2013
2011	70.6%	Aug 31, 2012
2010	70.6%	Aug 31, 2011
2009	70.6%	Aug 31, 2010
2008	69.2%	59.1% (Target Not Met)
2007	Set Baseline	68.5% (Baseline)

Table 114: Measure 2.3.45: Percent of participants (age 12-17) who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability) (Outcome)

FY	Target	Result
2012	94.9%	Aug 31, 2013
2011	94.9%	Aug 31, 2012
2010	94.9%	Aug 31, 2011
2009	94.9%	Aug 31, 2010
2008	93%	96% (Target Exceeded)
2007	Set Baseline	92.1% (Baseline)

Table 115: Measure 2.3.46: Percent of participants (age 18 and up) who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability) (Outcome)

FY	Target	Result
2012	94.6%	Aug 31, 2013
2011	94.6%	Aug 31, 2012
2010	94.6%	Aug 31, 2011
2009	94.6%	Aug 31, 2010
2008	92.7%	93.4% (Target Exceeded)
2007	Set Baseline	91.8% (Baseline)

Table 116: Measure 2.3.47: Percent of program participants (age 12-17) who somewhat disapprove or strongly disapprove of substance use (Outcome)

FY	Target	Result
2012	82.8%	Aug 31, 2013
2011	82.8%	Aug 31, 2012
2010	82.8%	Aug 31, 2011
2009	82.8%	Aug 31, 2010
2008	81%	72.9% (Target Not Met but Improved)
2007	Set Baseline	70.3% (Baseline)

Table 117: Measure 2.3.48: Number of evidence-based policies, practices, and strategies implemented by HIV program grantees[61] (Output)

FY	Target	Result
2012	110	Aug 31, 2013
2011	110[62]	Aug 31, 2012
2010	270	Aug 31, 2011
2009	160	Aug 31, 2010
2008	160	509 (Target Exceeded)
2007	Set Baseline	162 (Baseline)

Table 118: Measure 2.3.56: Number of individuals exposed to substance abuse/hepatitis education services (Output)

FY	Target	Result
2012	1,535	Aug 31, 2013
2011	1,535[63]	Aug 31, 2012
2010	2,327	Aug 31, 2011
2009	2,305	Aug 31, 2010
2008	2,283	3,298 (Target Exceeded)
2007	Set Baseline	2,260 (Baseline)

[61] This measure has been revised for the FY 2011 President's Budget. Previously the measure was cumulative. It has been revised to report its data annually. As a result, targets and data provided here may appear to differ from those previously published in the FY 2010 President's Budget.

[62] This measure is expected to decline in FY 2011 following the close-out of Cohort 6 grants and newer Cohorts not yet functioning at optimum levels.

[63] This measure is expected to decline in FY 2011 following the close-out of Cohort 6 grants and newer Cohorts not yet functioning at optimum levels.

Table 119: Measure 2.3.70: Cost per participant improved on one or more measures between pre-test and post-test[64] (Efficiency)

FY	Target	Result
2012	$10,890	Aug 31, 2013
2011	$10,890	Aug 31, 2012
2010	$20,167	Aug 31, 2011
2009	$20,167	Aug 31, 2010
2008	$20,167	$10,890 (Target Exceeded)[65]
2007	Set Baseline	$22,189 (Baseline)[66]

Table 120: Data Source and Validation for Performance Measures for Minority AIDS Initiative Grants

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

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

[65] Calculations have been adjusted somewhat from earlier years. See additional detail in the narrative.

[66] Calculations are extremely over-inflated due to exclusion of participant counts in other than direct services. Efforts are being made to gather those data which will then be used to provide more realistic projected targets.

Table 121: Data Source and Validation for Performance Measures for Minority AIDS Initiative Grants (continued)

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

Agency Program, Measure 2.3.35 - 2.3.70

NOTE: Some data have been revised from those previously reported. Previously, data collected in a given year was reported as a result for the following year: for example, results reported for 2008 reflected data collected in 2007. In order to achieve consistency throughout SAMHSA, reporting has been revised so that results reported for a given year reflect data actually collected in that year, so that results for 2008 reflect data collected in 2008.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

The goal of the Substance Abuse and HIV prevention program is to increase the capacity of communities serving minority target populations to deliver evidence-based prevention services. Evidence-based interventions are defined by inclusion in one or more of the three categories: a) included in Federal registries of evidence-based interventions; b) reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or c) documented effectiveness supported by other sources of information and the consensus judgment of informed experts.[67]

---

[67] Examples of HIV EBP's include Voices/Voces and the Sista Program which is listed in the CDC Directory of Evidence Based Interventions (DEBI). More information on EBPs can be found in Identifying and Selecting Evidence-Based Interventions. Revised

The program also incorporates SAMHSA's National Outcome Measures (NOMs), which is SAMHSA's core data collection requirement for all grant programs. This program is also using an approved efficiency measure (2.3.70) and a measure on the number of individuals exposed to substance abuse/hepatitis education services (2.3.56). These measures will illustrate the impact of outreach efforts to reach at risk minority subpopulations. Future cohorts do not include a focus on hepatitis. Other measures reflect program effects for both those who had used drugs before entering the program and those who had not. This last set of measures requires person-level matched data to assess person-level program outcomes such as non-user stability and user decrease to assess "improvement", and are used as a basis for calculating effectiveness. These matched data apply to clients who have participated in prevention interventions lasting at least 30 days. Thus, they do not reflect the broad range of shorter programs and outreach efforts serving many more thousands of people. Change is assessed by following each participant from program entry to program exit and to 3 to 6 month follow-up. Since this program has changed substantially by focusing on much higher risk minority and re-entry populations and by incorporating the SPF process, SAMHSA had to establish new baseline measures in FY 2007 using data collected during FY 2007. Cohort 7 data will be available in FY 2010. Both cohorts are now submitting their progress reporting online in SAMHSA's PMRTS to increase availability of real time data submission and availability.

Data collected during FY 2008 indicate that ten of the above measures reached or exceeded their targets. Of the measures that did not reach their targets, 2.3.43 and 2.3.44 (user decrease, illicit drugs other than marijuana for ages 12-17 and 18+) are based on small sample sizes because most participants were not users. Measure 2.3.56 (number of people exposed to education services) indicates an increase of over 30 percent in the number served from FY 2007 to FY 2008. Measure 2.3.47 (percent of youth disapproving peer substance use) indicates an improvement over FY 2007 (from 70.3 percent to 72.9 percent), although it did not reach the FY 2008 target of 81 percent.

There are other findings of interest, although they are not GPRA measures. For example, HIV Cohort 6 participants are more likely to report recent use of marijuana and illicit substances than the general U.S. population; therefore, the program is reaching its target population: those at high risk. The program was also effective in improving knowledge about substance use, HIV, and hepatitis. Youth participants increased their knowledge scores by 13.4 percentage points and adult participants raised their scores by 5.9 percentage points. Furthermore, the program had disproportionate effects on males vs. females, with males showing more improvement in perceived risk and peer disapproval than females.

SAMHSA has added a cost per improved client measure in order to monitor cost effectiveness. This measure is defined as the total cost of the HIV program divided by the number of participants who improved. A program participant is considered to have improved if baseline-to-exit comparisons indicate improvement on at least one NOM ATOD[68] measure. These include non-user stability, reduction in 30-day use, increase in perception of harm or perceived disapproval or non-user stability on at least one 30-day substance use measure and no worse on any other NOM. Estimating the number of persons served by environmental strategies is extremely difficult. Therefore, this has resulted in a significant overestimation in the cost per person served improved, because total program dollars were divided by only the number of

---

Guidance document for the Strategic Prevention Framework State Incentive Grant Program.HHS Pub. No. (SMA-4205). CSAP/SAMHSA, 2009. http://www.samhsa.gov/shin

[68] Alcohol, Tobacco, or Other Drugs

clients directly served by a program lasting over 30 days. For the HIV Cohort 6 program grantees, cost per improved participant (direct services lasting 30 or more days only) was $22,189 in FY 2007. Based on process data from grantee reports, SAMHSA estimates that no more than half of total program costs are used for direct services lasting 30 or more days. This suggests that a more realistic number for program costs per improved participant is approximately $10,890. As a result of this examination, SAMHSA has revised the calculation used for this measure to include only dollars spent on direct services divided by the number of program participants who "improved."

The FY 2010 cohort will continue to focus on high-risk minority subpopulations. The details of this revised program are still under development and performance measures will be added once the program is finalized. In the interim, targets for FY 2011 and FY 2012 have been included and are subject to change.

PROGRAM: PREVENTION PRNS - SOBER TRUTH ON PREVENTING UNDERAGE DRINKING

Table 122: Measure 3.3.01: Percentage of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades (Outcome)

FY	Target	Result
2012	41%	Aug 31, 2013
2011	41%	Aug 31, 2012
2010	41%	Aug 31, 2011
2009	40%	Aug 31, 2010
2008	Set Baseline	40% (Baseline)

Table 123: Measure 3.3.02: Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades (Outcome)

FY	Target	Result
2012	63.4%	Aug 31, 2013
2011	63.4%	Aug 31, 2012
2010	63.4%	Aug 31, 2011
2009	62.2%	Aug 31, 2010
2008	Set Baseline	60.9% (Baseline)

Table 124: Measure 3.3.03: Percentage of coalitions that report improvement in youth perception of parental disapproval on the use of alcohol in at least two grades (Outcome)

FY	Target	Result
2012	56.7%	Aug 31, 2013
2011	56.7%	Aug 31, 2012
2010	56.7%	Aug 31, 2011
2009	55.6%	Aug 31, 2010
2008	Set Baseline	54.5% (Baseline)

Table 125: Data Source and Validation for Performance Measures for Sober Truth on Preventing Underage Drinking Grants

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

Agency Program, Measure 3.3.01 - 3.3.03

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

The Sober Truth on Preventing Underage Drinking (STOP Act) program provides current or previously funded Drug Free Community grantees with an additional $50,000 funding to support

substance abuse prevention environmental strategies targeted to stop underage drinking. The purpose of this program is to prevent and reduce alcohol use among youth in communities throughout the United States. It was created to strengthen collaboration among communities, the federal government, and state, local and tribal governments; to enhance intergovernmental cooperation and coordination; to serve as a catalyst for increased citizen participation and greater collaboration among all sectors and organizations of a community that first demonstrates a long-term commitment to reducing alcohol use among youth; and to disseminate to communities timely information regarding state-of-the-art practices and initiatives that have proven to be effective in preventing and reducing alcohol use among youth. The initial program, funded in FY 2008, provided 79 four-year grants to local communities. In FY 2009, 20 more grants were awarded to strengthen these important efforts.

STOP Act grantees are required to report performance on three core measures. These are 1) 30 day alcohol use, 2) perception of harm from alcohol use and 3) parental disapproval of alcohol use. These measures are consistent with Drug Free Community program measures, as instructed by Congressional language. Baselines have been established for the STOP Act GPRA measures. Current data show that over 30 percent of strategies implemented by STOP Act grantees focus on community education/raising awareness.

An evaluation of the STOP ACT program is planned that will examine:

1. What effects result from the STOP Act program funding on attitudes and behaviors associated with underage drinking above and beyond the effects of DFC and/or SPF SIG funding?

2. Do STOP Act new and/or prevention strategies add to the mix of existing strategies funded through other sources in improving outcomes?

PROGRAM: PREVENTION PRNS - SCIENCE AND SERVICE ACTIVITIES

Table 126: Measure 2.3.71: Number of people provided technical assistance (TA) Services[69] (Output)

FY	Target	Result
2012	21,420	Aug 31, 2013
2011	21,420	Aug 31, 2012
2010	21,117	Aug 31, 2011
2009	21,117	Aug 31, 2010
2008	Set Baseline	22,889 (Baseline)[70]

[69] Updated to include Centers for the Application of Prevention Technology (CAPTs), Native American Center of Excellence (NACE), Fetal Alcohol Spectrum Disorder (FASD), MEI, and Prevention Fellowships

[70] Actual has been updated from previously reported and now contains data from the additional science and service activities.

Table 127: Measure 2.3.72: Percentage of TA recipients who reported that they are very satisfied with the TA received[71] (Outcome)

FY	Target	Result
2012	69.1%	Aug 31, 2013
2011	69.1%	Aug 31, 2012
2010	69.1%	Aug 31, 2011
2009	69.1%	Aug 31, 2010
2008	Set Baseline	69.6% (Baseline)[72]

Table 128: Measure 2.3.73: Percentage of TA recipients who reported that their ability to provide effective services improved a great deal[73] (Outcome)

FY	Target	Result
2012	53.4%	Aug 31, 2013
2011	53.4%	Aug 31, 2012
2010	53.4%	Aug 31, 2011
2009	53.4%	Aug 31, 2010
2008	Set Baseline	65.4% (Baseline)[74]

Table 129: Measure 2.3.74: Percentage of TA recipients who reported that the TA recommendations have been fully implemented[75] (Outcome)

FY	Target	Result
2012	54%	Aug 31, 2013
2011	54%	Aug 31, 2012
2010	54%	Aug 31, 2011
2009	54%	Aug 31, 2010
2008	Set Baseline	55.4% (Baseline)[76]

[71] Includes CAPTs, NACE, and Prevention fellowships.

[72] Actual has been updated from previously reported and now contains data from the additional science and service activities.

[73] Includes CAPTs and Prevention Fellowships.

[74] Actual has been updated from previously reported and now contains data from the additional science and service activities.

[75] Includes only the CAPTs.

[76] Actual has been updated from previously reported and now contains data from the additional science and service activities.

Table 130: Measure 2.3.75: Number of persons receiving prevention information directly[77] (Output)

FY	Target	Result
2012	120,223	Aug 31, 2013
2011	120,223	Aug 31, 2012
2010	120,223	Aug 31, 2011
2009	120,223	Aug 31, 2010
2008	Set Baseline	122,992 (Baseline)[78]

Table 131: Measure 2.3.76: Number of persons receiving prevention information indirectly from advertising, broadcast, or website[79] (Output)

FY	Target	Result
2012	906,707	Aug 31, 2013
2011	906,707	Aug 31, 2012
2010	906,707	Aug 31, 2011
2009	906,707	Aug 31, 2010
2008	Set Baseline	1,211,382 (Baseline)[80]

[77] Includes Town Hall Meetings and FASD.

[78] Actual has been updated from previously reported and now contains data from the additional science and service activities.

[79] Includes Town Hall Meetings, FASD, and MEI (Community Outreach).

[80] Actual has been updated from previously reported and now contains data from the additional science and service activities.

Table 132: Data Source and Validation for Performance Measures for Prevention Programs of Regional and National Significance – Science and Service Activities

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

Agency Program, Measure 2.3.71 - 2.3.76

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

SAMHSA has introduced six new measures to reflect SAMHSA CSAP's substantial and

increasing role in training, technical assistance and prevention information dissemination. In prior years, SAMHSA included data from the Centers for Application of Prevention Technologies (CAPT), but those measures have been retired in favor of aggregate reporting across several of the technical assistance activities. While these are not always construed as direct services programs, TA programs serve many more persons at a much lower cost and play an important role in advancing the field of substance abuse prevention.

The measures include several of the technical assistance activities and there are plans to incorporate more activities in the near future. Starting in FY 2010, we anticipate including data from additional service and science technical assistance contracts in addition to the CAPT such as the Native American Center of Excellence (NACE), Faith based, Town Hall Meetings (THM), Reach Out Now Teach Ins (RONTI), The Fetal Alcohol Spectrum Disorder (FASD) and Border Initiative contracts. These are described below:

- NACE provides comprehensive substance abuse prevention and related technical assistance services to Native governments, organizations, and peoples.
- THM and the RONTI are communication initiatives that develop informational materials and disseminate them nationwide to individual communities.
- The Border Initiative- U.S. Counties along the Mexican Border Initiative provides training and technical assistance on the Strategic Prevention Framework (SPF) process within the 24 counties contiguous to the U.S. Border. The primary audiences are 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.
- The FASD Center for Excellence identifies gaps and trends in the field, synthesizing these findings, and develops appropriate materials about Fetal Alcohol Spectrum Disorder for health and social service professionals, communities, States, and Tribal Organizations.
- The Faith-Based Initiative provides capacity-building assistance to community-based faith partners that serve racial and ethnic minorities, community partners with a history of serving people affected by or infected with HIV/AIDS, and other prevention providers.

Targets have been kept relatively stable because the focus for technical assistance is now on regional rather than individual services, which allows us to use fewer events to achieve outcomes.

MACRO PROGRAM: SUBSTANCE ABUSE TREATMENT PROGRAMS OF REGIONAL AND NATIONAL SIGNIFICANCE

PROGRAM: ACCESS TO RECOVERY

Table 133: Measure 1.2.32: Increase the number of clients gaining access to treatment[81] (Output)

FY	Target	Result
2012	70,750[82]	Oct 31, 2012
2011	33,500	Oct 31, 2011
2010	65,000	Oct 31, 2010
2009	65,000	89,595 (Target Exceeded)
2008	30,000	50,845 (Target Exceeded)
2007	50,000	79,150 (Target Exceeded)
2006	50,000	96,959 (Target Exceeded)

Table 134: Measure 1.2.33: Increase the percentage of adults receiving services who had no past month substance use (Outcome)

FY	Target	Result
2012	83%	Oct 31, 2012
2011	82%	Oct 31, 2011
2010	82%	Oct 31, 2010
2009	81%	81% (Target Met)
2008	80%	82.3% (Target Exceeded)
2007	81%	84.7% (Target Exceeded)
2006	79%	81.4% (Target Exceeded)

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

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

Table 135: Measure 1.2.34: Increase the percentage of adults receiving services who had improved family and living conditions (Outcome)

FY	Target	Result
2012	54%	Oct 31, 2012
2011	53%	Oct 31, 2011
2010	53%	Oct 31, 2010
2009	52%	47% (Target Not Met)
2008	52%	52.9% (Target Exceeded)
2007	52%	59.9% (Target Exceeded)
2006	63%	51% (Target Not Met)

Table 136: Measure 1.2.35: Increase the percentage of adults receiving services who had no/reduced involvement with the criminal justice system (Outcome)

FY	Target	Result
2012	96%	Oct 31, 2012
2011	96%	Oct 31, 2011
2010	96%	Oct 31, 2010
2009	96%	96% (Target Met)
2008	96%	96% (Target Met)
2007	97%	97.6% (Target Exceeded)
2006	95%	96.8% (Target Exceeded)

Table 137: Measure 1.2.36: Increase the percentage of adults receiving services who had improved social support (Outcome)

FY	Target	Result
2012	91%	Oct 31, 2012
2011	91%	Oct 31, 2011
2010	91%	Oct 31, 2010
2009	90%	91% (Target Exceeded)
2008	90%	91.7% (Target Exceeded)
2007	90%	75.1% (Target Not Met)
2006	90%	90% (Target Met)

Table 138: Measure 1.2.37: Increase the percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2012	55%	Oct 31, 2012
2011	54%	Oct 31, 2011
2010	54%	Oct 31, 2010
2009	53%	49% (Target Not Met)
2008	53%	59.1% (Target Exceeded)
2007	50%	61.7% (Target Exceeded)
2006	57%	50% (Target Not Met)

Table 139: Measure 1.2.39: Cost per client served[83] (Efficiency)

FY	Target	Result
2012	$1,413	Oct 31, 2012
2011	$2,985	Oct 31, 2011
2010	$1,572	Oct 31, 2010
2009	$1,588	$1,071 (Target Exceeded)
2008	$1,605	$1,888 (Target Not Met)
2007	N/A	$1,605 (Historical Actual)

Table 140: Data Source and Validation for Performance Measures for Access to Recovery Grants

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

Agency Program, Measure 1.2.32 - 1.2.39

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

SAMHSA's CSAT uses a series of key output and outcome measures to assess the effectiveness of its Services Programs. The primary key output measure used is the number of clients served. This measure represents an unduplicated count of individuals who have received services through grants in Access to Recovery Program. All outcome measures are based on a follow-up assessment conducted six months post admission to the program. Abstinence from substance use is a key outcome of the program. This measure examines the substance use patterns of the clients. The percent reported reflects the percent of individuals who have reported no use of alcohol or illegal drugs in the past 30 days at follow-up. The measure of employment/education shows the percent of people employed or in school or a job training program. The criminal justice measure refers to those clients who have reported no arrests in

[83] Successful result is below target.

the past 30 days. Social connectedness measures the percent of people who attend self-help or support groups in support of their recovery. Stability in housing refers to the percent of people who own/rent their own house or apartment. These measures combined provide a holistic view of the effectiveness of the services being provided by this program.

All FY 2008 outcome targets for this program were met or exceeded. Based on data, targets were set at appropriate levels and were neither missed nor substantially exceeded. Targets for abstinence, criminal justice involvement, social connectedness and number of clients served were all exceeded in FY 2009.

The target for number of clients served was exceeded. Grantees performed exceptionally well once infrastructure and program processes were fully in place. Eleven (out of 24) Cohort 2 grantees had experience implementing ATR as they had also received Cohort 1 grants. This accounted for a very quick start-up for these 11 grantees. Grantees were able to begin serving clients within three months post award, which accounts for the spike in client numbers as compared to the original target set. The first cohort of grantees ended in FY 2007. The second cohort of ATR grantees began providing services in FY 2008. Targets for FY 2008 were set lower to allow the new grantees to develop the appropriate infrastructure for a voucher-based system. In addition, the focus on methamphetamine users in the second cohort may have led to more significant barriers to service than the ATR population at large; therefore, targets have been kept at levels that are achievable but still ambitious. Targets for FY 2008 and FY 2009 were set during ATR's performance assessment in CY 2007.

Data for the second cohort of ATR shows a positive trend in its key measure of number of clients served. This measure shows an increase in clients served of over 38,000 clients. Though data are available from FY 2005, trend data from that time through the present do not yield an appropriate comparison as a new cohort began in FY 2007.

PROGRAM: SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

Table 141: Measure 1.2.40: Increase the number of clients served (Output)

FY	Target	Result
2012	47,500 [84]	Oct 31, 2012
2011	139,650	Oct 31, 2011
2010	139,650	Oct 31, 2010
2009	139,650	185,648 (Target Exceeded)
2008	139,650	192,840 (Target Exceeded)
2007	184,597	138,267 (Target Not Met)
2006	156,820	182,770 (Target Exceeded)

[84] Target lower than last year's actual due to grants coming to a natural end and new SBIRT dollars being spent on grants to the Mental Health SBIRT program.

Table 142: Measure 1.2.41: Increase the percentage of clients receiving services who had no past month substance use (Outcome)

FY	Target	Result
2012	50%	Oct 31, 2012
2011	50%	Oct 31, 2011
2010	50%	Oct 31, 2010
2009	50%	34% (Target Not Met)
2008	48%	46.5% (Target Not Met but Improved)
2007	48%	45.7% (Target Not Met)
2006	41.8%	47.5% (Target Exceeded)

Table 143: Data Source and Validation for Performance Measures for Screening, Brief Intervention and Referral to Treatment Grants

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

Agency Program, Measure 1.2.40 - 1.2.41

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

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

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

There was no effect on overall program or activity performance.

Data show a general positive trend in number of clients served by year. From FY 2005 to FY 2006, there was an increase of approximately 27,000; from FY 2007 to FY 2008, there was an increase of approximately 54,000 clients. While FY 2008 to FY 2009 shows a decrease in number served, this is expected as a cohort of grantees ended during this time period. The outcome measure of abstinence has also had a general positive trend from FY 2005 to FY 2008; though this is not seen in the current reporting year.

PROGRAM: CRIMINAL JUSTICE - JUVENILE AND ADULT DRUG COURTS

Table 144: Measure 1.2.62: Juvenile: Percentage of clients that complete treatment (Outcome)

FY	Target	Result
2012	76%	Oct 31, 2012
2011	76%	Oct 31, 2011
2009	75%	N/A[85]
2008	74%	75.1% (Target Exceeded)
2007	69%	73% (Target Exceeded)
2006	N/A	68% (Historical Actual)

Table 145: Measure 1.2.63: Juvenile: Increase percentage of clients receiving services who were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2012	88%	Oct 31, 2012
2011	88%	Oct 31, 2011
2009	88%	89% (Target Exceeded)
2008	87%	86% (Target Not Met)
2007	87%	86% (Target Not Met)
2006	N/A	86% (Historical Actual)

[85] The treatment completion measure for juveniles is collected upon discharge from treatment. Due to the small number of grantees during FY 2009, this measure could not be calculated with any reliability.

Table 146: Measure 1.2.64: Juvenile: Increase percentage of clients receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2012	82%	Oct 31, 2012
2011	82%	Oct 31, 2011
2010	N/A	Oct 31, 2010
2009	82%	79% (Target Not Met)
2008	81%	81% (Target Met)
2007	78%	80% (Target Exceeded)
2006	N/A	77% (Historical Actual)

Table 147: Measure 1.2.65: Juvenile: Increase percentage of clients receiving services who had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2012	95%	Oct 31, 2012
2011	95%	Oct 31, 2011
2009	93%	92% (Target Not Met)
2008	92%	94.3% (Target Exceeded)
2007	91%	91% (Target Met)
2006	N/A	90.3% (Historical Actual)

Table 148: Measure 1.2.66: Juvenile: Increase percentage of clients receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social consequences (Outcome)

FY	Target	Result
2012	93%	Oct 31, 2012
2011	93%	Oct 31, 2011
2009	93%	99% (Target Exceeded)
2008	92%	92% (Target Met)
2007	90%	91.2% (Target Exceeded)
2006	N/A	89% (Historical Actual)

Table 149: Measure 1.2.67: Juvenile: Increase percentage of clients receiving services who had no past month substance use (Outcome)

FY	Target	Result
2012	73%	Oct 31, 2012
2011	73%	Oct 31, 2011
2009	73%	73% (Target Met)
2008	72%	69% (Target Not Met)
2007	69%	71% (Target Exceeded)
2006	N/A	68% (Historical Actual)

Table 150: Measure 1.2.68: Juvenile: Percent of drug court participants who exhibit a reduction in substance use while in the drug court program (Developmental) (Outcome)

FY	Target	Result
2010	N/A	Oct 31, 2010

Table 151: Measure 1.2.69: Juvenile: Reduce cost-per-client served[86] (Outcome)

FY	Target	Result
2012	$5,610	Oct 31, 2012
2011	$5,610	Oct 31, 2011
2009	$5,610	$5,215 (Target Exceeded)
2008	$5,905	$6,790 (Target Not Met)
2007	$6,742	$6,463 (Target Exceeded)
2006	N/A	$8,742 (Historical Actual)

Table 152: Measure 1.2.70: Juvenile: Increase number of clients served (Output)

FY	Target	Result
2012	1881	Oct 31, 2012
2011	1463[87]	Oct 31, 2011
2009	449	376 (Target Not Met)
2008	929	783 (Target Not Met)
2007	821	856 (Target Exceeded)
2006	N/A	477 (Historical Actual)

[86] Successful result is below target.

[87] This target has been revised from the FY 2010 President's Budget based on the FY 2010 Appropriation.

Table 153: Measure 1.2.71: Adult: Percentage of clients that complete treatment[88] (Outcome)

FY	Target	Result
2012	54%	Oct 31, 2012
2011	53%	Oct 31, 2011
2010	53%	Oct 31, 2010
2009	67%	51% (Target Not Met)
2006	N/A	66% (Historical Actual)

Table 154: Measure 1.2.72: Adult: Increase percentage of clients receiving services who were currently employed or engaged in productive activities[89] (Outcome)

FY	Target	Result
2012	65%	Oct 31, 2012
2011	64%	Oct 31, 2011
2010	64%	Oct 31, 2010
2009	88%	63% (Target Not Met)
2006	N/A	86% (Historical Actual)

[88] Targets set for this measure in the FY 2010 President's Budget were based on Juvenile Drug Court data. Data for Adult Drug Courts clients is now available. As a result, the targets for FY 2010, 2011 and 2012 have been revised to be more appropriate to the population of this program.

[89] Targets set for this measure in the FY 2010 President's Budget were based on Juvenile Drug Court data. Data for Adult Drug Courts clients is now available. As a result, the targets for FY 2010, 2011 and 2012 have been revised to be more appropriate to the population of this program.

Table 155: Measure 1.2.73: Adult: Increase percentage of clients receiving services who had a permanent place to live in the community[90] (Outcome)

FY	Target	Result
2012	43%	Oct 31, 2012
2011	42%	Oct 31, 2011
2010	42%	Oct 31, 2010
2009	82%	41% (Target Not Met)
2006	N/A	77% (Historical Actual)

Table 156: Measure 1.2.74: Adult: Increase percentage of clients receiving services who had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2012	93%	Oct 31, 2012
2011	93%	Oct 31, 2011
2010	93%	Oct 31, 2010
2009	93%	95% (Target Exceeded)
2006	N/A	90.3% (Historical Actual)

Table 157: Measure 1.2.75: Adult: Increase percentage of clients receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences (Outcome)

FY	Target	Result
2012	93%	Oct 31, 2012
2011	93%	Oct 31, 2011
2010	93%	Oct 31, 2010
2009	93%	89% (Target Not Met)
2006	N/A	89% (Historical Actual)

[90] Targets set for this measure in the FY 2010 President's Budget were based on Juvenile Drug Court data. Data for Adult Drug Courts clients is now available. As a result, the targets for FY 2010, 2011 and 2012 have been revised to be more appropriate to the population of this program.

Table 158: Measure 1.2.76: Adult: Increase percentage of clients receiving services who had no past month substance use (Outcome)

FY	Target	Result
2012	73%	Oct 31, 2012
2011	73%	Oct 31, 2011
2010	73%	Oct 31, 2010
2009	73%	89% (Target Exceeded)
2006	N/A	68% (Historical Actual)

Table 159: Measure 1.2.77: Adult: Percent of drug court participants who exhibit a reduction in substance use while in the drug court program. Measured in conjunction with DOJ. (Outcome)

FY	Target	Result
2010	N/A	Oct 31, 2010

Table 160: Measure 1.2.78: Adult: Reduce cost-per-client served[91] (Outcome)

FY	Target	Result
2012	$6,000	Oct 31, 2012
2011	$5,554	Oct 31, 2011
2010	$5,554	Oct 31, 2010
2009	$5,610	$4,320 (Target Exceeded)

[91] Successful result is below target.

Table 161: Measure 1.2.79: Adult: Increase number of clients served (Output)

FY	Target	Result
2012	6770	Oct 31, 2012
2011	5265[92]	Oct 31, 2011
2010	2832	Oct 31, 2010
2009	960	1,183 (Target Exceeded)
2006	N/A	357 (Historical Actual)

Table 162: Data Source and Validation for Performance Measures for Juvenile and Adult Drug Courts Grants

Measure	Data Source	Data Validation
1.2.62 1.2.63 1.2.64 1.2.65 1.2.66 1.2.67 1.2.69 1.2.70 1.2.71 1.2.72 1.2.73 1.2.74 1.2.75 1.2.76 1.2.78 1.2.79	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.68 1.2.77	To be determined	To be determined

Agency Program, Measure 1.2.62 - 1.2.79

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

[92] The FY 2011 target has been revised based on the assumption that SAMHSA will fund primarily Adult Drug Courts with FY 2010 funds. This target may be revised if this does not occur. This target has been revised from the FY 2010 President's Budget based on the FY 2010 Appropriation.

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

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

The Treatment Drug Court Program met or exceeded its housing, criminal justice, social consequences, and treatment completion targets. Employment and abstinence targets were missed. The targets were missed by a small amount and program performance was not affected. In 2009, for the Juvenile Drug Court Program, targets for employment/education, health consequences, abstinence from substance use were all met. The number of clients served target was not met; however, this was due to the grants being in their final wind-down year.

In the Adult Courts, targets for number served, criminal justice involvement, and abstinence were all met. The 2009 targets for employment and housing status were set based on Juvenile Drug Court data as this was the data available at the time. New targets have been revised for this Program based on actual data from FY 2009.

For Juvenile Drug Courts, the trend in number served from FY 2006 is consistent with expectations based on funding of juvenile drug court cohorts. The trend seen is positive from 2006 to 2007. From 2008 to 2009, there was an expected decrease as the grant cohort ended. Abstinence increased over time with a 68% rate in FY 2006 and a 73% rate in FY 2009.

PROGRAM: CRIMINAL JUSTICE - EX-OFFENDER RE-ENTRY PROGRAM

Table 163: Measure 1.2.80: Number of clients served (Outcome)

FY	Target	Result
2012	3,712	Oct 31, 2012
2011	2,912[93]	Oct 31, 2011
2010	1,312	Oct 31, 2010

Table 164: Measure 1.2.81: Percentage of clients who had no past month substance use (Outcome)

FY	Target	Result
2012	69%	Oct 31, 2012
2011	70%	Oct 31, 2011
2010	68.9%	Oct 31, 2010

Table 165: Data Source and Validation for Performance Measures for Ex-Offender Re-Entry Grants

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

Agency Program, Measure 1.2.80 - 1.2.81

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

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

[93] This target has been revised from the FY 2010 President's Budget based on the FY 2010 Appropriation.

substance use is a key outcome of the program. This measure examines the substance use patterns of the clients. The percent reported reflects the percent of individuals who have reported no use of alcohol or illegal drugs in the past 30 days at follow-up.

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

PROGRAM: GRANTS FOR THE BENEFIT OF HOMELESS INDIVIDUALS (GBHI)

Table 166: Increase percentage of adults receiving services who had no past month substance use (Outcome)

FY	Target	Result
2012	67.4%	Oct 31, 2012
2011	67.4%	Oct 31, 2011
2010	67.4%	Oct 31, 2010
2009	66.9%	66.4% (Target Not Met)
2008	N/A	66.9% (Historical Actual)

Table 167: Increase the number of clients served (Output)

FY	Target	Result
2012	7,005	Oct 31, 2012
2011	7,005	Oct 31, 2011
2010	7,005	Oct 31, 2010
2009	5,730	6,935 (Target Exceeded)
2008	N/A	5,730 (Historical Actual)

Table 168: Increase percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2012	32.7%	Oct 31, 2012
2011	32.7%	Oct 31, 2011
2010	32.7%	Oct 31, 2010
2009	34.7%	31.7% (Target Not Met)
2008	N/A	34.7% (Historical Actual)

Table 169: Increase percentage of adults receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2012	25.6%	Oct 31, 2012
2011	25.6%	Oct 31, 2011
2010	25.6%	Oct 31, 2010
2009	23.6%	24.6% (Target Exceeded)
2008	N/A	23.6% (Historical Actual)

Table 170: Increase percentage of adults receiving services who had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2012	96.8%	Oct 31, 2012
2011	96.8%	Oct 31, 2011
2010	96.8%	Oct 31, 2010
2009	96.2%	95.8% (Target Not Met)
2008	N/A	96.2% (Historical Actual)

Table 171: Increase percentage of adults receiving services who had improved social support (Outcome)

FY	Target	Result
2012	89.3%	Oct 31, 2012
2011	89.3%	Oct 31, 2011
2010	89.3%	Oct 31, 2010
2009	85.9%	88.3% (Target Exceeded)
2008	N/A	85.9% (Historical Actual)

Table 172: Data Source and Validation for Performance Measures for Grants for the Benefit of Homeless Individuals Program

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

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

The Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment manages two grant portfolios under its Grants for the Benefit of Homeless Individuals (GBHI) program, both of which provide focused services to individuals with a substance use disorder or who have co-occurring disorders.

FY 2009 data show that the GBHI Program has performed successfully with respect to its outcome measures. Targets for clients served, improved living conditions and social support were met or exceeded. Targets for abstinence and involvement in the criminal justice system were missed by less than one percent.

PROGRAM: TREATMENT PRNS - ALL OTHER CAPACITY[94]

Table 173: Measure 1.2.25: Increase percentage of adults receiving services who had no past month substance use (Outcome)

FY	Target	Result
2012	62%	Oct 31, 2012
2011	62%	Oct 31, 2011
2010	62%	Oct 31, 2010
2009	61%	66% (Target Exceeded)
2008	63%	62% (Target Not Met but Improved)
2007	63%	59% (Target Not Met)
2006	67%	63% (Target Not Met)

Table 174: Measure 1.2.26: Increase the number of clients served (Output)

FY	Target	Result
2012	34,784	Oct 31, 2012
2011	34,784	Oct 31, 2011
2010	34,784	Oct 31, 2010
2009	31,659	32,939 (Target Exceeded)
2008	35,334	33,446 (Target Not Met)
2007	35,334	35,516 (Target Exceeded)
2006	34,300	35,334 (Target Exceeded)

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

Table 175: Measure 1.2.27: Increase percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2012	51%	Oct 31, 2012
2011	51%	Oct 31, 2011
2010	51%	Oct 31, 2010
2009	50%	44% (Target Not Met)
2008	52%	54.3% (Target Exceeded)
2007	52%	57% (Target Exceeded)
2006	49%	52% (Target Exceeded)

Table 176: Measure 1.2.28: Increase percentage of adults receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2012	49%	Oct 31, 2012
2011	49%	Oct 31, 2011
2010	49%	Oct 31, 2010
2009	49%	44% (Target Not Met)
2008	51%	47% (Target Not Met but Improved)
2007	53%	46% (Target Not Met)
2006	51%	49.3% (Target Not Met but Improved)

Table 177: Measure 1.2.29: Increase percentage of adults receiving services who had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2012	95%	Oct 31, 2012
2011	95%	Oct 31, 2011
2010	95%	Oct 31, 2010
2009	94%	96% (Target Exceeded)
2008	96%	96% (Target Met)
2007	96%	96% (Target Met)
2006	98%	96% (Target Not Met)

Table 178: Measure 1.2.30: Increase percentage of adults receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences (Outcome)

FY	Target	Result
2012	66%	Oct 31, 2012
2011	66%	Oct 31, 2011
2010	66%	Oct 31, 2010
2009	65%	86% (Target Exceeded)
2008	67%	68% (Target Exceeded)
2007	67%	65% (Target Not Met)
2006	67%	67% (Target Met)

Table 179: Measure 1.2.31: Increase the percentage of grantees in appropriate cost bands (Outcome)

FY	Target	Result
2012	79%	Oct 31, 2013
2011	79%	Oct 31, 2012
2010	79%	Oct 31, 2011
2009	78%	79% (Target Exceeded)
2008	80%	80% (Target Met)
2007	80%	80% (Target Met)
2006	80%	81% (Target Exceeded)

Table 180: Data Source and Validation for Performance Measures for Treatment Programs of Regional and National Significance - All Other Capacity Grants

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

Agency Program, Measure 1.2.25 - 1.2.31

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

SAMHSA's CSAT uses a series of key output and outcome measures to assess the effectiveness of its Services Programs. The primary key output measure used is the number of clients served. This measure represents an unduplicated count of individuals who have received services through grants in Other Capacity programs. All outcome measures are based on a follow-up assessment conducted six months post admission to the program. Abstinence from substance use is a key outcome of these programs. This measure examines the substance use patterns of the clients. The percent reported reflects the percent of individuals who have reported no use of alcohol or illegal drugs in the past 30 days at six month follow-up. The measure of employment/education shows the percent of people employed or in school or a job

training program. The criminal justice measure refers to those clients who have reported no arrests in the past 30 days. Social connectedness measures the percent of people who attend self-help or support groups in support of their recovery. Stability in housing refers to the percent of people who own/rent their own house or apartment. These measures combined provide a holistic view of the effectiveness of the services being provided by the Other Capacity Programs. The efficiency measure of grantees in appropriate cost bands gives the percent of grantees that fall into acceptable cost ranges for each modality of treatment provided.

The targets for employment, criminal justice, health consequences and social connectedness were either met or exceeded. The targets for abstinence, housing and number served were missed; however, the deviation is slight and does not affect overall program performance. Targets for FY 2009 are lower than FY 2008 target due to anticipated funding decreases. In addition, the target for the efficiency measure was met.[95] In 2009, The Capacity Program met or exceeded the following targets: number of clients served, abstinence from use, criminal justice involvement, health consequences.

Data on number served show a positive trend from 2005 to 2006 and 2006 to 2007. There was a slight downward trend from 2007 to 2008 and a negligible downward trend from 2008 to 2009. Data on abstinence shows a positive trend from 2005 to 2009 with a rate of 66% in FY 2009 and 64.1% in FY 2005.

PROGRAM: TREATMENT PRNS - SCIENCE AND SERVICE[96]

Table 181: Measure 1.4.01: Report implementing improvements in treatment methods on the basis of information and training provided by the program (Outcome)

FY	Target	Result
2012	90%	Oct 31, 2012
2011	90%	Oct 31, 2011
2010	90%	Oct 31, 2010
2009	90%	82% (Target Not Met)
2008	90%	92% (Target Exceeded)
2007	93%	90% (Target Not Met)
2006	89%	93% (Target Exceeded)

[95] Percentage of grantees that provide drug treatment services within approved cost per person bands is measured by the type of treatment including outpatient non-methadone, outpatient methadone, and residential treatment services. The cost ranges are for outpatient non-methadone $1,000-$5,000, outpatient methadone $1,500-$8,000, and residential $3,000-$10,000.

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

Table 182: Measure 1.4.02: Increase the number of individuals trained per year (Output)

FY	Target	Result
2012	20,516	Oct 31, 2012
2011	20,516	Oct 31, 2011
2010	20,516	Oct 31, 2010
2009	20,516	22,943 (Target Exceeded)
2008	20,516	21,490 (Target Exceeded)
2007	23,141	20,516 (Target Not Met)
2006	28,916	23,141 (Target Not Met)

Table 183: Measure 1.4.03: Increase the percentage of drug treatment professionals trained by the program who would rate the quality of the events as good, very good, or excellent (Outcome)

FY	Target	Result
2012	96%	Oct 31, 2012
2011	96%	Oct 31, 2011
2010	96%	Oct 31, 2010
2009	96%	95% (Target Not Met)
2008	96%	95% (Target Not Met)
2007	96%	95% (Target Not Met)
2006	96%	96% (Target Met)

Table 184: Measure 1.4.04: Increase the percentage of drug treatment professionals trained by the program who shared any of the information from the events with others (Outcome)

FY	Target	Result
2012	92%	Oct 31, 2012
2011	92%	Oct 31, 2011
2010	92%	Oct 31, 2010
2009	92%	85% (Target Not Met)
2008	90%	93.5% (Target Exceeded)
2007	90%	89% (Target Not Met but Improved)
2006	88%	87% (Target Not Met but Improved)

Table 185: Measure 1.4.05: Increase the percentage of grantees in appropriate cost bands (Outcome)

FY	Target	Result
2012	100%	Oct 31, 2013
2011	100%	Oct 31, 2012
2010	100%	Oct 31, 2011
2009	100%	100% (Target Met)
2008	100%	100% (Target Met)
2007	100%	100% (Target Met)
2006	100%	100% (Target Met)

Table 186: Data Source and Validation for Performance Measures for Treatment Programs of Regional and National Significance - Science and Service Activities

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

Agency Program, Measure 1.4.01 - 1.4.05

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

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

From FY 2005, there was a downward trend in number of clients served to the number served in 2006 and 2007. However, this is consistent with the number of programs included in this reporting group. From 2007 to 2009, there is a positive trend with 22,943 participants trained as compared to 20,516. A consistent trend is seen in those who rate the overall quality of the event as good, very good or excellent. Data show that this measure is consistently high at rates over 95%.

MACRO PROGRAM: SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG)

PROGRAM: SAPTBG - TREATMENT ACTIVITIES

Table 187: Measure 1.2.43: Number of admissions to substance abuse treatment programs receiving public funding[97] (Output)

FY	Target	Result
2012	2,372,302	Nov 30, 2014
2011	1,881,515	Nov 30, 2013
2010	1,881,515	Nov 30, 2012
2009	1,881,515	Nov 30, 2011
2008	1,881,515	2,272,250 (Target Exceeded)
2007	2,003,324	2,372,302 (Target Exceeded)[98]
2006	1,983,490	1,849,891 (Target Not Met but Improved)

Table 188: Measure 1.2.45: Increase the percentage of States and Territories that express satisfaction with Technical Assistance (TA) provided[99] (Output)

FY	Target	Result
2010	Discontinued	N/A
2009	97%	Nov 30, 2010
2008	97%	Nov 30, 2009[100]
2007	97%	92% (Target Not Met but Improved)
2006	97%	83% (Target Not Met)

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

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

[99] Measure 1.2.45 will be retired from public reporting in FY 2010. Please see explanation in the narrative for this program.

[100] The data for the final years of this measure are unavailable. As a result, this measure will be discontinued after the FY 2011 President's Budget.

Table 189: Measure 1.2.47: Increase the percentage of States in appropriate cost bands (Outcome)

FY	Target	Result
2012	71%	Nov 30, 2013
2011	70%	Nov 30, 2012
2010	68%	Nov 30, 2011
2009	68%	Nov 30, 2010
2008	67%	77% (Target Exceeded)
2007	67%	65% (Target Not Met)
2006	100%	65% (Target Not Met)

Table 190: Measure 1.2.48: Percentage of clients reporting abstinence from drug use at discharge (Outcome)

FY	Target	Result
2012	70%	Nov 30, 2013
2011	70.3%	Nov 30, 2012
2010	70.3%	Nov 30, 2011
2009	69.3%	Nov 30, 2010
2008	69.3%	73.7% (Target Exceeded)
2007	68.3%	73.7% (Target Exceeded)
2006	N/A	68.3% (Historical Actual)

Table 191: Measure 1.2.49: Percentage of clients reporting abstinence from alcohol at discharge (Outcome)

FY	Target	Result
2012	75%	Nov 30, 2013
2011	74.7%	Nov 30, 2012
2010	74.7%	Nov 30, 2011
2009	74.7%	Nov 30, 2010
2008	74.7%	78.2% (Target Exceeded)
2007	73.7%	80.9% (Target Exceeded)
2006	N/A	73.7% (Historical Actual)

Table 192: Measure 1.2.50: Percentage of clients reporting being employed/in school at discharge (Outcome)

FY	Target	Result
2012	43%	Nov 30, 2013
2011	43.9%	Nov 30, 2012
2010	43.9%	Nov 30, 2011
2009	42.9%	Nov 30, 2010
2008	42.9%	37.2% (Target Not Met)
2007	N/A	42.9% (Historical Actual)
2006	N/A	40.9% (Historical Actual)

Table 193: Measure 1.2.51: Percentage of clients reporting no involvement with the Criminal Justice System (Outcome)

FY	Target	Result
2012	89%	Nov 30, 2013
2011	88.9%	Nov 30, 2012
2010	88.9%	Nov 30, 2011
2009	88.9%	Nov 30, 2010
2008	88.9%	92% (Target Exceeded)
2007	N/A	88.9% (Historical Actual)
2006	N/A	88.9% (Historical Actual)

Table 194: Data Source and Validation for Performance Measures for SAPTBG - Treatment Activities

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

Agency Program, Measure 1.2.43 - 1.2.51

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

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

The performance target for admissions for FY 2006 was set at an approximate appropriate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance. The target of number of admissions was exceeded with a total of 2.3 million admissions reported. The number of admissions reflects the number of entrances into services provided under the block grant program. All outcome targets (abstinence from drugs and alcohol use) were either met or exceeded. The measure related to percentage of grantees in cost bands[101] was missed by a slight deviation which did not affect overall program performance.

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

Data show consistent high performance across years with respect to key program measures of abstinence from both illegal drugs and alcohol use. The SAPT Program continues to exceed its targets on these key measures. In addition, data show that over 2.2 million client admissions have been made in FY 2008 exceeding the target set for the year.

[101] Percentage of states that provide drug treatment services within approved cost per person bands is measured by the type of treatment including outpatient non-methadone, outpatient methadone, and residential treatment services. The cost ranges are for outpatient non-methadone $1,000-$5,000, outpatient methadone $1,500-$8,000, and residential $3,000-$10,000.

PROGRAM: SAPTBG - PREVENTION SET-ASIDE – SYNAR AMENDMENT IMPLEMENTATION ACTIVITIES

Table 195: Measure 2.3.49: Increase number of States (including Puerto Rico) whose retail sales violations is at or below 20%[102] (Outcome)

FY	Target	Result
2012	52	Aug 31, 2013
2011	52	Aug 31, 2012
2010	52	Aug 31, 2011
2009	52	Aug 31, 2010
2008	52	52 (Target Met)
2007	52	52 (Target Met)
2006	52	52 (Target Met)

Table 196: Measure 2.3.62: Number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% (Outcome)

FY	Target	Result
2012	28	Aug 31, 2013
2011	26	Aug 31, 2012
2010	25	Aug 31, 2011
2009	28	Aug 31, 2010
2008	29	22 (Target Not Met)
2007	28	26 (Target Not Met but Improved)
2006	Set Baseline	25 (Baseline)[103]

[102] The 20% retail sales violation data apply to the 50 states, D.C., and Puerto Rico.

[103] FY 2007 Actual was inadvertently reported as 27 (the FY 2006 Actual) [when? In the FY 2010 PB?]

Table 197: Data Source and Validation for Performance Measures for SAPTBG - Prevention Set-Aside – Synar Amendment Implementation Activities

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

Agency Program, Measure 2.3.49 - 2.3.62

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

The Synar Regulation requires the 50 states, the District of Columbia, and the 8 U.S. territories to: 1) have in effect a law prohibiting any manufacturer, retailer, or distributor of tobacco products from selling or distributing such products to any individual younger than age 18; 2) enforce this law; 3) conduct annual, unannounced inspections (referred to as the Synar survey) in a way that provide a valid probability sample of tobacco sales outlets accessible to minors; 4) negotiate interim targets and a date to achieve a noncompliance rate (or retailer violation rate) of no more than 20 percent (SAMHSA required that each state reduce its retailer violation rate (RVR) to 20 percent or less by FY 2002); and 5) submit an annual report detailing state activities to enforce its law. The measures in these tables refer to the results of each state's Synar survey and reflect the percentage of retail outlets in the survey that sold tobacco to youth.

The Synar program has been successful in reducing youth access to tobacco through retail sources. While the national weighted average retailer violation rate for the 50 states, Puerto Rico and the District of Columbia (weighted by state population) was 40.1 percent in FY 1996, the rate steadily fell to 9.9 percent in FY 2007. However, the national weighted average retailer violation rate slightly rebounded in FY 2008 to 10.9 percent. There are several potential reasons for the increase. First, one of the greatest predictors of a state's retailer violation rate is the amount and reach of a state's youth tobacco access enforcement efforts. Specifically, states that have consistent state-wide enforcement of youth tobacco access laws tend to have much lower RVRs than states without such rigorous enforcement programs. However, the Synar regulation specifically forbids states from spending SAPTBG monies to fund the enforcement of their access laws. Consequently, states must utilize other sources of funding (usually state general funds, Master Settlement Agreement funds, or funds dedicated for this purpose to a

state enforcement agency) for enforcement purposes. In a worsening economy and as state budgets decrease, these funds are at risk. As a result, some states are reducing the number of enforcement inspections they conduct, which has the potential to result in higher retailer violation rates. At the same time, states have been cutting the budgets of their comprehensive tobacco control programs, most notably cutting back funds spent on anti-smoking campaigns that had been funded by nationwide 1998 settlement of a class-action lawsuit against the tobacco industry (Master Settlement Agreement). Many tobacco control advocates believe that cuts in comprehensive tobacco control programs has lead to the leveling off of youth tobacco use rates between 2003 and 2007, after a period of rapid decline between 1997 and 2003. We are seeing a similar leveling off in the retailer violation rates reported by states.

SAMHSA is working with states to address this issue, including holding sessions at the 10th National Workshop on topics such as the impact of the recession on Synar: what states are doing to maintain outcomes with less money and how to use local tobacco licensing to help fund enforcement. Additionally, the newly passed FDA tobacco regulation will provide states with funding to enforce youth tobacco access laws, which will hopefully result in a decrease in the RVR.

Since FY 2005, all 50 states, the District of Columbia and Puerto Rico have been in compliance with the Synar requirements.

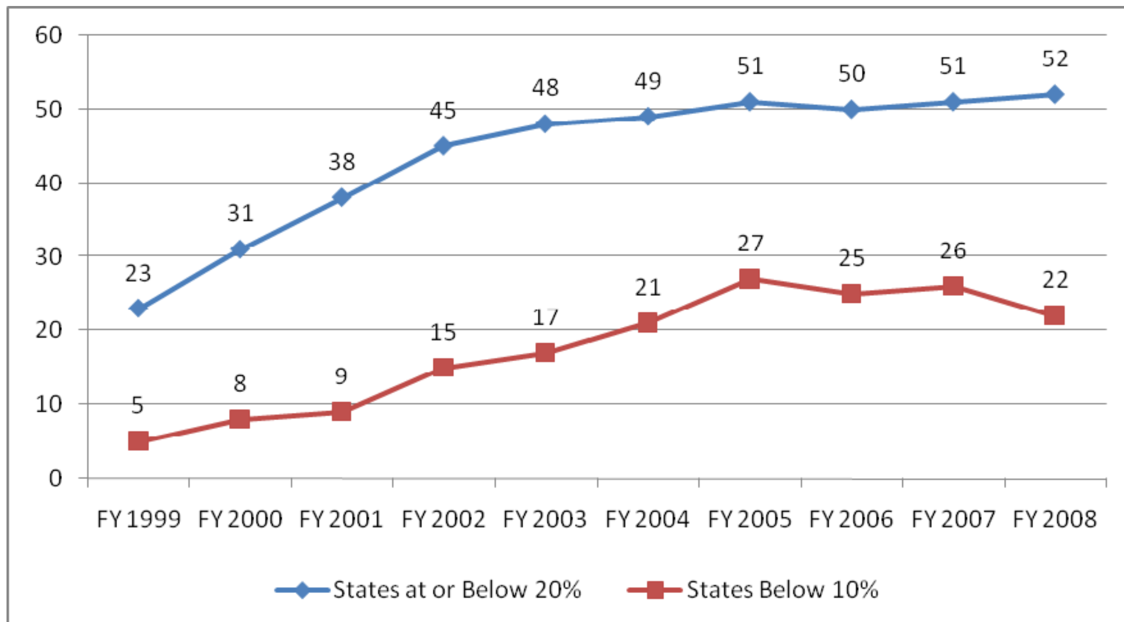
Since each state has met the 20 percent requirement for the past four years, SAMHSA set a new program goal to encourage all states to reduce the sales rate to less than 10 percent which is in keeping with the initial intent of the Synar legislation, to reduce minors' access to tobacco products. It is also consistent with research[104] suggesting that effectively reducing youth access requires rates lower than the 20 percent target.

While this does not change the legally required target rate of 20 percent, it provides SAMHSA and states with a program goal that fits the legislative intent. In FY 2006, 25 states reported rates below 10 percent. In FY 2007, 26 states reported rates below 10 percent and in FY 2008, 22 states reported rates below 10 percent. Due to the factors explained above, SAMHSA has lowered the target for FY 2010 to be more feasible in this economic environment. SAMHSA has increased the targets for FY 2011 and FY 2012 in the hopes that the economy will regain its stability.

---

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

Figure 1: States Reporting Retailer Violation Rates At or Below 20% and Below 10%[105]



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

[105] Note: The first measure States at or below 20% includes the 50 States, DC and PR while the second measure States below 10% only includes the 50 States and DC.

PROGRAM: SAPTBG – PREVENTION SET-ASIDE – OTHER SET-ASIDE ACTIVITIES

Table 198: Measure 2.3.53: Number of evidence-based policies, practices, and strategies implemented[106] (Output)

FY	Target	Result
2012	10,393	Aug 31, 2013
2011	10,393	Aug 31, 2012
2010	7,000	Aug 31, 2011
2009	7,000	Aug 31, 2010
2008	7,000	10,393 (Target Exceeded)
2007	11,000	17,056 (Target Exceeded)
2006	Set Baseline	10,090 (Baseline)

Table 199: Measure 2.3.69: Percent of program costs spent on evidence-based practices (EBP) (Efficiency)

FY	Target	Result
2012	75%	Aug 31, 2013
2011	75%	Aug 31, 2012
2010	71%	Aug 31, 2011
2009	71%	Aug 31, 2010
2008	70%	75% (Target Exceeded)
2007	Set Baseline	69% (Baseline)

[106] This measure has been revised for the FY 2011 President's Budget. Previously the measure was cumulative. It has been revised to report its data annually. As a result, targets and data provided here may appear to differ from those previously published in the FY 2010 President's Budget.

Table 200: Measure 2.3.54: Number of participants served in prevention programs (Output)

FY	Target	Result
2012	70,647,674	Aug 31, 2013
2011	70,647,674	Aug 31, 2012
2010	17,482,060	Aug 31, 2011
2009	17,482,060	Aug 31, 2010
2008	17,482,060	70,647,674 (Target Exceeded)
2007	17,482,060	25,258,287 (Target Exceeded)
2006	Set Baseline	6,322,551 (Baseline)

Table 201: Measure 2.3.63: Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17) (Outcome)

FY	Target	Result
2012	47.1%	Aug 31, 2013
2011	47.1%	Aug 31, 2012
2010	45.1%	Aug 31, 2011
2009	45.1%	Aug 31, 2010
2008	45.1%	47.1% (Target Exceeded)
2007	Set Baseline	45.1% (Baseline)

Table 202: Measure 2.3.64: Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 18+) (Outcome)

FY	Target	Result
2012	37.3%	Aug 31, 2013
2011	37.3%	Aug 31, 2012
2010	27.5%	Aug 31, 2011
2009	27.5%	Aug 31, 2010
2008	27.5%	37.3% (Target Exceeded)
2007	Set Baseline	27.4% (Baseline)

Table 203: Measure 2.3.65: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 12-20) (Outcome)

FY	Target	Result
2012	52.9%	Aug 31, 2013
2011	52.9%	Aug 31, 2012
2010	51%	Aug 31, 2011
2009	51%	Aug 31, 2010
2008	51%	52.9% (Target Exceeded)
2007	Set Baseline	51% (Baseline)

Table 204: Measure 2.3.66: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 21+) (Outcome)

FY	Target	Result
2012	47.1%	Aug 31, 2013
2011	47.1%	Aug 31, 2012
2010	37.3%	Aug 31, 2011
2009	37.3%	Aug 31, 2010
2008	37.3%	47.1% (Target Exceeded)
2007	Set Baseline	37.3% (Baseline)

Table 205: Measure 2.3.67: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 12-17) (Outcome)

FY	Target	Result
2012	64.7%	Aug 31, 2013
2011	64.7%	Aug 31, 2012
2010	52.9%	Aug 31, 2011
2009	52.9%	Aug 31, 2010
2008	52.9%	64.7% (Target Exceeded)
2007	Set Baseline	52.9% (Baseline)

Table 206: Measure 2.3.68: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 18+) (Outcome)

FY	Target	Result
2012	37.3%	Aug 31, 2013
2011	37.3%	Aug 31, 2012
2010	33.3%	Aug 31, 2011
2009	33.3%	Aug 31, 2010
2008	33.3%	37.3% (Target Exceeded)
2007	Set Baseline	33.3% (Baseline)

Table 207: Data Source and Validation for Performance Measures for SAPTBG – Prevention Set-Aside – Other Set-Aside Activities

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

Table 208: Data Source and Validation for Performance Measures for SAPTBG – Prevention Set-Aside – Other Set-Aside Activities (continued)

Measure	Data Source	Data Validation
2.3.69 2.3.54	Reported by States in the Block Grant Applications.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data, as well as the entire SAPT application, are reviewed jointly by SAMHSA's CSAT and CSAP project officers for accuracy and compliance. Discussions between project officers and states are scheduled to clarify ambiguities or inconsistencies in data which are resolved prior to approval. The Data Analytic Coordination and Consolidation Center (DACCC) Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the DACCC Government Project Officer who works with the Program Project Officers and grantees to identify a resolution. Communications are supported by regularly submitted program data inventories, preliminary reports and variable by variable cleaning sheets. The Data Management team then makes any required edits to the files. The edited files are then available to the DACCC Data Analysis Team for analysis and reporting. Grantees are instructed in the use of data collection protocols through grantee meetings and questionnaire administrative guides. The Block Grant Technical Assistance providers have also received training and have begun providing TA to the states.
2.3.63 2.3.64 2.3.65 2.3.66 2.3.67 2.3.68	Outcome data are from the National Survey on Drug Use and Health.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data, as well as the entire SAPT application, are reviewed jointly by SAMHSA's CSAT and CSAP project officers for accuracy and compliance. Discussions between project officers and states are scheduled to clarify ambiguities or inconsistencies in data which are resolved prior to approval. The Data Analytic Coordination and Consolidation Center (DACCC) Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the DACCC Government Project Officer who works with the Program Project Officers and grantees to identify a resolution. Communications are supported by regularly submitted program data inventories, preliminary reports and variable by variable cleaning sheets. The Data Management team then makes any required edits to the files. The edited files are then available to the DACCC Data Analysis Team for analysis and reporting. Grantees are instructed in the use of data collection protocols through grantee meetings and questionnaire administrative guides. The Block Grant Technical Assistance providers have also received training and have begun providing TA to the states.

Agency Program, Measure 2.3.53 - 2.3.68

NOTE: Some data have changed from those previously reported. Previously, data were reported as a result for the following year. For example, results for 2008 reflected data collected in 2007. In order to achieve consistency across SAMHSA, reporting has been revised so that results reflect data actually collected in that year.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

Compliance years reflect results three years prior to the current submission. Therefore, the FY 2008 percentages reported in the tables were obtained from the FY 2009 application and calculated by comparing state estimates from pooled 2005-2006 samples with estimates from pooled 2006-2007 samples.

The prevention efficiency measure (2.3.69) is the percent of block grant dollars spent on evidence-based practices (EBPs).[107] In FY 2007, this was 69 percent and increased to 75 percent in data received in FY 2008 (in the FY 2009 Block Grant application). Because these programs have been demonstrated to be effective, the proportion of total grant dollars spent on EBPs is an indicator of the ability of the program to channel resources towards proven-effective strategies, that is, an indicator of the efficient use of resources.

The targets for numbers served up through FY 2010 reflect projections based on the FY 2007 baseline which aggregates the results from 28 voluntary State reports. The projection assumes that all states will report on this new data reporting requirement and takes into account the size of states that did/did not voluntarily report for FY 2007. The target for numbers served for FY 2008 was exceeded substantially as was the number of EBPs implemented. Targets beginning in 2011 reflect this adjustment.

The numbers reported for FY 2008 are substantially higher than the previous year. The large difference in the reported numbers served reflects states' continuing efforts to bring their data collection systems in line with the National Outcome Measures (NOMs). As a result of increased correspondence between states' ability to provide accurate data on the people served and populations reached by their interventions, the reported numbers have increased substantially since the NOMs were fully implemented for the first time. A large portion of the increase in reported numbers is due to larger reported numbers of people reached through environmental strategies. These have extensive reach through advertising, print, radio, and television public service announcements. As many of the audiences for these media campaigns overlap, there would be duplication in the numbers provided by the states. States are not capable of correcting for this due to the design of their management information systems.

These improvements in states' ability to report accurate NOMs data have contributed to the program's ability to meet its performance targets. The program met or exceeded all of its FY 2009 targets.

Results for the 20 percent prevention set-aside activities in the SAPT Block Grant are reported for the compliance year of the program. Output results are aligned with NSDUH state outcome estimates for a comparable timeframe.

Although state level change cannot be attributed directly to the SAPT activities, a number of state level estimates indicate that progress is being made toward reducing substance use and

---

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

its associated risk factors. For example, state-level changes in perception of risk of harm from substance use between 2005/2006 and 2006/2007 indicate that with respect to youth ages 12 to17, almost half of the state grantees (47.1 percent) showed improvement. Nineteen state grantees (37.3 percent) showed improvement among respondents ages 18 or older. Thirty-eight states (74.5 percent) showed an improvement in the composite disapproval measure for youth ages 12 to 17 between 2005/2006 and 2006/2007 .State-level changes in past 30-day substance use between 2005/2006 and 2006/2007 indicated that 27 state grantees (52.9 percent) achieved a decrease in past 30-day alcohol use for underage youth.

PROGRAM: SAPTBG - NATIONAL SURVEYS[108]

Table 209: Measure 4.4.01: Availability and timeliness of data for the National Survey on Drug Use and Health (NSDUH) (Output)

FY	Target	Result
2011	8 months	Sep 30, 2011
2010	8 months	Sep 30, 2010
2009	8 months	8 months (Target Met)
2008	8 months	8 months (Target Met)
2007	8 months	8 months (Target Met)
2006	8 months	8 months (Target Met)

Table 210: Measure 4.4.02: Availability and timeliness of data for the Drug Abuse Warning Network (DAWN) (Output)

FY	Target	Result
2011	10 months	Oct 31, 2012
2010	10 months	Oct 31, 2011
2009	10 months	Oct 31, 2010
2008	10 months	13 months (Target Not Met but Improved)[109]
2007	12 months	22 months (Target Not Met)[110]
2006	15 months	16 months (Target Not Met)

[108] The National Surveys are completed using contracts instead of grants. As a result, they are awarded earlier in the fiscal year than grants. There is no delay between fiscal year funding and the performance year. As a result, FY 2012 targets have not been set for these performance measures as they have been for programs that are funded using grants.

[109] This was erroneously reported as 22 months in the FY 2010 President's Budget.

[110] This data was erroneously reported at 14 months in the FY 2010 President's Budget.

Table 211: Measure 4.4.03: Availability and timeliness of data for the Drug and Alcohol Services Information System (DASIS) (Output)

FY	Target	Result
2011	10 months	Sep 30, 2011
2010	10 months	Sep 30, 2010
2009	10 months	10 months (Target Met)
2008	10 months	10 months (Target Met)
2007	15 months	8 months (Target Exceeded)
2006	15 months	9 months (Target Exceeded)

Table 212: Data Source and Validation for Performance Measures for SAPTBG - National Surveys

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

Agency Program, Measure 4.4.01 - 4.4.03

The National Surveys are implemented using multi-year contracts instead of grants and as a result have funding schedules than grants. There is no delay between fiscal year funding and the performance year. As a result, FY 2012 targets have not been set for these performance measures as they have been for programs that are funded using grants.

The three performance measures for the National Surveys measure the timeliness of the publication of reports after the conclusion of data collection. The target for the publication of the National Survey on Drug Use and Health was met in FY 2008 and FY 2009. The performance target for publication of the Drug Abuse Warning Network System reports for 2006, 2007, and 2008 were not met because of technical errors by the contractor which required that the reports be pulled, rewritten, and disseminated. All reports are now updated and the 2009 data release will meet the target of November 2009. There was no affect on overall program or activity performance. The target for publication of the Drug and Alcohol Services Information System was met in FY 2009.

MACRO PROGRAM: CROSS-CENTER INITIATIVES

PROGRAM: SAMHSA'S MENTAL HEALTH/SUBSTANCE ABUSE SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

Table 213: Increase the number of individuals screened for mental disorders (including PTSD) and substance use disorders

FY	Target	Result
2012	58,456	Dec 31, 2012

Table 214: Increase the number of individuals receiving a brief intervention for MH and/or SUD

FY	Target	Result
2012	9,998	Dec 31, 2012

Table 215: Increase number of individuals assessed and referred for specialty MH and/or SA treatment

FY	Target	Result
2012	2,449	Dec 31, 2012

Table 216: Increase the percentage of individuals receiving mental health and/or substance abuse treatment services who report improved functioning

FY	Target	Result
2012	47%	Dec 31, 2012

Table 217: Data Source and Validation for Performance Measures for SAMHSA's Mental Health/Substance Abuse Screening, Brief Intervention and Referral to Treatment

Measure	Data Source	Data Validation
TBD	Data source has not been determined at this time but will most likely be a common co-occurring data collection tool that will be collected by the TRAC on-line data reporting and collection system for mental health grantees and SAIS on-line data reporting and collection system for treatment grantees.	All TRAC and SAIS data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

Agency Program

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supporting by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

This SAMHSA program will establish a public health approach to serving individuals with and at risk for mental illnesses and substance abuse disorders, including Post-Traumatic Stress Disorder (PTSD). Specifically, this program seeks to enhance and expand the capacity of community based settings to provide clinically and culturally appropriate screening, assessment and referral to specialty treatment services for individuals with and at risk for these disorders. SAMHSA is building on the success of the existing SBIRT program by adopting critical aspects of the SBIRT program to include not only the provision of appropriate services, but also to expand behavioral health system capacity for mental health disorder prevention/mental health promotion, screening, access to quality, integrated, individualized care and treatment that fosters recovery from mental health and substance abuse related issues. Additionally, this program will expand the service settings of SBIRT to include non-traditional settings such as One Stop shops and employment centers.

PROGRAM: CO-OCCURRING STATE INCENTIVE GRANTS

Table 218: Measure 1.2.17: Increase the number of persons with co-occurring disorders served (Output)

FY	Target	Result
2012	124,524	Oct 31, 2012
2011	103,679	Oct 31, 2011
2010	103,679	Oct 31, 2010
2009	103,679	94,034 (Target Not Met)
2008	Set Baseline	103,679 (Baseline)

Table 219: Measure 1.2.18: Increase the percentage of treatment programs that **screen** for co-occurring disorders (Outcome)

FY	Target	Result
2012	68%	Oct 31, 2012
2011	68%	Oct 31, 2011
2010	68%	Oct 31, 2010
2009	68%	29% (Target Not Met)
2008	Set Baseline	96.1% (Baseline)[111]

Table 220: Measure 1.2.19: Increase the percentage of treatment programs that **assess** for co-occurring disorders (Outcome)

FY	Target	Result
2012	32%	Oct 31, 2012
2011	32%	Oct 31, 2011
2010	32%	Oct 31, 2010
2009	32%	17% (Target Not Met)
2008	Set Baseline	76.4% (Baseline)[112]

[111] Previously reported result was calculated using erroneous unit of analysis. It has been revised from the FY 2010 President's Budget.

Table 221: Measure 1.2.20: Increase the percentage of treatment programs that **treat** co-occurring disorders through collaborative, consultative, and integrated models of care (Outcome)

FY	Target	Result
2012	53%	Oct 31, 2012
2011	53%	Oct 31, 2011
2010	53%	Oct 31, 2010
2009	53%	6% (Target Not Met)
2008	Set Baseline	50.4% (Baseline)[113]

Table 222: Data Source and Validation for Performance Measures for SAMHSA's Co-Occurring State Incentive Grants

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

Agency Program, Measure 1.2.17 - 1.2.20

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2011 appropriated funding will be reflected in the targets set for FY 2012.

People with co-occurring substance abuse and mental disorders are individuals who have at least one psychiatric disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms) at least one disorder of each type can be diagnosed independently of the other. The first three years of these grants focus on infrastructure development and enhancements. Grantees have the flexibility to identify specific infrastructure development and enhancement activities that support the goals selected and respond to the needs and priorities they have identified. Certain areas of infrastructure development (e.g., standardized screening and assessment, complementary

[112] Previously reported result was calculated using erroneous unit of analysis. It has been revised from the FY 2010 President's Budget.

[113] Previously reported result was calculated using erroneous unit of analysis. It has been revised from the FY 2010 President's Budget.

licensure and credentialing requirements, service coordination and network building, financial planning, and information sharing) reflect critical pathways for establishing complementary service delivery capacity in substance abuse and mental health service systems. After this period, grantees implemented service pilot programs, which generated data for the above outcome measures. In July 2007, CO-SIG States were required to begin collecting the necessary data, with the first reports due in October 2008. FY 2008 is the first year the data is available and baselines have been established. Grants will end at the close of FY 2010. Data is being collected from grantees through the Services Accountability Improvement System (SAIS).

PROGRAM: SAMHSA'S HEALTH INFORMATION NETWORK (SHIN)[114]

Table 223: Measure 4.4.04: Total number of SAMHSA knowledge products disseminated (Output)

FY	Target	Result
2011	8,607,392[115]	May 31, 2011
2010	13,909,297	Oct 31, 2010
2009	13,909,297	16,360,389 (Target Exceeded)
2008	Set Baseline	13,909,297 (Baseline)

Table 224: Measure 4.4.05: Total number of individuals referred for treatment resources (Output)

FY	Target	Result
2011	216,871[116]	May 31, 2011
2010	373,916	Oct 31, 2010
2009	Set Baseline	373,916 (Baseline)

[114] The SAMHSA's Health Information Network is completed using contracts instead of grants. As a result, they are awarded earlier in the fiscal year than grants. There is no delay between fiscal year funding and the performance year. As a result, FY 2012 targets have not been set for these performance measures as they have been for programs that are funded using grants.

[115] Contract ends April 30, 2011, with final report due 30 days after. Target for 2011 is an estimate based on activity for 7 months (or 58 per cent) of FY 2011.

[116] Contract ends April 30, 2011, with a final report due 30 days after. Target for 2011 is an estimate based on activity for 7 months (or 58 percent) of FY 2011.

Table 225: Data Source and Validation for Performance Measures for SAMHSA's Health Information Network

Measure	Data Source	Data Validation
4.4.04	The number of knowledge products disseminated by SAMHSA includes (1) physical inventory shipped by SHIN warehouse on behalf of SAMHSA, HHS-OWH, PDFA and ONDCP; (2) the number of electronic items successfully e-mailed via SAMHSA's eNetwork; and (3) the number of physical SAMHSA News copies sent to subscribers beginning in October 2008.	SHIN uses an inventory and order management system to track physical inventory and shipment data. This inventory and order management system implements a relational database that is supported with log files and data change tracking that provides data validation at each functional process. Data is validated through one additional step during its transition to the data warehouse reporting system. Distribution of electronic items is reported to SHIN by GovDelivery, a third party vendor that serves multiple Federal agencies and the White House. SAMHSA News' subscriber database is maintained by IQ Solutions and volume is validated by reports from a third party fulfillment center on number of copies sent.
4.4.05	The number of individuals SHIN refers to treatment facilities/resources includes (1) the number of calls answered by the SAMHSA Treatment Line (800.662.HELP); and (2) the number of callers to other SHIN managed phone numbers who select the option to speak to an Information Specialist regarding treatment resources.	Calls answered on the SAMHSA Treatment Line are reported to SHIN by Verizon. The SHIN contact center manager reviews the data daily, monthly, and annually for consistency. IQ Solutions telephony system (InterTel) tracks the number of treatment calls answered on other SHIN-managed lines including SAMHSA7, ONDCP, and the legacy NCADI and NMHIC telephone numbers. Referrals are measured by the number of callers to these lines who select the recorded option that they are looking for treatment referral support.

Agency Program, Measure 4.4.04 – 4.4.05

SAMHSA has introduced two new measures to reflect the substantial and increasing role in knowledge product dissemination of the SAMHSA Health Information Network (SHIN). The SHIN contract serves all three SAMHSA Centers and SAMHSA's Office of Applied Studies, and is managed by SAMHSA's Office of Communications.

The SAMHSA Health Information Network is funded by a contract that is awarded earlier in the fiscal year than most grants. Consequently, there is no delay between fiscal year funding and the performance year. For this reason, and also because the SHIN contract ends in April 30, 2011, FY 2012 targets have not been set for this performance measure and FY 2011 targets are based upon 7 months of activity.

The first measure to monitor SHIN's impact is the total number of knowledge products disseminated. For FY 2009, the target for number of SAMHSA knowledge products disseminated was substantially exceeded. Two factors are primarily responsible for this outcome: (1) copies of SAMHSA News distributed to subscribers were included for the first time in FY 2009; and (2) inventory of several highly popular publications was not available for much of FY 2008 due to resource constraints. (SHIN is not primarily responsible for inventory replenishment; printing costs are defrayed from other SAMHSA funds.) In addition, no increase is anticipated in SHIN resources for the remainder of the contract. For these reasons, the target for FY 2010 is maintained at the baseline level. The target for FY 2011 also assumes level performance. SAMHSA will launch a new, unified SHIN Website in the first quarter of FY 2011. While we expect that this new site ultimately will enhance the dissemination of SAMHSA knowledge products, distribution will likely drop during the transition to the new site until users become familiar with the change.

SAMHSA will also be reporting on a second SHIN performance measure for treatment referrals. These inquiries represent a large majority of calls received by SHIN and provide a valuable public service. Baseline data has been reported for FY 2009. As with the product dissemination measure, SAMHSA has assumed level performance of this measure and has set targets accordingly.

SAMHSA is considering the addition of other dissemination measures in future years, but the necessary taxonomy and IT infrastructure must be in place before those measures can be developed. The taxonomy and certain automated reporting functions will not be fully deployed until the new, unified SHIN Web site is launched in November/December 2010.

OVERVIEW OF PERFORMANCE

SAMHSA uses performance data to manage grants, contracts and data collection activities, and to report performance results to the President, Congress, and other stakeholders. SAMHSA's performance measures include both long-term and annual measures covering clients and systems outcomes, outputs, and efficiencies. SAMHSA's performance measures are built around three strategic goals: Accountability, Capacity, and Effectiveness. These goals, in turn, link with relevant HHS Strategic Goals and Objectives.

SAMHSA's Data Strategy, which is available at http://samhsa.gov/about/DataStrategyPlan.pdf, established three goals for FY 2007 through FY 2011:

- Goal 1: Provide periodic national information on the incidence and prevalence of substance abuse and mental illness; associated characteristics of individuals and communities; specialty and non-specialty treatment and prevention providers and their services; and payers and financing of such services.

- Goal 2: Provide effective performance information from block/formula and discretionary grant programs through developing and implementing SAMHSA-wide performance measures and rigorous evaluations.

- Goal 3: Promote the use of interoperable electronic health records and health information technology to improve quality and safety of care, increase administrative efficiencies, and encourage consumer and family participation in their health care.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has partnered with the States and SAMHSA grantees to implement the National Outcome Measures (NOMs) for prevention and treatment of substance use and/or mental disorders. The NOMs have been defined to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities.

As of February 2009, most States are fully reporting NOMs for mental health services, substance abuse prevention, and substance abuse treatment. In addition to reporting these measures to SAMHSA, States are using these NOMs within their own systems to measure outcomes at the State and substate level. State Substance Abuse Agencies reported the following outcomes for treatment services provided during 2007 and submitted through the Substance Abuse Prevention and Treatment Block Grant application:

- For the 51 States that reported data in the Abstinence from Drug/Alcohol Use Domain for alcohol, 51 of 51 identified improvements in client abstinence. Forty-five of these States reported improvements based on information submitted to TEDS and 6 reported improvements based on their own data collection systems.
- Similarly, for the 51 States that reported data in the Reduced Morbidity—Abstinence from Drug/Alcohol Use Domain for drug use, 50 of 51 identified improvements in client abstinence. Forty-four of these States reported improvements based on information submitted to TEDS and six reported improvements based on their own data collection systems.
- For the 51 States that reported data in the Employment Domain, 46 of 51 identified improvements in client employment. Forty-one of these States reported improvements

based on information submitted to TEDS and five reported improvements based on their own data collection systems.
- For the 51 States that reported in the Criminal Justice Domain, 36 of 40 reported an increase in clients with no arrests based on data reported to TEDS.
- For the 51 States that reported data in the Stability in Housing Domain, 38 of 47 identified improvements in stable housing for clients based on data reported to TEDS.

The National Outcome Measures for prevention use State-level estimates for the NSDUH. Combined NSDUH samples for 2006 and 2007 showed the following improvements over the combined samples for 2005 and 2006:

- Twenty-seven States (52.9 percent) showed a decrease in past-30-day alcohol use in the 12-17 age group. Twenty-eight States (54.9 percent) showed an increase in the perception of risk of harm from having five or more drinks of an alcoholic beverage once or twice a week among the same age group.
- Twenty-five States (49.0 percent) showed a decrease in past-30-day marijuana use among persons aged 12-17. Twenty-one States (41.2 percent) showed an increase in perception of risk of harm from smoking marijuana once or twice per week among the same age group.
- Twenty-nine States (56.9 percent) witnessed increases in the age of first marijuana use, while 31 States (60.8 percent) had increases in the age of first alcohol use.
- Thirty-two States (62.7 percent) witnessed an increase in percentages of persons aged 12-17 reporting that they somewhat or strongly disapproved of their peers having one or two drinks of an alcoholic beverage nearly every day.
- Thirty-four States (66.7 percent) showed increased percentages of persons aged 12-17 reporting that their close friends would somewhat or strongly disapprove of their smoking one or more packs of cigarettes a day.
- Fifteen States showed higher percentages of employed persons aged 15-17 reporting that they would be more likely to work for an employer who randomly tests for drugs and alcohol. This constitutes 57.7 percent of the 26 States for which valid comparisons of this measure were possible across the two combined samples.
- Twenty-five States (49.0 percent) showed increased percentages of persons aged 12-17 reporting a conversation with a parent/guardian about the dangers of alcohol, tobacco, or other drugs during the past 12 months.
- Twelve States showed increased percentages of persons aged 12-17 who reported having been exposed to substance abuse prevention messages during the past 12 months.

State-level outcome data for mental health are currently reported by State Mental Health Agencies through the URS. The following outcomes for services provided during 2008 show that:

- For the 49 States that reported data in the Employment Domain, 21 percent of the mental health consumers were in competitive employment. (This is an expansion of the reporting base by one State.)
- For the 49 States that reported data in the Housing Domain, 80 percent of the mental health consumers were living in private residences.
- For the District of Columbia and 50 States that reported data in the Access/Capacity Domain, State mental health agencies provided mental health services for 21 people per 1,000 population. All States and the District of Colombia report this measure.

- For the 47 States that reported data in the Retention Domain, only nine percent of the mental health patients returned to a State hospital within 30 days of State hospital discharge.
- For the 49 States that reported data in the Perception of Care Domain, 70 percent of adult mental health consumers and 75 percent of families of child/adolescent consumers reported that, as a direct result of the mental health services they received, they were doing better.

SAMHSA also continues to refine its performance data for discretionary programs as data collection procedures are implemented and improved. Each Center now has an automated web-based system for collection of performance data from their discretionary grants. Grantees are required to submit data within a specified time frame on clients served in their program. Those data are then used to produce regular reports which are used for program management and shared with senior SAMHSA and other Federal officials. SAMHSA has also revised its Substance Abuse Prevention and Treatment Block Grant application to include more performance information. The data from both the discretionary grants and the block grants are used in public reports and for SAMHSA's Annual Performance Report and its Annual Performance Plan to Congress.

SAMHSA's performance goals and targets are reported for 31 major programs and activities. Detailed performance tables are reported within the narrative summaries for each of those programs and activities in the Congressional Justification. For Programs of Regional and National Significance, major activities such as the Strategic Prevention Framework and Access to Recovery are reported individually; smaller activities are reported in aggregate. The Online Performance Appendix provides historical and current data and targets as well as additional detail about trends in program performance.

In the FY 2011 Online Performance Appendix, SAMHSA has expanded the display of its performance tables to include targets for FY 2012. As many of SAMHSA's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, the performance tables throughout the two documents include targets for the year that will be revised according to FY 2011 appropriated funding.

STRATEGIC PLAN

SAMHSA's strategic plan encompasses three strategic goals: Accountability, Capacity, and Effectiveness. Accountability activities support performance measurement and transparency; Capacity activities are designed to increase service availability; and Effectiveness activities aim to improve service quality. All SAMHSA activities support at least one HHS strategic objective; most support more than one.

SAMHSA's Accountability activities primarily support Strategic Objective 4.4: Communicate and transfer research results into clinical, public health, and human service practice. These include SAMHSA's National Surveys and the SAMHSA Health Information Network.

SAMHSA's Capacity activities are distributed among HHS Strategic Goals 1, 2, and 3. SAMHSA's largest program, the Substance Abuse Prevention and Treatment Block Grant, primarily supports objective 1.2, Increase health care service availability and accessibility; the prevention set-aside of the Block Grant supports objective 2.3: Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery. The Mental Health Block Grant also supports objective 2.3, as do some of the discretionary capacity programs in both mental health and prevention. All treatment capacity programs, as well as several mental health discretionary programs, support objective 1.2. CMHS's Homeless Prevention and the PATH and PAIMI formula grants, support objective 3.4: Address the needs, strengths and abilities of vulnerable populations. SAMHSA's youth-focused capacity activities, including Youth Violence Prevention and the National Trauma Stress Network support objective 3.2: Protect the safety and foster the well-being of children and youth. Community-focused prevention programs, including the Strategic Prevention Framework State Incentive Grants and the Sober Truth of Preventing Underage Drinking Grants, support objective 3.3: Encourage the development of strong, healthy and supportive communities.

SAMHSA's Effectiveness programs comprise the Science and Service Portfolio. The National Repository of Evidence-Based Programs and Practices supports objective 1.3: Improve health care quality, safety and cost/value. Most technical assistance and training activities including the Minority Fellowship Program support objective 1.4: Recruit, develop, and retain a competent health care workforce; remaining science and service activities are distributed among objectives 2.3 and 3.3.

As the nation moves toward mental health parity and health reform, SAMHSA will continue to examine its strategic plan and goals to assure that they are consistent with national needs and priorities.

SAMHSA LINKAGES TO HHS STRATEGIC PLAN

The table below shows the alignment of SAMHSA's strategic goals with HHS Strategic Plan goals.

Table 226: SAMHSA linkages with Goal 1 Health Care: Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care

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

Table 227: SAMHSA linkages with Goal 2 Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness: Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats

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

Table 228: SAMHSA linkages with Goal 3 Human Services: Promote the economic and social well-being of individuals, families, and communities

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

Table 229: SAMHSA linkages with Goal 4 Scientific Research and Development Advance scientific and biomedical research and development related to health and human services

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

ADDITIONAL ITEMS

FULL COST TABLE

Methodology: Reporting full cost involves two types of information. First, the full cost for each program is calculated. Second, SAMHSA sums those estimates by each Program's alignment with the HHS Strategic Plan goals and objectives.

Each Program is reporting full cost information using the HHS standard methodology. SAMHSA's application of the methodology involves assigning Program Management dollars across budget lines based upon the number of FTEs directly assigned to the program.

Table 230: SAMHSA program full cost associated with HHS Goal 1 Health Care (Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2009	FY 2010	FY 2011
1.1 Broaden health insurance and long-term care coverage.	0	0	0
1.2 Increase health care service availability and accessibility.	1,933.636	1,997.988	2,026.157
1.3 Improve health care quality, safety and cost/value.	1.668	1.670	1.697
1.4 Recruit, develop, and retain a competent health care workforce.	44.396	44.489	43.580
Agency Subtotal Goal 1	**1,979.701**	**2,044.147**	**2,071.434**
Agency Total	**3,466.491**	**3,563.209**	**3,673.596**

Table 231: SAMHSA program full cost associated with HHS Goal 2 Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness (Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2009	FY 2010	FY 2011
2.1 Prevent the spread of infectious diseases.	0	0	0
2.2 Protect the public against injuries and environmental threats.	0	0	0
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	971.520	988.690	1,006.250
2.4 Prepare for and respond to natural and man-made disasters.	0	0	0
Agency Subtotal Goal 2	971.520	988.690	1,006.250
Agency Total	**3,466.491**	**3,563.209**	**3,673.596**

Table 232: SAMHSA program full cost associated with HHS Gal 3 Human Services (Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2009	FY 2010	FY 2011
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.	0	0	0
3.2 Protect the safety and foster the well being of children and youth.	148.921	152.649	154.899
3.3 Encourage the development of strong, healthier and supportive communities.	158.032	161.487	178.357
3.4 Address the needs, strengths and abilities of vulnerable populations.	139.773	145.897	160.321
Agency Subtotal Goal 3	**446.727**	**460.033**	**493.578**
Agency Total	**3,466.491**	**3,563.209**	**3,673.596**

Table 233: SAMHSA program full cost associated with HHS Goal 4 Scientific Research and Development (Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2009	FY 2010	FY 2011
4.1 Strengthen the pool of qualified health and behavioral science researchers.	0	0	0
4.2 Increase basic scientific knowledge to improve human health and human development.	0	0	0
4.3 Conduct and oversee applied research to improve health and well-being.	0	0	0
4.4 Communicate and transfer research results into clinical, public health and human service practice.	68.544	70.338	102.333
Agency Subtotal Goal 4	68.544	70.338	102.333
Agency Total	**3,466.491**	**3,563.209**	**3,673.596**

EVALUATIONS INCLUDED IN HHS EVALUATIONS DATABASE FOR FY 2009

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

Report Title: National Evaluation of the Safe Schools/Healthy Students (1999-2001)
Coordinating Office: SAMHSA's Center for Mental Health Services

Key Study Question: To assess whether SS/HS grants develop systemic change that results in beneficial outcomes for children, families, and schools.

Summary: The Safe Schools/Healthy Students Interdepartmental Initiative (SS/HS) is a landmark effort supported by an unprecedented collaboration among the Departments of Education, Health and Human Services, and Justice. The goals were to: (1) help students develop the skills and emotional resilience necessary to promote positive mental health, engage in prosocial behavior, and prevent violent behavior and drug use; (2) ensure that all students learn in a safe, disciplined, and drug-free environment; and (3) develop an infrastructure that will institutionalize and sustain integrated services. This national evaluation of SS/HS was designed to document how coalitions and collaborations at the community level develop systemic change that results in beneficial outcomes for children, families, and schools.

Report Title: Campus Suicide Prevention Program Cross-site Evaluation, Garrett Lee Smith (GLS) Memorial Act
Coordinating Office: SAMHSA's Center for Mental Health Services

Key Study Question: To assess whether GLS grants increased early identification, awareness, and knowledge related to suicide prevention on college campuses.

Summary: To address the need for evaluation in the field of suicide prevention and to respond to Congress's request for a cross-site evaluation of the Garrett Lee Smith Suicide Prevention Program, the Substance Abuse and Mental Health Services Administration (SAMHSA) requires that all grant recipients participate in a national cross-site evaluation. This participation allows for large sample comparisons of early intervention activities and the collection of information on the use of best and promising practices. The cross-site evaluation will establish the largest database available to the public, policymakers, grantees, and the suicide prevention field of gatekeeper training experiences, early identification activity outcomes, referral network processes and agency interactions, college student and faculty/staff awareness and knowledge related to suicide, and campus suicide prevention infrastructures. A final report for this evaluation will be submitted to SAMHSA for this evaluation by June 1, 2010. A no-cost extension was given to the evaluation contract to complete data analysis.

Report Title: Evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program – Phase III
Coordinating Office: SAMHSA's Center for Mental Health Services

Summary: The Center for Mental Health Services (CMHS) conducted a third phase of the evaluation with a six-year evaluation of 22 grant communities funded in fiscal years 1999 and 2000 on April 30, 2007. During the 6 year grant program, 10,722 children were enrolled in systems of care in these communities. Evaluators hired at each site gathered descriptive data on demographics and clinical characteristics, as well as child clinical and functional outcomes, family outcomes, and service experience. System of care development, service costs, evidence-based treatments, and program sustainability were assessed. Outcomes data collection on a representative sample included areas such as child behavioral and emotional problems and strengths, functioning in the home, school, and community, and caregiver strain. Descriptive and demographic data were obtained for 9,456 children. The average age of these children was 12.4 years, and 66% were boys; 50.5% were White. The most common diagnoses were 41 percent with attention deficit hyperactivity disorders, 35.3% with mood disorders, and 27.6% with oppositional defiant disorder. Children and youth made significant improvements in behavioral and emotional problems, functioning in home, school, and community, strengths and school performance. Caregivers reported significant reductions in strain associated with caring for a child with a serious emotional disturbance. Findings are available in a range of publications. Findings are included within mandated annual Reports to Congress.

Report Title: Cooperative Agreements to Evaluate Housing Approaches for Persons with Serious Mental Illness - Phase II
Coordinating Office: SAMHSA's Center for Mental Health Services

Summary: This multi-site, longitudinal study examined the effects of supported housing compared to housing approaches in the more traditional residential continuum on resident outcomes. Across six study sites, 952 individuals with serious mental illness were placed in either supported housing or one of the comparison housing approaches. Major outcome measures included residential tenure, time in initial placement, homelessness, hospitalization, and mental health symptoms. Hierarchical linear models controlling on baseline site and group differences were used to examine change in the outcomes over an 18-month period. Significant, sustained increases were found for all measures of residential stability and modest increases in mental health and several other outcome measures, regardless of the specific housing approach. There were no differential effects for supported housing compared to the other housing approaches on any of the outcomes tested nor differences that can be accounted for by the various features examined. Age and mental health hospitalization history were the two most common moderators of resident outcomes. The findings demonstrate the potency of housing with supports for people with severe mental illnesses. The lack of differential findings offers providers some flexibility in their approaches and use of housing stock. In the context of consumer preferences, housing that incorporates the principles of supported housing may be the best direction for providers to strive.

Report Title: Evaluation of the Effectiveness of Time-Limited Interventions for Homeless Families

Coordinating Office: SAMHSA's Center for Mental Health Services

Summary: SAMHSA funded the Collaborative Initiative on Homeless Families as five-year, two-phased program and service evaluation study. Data were collected at baseline and three follow-up time points (3-, 9-, and 15-months) from 1573 homeless mothers at the eight sites participating in the Homeless Families Program. A basic premise for the program was that a primary emphasis on short-term interventions and appropriate follow-up targeted to homeless mothers with psychiatric and/or substance use disorders who are caring for their dependent children would result in movement out of homelessness, stability in housing placement, decreased alcohol and drug use, and improvement in mental health and family functioning at both the parent and child levels. It was specifically designed to be the first multi-site evaluation of the effectiveness of innovative interventions in addressing the particular treatment and service needs of homeless families. Overall, the average rate of change for families on most outcomes, including mental health, substance use, trauma recovery, and residential status, was positive, regardless of whether they were served in the target interventions or in comparison interventions (typically, whatever services are generally available). Even samples of mothers with specific needs (e.g., heightened mental health needs, those with prior substance abuse) generally improved on those specific outcomes. There was also some indication that more availability of onsite mental health services and onsite substance abuse services related to better outcomes for homeless mothers as well and even more so for individuals with those specific needs.

Report Title: Client/Patient Sample Survey Evaluation
Coordinating Office: SAMHSA's Center for Mental Health Services

Summary: The 2007 CPSS contract was extended through April 2008. Because analysis of the 2007 CPSS dataset was not part of the original contract responsible for conducting the survey in the field and development of the final dataset, another contract was tasked with providing an analysis of the 2007 CPSS dataset. A draft SAMHSA report is currently under major revision, with an expected publication date in 2010.

Report Title: Minority AIDS Initiative (MAI) Cross-Site Evaluation of Cohorts 6, 7, 8 and Future Grant Programs
Coordinating Office: SAMHSA's Center for Substance Abuse Prevention

Summary: The Minority AIDS Initiative (MAI) cross-site evaluation of Cohorts 6, 7, 8 and future grant programs to prevent substance abuse and HIV uses CSAP's Strategic Prevention Framework (SPF) to gain a broader understanding of substance abuse and HIV prevention and to inform future work in this field. The SPF calls for grantees to assess community needs, build capacity, plan, implement evidence-based programs and evaluate their effectiveness. This information includes the program effects on clients' knowledge, attitudes, and behaviors related to the risks of substance abuse and risky sexual behavior. The goals are to 1) aggregate data from similar programs serving similar participants to detect smaller and more complex program effects, 2) compare the effects of different interventions implemented across different sites, 3) explore the impacts of similar interventions on different categories of participants served at different sites, and 4) examine the effects of similar programs delivered in different

environments. These analyses will employ quantitative and qualitative analyses of individual client level entry, exit and follow-up survey data, program level progress report information though the Management Reporting Tool (MRT) and program descriptions. The quantitative data shall incorporate CSAP's required NOMs and GPRA performance measurement data and other variables where appropriate and focus on process/dosage and output/outcomes linked to the programs' objectives.

Report Title: Evaluation of Methamphetamine Preventions Abuse Program
Coordinating Office: SAMHSA's Center of Substance Abuse Prevention

Summary: Program evaluation is not the same as performance measurement, which is the ongoing monitoring and reporting of program outputs and outcomes, particularly the documentation of progress towards pre-established goals. The collection of performance measures addresses the target populations served, the type of program activities conducted (process), the direct products and services delivered by a program (outputs), and/or the results of those products and services (outcomes). In contrast, program evaluations usually examine a broader range of performance information than is normally collected on an ongoing basis. This program is tracking and monitoring program performance of the twelve Methamphetamine grantees as described above. Of those twelve grantees, eight grantees are prevention intervention focused and the other four are a combination of prevention intervention and infrastructure development grantees. The primary focus of the evaluation includes an analysis of program performance based on the National Outcomes Measures (NOMs) and program specific data on youth and adults. This program started in October of 2006 and differs from the previous Methamphetamine program because it specifically focuses on Methamphetamine intervention and infrastructure development in the actual high-risk communities that it affects. The current reporting cycle runs every 4th and 8th month of the fiscal year with a year-end report expected to be complete by end of this calendar year. Methamphetamine grantee data are collected annually. Performance data are analyzed and reported yearly and over time. All the data is collected online on the Performance Management Reporting and Training system (www.pmrts.samhsa.gov) and is available to the grantees and hopefully in the future to the public for secondary analysis.

Report Title: Cross-Site Evaluation Report on the Strategic Prevention Framework State Incentive Grants, Cohort 1 and 2
Coordinating Office: SAMHSA's Center for Substance Abuse Prevention

Summary: The cross-site evaluation design is a quasi-experimental, process oriented study at three levels: (a) national level across states/jurisdictions, (b) state level, and (c) sub-recipient community level. Evaluation data are collected through interviews of state level program personnel and through Web-based community level instruments. State level interviews are conducted once at the beginning of the grant cycle and once toward the end of the grant period. Community level data are reported twice a year.

The cross-site evaluation provides a comprehensive evaluation of Cohorts I and II of the Strategic Prevention Framework State Incentive Grants (SPF SIG) program. SAMHSA's SPF lays out five ordered steps to guide states and communities through a logical planning process. Evaluation of this framework is expected enable grantees to promote better decision-making around assessment of community needs and resources, planning around prevention activity, selection and delivery of prevention service and strategies, and meaningful monitoring and evaluation.

Report Title: Cross-Site Evaluation Report on the Strategic Prevention Framework State Incentive Grants, Cohort 3 and 4
Coordinating Office: SAMHSA's Center of Substance Abuse Prevention

Summary: This cross-site evaluation study received funding in FY 2009 and is based on a nested design that combined data at three different levels: (a) the grantee state/jurisdiction, (b) the subrecipient community, and (c) the individual service recipient. State/Jurisdiction Program Directors are interviewed twice, once at the beginning of their grant period and once at the end, about the grantee needs assessment, infrastructure building, program implementation, and evaluation activities. The subrecipient communities submit community-level data semi-annually, describing their needs assessment, infrastructure/capacity building, and program implementation activities, using an online data entry system designed specifically for this group of funded communities and available on the Performance Management and Reporting Training System which is the centralized data collection portal for CSAP's programs (PMRTS). Data are collected from individual service recipients of direct prevention services lasting 30 days or longer at program entry, program exit, and six months following program completion, using CSAP's National Outcome Measures for Youth (ages 12-17) and Adults (ages 18 or older). Data are also collected from participants receiving less exposure to prevention services. Population data are obtained to assess environmental strategy outcomes. Analyses will focus on the individual and interactive effects of infrastructure and program characteristics on outcomes by demographic group as well as geographic areas.

Report Title: Results from the 2008 National Survey on Drug Use and Health: National Findings
Coordinating Office: SAMHSA's Office of Applied Studies

Summary: The 2008 National Survey on Drug Use and Health was administered to a sample of 68,736 persons representative of the U.S. civilian, non-institutional population aged 12 or older. This initial report on the 2008 data provided national estimates of rates of use, numbers of users, persons meeting criteria for substance use disorders, substance use treatment, and other measures related to illicit drugs, alcohol, and tobacco products. Results also were presented for measures of mental health problems, including serious mental illness and major depressive episode, as well as data on the co-occurrence of substance use disorders and mental health problems. In 2008, an estimated 20.1 million Americans aged 12 and older (8.0 percent) were current (past month) illicit drug users, a rate the same as that in 2007 (8.3 percent) and similar to that in 2002-2006. Among youths aged 12 to 17, 9.3 percent were current illicit drug users, down from 11.6 percent in 2002 but statistically unchanged from the 9.5 percent seen in 2007. Current marijuana use among youths aged 12-17 declined from 8.2 percent in 2002 to 6.7 percent in 2008. In 2008, 129 million persons aged 12 or older (51.6 percent) were current alcohol users, and 58.1 million (23.3 percent) engaged in binge drinking (five or more drinks on the same occasion) at least once in the past month. Underage (ages 12-20) drinking in the past month declined from 28.8 percent in 2002 to 26.4 percent in 2008 and binge drinking in this age group declined from 19.3 to17.4 percent. The rate of current cigarette smoking among persons aged 12 or older declined from 26.0 percent in 2002 to 23.9 percent in 2008. From 2007 to 2008, current cigarette smoking among youths aged 12-17 declined from 9.8 to 9.1 percent, continuing a decrease from its rate of 13.0 percent in 2002, the earliest year for which the survey provides trendable data. In 2008, an estimated 23.1 million persons aged 12 or older (9.2 percent) needed treatment for an alcohol or illicit drug problem. Of those persons, 2.3 million (9.9 percent) received treatment at a specialty facility; 20.8 million in need of treatment did not receive it. In 2008, an estimated 9.8 million adults aged 18 or older (4.4 percent) had

serious mental illness. The rate of past year major depressive episode in 2008 was 6.4 percent for persons aged 18 or older and 8.3 percent among adolescents aged 12 to 17.

Report Title: State Estimates of Substance Use from the 2006–2007 National Surveys on Drug Use and Health (http://www.oas.samhsa.gov/2k7State/toc.cfm)
Coordinating Office: SAMHSA's Office of Applied Studies

Summary: Researchers prepared State estimates for 23 measures of substance use or mental health problems based on the 2006 and 2007 National Surveys on Drug Use and Health. The surveys are ongoing and cover the civilian, non-institutionalized population of the 50 States and the District of Columbia aged 12 years or older. These estimates are based on combined data collected from 135,672 respondents surveyed in 2006 and 2007. Past month use of illicit drugs among persons aged 12 or older ranged from 5.2% in Iowa to 12.5% in Rhode Island. The percentage of persons aged 12 or older who used an illicit drug in the past month increased in the period between 2005-2006 and 2006-2007 in Arizona, Kentucky, New Mexico, Rhode Island, Virginia, and Wisconsin. Decreases were observed in Connecticut, Iowa, New Jersey, and Pennsylvania. Iowa had the lowest rate of past month marijuana use among persons age 12 or older (3.8%) while Rhode Island had the highest rate (10.3%). Utah had the lowest rate of past month underage (age 12 to 20) binge drinking of alcohol (13.3%) and North Dakota had the highest rate (29.5%). Increases in underage binge drinking between 2005-2006 and 2006-2007 occurred in Connecticut (from 21.2% to 23.5%) and the District of Columbia (from 18.9% to 22.5%). Underage binge drinking rates decreased in Texas (from 17.6% to 16.3%) and Utah (from 17.0% to 13.3%) during the same time period. The percentage of persons with a substance use disorder (i.e., dependent on or abuse of illicit drugs or alcohol) ranged from 7.5% in New Jersey to 12.6% in the District of Columbia. Hawaii had the lowest rate of adults aged 18 or older who experienced a major depressive episode in the past year (5.0%) while Tennessee had the highest rate (9.8%).

Report Title: Substate estimates from the 2004-2006 National Surveys on Drug Use and Health (http://www.oas.samhsa.gov/substate2k8/toc.cfm)
Coordinating Office: SAMHSA's Office of Applied Studies

Summary: This report presents estimates for 23 substance abuse and mental health-related behavior levels in 345 substate regions representing all 50 states and the District of Columbia. The results were based on the combined data from SAMHSA's 2004 to 2006 National Surveys on Drug Use and Health (NSDUH) and involved responses from 203,870 people aged 12 or older throughout the United States. The report offers highly detailed analyses of the substance abuse and mental health problems occurring within smaller geographical areas. During 2004-2006, 4.9 percent of all persons in the U.S. aged 12 or older had used a pain reliever for nonmedical use within the past year. Estimates ranged from 2.5 percent in District of Columbia's Ward 7 to 7.9 percent in Florida's Circuit 1. Oklahoma (Oklahoma County and Tulsa County), Tennessee (Region 1 and Region 4 [Davidson]), Utah (Salt Lake County and Weber-Morgan), and West Virginia (Northern C and D, and South Central II) had more than one substate region among the regions with the highest 15 prevalence rates. Regions with the 15 lowest rates included 5 in the District of Columbia (Wards 4 through 8), 3 in South Dakota (Region 2, Region 3, and Region 6), 2 in Maryland (Montgomery and Prince George's Counties), and 2 in Pennsylvania (Regions 19, 26, 28, and 42 and Regions 5, 18, 23, 24, and 46). The highest rate of past month cigarette use was in West Virginia's South Central II region (35.4 percent), and the lowest rate was in Utah County, Utah (15.9 percent). The majority of the 15 substate regions with the highest rates of past month cigarette use were in Kentucky (3 regions) and West

Virginia (6 regions). Of the 15 substate regions with the lowest rates of past month cigarette use, 9 were in California and 4 were in Utah.

Report Title: Treatment Episode Data Set (TEDS) –1997-2007. National Admissions to Substance Abuse Treatment Services
Coordinating Office: SAMHSA's Office of Applied Studies

Summary: This report presents results from the Treatment Episode Data Set (TEDS) for 2006, and trend data for 1997 to 2007. The report provides information on the demographic and substance abuse characteristics of the 1.8 million annual admissions to treatment for abuse of alcohol and/or drugs in facilities that report to individual State administrative data systems. Between 1997 and 2007, TEDS treatment admissions were dominated by five substances: alcohol, opiates (primarily heroin), marijuana, cocaine, and stimulants (primarily methamphetamine). These substances together consistently accounted for between 95 and 96 percent of all TEDS admissions from 1997 through 2007. The age distribution of TEDS admissions changed between 1996 and 2006. The proportion of TEDS admissions aged 25 to 34 years declined from 32 percent in 1997 to 26 percent in 2007. This decline was offset by overall increases in the proportions of both older and younger admissions. The proportion of older admissions (aged 45 and older) increased from 14 percent in 1997 to 23 percent in 2007. The proportion of younger admissions (less than 25 years of age) increased from 22 percent in 1997 to 26 percent in 2007.

Report Title: National Survey of Substance Abuse Treatment Services (N-SSATS): 2008. Data on Substance Abuse Treatment Facilities
Coordinating Office: SAMHSA's Office of Applied Studies

Summary: This report presents results from the 2008 National Survey of Substance Abuse Treatment Services (N-SSATS), an annual census of facilities providing substance abuse treatment. Conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), N-SSATS is designed to collect data on the location, characteristics, and use of alcoholism and drug abuse treatment facilities and services throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.

A total of 14,423 facilities completed the survey. The 13,688 facilities eligible for this report had a one-day census of 1,192,490 clients enrolled in substance abuse treatment on March 30, 2007. There were 85,518 clients under age 18 in treatment on March 30, 2008, making up 7 percent of the total population in treatment on that date. Forty-six percent of all clients were in treatment for both alcohol and drug abuse, 35 percent were in treatment for drug abuse only, and 19 percent were in treatment for abuse of alcohol alone. Eighty-eight percent of facilities had clients in treatment for co-occurring mental health and substance abuse disorders. Thirty-nine percent of all clients were in treatment for these disorders.

Report Title: Drug Abuse Warning Network, 2007: Area Profiles Of Drug-Related Mortality Coordinating
Coordinating Office: SAMHSA's Office of Applied Studies

Summary: The Drug Abuse Warning Network (DAWN) is a public health surveillance system that monitors drug-related deaths referred to medical examiners and coroners (ME/Cs) in selected metropolitan areas and States. Findings in this publication reflect data on drug-related deaths that occurred during calendar year 2007 and were reported by participating ME/Cs to

DAWN. In selected tables, data from reporting year 2006 are included for comparison. The Office of Applied Studies (OAS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, is responsible for DAWN.

Page Intentionally Left Blank