DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2018

Substance Abuse and Mental Health Services Administration

Justification of Estimates for Appropriations Committees

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I am pleased to present the Substance Abuse and Mental Health Services Administration (SAMHSA) fiscal year (FY) 2018 Budget Request. SAMHSA is requesting a total of $3.9 billion. As a primary federal agency responsible for addressing substance abuse and mental health services, SAMHSA proudly leads public health efforts to advance the behavioral health of the nation. Now, more than ever, we must ensure individuals living with substance use and mental disorders gain access to high quality prevention, treatment, and recovery services.

SAMHSA is committed to optimizing the impact of every dollar entrusted to our agency. This budget aligns with the Administration's priorities to address behavioral health for children, adults, families, and communities. Through a sustained focus on enhancing and developing critical partnerships, SAMHSA's budget aims to improve the lives of people and patients across the nation.

SAMHSA's FY 2018 budget request includes investments to:

- Expand access to care for opioid use disorders through the State Targeted Response program financed with a continued investment of $500 million to combat the nation's opioid crisis. In addition, the budget invests in Medication Assisted Treatment (MAT) and continued strategies to prevent opioid abuse through evidence-based prevention strategies, including the use of the live-saving drug, naloxone.
- Help engage individuals with serious mental illness into care, especially those who are hardest to reach and the most vulnerable.
- Address the alarming rate of suicide across the nation.
- Make critical data from national surveys and surveillance available to support innovation and improve patient outcomes.

SAMHSA provides strategic investments that foster flexibility and leverage change across the nation. Program performance and continuous quality improvement are critical aspects of our work. We carefully monitor and measure our programs to ensure the needs of the public are being met. In FY 2018, SAMHSA initiative to support its highly trained workforce and robust business practices will ensure responsible stewardship of the American taxpayer's dollar.

What SAMHSA does every day helps save lives. Reversing opioid overdose, preventing suicide, or building the foundation for a socially and emotionally healthy childhood, a strong community, a drug-free workplace, or an individual pathway to recovery – the work SAMHSA does is vital to the health of this country. I am confident this budget supports SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities.

Kana Enomoto
Acting Deputy Assistant Secretary for
Mental Health and Substance Use

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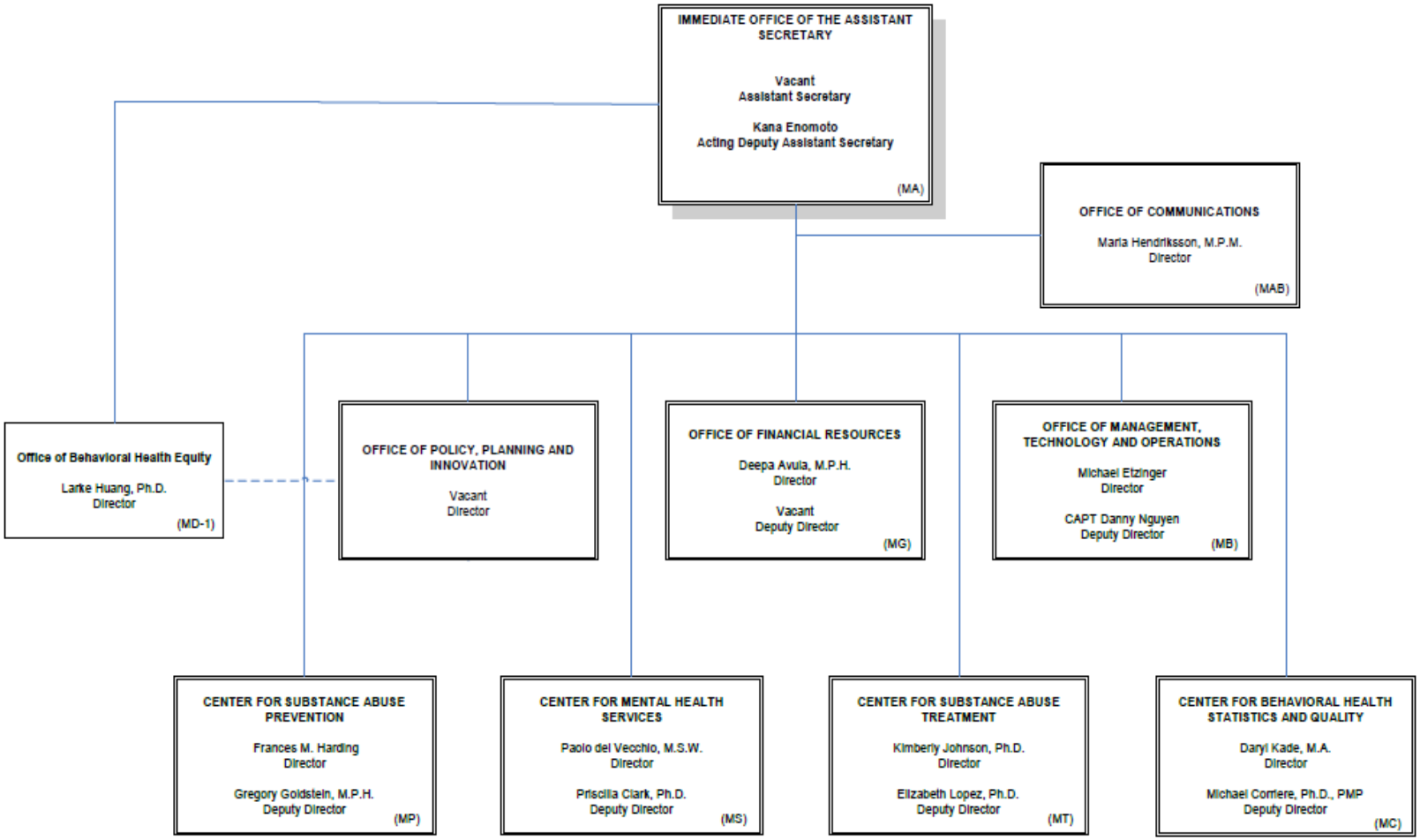
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Table of Contents

Fiscal Year 2018 Budget **Page**

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



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Performance Budget Overview

Introduction

Now, more than ever, the need to face mental health and substance abuse is critical to the nation's future. Prevention, treatment, and support to help people recover from mental illness and drug/alcohol addiction are essential strategies for the health and prosperity of individuals, families, communities, and the country. Half of all Americans will meet criteria for a mental or substance use disorder during their lives. Unfortunately, the majority of those who need treatment do not receive it. Only 41 percent of the 43 million adults with diagnosable mental health problems received treatment. The unmet treatment need for those with substance abuse problems (21 million adults) is even greater with only one in 10 individuals receiving specialty treatment.[1] The nation can do better. SAMHSA has a unique responsibility to focus on these preventable and treatable problems, which, if unaddressed, lead to significant individual, societal, and economic consequences.

Mission

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes this mission through providing leadership and devoting its resources, including programs, policies, information and data, contracts and grants to help demonstrate that:

- Behavioral Health is essential to health
- Prevention works
- Treatment is effective
- People recover

[1] Substance Abuse and Mental Health Services Administration, *Results from the National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series Rockville, MD: Substances Abuse and Mental Health Services Administration, 2014.

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Overview of Budget Request

The FY 2018 President's Budget Request is $3.9 billion, a decrease of $399.1 million from the FY 2017 Annualized CR. This budget request seeks to advance SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. The need to advance the nation's behavioral health is more apparent than ever. Along with other behavioral health priorities, the proposed budget aims to combat the nation's opioid crisis, address serious mental illness, and continue to develop and implement strategies to prevent suicide.

Key Budget Highlights:

Substance Abuse Prevention and Treatment Block Grant

The FY 2018 Budget Request is $1.9 billion. This funding serves as a critical safety net for substance abuse prevention and treatment services. The states and jurisdictions have the flexibility to plan, carry out, and evaluate substance abuse prevention, treatment, and recovery services that address the needs of individuals, families, and communities. Recognizing that prevention works, the statute requires that twenty percent of the SABG state allocation must be spent on primary prevention services.

State Targeted Response (STR) to the Opioid Crisis

The FY 2018 Budget Request is $500.0 million. In 2015, the United States lost 33,000 Americans due to opioid overdose-related deaths. The tragic rates of opioid abuse across the nation are unacceptable. The STR Program addresses this crisis directly and comprehensively. The program combats the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid abuse (including prescription opioids as well as illicit drugs such as heroin). In FY 2017, grants were awarded via formula to all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Northern Marianas, Micronesia, Palau, and American Samoa. The FY 2018 Budget Request supports the continuation of these grants. Knowledge gained through the first year of the program as well as through the newly created President's Commission on Combating Drug Addiction and the Opioid Crisis will be used to determine the resource allocations and priorities for the program's second year (FY 2018).

Suicide Prevention Activities

The FY 2018 Budget Request is $59.9 million. Suicide is a critical public health issue involving multiple psychological and social factors. It is one of the ten leading causes of death in the United States. Suicide rates have increased steadily for individuals of all ages from 1999 to 2014 with the rate increasing by 24 percent during this time period. SAMHSA supports a full complement of programs which address the nation's alarming rates of suicide. These include: the National Strategy for Suicide Prevention, which focuses on adult suicide prevention, the Garrett Lee Smith State and Campus Suicide Programs, which address youth and young adult suicide, and the Tribal Training and Technical Assistance Center, which aims to provide needed training and TA to tribal communities to develop comprehensive suicide prevention strategies.

Children's Mental Health Initiative

The FY 2018 Budget Request is $118.8 million. It is estimated that over 7.4 million children and youth in the United States have a serious mental disorder. Unfortunately, only 41 percent of those in need of mental health services actually receive treatment.[2] The request supports the continuation of the Children's Mental Health Services grants to enable states and communities to design comprehensive systems of care to develop strategies that address the needs of children and youth with serious emotional disturbances. As part of this budget request, SAMHSA seeks to develop and implement a services research demonstration effort based on the North American Prodrome Longitudinal Study funded by the National Institute of Mental Health. During the prodrome phase, a disease process has begun but is not yet diagnosable or inevitable. The demonstration will address whether community-based intervention during this phase can prevent the further development of serious emotional disturbances and ultimately serious mental illness. The project will examine the extent to which evidence-based early intervention for young people at clinical high risk for psychosis can be scaled up to mitigate or delay the progression of mental illness, reduce disability, and/or maximize recovery. The new effort will be funded from a 10 percent set-aside of the base program, and will focus on youth and young adults who are identified to be at clinical high risk for developing a first episode of psychosis. Funding of this new effort will not affect continuation funding of any CMHI-base funded program.

Community Mental Health Services Block Grant

The FY 2018 Budget Request is $415.5 million. This funding continues to serve as a safety net for mental health services for some of the nation's most vulnerable populations. By statute, MHBG funds must be used to address the needs of adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). SAMHSA will maintain the ten percent set-aside for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The set-aside funds help reduce costs to society, as intervening early helps prevent deterioration of functioning in individuals experiencing a first episode of serious mental illness.

[2] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 144863. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Overview of Performance

Consistent with the Government Performance and Results Modernization Act of 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) continues to refine its use of performance and evaluation data to measure impact and mitigate risk. Data-driven performance reviews help SAMHSA leadership analyze outcome data and learn the extent to which strategies work or need improvement. As impact is measured and reported, SAMHSA seeks to identify the conditions that foster success, address barriers, enable collaboration across programs, and promote overall efficiency.

SAMHSA reports performance information for 18 of the 21 HHS 2014-2018 Strategic Plan goals and objectives, HHS's Annual Performance Plan and Report, as well as the HHS Summary of Findings (also called the "Strategic Reviews"), which includes evidence of progress and leadership. SAMHSA continues to participate in an HHS agency priority goal to reduce cigarette smoking and is discussing contributions to three additional agency priority goals.

SAMHSA collects critical performance data on both output and outcome measures. Data on services programs include: abstinence from substance use, mental health functioning, overall physical health, criminal justice involvement, stable housing, social connectedness, and employment. Additionally, SAMHSA collects data on the numbers of people served, the numbers trained, and the number of training events held.

SAMHSA also maintains its commitment to utilize these performance data to manage and monitor its robust portfolio of grants. In FY 2017, SAMHSA reconfigured its approach to uniform data collection with the successful launch and implementation of SAMHSA's Performance Accountability and Reporting System (SPARS). This system provides a common data and reporting system for all SAMHSA discretionary grantees and allows for programmatic technical assistance on use of the data to enhance grantee performance monitoring and improve quality of service delivery.

All-Purpose Table
Substance Abuse and Mental Health Services Administration

(Dollars in thousands)

Program	FY 2016 Final	FY 2017 Annualized CR /1 12/10/16	FY 2018 President's Budget	FY 2018 President's Budget +/− FY 2017 Annualized CR
Mental Health				
Programs of Regional and National Significance	**414,609**	**413,843**	**277,419**	**−136,424**
Prevention and Public Health Fund (non-add)	*12,000*	*12,000*	--	*−12,000*
Children's Mental Health Services	119,026	118,800	118,800	--
Set-Aside for Youth in Prodrome Phase of Psychosis (non-add)	*11,903*	*11,880*	*11,880*	--
Projects for Assistance in Transition from Homelessness	64,635	64,512	64,512	−0.129
Protection and Advocacy for Individuals with Mental Illness	36,146	36,077	36,077	−0.286
Community Mental Health Services Block Grant	532,571	531,599	415,539	−116,060
Budget Authority (non-add)	*511,532*	*510,560*	*400,000*	*−110,560*
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*15,539*	*−5,500*
Total, Mental Health	**1,166,987**	**1,164,831**	**912,347**	**−252,484**
Budget Authority (non-add)	*1,133,948*	*1,131,792*	*896,808*	*−234,984*
Prevention and Public Health Fund (non-add)	*12,000*	*12,000*	--	*−12,000*
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*15,539*	*−5,500*
Substance Abuse Prevention				
Programs of Regional and National Significance	211,219	222,817	149,703	−73,114
Total, Substance Abuse Prevention	**211,219**	**222,817**	**149,703**	**−73,114**
Substance Abuse Treatment				
Programs of Regional and National Significance	337,345	341,708	341,738	+30
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*2,000*	--
State Targeted Response to the Opioid Crisis Grants /2	--	500,000	500,000	--
Substance Abuse Prevention and Treatment Block Grant	1,858,079	1,854,697	1,854,697	--
Budget Authority (non-add)	*1,778,879*	*1,775,497*	*1,775,497*	--
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	--
Total, Substance Abuse Treatment	**2,195,424**	**2,696,405**	**2,696,435**	**+30**
SAT Budget Authority (non-add)	*2,114,224*	*2,615,205*	*2,615,235*	*+30*
SAT PHS Evaluation Funds (non-add)	*81,200*	*81,200*	*81,200*	--
Health Surveillance and Program Support				
Health Surveillance and Program Support	**126,817**	**126,635**	**106,885**	**−19,750**
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*22,428*	*−8,000*
Public Awareness and Support	15,571	15,541	11,572	−3,969
Performance and Quality Information Systems	12,918	12,893	12,893	--
Agency-Wide Initiatives	51,000	50,905	998	−49,907
PHS Evaluation Funds (non-add)	*1,000*	*1,000*	*998*	*−1.901*
Data Request and Publications User Fees	1,500	1,500	1,500	--
Total, Health Surveillance and Program Support	**207,806**	**207,474**	**133,848**	**−73,626**
HSPS Budget Authority (non-add)	*174,878*	*174,546*	*108,922*	*−65,624*
HSPS PHS Evaluation Funds (non-add)	*31,428*	*31,428*	*23,426*	*−8,002*
Data Request and Publications User Fees (non-add)	*1,500*	*1,500*	*1,500*	--
TOTAL, SAMHSA Program Level	**3,781,436**	**4,291,527**	**3,892,333**	**−399,194**
Less Funds from Other Sources:				
Prevention and Public Health Fund (non-add)	*−12,000*	*−12,000*	--	*+12,000*
PHS Evaluation Funds	*−133,667*	*−133,667*	*-120,165*	*+13,502*
Data Request and Publications User Fees	*−1,500*	*−1,500*	*-1,500*	--
TOTAL, SAMHSA Budget Authority	**3,634,269**	**4,144,360**	**3,770,668**	**−373,692**
FTEs	**620**	**615**	**610**	**−5**

1/ Reflects Annualized CR ending April 28, 2017 including the ATB rescission, Cures, and Prevention Funding at FY 2016 minus rescissions.

2/ This program's funding is required by the 21st Century Cures Act to be subtracted from the estimate of discretionary budget authority under the Congressional Budget and Impoundment Control Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.

Budget Exhibits
Table of Contents

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Appropriations Language

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

MENTAL HEALTH

For carrying out titles III, V, and XIX of the PHS Act with respect to mental health, and the Protection and Advocacy for Individuals with Mental Illness Act, **[**$1,133,948,000**]***$896,808,000*: *Provided,* That notwithstanding section 520A(f)(2) of the PHS Act, no funds appropriated for carrying out section 520A shall be available for carrying out section 1971 of the PHS Act: *Provided further*, That in addition to amounts provided herein, **[**$21,039,000**]***$15,539,000* shall be available under section 241 of the PHS Act *to supplement funds otherwise available for mental health activities and to* carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1920(b) activities shall not exceed 5 percent of the amounts appropriated for subpart I of part B of title XIX: *Provided further, That up to 10 percent of the amounts made available to carry out the Children's Mental Health Services program may be used to carry out demonstration grants or contracts for early interventions with persons not more than 25 years of age at clinical high risk of developing a first episode of psychosis:* **[***Provided further,* That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated in this Act for fiscal year 2016: *Provided further*, That of the amount appropriated under this heading, $46,887,000 shall be for the National Child Traumatic Stress Initiative as described in section 582 of the PHS Act: *Provided further*, That notwithstanding section 565(b)(1) of the PHS Act, technical assistance may be provided to a public entity to establish or operate a system of comprehensive community mental health services to children with a serious emotional disturbance, without regard to whether the public entity receives a grant under section 561(a) of

such Act: *Provided further,* That States shall expend at least 10 percent of the amount each receives for carrying out section 1911 of the PHS Act to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset**]**: *Provided further*, That none of the funds provided for section 1911 of the PHS Act shall be subject to section 241 of such Act: *Provided further*, That of the funds made available under this heading, **[**$15,000,000**]***$14,971,000* shall be to carry out section 224 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 42 U.S.C. 290aa 22 note).

SUBSTANCE ABUSE TREATMENT

For carrying out titles III**[**,**]** *and* V**[**, and XIX**]** of the PHS Act with respect to substance abuse treatment and **[**section 1922(a) of the PHS Act **]***title XIX* of such Act with respect to *substance abuse treatment* and prevention, **[**$2,114,224,000**]***$2,115,235,000*: *Provided*, That in addition to amounts provided herein, **[**the following amounts**]***$81,200,000* shall be available under section 241 of the PHS Act**[**: (1) $79,200,000**]** *to supplement funds otherwise available for substance abuse treatment activities and* to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX**[**; and (2) $2,000,000 to evaluate substance abuse treatment programs**]**: *Provided further*, That none of the funds provided for section 1921 of the PHS Act shall be subject to section 241 of such Act.

SUBSTANCE ABUSE PREVENTION

For carrying out titles III and V of the PHS Act with respect to substance abuse prevention, **[**$211,219,000**]***$149,703,000*.

HEALTH SURVEILLANCE AND PROGRAM SUPPORT

For program support and cross-cutting activities that supplement activities funded under the headings "Mental Health", "Substance Abuse Treatment", and "Substance Abuse Prevention" in carrying out titles III, V, and XIX of the PHS Act and the Protection and Advocacy for Individuals with Mental Illness Act in the Substance Abuse and Mental Health Services Administration ("*SAMHSA*"), **[**$174,878,000**]***$108,922,000*: Provided, That in addition to amounts provided herein, **[**$31,428,000**]***$23,426,000* shall be available under section 241 of the PHS Act to supplement funds available to carry out national surveys on drug abuse and mental health, to collect and analyze program data, and to conduct public awareness and technical assistance activities: *Provided further*, That, in addition, fees may be collected for the costs of publications, data, data tabulations, and data analysis completed under title V of the PHS Act and provided to a public or private entity upon request, which shall be credited to this appropriation and shall remain available until expended for such purposes: *Provided further*, That amounts made available in this Act for carrying out section 501**[**(m)**]***(o)* of the PHS Act shall remain available through September 30, **[**2017**]***2019*: *Provided further*, That funds made available under this heading may be used to supplement program support funding provided under the headings "Mental Health", "Substance Abuse Treatment", and "Substance Abuse Prevention"**[.]**: *Provided further, That the Assistant Secretary for Mental Health and Substance Use may transfer discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated for the current fiscal year for SAMHSA in this Act between any of the accounts of SAMHSA with*

notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.

Note.—A full-year 2017 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Further Continuing Appropriations Act, 2017 (P.L. 114-254). The amounts included for 2017 reflect the annualized level provided by the continuing resolution.

Language Analysis

Language Provision	Explanation
Provided further, That in addition to amounts provided herein, **[**$21,039,000**]***$15,539,000* shall be available under section 241 of the PHS Act *to supplement funds otherwise available for mental health activities and to* carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities,	Sets the amount of Public Health Service Evaluation Fund dollars allocated to supplement the budget authority for programs and activities authorized under title XIX as well as under titles III and V.
Provided further, That up to 10 percent of the amounts made available to carry out the Children's Mental Health Services program may be used to carry out demonstration grants or contracts for early interventions with persons not more than 25 years of age at clinical high risk of developing a first episode of psychosis:	This provision permits SAMHSA to set aside up to 10 percent of CMHS for a demonstration with flexibility which would help address youth (which addresses 75 percent of first time psychotic episodes) instead of only children (which represent less than 50 percent of first time psychotic episodes) in the prodrome phase, which evidence indicates may prevent the further development of serious emotional disturbances and ultimately serious mental illness.

Language Analysis (continued)

Language Provision	Explanation
[*Provided further,* That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated in this Act for fiscal year 2016:	This language is no longer necessary due to changes made in the authorization by the 21st Century Cures Act.
Provided further, That of the amount appropriated under this heading, $46,887,000 shall be for the National Child Traumatic Stress Initiative as described in section 582 of the PHS Act:	The FY 2018 Budget pursues this policy using administrative authority. A statutory earmark is not required.
Provided further, That notwithstanding section 565(b)(1) of the PHS Act, technical assistance may be provided to a public entity to establish or operate a system of comprehensive community mental health services to children with a serious emotional disturbance, without regard to whether the public entity receives a grant under section 561(a) of such Act:	Authorization for these activities is provided by the 21st Century Cures Act.
Provided further, That States shall expend at least 10 percent of the amount each receives for carrying out section 1911 of the PHS Act to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset:	This language is no longer necessary because this requirement on State expenditures was added to the authorization by the 21st Century Cures Act.

Language Analysis (continued)

Language Provision	Explanation
For carrying out titles III *and* V of the PHS Act with respect to substance abuse treatment and title XIX of such Act with respect to substance abuse treatment and prevention,	Sets out the budget authority for the Substance Abuse Treatment appropriation.
Provided, That in addition to amounts provided herein, **[**the following amounts **]***$81,200,000* shall be available under section 241 of the PHS Act**[**: (1) $79,200,000**]** *to supplement funds otherwise available for substance abuse treatment activities and* to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX**[**; and (2) $2,000,000 to evaluate substance abuse treatment programs**]**:	Sets the amount of Public Health Service Evaluation Fund dollars allocated to supplement the budget authority available for programs and activities authorized under title XIX as well as under titles III and V. These evaluation efforts will enable the gathering and dissemination of best practices.

Language Analysis (continued)

Language Provision	Explanation
Provided further, That the Assistant Secretary for Mental Health and Substance Use may transfer discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated for the current fiscal year for SAMHSA in this Act between any of the accounts of SAMHSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.	Establishes a permissive authority to transfer a small portion of funds between any of the SAMHSA accounts in order to ensure that multiple accounts are not a barrier to the efficient administration of the agency, or appropriate responsiveness to emerging issues with congressional notification.

Amounts Available for Obligation

(Whole dollars)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS, Ag, or, Interior)	$3,634,269,000	$4,144,360,000	$3,770,668,000
Across-the-board reductions (L/HHS, Ag, or Interior)	---	---	---
Subtotal, Appropriation (L/HHS, Ag, or Interior)	3,634,269,000	4,144,360,000	3,770,668,000
Rescission (other appropriation bills, provide PL ##-###)	---	---	---
Subtotal, adjusted appropriation	3,634,269,000	4,144,360,000	3,770,668,000
Total, Discretionary Appropriation	**3,634,269,000**	**4,144,360,000**	**3,770,668,000**
Mandatory Appropriation:			
Transfer from the Prevention and Public Health Funds	12,000,000	12,000,000	---
Subtotal, adjusted mandatory appropriation	12,000,000	12,000,000	---
Offsetting collections from:			
Federal Source	133,667,000	133,667,000	120,165,000
Data Request and Publications User Fees	1,500,000	1,500,000	1,500,000
Unobligated balance, start of year	289,482	973,128	---
Unobligated balance, end of year	1,020,913	968,063	880,774
Unobligated balance, lapsing	---	---	---
Total obligations	**$3,781,436,000**	**$4,291,527,000**	**$3,892,333,000**

Summary of Changes

(Whole dollars)

2017	
Total estimated budget authority	$4,144,360,000
(Obligations)	4,144,360,000
2018	
Total estimated budget authority	3,770,668,000
(Obligations)	3,770,668,000
Net Change	**−$373,692,000**

	FY 2018 PB FTE	FY 2018 PB BA	FY 2018 +/- FY 2017 FTE	FY 2018 +/− FY 2017 BA
Increases:				
A. Built-in:				
1. Annualization of 2017 commissioned corps pay increase		$8,282,276		+$856,584
2. Annualization of 2017 civilian pay increase		83,591,849		−661,171
Subtotal, Built-in Increases		**91,874,125**		**+195,413**
A. Program:				
1. Pregnant and Postpartum Women		30,000		+30,000
Subtotal, Program Increases		**30,000**		**+30,000**
Total Increases	**---**	**---**	**---**	**+225,413**
Decreases:				
A. Built-in:				
1. Absorption of built-in increases				−195,413
Subtotal, Built-in Decreases				**−195,413**
A. Program:				
1. Mental Health		896,808,000		−234,984,000
2. Substance Abuse Prevention PRNS		149,703,000		−73,114,000
3. Health Surveillance		33,842,000		−5,384,000
4. Program Support		73,043,000		−6,366,000
5. Public Awareness and Support		11,572,000		−3,969,000
6. Agency-Wide Initiatives		998		−49,905,000
Subtotal, Program Decreases		**1,164,968,998**		**−373,722,000**
Total Decreases	**---**	**---**	**---**	**−373,917,413**
Net Change	---	$---	**---**	**−$373,692,000**

Summary of Changes (Continued)

(Whole dollars)

2017	
Total estimated mandatory	$12,000,000
(Obligations)	12,000,000
2018	
Total estimated mandatory	-
(Obligations)	-
Net Change	**−$12,000,000**

	FY 2018 PB FTE	**FY 2018 PB Mandatory**	**FY 2018 +/- FY 2017 FTE**	**FY 2018 +/− FY 2017 Mandatory**
Increases:				
A. Program:				
1. Mental Health		$0		$0
Subtotal, Program Increases		**0**		**---**
Decreases:				
A. Program:				
1. Mental Health PRNS		---		−12,000,000
Subtotal, Program Decreases	**---**	**---**	**---**	**−12,000,000**
Net Change	---	**$---**	**---**	**−$12,000,000**

Budget Authority by Activity

(Dollars in thousands)

Program	FY 2016 Final	FY 2017 Annualized CR /1 12/10/16	FY 2018 President's Budget	FY 2018 President's Budget '+/− FY 2017 Annualized CR
Mental Health				
Programs of Regional and National Significance	**414,609**	**413,843**	**277,419**	**−136,424**
Prevention and Public Health Fund (non-add)	*12,000*	*12,000*	--	*−12,000*
Children's Mental Health Services	119,026	118,800	118,800	--
Projects for Assistance in Transition from Homelessness	64,635	64,512	64,512	--
Protection and Advocacy for Individuals with Mental Illness	36,146	36,077	36,077	--
Community Mental Health Services Block Grant	532,571	531,599	415,539	−116,060
Budget Authority (non-add)	*511,532*	*510,560*	*400,000*	*−110,560*
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*15,539*	*−5,500*
Total, Mental Health	**1,166,987**	**1,164,831**	**912,347**	**−252,484**
Substance Abuse Prevention				
Programs of Regional and National Significance	211,219	222,817	149,703	−73,114
Total, Substance Abuse Prevention	**211,219**	**222,817**	**149,703**	**−73,114**
Substance Abuse Treatment				
Programs of Regional and National Significance	337,345	341,708	341,738	+30
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*2,000*	--
State Targeted Response to the Opioid Crisis Grants /2	--	500,000	500,000	--
Substance Abuse Prevention and Treatment Block Grant	1,858,079	1,854,697	1,854,697	-0
Budget Authority (non-add).	*1,778,879*	*1,775,497*	*1,775,497*	*-0*
PHS Evaluation Funds (non-add).	*79,200*	*79,200*	*79,200*	--
Total, Substance Abuse Treatment	**2,195,424**	**2,696,405**	**2,696,435**	**+30**
Health Surveillance and Program Support				
Health Surveillance and Program Support	**126,817**	**126,635**	**106,885**	**−19,750**
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*22,428*	*−8,000*
Public Awareness and Support	15,571	15,541	11,572	−3,969
Performance and Quality Information Systems	12,918	12,893	12,893	--
Agency-Wide Initiatives	51,000	50,905	998	−49,907
PHS Evaluation Funds (non-add)	*1,000*	*1,000*	*998*	*−2.000*
Data Request and Publications User Fees	1,500	1,500	1,500	--
Total, Health Surveillance and Program Support	**207,806**	**207,474**	**133,848**	**−73,626**
TOTAL, SAMHSA Program Level	**3,781,436**	**4,291,527**	**3,892,333**	**−399,194**
Less Funds from Other Sources:				
Prevention and Public Health Fund (non-add)	*−12,000*	*−12,000*	--	*+12,000*
PHS Evaluation Funds	*−133,667*	*−133,667*	*−120,165*	*+13,502*
Data Request and Publications User Fees.	*−1,500*	*−1,500*	*−1,500*	--
TOTAL, SAMHSA Budget Authority	**3,634,269**	**4,144,360**	**3,770,668**	**−373,692**
FTEs	**620**	**615**	**610**	**−5**

1/ Reflects Annualized CR ending April 28, 2017 including the ATB rescission, Cures, and Prevention Funding at FY 2016 minus rescissions.

2/ This program's funding is required by the 21st Century Cures Act to be subtracted from the estimate of discretionary budget authority under the Congressional Budget and Impoundment Control Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.

Authorizing Legislation

(Whole dollars)

Program Description/PHS Act:	FY 2017 Amount Authorized	FY 2017 Appropriations Act	FY 2018 Amount Authorized	FY 2018 President's Budget
Grants for the Benefit of Homeless Individuals				
Sec. 506	Expired	$41,225,000	$41,304,000	$41,225,000
Residential Treatment Programs for Pregnant and Postpartum Women				
Sec. 508	Expired	$15,900,715	$16,900,000	$15,930,715
Priority Substance Abuse Treatment Needs of Regional and National Significance				
Sec. 509*	Expired	$753,033,073	$751,954,788	$753,033,213
Substance Abuse Treatment Services for Children and Adolescents				
Sec. 514*	Expired	$29,548,721	$29,548,721	$29,548,721
Priority Substance Abuse Prevention Needs of Regional and National Significance				
Sec. 516*	Expired	$215,830,780	$143,703,077	$142,715,925
Programs to Reduce Underage Drinking				
Sec. 519B*	Expired	$ 6,986,693	$6,000,000	$ 6,987,000
Priority Mental Health Needs of Regional and National Significance				
Sec. 520A*	Expired	$227,141,381	$277,419,000	$135,471,340
Youth Interagency Research, Training, and Technical Assistance Centers				
Sec. 520C*	Expired	$5,976,617	$5,976,617	$5,976,617
Suicide Prevention for Children and Youth				
Sec. 520E*	Expired	$23,382,465	$35,382,465	$35,382,465
Sec. 520E2*	Expired	$6,475,666	$6,475,666	$6,475,666
Grants for Jail Diversion Programs				
Sec. 520G*	Expired	$4,260,885	$4,269,000	$4,260,885
Awards for Co-locating Primary and Specialty Care in Community-based Mental Health Settings				
Sec. 520K*	Expired	$49,782,184	$51,878,000	---
PATH Grants to States				
Sec. 535(a)	Expired	$64,512,129	$64,512,129	$64,512,052
Community Mental Health Services for Children with Serious Emotional Disturbances				
Sec. 565 (f)	Expired	$118,799,732	$118,799,732	$118,799,732
Children and Violence Program				
Sec. 581*	Expired	$23,055,089	$23,055,089	$ 23,055,089
Grants for Persons who Experience Violence Related Stress				
Sec. 582	Expired	$46,797,868	$46,797,868	$46,797,868
Community Mental Health Services Block Grants				
Sec. 1920(a)	Expired	$510,559,578	$400,000,000	$400,000,000
Substance Abuse Prevention and Treatment Block Grants				
Sec. 1935(a)	Expired	$1,775,497,351	$1,858,079,000	$1,775,497,351

Authorizing Legislation (Continued)

(Whole dollars)

	FY 2017 Amount Authorized	FY 2017 Appropriations Act	FY 2018 Amount Authorized	FY 2018 President's Budget
Other Legislation/Program Description				
Protecting Access to Medicare Act of 2014				
P.L. 113-93, Sec. 224	$15,000,000	$14,971,485	$15,000,000	$20,000,000
Protection and Advocacy for Individuals with Mental Illness Act				
P.L. 99-319, Sec. 117	Expired	$36,077,286	Expired	$36,077,286
Health Surveillance and Program Support				
Program Management, Sec. 501	Indefinite	$79,407,758	Indefinite	$73,043,000
Total, Program Management	Indefinite	$79,407,758	Indefinite	$73,043,000
Heath Surveillance, Sec. 501, 505	Indefinite	$16,798,066	Indefinite	$ 11,414,000
Public Awareness and Support (FY12)	Indefinite	$15,541,400	Indefinite	$ 11,572,000
PQIS(FY12)	Indefinite	$12,893,443	Indefinite	$ 12,893,000
Agency-Wide Initiatives	Indefinite	$49,905,049	Indefinite	---
TOTAL, SAMHSA Budget Authority	$15,000,000	$4,144,360,414	$3,897,055,152	$3,770,668,925
Mandatory Legislation/Program Description				
Prevention and Public Health Fund				
P.L. 111-148, Sec. 4002	N/A	---	N/A	---
Mental Health Initiative	N/A	---	N/A	---
Expanding Access to Treatment to Reduce Prescription Drug Abuse and Heroin Use	N/A	---	N/A	---
TOTAL, SAMHSA Mandatory	---	---	---	---

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

Appropriations History

(Whole dollars)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
FY 2009					
General Fund Appropriation:					
Base	$3,024,967,000	$3,303,265,000	$3,257,647,000	$3,334,906,000	
P.L. 111-8					
Subtotal	$3,024,967,000	$3,303,265,000	$3,257,647,000	$3,334,906,000	
FY 2010					
General Fund Appropriation:					
Base	$3,393,882,000	$3,429,782,000	$3,419,438,000	$3,431,116,000	1/
P.L. 111-117					
Subtotal	$3,393,882,000	$3,429,782,000	$3,419,438,000	$3,431,116,000	
FY 2011					
General Fund Appropriation:					
Base	$3,541,362,000	$3,565,360,000	$3,576,184,000	$3,386,311,000	
P.L. 112-10					
Subtotal	$3,541,362,000	$3,565,360,000	$3,576,184,000	$3,386,311,000	
FY 2012					
General Fund Appropriation:					
Base	$3,386,903,000	$3,096,914,000	$3,354,637,000	$3,347,020,000	2/
P.L. 112-74					
Subtotal	$3,386,903,000	$3,096,914,000	$3,354,637,000	$3,347,020,000	
FY 2013					
General Fund Appropriation:					
Base	$3,151,508,000	---	$3,472,213,000	$3,172,154,778	3/
S.R. 112-176					
Subtotal	$3,151,508,000	---	$3,472,213,000	$3,172,154,778	
FY 2014					
General Fund Appropriation:					
Base	$3,347,951,097	---	$3,529,944,000	$3,434,935,000	4/
S.R. 113-071					
Subtotal	$3,347,951,097	---	$3,529,944,000	$3,434,935,000	

1/ Reflects a $508 thousand transfer to HHS.
2/ Reflects a 0.189 percent across-the-board Rescission from the P.L. 112-74, and $953,809 Ryan White transfer.
3/ Reflects the annualized level provided by the continuing resolution.
4/ Reflects the whole year appropriation.

Appropriations History (continued)

(Whole dollars)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
FY 2015					
General Fund Appropriation:					
Base	$3,297,669,000	---	$3,431,878,000	$3,474,045,000	5/
P.L. 113-235					
Subtotal	$3,297,669,000	---	$3,431,878,000	$3,474,045,000	
FY 2016					
General Fund Appropriation:					
Base	$3,395,663,000	$3,642,710,000	$3,314,817,000	$3,634,269,000	6/
P.L. 114-113					
Subtotal	$3,395,663,000	$3,642,710,000	$3,314,817,000	$3,634,269,000	
FY 2017					
General Fund Appropriation:					
Comprehensive Addiction and Recovery Act				$17,000,000	7/
21st Century Cures Act				$500,000,000	8/
Base	$3,488,783,000	$4,211,603,000	$3,739,577,000	$4,144,360,000	9/
Subtotal	$3,488,783,000	$4,211,603,000	$3,739,577,000	$4,144,360,000	
FY 2018					
General Fund Appropriation:					
Comprehensive Addiction and Recovery Act				$17,000,000	7/
21st Century Cures Act				$500,000,000	8/
Base	$3,779,668,000				
Subtotal	$3,779,668,000				

5/ Reflects the whole year appropriation.
6/ Reflects the whole year appropriation.
7/ Reflects the Annualized Continuing Resolution through April 28, 2017.
8/ Reflects the additional amount provided to the Secretary of Health and Human Services to carry out the authorizations in the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–198), at a rate for operations of $17,000,000.
9/ Reflects the Annualized Continuing Resolution..

SAMHSA
Mental Health
Table of Contents

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Mental Health Appropriation

(Dollars in thousands)

Program Activities	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Programs of Regional and National Significance	$414,609	$413,844	$277,419	−136,424
Prevention and Public Health Fund (non-add)	*12,000*	*12,000*	---	*−12,000*
Children's Mental Health Services	119,026	118,800	118,800	---
Projects for Assistance in Transition From Homelessness.	64,635	64,512	64,512	---
Protection and Advocacy For Individuals with Mental Illness	36,146	36,077	36,077	---
Community Mental Health Services Block Grant	532,571	531,599	415,539	−116,060
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*15,539*	*−5,500*
Total, Mental Health	**$1,166,987**	**$1,164,831**	**$912,347**	**-252,484**

The Mental Health FY 2018 Budget Request is $912.3 million, a decrease of $252.5 million from the FY 2017 Annualized CR. The request includes $896.8 million in Budget Authority and $15.5 million in PHS Evaluation Funds.

Programs of Regional and National Significance (PRNS)
Mental Health Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Capacity:				
National Child Traumatic Stress Network	46,887	46,798	46,798	---
Youth Violence Prevention	23,099	23,055	23,055	---
Project AWARE	64,865	64,742	---	−64,742
Project AWARE State Grants (non-add	*49,902*	*49,807*	---	*−49,807*
Mental Health First Aid (non-add)	*14,963*	*14,935*	---	*−14,935*
Healthy Transitions	19,951	19,913	---	−19,913
Children and Family Programs	6,458	6,446	6,446	---
Consumer and Family Network Grants	4,954	4,945	4,945	---
Project LAUNCH	34,555	34,489	34,489	---
Mental Health System Transformation and Health Reform	3,779	3,772	3,772	---
Primary and Behavioral Health Care Integration	49,877	49,782	---	−49,782
Suicide Prevention	60,032	59,940	59,940	---
National Strategy for Suicide Prevention (non-add)	*2,000*	*1,996*	*1,996*	---
Suicide Lifeline (non-add)	*7,198*	*7,184*	*7,184*	---
GLS - Youth Suicide Prevention - States (non-add).	*35,427*	*35,382*	*35,382*	---
Prevention & Public Health Fund (non-add	*12,000*	*12,000*	---	*−12,000*
GLS - Youth Suicide Prevention - Campus (non-add)	*6,488*	*6,476*	*6,476*	---
GLS - Suicide Prevention Resource Center (non-add)	*5,988*	*5,977*	*5,977*	---
AI/AN Suicide Prevention Initiative (non-add	*2,931*	*2,925*	*2,925*	---
Homelessness Prevention Programs	30,696	30,638	30,638	---
Minority AIDS	9,224	9,206	4,206	−5,000
Criminal and Juvenile Justice Programs	4,269	4,261	4,261	---
Seclusion and Restraint	1,147	1,145	1,145	---
Assisted Outpatient Treatment for Individuals with SMI	15,000	14,971	14,971	---
Assertive Community Treatment for Individuals with SMI	---	---	5,000	5,000
Tribal Behavioral Health Grants	15,000	14,971	14,971	---
Subtotal, Capacity	**389,793**	**389,074**	**254,637**	**−134,437**
Science and Service:				
Primary and Behavioral Health Care Integration TTA	1,991	1,987	---	−1,987
Practice Improvement and Training	7,828	7,813	7,813	---
Consumer and Consumer-Supporter TA Centers	1,918	1,914	1,914	---
Disaster Response	1,953	1,949	1,949	---
Homelessness	2,296	2,292	2,292	---
Minority Fellowship Program.	8,059	8,044	8,044	
HIV/AIDS Education	771	770	770	---
Subtotal, Science and Service	**24,816**	**24,769**	**22,782**	**−1,987**
Total, PRNS	**$414,609**	**$413,843**	**$277,419**	**−$136,424**

Authorizing Legislation ..... Sections 520A of the Public Health Service Act
FY 2018 Authorization $394,550
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities……..……States, Federally Recognized, American Indian/Alaska Native tribe or tribal organizations, Indian Health Service-operated and contracted health facilities and programs, other public and private nonprofit entities

National Child Traumatic Stress Network

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
National Child Traumatic Stress Network	$46,887	$46,798	$46,798	$---

Authorizing Legislation .....Section 582 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Local Governments, Tribes, Institutions of Higher Education, and Community Organizations

Program Description and Accomplishments

Child traumatic stress is a pervasive and potentially life changing experience that affects tens of thousands of children each year. Child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations that overwhelm their ability to cope with what they have experienced. Child traumatic stress can interfere with a wide range of childhood developmental capabilities, including social and educational functioning. There is strong evidence that the negative impact of child trauma progresses into adulthood and increases the likelihood of later adverse physical and behavioral health outcomes if not recognized and addressed early in life.[3,4] Studies show that 25 percent to 80 percent or more of children and adolescents are exposed to traumatic events, with many exposed to multiple traumatic events.[5] While the effects of trauma and exposure to violence are found in all service sectors, it is particularly prominent among youth with mental illness and/or drug/alcohol addiction involved in the child welfare, and juvenile justice systems. Studies show that youth in foster care can have rates of Post-Traumatic Stress Disorder that are nearly double those of combat veterans.[6]

Established in 2000, the National Child Traumatic Stress Initiative (NCTSI) aims to improve behavioral health services and interventions for children and adolescents exposed to traumatic events. SAMHSA has provided funding for a national network of grantees known as the National Child Traumatic Stress Network (NCTSN) to develop and promote effective community practices for children and adolescents exposed to a wide array of traumatic events. The NCTSN has grown from a collaborative network of 17 sites to more than 225 funded and affiliate centers located nationwide in universities, hospitals, and other diverse community-based organizations with thousands of national and local partners. The NCTSN's mission is to raise the standard of care and improve access to evidence-based services for children experiencing trauma, their families, and communities. A rapidly expanding component of this work has been the development of

[3] Putnam, K.T., Harris, W.W., Putnam, F.W. (2013). Synergistic childhood adversities and complex adult psychopathology. Journal of Traumatic Stress, 26(4), 435-442.
[4] Kerker, B.D., Zhang, J., Nadeem, E., Stein, R.E., Hurlburt, M.S., Heneghan, A., Landsverk, J., McCue Horwitz S.(2015). Adverse Childhood Experiences and mental health, chronic medical conditions, and development in young children. Academy of Pediatrics, 13(15), 00173-00174.
[5] Fairbank, J.A. (2008). The epidemiology of trauma, and trauma related disorders in children and youth. PTSD Research Quarterly, (19), 1050-1835.
[6] Pecora, P.J., Kessler, R.C., Williams, J., O'Brien, K., Downs, A.C., English, E., Holmes, K. (2005). Improving family foster care: Findings from the northwest foster care alumni study. Casey Family Programs. Retrieved from http://www.casey.org/resources/publications/ImprovingFamilyFosterCare.htm

resources and delivery of training and consultation to support the development of trauma-informed child-serving systems. Network members work together within and across diverse settings, including a wide variety of governmental and non-governmental organizations.

Data collected in FY 2016 demonstrate that the current NCTSN grantees have provided evidence-based treatment to over 47,000 children, adolescents, and family members. Seventy-seven percent reported positive functioning at six months, far exceeding the target of 65 percent. In addition, thousands more youth and families have benefited indirectly from the training and consultation provided by NCTSN grantees to organizations not receiving direct NCTSN funding enabling these organizations to deliver evidence-based trauma interventions.

The NCTSN continues to be a principal source of child-trauma information and training for the nation. In FY 2016, NCTSN grantee sites provided trauma-informed training to over 200,000 individuals. Since its inception, the NCTSN has provided training on best practices and other aspects of child trauma to over one million participants throughout the country. The NCTSI's newly created Helping Kids Recover and Thrive Campaign generated 100 online social media touches (e.g., Facebook, Twitter, etc.). This campaign informed the public about the efforts and resources available through the NCTSI.

In FY 2016, SAMHSA awarded 82 new five-year NCTSI grants for the program. SAMHSA will continue to encourage grantees to disseminate information regarding evidence-based interventions for the prevention and treatment of childhood trauma so more children can benefit from proven practices. In FY 2017, SAMHSA will support 82 grant continuations of the program.

Funding History

Fiscal Year	Amount
FY 2014	$45,887,000
FY 2015	$45,887,000
FY 2016	$46,887,000
FY 2017	$46,798,000
FY 2018	$46,798,000

Budget Request

The FY 2018 Budget Request is $46.8 million, level with the FY 2017 Annualized CR. SAMHSA requests funding to continue support for 82 continuation grants for the improvement of mental disorder treatment, services, and interventions for children and adolescents exposed to traumatic events and plans to provide trauma-informed services for children and adolescents as well as provide training.

Outputs and Outcomes Table

Program: National Child Traumatic Stress Network

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
3.2.02a Increase the percentage of children receiving trauma informed services who report positive functioning at 6 month follow-up. (Outcome)	FY 2016: 77 % Target: 65.9 % (Target Exceeded)	77 %	77 %	Maintain
3.2.23 Increase the unduplicated count of the number of children and adolescents receiving trauma-informed services. (Outcome)	FY 2016: 52,603 Target: 48,872[1] (Target Exceeded)	48,872	48,872	Maintain
3.2.24 Increase the number of child-serving professionals trained in providing trauma-informed services. (Outcome)	FY 2016: 204,122 Target: 225,710 (Target Not Met but Improved)	225,710	225,710	Maintain

[1]Target has been revised to include an additional data source. Previously, the measure greatly underreported the number of children benefitting from NCTSI evidence–based practices as it only included those children who received services provided by the NCTSI Category III grantees. By including the additional data source, the total now includes the number of children receiving services from providers trained by NCTSI Category II and Category III grantees.

Youth Violence Prevention

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Youth Violence Prevention	$23,099	$23,055	$23,055	$---

Authorizing Legislation ..... Sections 501 and 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... State Education Agencies, State Mental Health Authorities, Tribes and Territories

Program Description and Accomplishments

Although dimensions of youth violence have decreased in parts of the country, youth violence remains a public health problem in the United States. Studies show that fewer students are engaging in fights.[7] The percent of high school students who have been in a physical fight decreased from 32.8 percent in 2011 to 22.6 percent in 2015.[8] Fights on school property also decreased during the past five years, with 11 percent of high school students having been in a fight on school property in 2011, compared to 7.8 percent in 2015. However, other indicators of violence have not significantly improved in recent years. Nationwide, in 2015, 16.2 percent of students had carried a weapon (e.g., gun, knife, or club) on at least one day during the 30 days before the survey. In 2015, an estimated 20 percent of high school students reported being bullied on school property and 15.5 percent reported being bullied electronically.

The Safe Schools/Healthy Students (SS/HS) Initiative is a discretionary grant program that seeks to create healthy learning environments that help students thrive, succeed in school, and build healthy relationships. For more than a decade, the SS/HS Initiative has successfully decreased violence and increased the number of students receiving mental health services, supporting programs in more than 300 local school districts.[9] The initiative implements an enhanced, coordinated, and comprehensive plan of activities, programs, and services that promote healthy childhood development, prevent violence, and prevent alcohol and drug use. Grantees are required to develop local strategic plans that address five required elements: 1) safe school environments and violence prevention activities; 2) alcohol, tobacco, and other drug prevention activities; 3) student behavioral, social, and emotional supports; 4) mental health services; and 5) early childhood social and emotional learning programs.

In addition to the SS/HS grants, SAMHSA has supported an ongoing SS/HS State Program evaluation. The final SS/HS evaluation report will be completed in September 2017. This evaluation will focus on four areas:

[7] The *2013 Youth Risk Behavior Surveillance System – United States complete reference*
[8] The *2013 Youth Risk Behavior Surveillance System – United States complete reference*
[9] http://www.sshs.samhsa.gov/initiative/currentinit.aspx

1) Assessing the extent to which comprehensive school violence prevention initiatives, guided by the SS/HS framework, are implemented at the state and community level;
2) Determining the breadth and volume of activities necessary to achieve coordination across multiple service systems;
3) Identifying and describing the elements or activities associated with improved child wellness; and
4) Estimating the extent to which states and communities improve access to mental health services for target populations and reduce subpopulation disparities in access, services, and outcomes.

In FY 2016, SAMHSA provided continuation funds for eight four-year grants through the SS/HS State Planning, Local Education Agency and Local Community program grants (SS/HS State program). In FY 2016, SAMHSA awarded continuation funds for the fourth year for these same grants and contracts. This includes adjusting the applicant to the State Education Agency, with required partnership between the State Children's Behavioral/Mental Health Agency.

Funding History

Fiscal Year	Amount
FY 2014	$23,099,000
FY 2015	$23,099,000
FY 2016	$23,099,000
FY 2017	$23,055,000
FY 2018	$23,055,000

Budget Request

The FY 2018 Budget Request is $23.1 million, level with the FY 2017 Annualized CR. The budget request supports the continuation of 7 grants to implement an enhanced, coordinated, and comprehensive plan of activities, programs, and services that promote healthy childhood development, prevent violence, and prevent alcohol and drug use. Grantees are required to develop local strategic plans that address four required elements: 1) promoting early childhood social and emotional learning and development; 2) promoting emotional, physical and behavioral health (mental health promotion and substance use prevention); 3) connecting families, schools, and communities; and 4) creating safe and violence-free schools.

Outputs and Outcomes Table

Program: Youth Violence Prevention -Safe Schools Healthy Students State and Tribal

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/− FY 2018 Target
3.2.46 Increase the number of individuals who receive training in prevention or mental health promotion (Intermediate Outcome)	FY 2016: 9,840 Target: 680 (Target Exceeded)	4,787	4,787	Maintain
3.2.47 Increase the number of people in mental health and related workforce trained in mental health-related practices/activities that are consistent with the goals of the grant (Output)	FY 2016: 23,569 Target: 737 (Target Exceeded)	2,070	2,070	Maintain
3.2.48 Increase the number of state and local policy changes completed as a result of the grant (Output)	FY 2016: 23 Target: 2 (Target Exceeded)	12	12	Maintain
3.2.49 Increase the number of organizations that entered into a formal written inter/intra organizational agreements (such as an MOU) to improve mental health related practices/activities that are consistent with the goals of the grant (Output)	FY 2016: 274 Target: 52 (Target Exceeded)	52	52	Maintain
3.2.50 Decrease the percentage of middle and high school students who report current alcohol use (Intermediate Outcome)	FY 2016: 22.2 % Target: 18.1 % (Target Not Met but Improved)	25 %	25 %	Maintain

Project AWARE

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Project AWARE	$64,865	$64,742	$---	−$64,742
Project AWARE State Grants (non-add)	*49,902*	*49,807*	---	*−49,807*
Mental Health First Aid (non-add)	*14,963*	*14,935*	---	*−14,935*

Authorizing Legislation ..... Sections 501 and 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....State and Local Education Agencies, Local Governmental Entities, Community Organizations and Provider Organizations, Community Colleges, Networks, National Non-Profit Organizations, States, and Tribes

Program Description and Accomplishments

Project AWARE is made up of three components: Project AWARE State Educational Agency (SEA) grants, Mental Health First Aid Grants, and Resilience in Communities After Stress and Trauma Grants. Project AWARE State Educational Agency grants are awarded to State Education Authorities (SEAs) to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services. Mental Health First Aid grants provide supports to teachers and other individuals who work with youth to help schools and communities understand, recognize, and response to signs of mental health issues and/or substance abuse in children and youth. Resiliency in Communities After Stress and Trauma (ReCAST) program assists high-risk youth and families and promotes resilience in communities that have recently faced civil unrest through implementation of evidence-based, violence prevention and community youth engagement programs as well as linkages to trauma-informed behavioral health services.

In FY 2016, SAMHSA supported the continuation of 89 grants (20 AWARE SEA grants and 69 MHFA Community grants) and related contracts. In addition, SAMHSA awarded eight new grants under the *Resiliency in Communities After Stress and Trauma* (ReCAST) program. The program assists high-risk youth and families and promotes resilience in communities that have recently faced civil unrest through implementation of evidence-based, violence prevention and community youth engagement programs as well as linkages to trauma-informed behavioral health services.

In FY 2017, SAMHSA will support the continuation of 97 grants (20 AWARE SEA grants, 69 MHFA Community grants, and 8 ReCAST grants), a new cohort of ReCAST grants, technical assistance, and evaluation activities.

Funding History

Fiscal Year	Amount
FY 2014	$54,865,000
FY 2015	$54,865,000
FY 2016	$64,865,000
FY 2017	$64,742,000
FY 2018	$0

Budget Request

The FY 2018 Budget Request is $0.0, a decrease of $64.7 million from the FY 2017 Annualized CR. SAMHSA is eliminating this program to reduce duplication of efforts. Additionally, SAMHSA has developed significant knowledge and evidence for states to begin implementing and bringing to scale these efforts; SAMHSA will continue to ensure this knowledge is disseminated.

Outputs and Outcomes Table

Program: Project AWARE

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
3.2.18 Increase the number of children served. (Output)	FY 2016: 7,313,144 Target: 750,000 (Target Exceeded)	4,696,119		Elimination
3.2.19 Increase the number of children referred to mental health or related services. (Output)	FY 2016: 145,830 Target: 16,508 (Target Exceeded)	16,508		Elimination
3.2.39 Increase the number of individuals who have received training in prevention or mental health promotion (Outcome)	FY 2016: 63,581 Target: 145,356 (Target Not Met)	145,356		Elimination

Healthy Transitions

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Healthy Transitions	$19,951	$19,913	$---	−$19,913

Authorizing Legislation .....Section 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Tribes

Program Description and Accomplishments

Youth and young adults with serious mental illness, along with those with co-occurring mental illness and drug/alcohol addiction, face a more difficult transition to adulthood than do their peers. Nearly 20 percent of young adults aged 18 to 25 living in U.S. households had a diagnosable mental health condition in the past year. Of these, more than 1.3 million had a disorder so serious, such as schizophrenia, bipolar disorder, and major depression, that it compromised their ability to function. Compared to their peers, these young people were significantly more likely to experience homelessness,[10] be arrested,[11] drop out of school,[12] and be unemployed.[13] It is important to identify these young people, develop appropriate outreach and engagement processes, and facilitate access to effective clinical and supportive interventions. Outreach and engagement are essential to these youth and young adults, and their families, as many are disconnected from social and other community supports.

In FY 2014, SAMHSA provided $20.0 million for the Healthy Transitions initiative. The Healthy Transitions program awarded five-year grants to 17 states to improve access to mental disorder treatment and related support services for young people aged 16 to 25 who either have, or are at risk of developing, a serious mental health condition. Individuals who are 16 to 25 years old are at high risk of developing a mental illness or drug/alcohol addiction and are at high risk for suicide. Unfortunately, these youth are among the least likely to seek help.[14] Through this program, states are expanding services, developing family and youth networks for information sharing and peer support, and disseminating best practices for services for these young individuals.
In FY 2016, SAMHSA supported 17 Healthy Transitions continuation grants and technical assistance and evaluation contracts. In FY 2017, SAMHSA will continue to support the continuation grants and the technical assistance and evaluation contracts.

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[10] Embry, L. E., Vander Stoep, A., Evens, C., Ryan, K. D., & Pollock, A. (2009). Risk factors for homelessness in adolescents released from psychiatric residential treatment. Journal of the American Academy of Child and Adolescent Psychiatry, 39(10), 1293-1299.
[11] Davis, M., Banks, S. M., Fisher, W. H., Gershenson, B.,& Grudzinskas, A. J. (2007). Arrests of adolescents clients of a public mental health system during adolescence and young adulthood. Psychiatric Services, 58(11), 1454-1460.
[12] Planty, M., Hussar, W., Snyder, T., Provasnik, S., Kena, G., Dinkes, R., Kemp, J. (2008). The condition of education 2008 (NCES 2008-031).
[13] Newman, L., Wagner, M., Cameto, R., & Knokey, A. M. (2009). *The post-high school outcomes of youth with disability up to 4 years after high school: A report from the national longitudinal transition study-2 (NLTSC)* (NCSER 2009-3017). Menlo Park, CA: SRI International.
[14] IOM (Institute of Medicine) and NRC (National Research Council). (2015), p. 56. *Investing in the health and well-being of young adults.* Washington, D.C.: The National Academies Press.

Funding History

Fiscal Year	Amount
FY 2014	$19,951,000
FY 2015	$19,951,000
FY 2016	$19,951,000
FY 2017	$19,913,000
FY 2018	$0

Budget Request

The FY 2018 Budget Request is $0.0, a decrease of $19.9 million from the FY 2017 Annualized CR. SAMHSA has developed significant knowledge and evidence for states to begin implementing and bringing to scale these efforts. SAMHSA will continue to ensure this knowledge is disseminated.

Outputs and Outcomes Table

Program: Healthy Transitions

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
3.2.34 Increase the percentage of clients receiving services who report positive functioning at 6-month follow-up. (Outcome)	FY 2016: 58.5% Target: 64% Target Not Met	64%		Elimination
3.2.35 Increase the percentage of clients receiving services who had a permanent place to live in the community at 6-month follow-up. (Outcome)	FY 2016: 38 % Target: 36 % (Target Exceeded)	36 %		Elimination
3.2.36 Increase the percentage of clients receiving services who are currently employed at 6-month follow-up. (Outcome)	FY 2016: 65.9% Target: 56% Target Exceeded	56%		Elimination

Children and Family Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Children and Family Programs	$6,458	$6,446	$6,446	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
Allocation Method ..... Competitive Grants/Contracts/ Interagency Agreements
Eligible Entities..... Tribes

Program Description and Accomplishments

Without early identification, intervention, treatment, and support, children with serious emotional disturbances (SED) are likely to face challenges at home, in school, and in their psychosocial development. It is a public health priority that these children and their families have access to effective, evidence-based services, and support.

SAMHSA's Children and Family Programs provide funding for the Circles of Care grant program. Initially funded in 1998, the Circles of Care Program is a three-year infrastructure/planning grant which seeks to promote mental disorder treatment equity by providing American Indian/Alaska Native (AI/AN) communities with tools and resources to design and sustain their own culturally competent system of care approach for children. Circles of Care reflects the unique history and needs of individual AI/AN communities and promotes the idea of building on cultural strengths. The program increases capacity and community readiness to address the mental health issues of children and their families through the provision of evidence based treatment services and supports. This grant program is of critical importance as there are significant mental health needs in AI/AN communities. For example, suicide is the second leading cause of death for Indian youth ages 15 to 24. Through Circles of Care, SAMHSA has improved the availability, accessibility, and acceptability of behavioral health services for native youth. For example, data from the previous cohort of grantees show that over 3,000 consumer/family members were involved in ongoing mental health related planning activities and there were 4,300 peer-to-peer collaborations.

Rehabilitation Research and Training Centers (RRTCs) seek to advance the current knowledge base by supporting research, training, technical assistance, and knowledge translation activities that help youth and young adults with serious mental health conditions, including youth and young adults from high-risk, disadvantaged backgrounds, achieve their life goals. SAMHSA's Children and Family Program supports two RRTC programs that are co-funded with the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR). The first, RRTC on Transition to Employment for Youth and Young Adults with Serious Mental Health Conditions will conduct research and evaluative studies that contribute to improved employment outcomes for youth and young adults with serious mental health conditions, including those from high-risk, disadvantaged backgrounds. The second program, RRTC on Community Living and Participation for Youth and Young Adults with Serious Mental Health Conditions, will conduct research and evaluative studies that contribute to improved community participation for youth and young adults with SMHC. Unemployment rates for youth with mental disorders are significantly higher than those for youth with no disabilities. Unemployed young adults are three times more likely to suffer

from depression, and youth without jobs are at higher risk to use alcohol, drugs, and engage in risky behaviors that have negative health outcomes.[15]

In FY 2016, SAMHSA provided continuation support for 11 three-year Circles of Care grants to AI/AN communities and two RRTCs.

In FY 2017, SAMHSA is awarding a new cohort of Circles of Care grants and the continuation of RRTCs.

Funding History

Fiscal Year	Amount
FY 2014	$6,458,000
FY 2015	$6,458,000
FY 2016	$6,458,000
FY 2017	$6,446,000
FY 2018	$6,446,000

Budget Request

The FY 2018 Budget Request is $6.4 million, level with the FY 2017 Annualized CR. SAMHSA requests funding to enhance and improve the quality of existing services and promote the use of culturally competent services and support for children and youth with, or at risk for, serious mental health conditions and their families. This funding will be used to support existing Circles of Care grants RRTCs.

The output and outcome measures for Children and Family Programs are part of the Mental Health - Other Capacity Activities outputs and outcomes table shown on page 80.

[15] McGee RE, Thompson NJ. Unemployment and Depression Among Emerging Adults in 12 States, Behavioral Risk Factor Surveillance System, 2010. Prev Chronic Dis 2015; 12:140451.

Consumer and Family Network Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Consumer and Family Network Grants	$4,954	$4,945	$4,945	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....Community Organizations

Program Description and Accomplishments

Across the healthcare arena, there is growing recognition and evidence that patient-centered care positively influences an individual's health outcomes, improves quality and efficacy of care received, and provides feedback to drive service and systems improvements. As with other health disciplines, people with serious mental illness and their family members should have meaningful involvement in all aspects of their health care and treatment, including behavioral health care.

The Consumer and Family Network Programs support SAMHSA's Recovery Support Strategic Initiative by providing consumers, families, and youth with opportunities to participate meaningfully in the development of policies, programs, and quality assurance activities related to mental health systems across the United States. The Consumer and Family Network Programs support two primary grant activities: the Statewide Consumer Network Program and the Statewide Family Network Program.

The Statewide Consumer Network Grant Program focuses on the needs of adults (18 years and older) with serious mental illness by strengthening the capabilities of statewide consumer-run organizations. These entities serve an important role in engaging consumers of mental health services, caregivers, and providers in improving and transforming the mental health and related systems in their states. This network is a sustainable mechanism for integrating the consumer voice in state mental health and allied systems to: 1) expand service system capacity; 2) support policy and program development; and 3) enhance peer support. This program promotes skill development with an emphasis on leadership and business management as well as coalition/partnership-building and economic empowerment as part of the recovery process for consumers.

The Statewide Family Network Grant Program provides education and training to increase family organizations' capacity for policy and service development. This is accomplished by: 1) strengthening organizational relationships and business management skills; 2) fostering leadership skills among families of children and adolescents with serious emotional disturbances; and 3) identifying and addressing the technical assistance needs of children and adolescents with serious emotional disturbances and their families. The Statewide Family Network Program focuses on families, parents, and the primary caregivers of children, youth, and young adults.

In FY 2016, SAMHSA awarded nine Statewide Consumer Network continuation and nine new Statewide Consumer Network grants, five Statewide Family Network continuations and 21 new Statewide Family Network grants, and a technical assistance contract.

In FY 2016, the Statewide Consumer Networks trained over 3,000 people, including 1,635 people in the mental health and related workforce, as well as 1,373 members of the public. They reached over 70,000 people through mental health awareness and promotion activities. Grantees collaborated with 225 organizations, and more than 300 consumers and family members participated in mental health-related planning, systems improvement, and evaluation-related activities.

In FY 2017, SAMHSA will support 18 Statewide Consumer Network continuations, 26 Statewide Family Network continuations, a technical assistance contract, and a Statewide Peer Network Development activity demonstrating collaboration between the addiction recovery network and the consumer and family networks.

Funding History

Fiscal Year	Amount
FY 2014	$4,954,000
FY 2015	$4,954,000
FY 2016	$4,954,000
FY 2017	$4,945,000
FY 2018	$4,945,000

Budget Request

The FY 2018 Budget Request is $4.9 million, level with the FY 2017 Annualized CR. SAMHSA requests funding to continue support for 30 grants that promote consumer, family, and youth participation in the development of policies, programs, and quality assurance activities related to mental health systems reform across America. SAMHSA will also fund new cohorts of Family and Consumer Network programs.

The output and outcome measures for Consumer and Family Network Programs are part of the Mental Health - Other Capacity Activities outputs and outcomes table shown on page 80.

Project LAUNCH

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Project LAUNCH	$34,555	$34,489	$34,489	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....States and Tribes

Program Description and Accomplishments

Researchers estimate that between 9.5 percent and 14.2 percent of children aged five or under experience an emotional or behavioral disturbance. Studies also show that half of all lifetime cases of mental illness begin before age 14.[16] The preschool expulsion rate is more than three times the expulsion rate of students in kindergarten through 12th grade. Boys are more than four times as likely to be expelled than girls. African American preschoolers are almost twice as likely to be expelled than Caucasian preschoolers.[17] School suspensions and expulsions have shown to increase the likeliness of later life negative outcomes. Research has shown that prevention and early treatment of mental disorders is more beneficial and cost-effective than waiting to address these issues later in life. Integrating behavioral health into primary care and early childcare settings, increasing screening for developmental and social/emotional issues, and training people who interact with young children to help them feel safe and secure are all critical elements to ensure children start life with the tools and skills needed to succeed.

Established in 2008, Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) is a national initiative that has funded 55 sites, including states, tribes, territories, communities, and the District of Columbia. The purpose of the Project LAUNCH initiative is to promote the wellness of young children from birth to eight years of age by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Project LAUNCH pays particular attention to the social and emotional development of young children and works to ensure that the systems that serve them (including early child care and education, home visiting, and primary care) are equipped to promote and monitor healthy social and emotional development. The program also ensures that the systems intervene to prevent mental, emotional, and behavioral disorders in early childhood and into the early elementary grades.

[16] Brauner, Cheryl, and Cheryll Stephens. "Estimating the Prevalence of Early Childhood Serious Emotional/Behavioral Disorders: Challenges and Recommendations." Public Health Reports 121.3 (2006): 303-10.
[17] Gilliam, W. (2005). Pre-kindergarteners left behind: Expulsion rates in state prekindergarten systems. Foundation for Child Development.

As of 2016, performance data for the program found that:

- Approximately 175,000 children and parents have been screened or assessed for behavioral health concerns across a range of diverse settings (e.g., primary care, child care, and home visiting);
- Approximately 122,235 families have been served through home visiting programs with an added focus on the social/emotional and behavioral health needs of children and parents;
- Approximately 65,000 community providers have been trained on social/emotional development and behavioral health for young children;
- Over 136,000 individuals received evidence-based mental health-related services, this includes:
- Nearly 7,200 new organizations are collaborating, coordinating, and sharing resources to implement prevention/promotion strategies for young children and their families.

The multi-site evaluation of Project LAUNCH is ongoing. Phase one of the evaluation used a meta-analytical approach to assess the implementation of the program. The findings indicate that grantees successfully achieved three goals: 1) improvements to the local child services system in the LAUNCH communities; 2) improvements to the state child services system; and 3) enhancements to the child and family services in the communities. In addition, Project LAUNCH grantees have reported improved social and academic functioning among the targeted population, and 78 percent have reported decreases in problem behaviors among the targeted population. As the program expands to new states and territories, the current phase of the multi-site evaluation has evolved to a quasi-experimental design to assess the impact of Project LAUNCH more effectively.

In FY 2016, SAMHSA supported 36 five-year continuation grants, a new cohort of grants, and a technical assistance and evaluation contract. The new grant cohort provides support to states and tribes that have successfully implemented Project LAUNCH with the goal of expanding the work beyond the pilot communities to additional communities across the states and tribes. In FY 2017, SAMHSA will award 25 continuation grants, a new cohort of Project LAUNCH grants focusing on tribes and territories, and a technical assistance and evaluation contract.

Funding History

Fiscal Year	Amount
FY 2014	$34,555,000
FY 2015	$34,555,000
FY 2016	$34,555,000
FY 2017	$34,489,000
FY 2018	$34,489,000

Budget Request

The FY 2018 Budget Request is $34.5 million, level with the FY 2017 Annualized CR. This funding will support 33 five-year continuation grants, a new grant cohort, and contract activities that will improve health outcomes for young children. Funding will support children at high risk for mental illness and their families in order to prevent future disability. This funding request will provide services for over 38,000 individuals, training to 13,102 people, and screening for mental health or related intervention to 44,775 children up to eight years old.

Outputs and Outcomes Table

Program: Mental Health-Project LAUNCH

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
2.3.94 Increase the number of persons served (Output)	FY 2016: 25,128 Target: 38,588 (Target Not Met but Improved)	38,594	38,594	Maintain
2.3.95 Increase the number of persons trained in mental illness prevention or mental health promotion (Outcome)	FY 2016: 10,182 Target: 13,102 (Target Not Met)	13,102	13,102	Maintain
2.4.00 Increase the number of 0-8 year old children screened for mental health or related interventions (Outcome)	FY 2016: 22,472 Target: 44,775 (Target Not Met but Improved)	44,775	44,775	Maintain
2.4.01 Increase the number of 0-8 year old children referred to mental health or related interventions (Outcome)	FY 2016: 7337 Target: 9,114 (Target Not Met but Improved)	9,114	9,114	Maintain

Mental Health System Transformation and Health Reform

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Mental Health System Transformation and Health Reform	$3,779	$3,772	$3,772	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Tribes

Program Description and Accomplishments

There is a significant gap between the number of people with serious mental illness, such as schizophrenia, bipolar disorder, and major depression, who want to work (66 percent) and the number of people who are actually employed (less than 20 percent). The benefits of steady competitive employment are substantial and include increased income, improved adherence with mental disorder treatment, enhanced self-esteem, reduced use of substances, and improved quality of life.[18] The Transforming Lives through Supported Employment Grant program is the remaining component of the Mental Health System Transformation program. This program was implemented to help states foster the adoption and implementation of permanent transformative changes in how public health services are organized, managed, and delivered throughout the United States.

The program began in FY 2014 as a focused effort to enhance state and community capacity to provide evidence-based supported employment programs for adults and youth with serious mental illnesses/serious emotional disturbances (SMI/SED). These grants help people with serious mental illnesses build paths to self-sufficiency and recovery rather than disability and dependence. They also support mental health consumers, treatment and service providers, and employers to develop and maintain sustained competitive employment circumstances for people with serious mental illness. The grant program helps states to identify and implement the structural and financing changes that are essential to make supported employment programs sustainable and statewide. FY 2016 data show that sixty percent of individuals were employed at six month follow-up.

In FY 2016, SAMHSA provided continuation funds for seven grants and related technical assistance activities. In FY 2017, SAMHSA is supporting the continuation of these grants and related technical assistance activities.

[18] IPS Supported Employment: The Evidence-Based Practice for Employment. (n.d.). Retrieved August 4, 2015.

Funding History

Fiscal Year	Amount
FY 2014	$10,556,000
FY 2015	$3,779,000
FY 2016	$3,779,000
FY 2017	$3,772,000
FY 2018	$3,772,000

Budget Request

The FY 2018 Budget Request is $3.7 million, level with the FY 2017 Annualized CR. SAMHSA requests funding to support the continuation of seven five-year Transforming Lives Through Supported Employment grants to enhance state and community capacity to provide evidence-based supported employment programs for adults and youth with serious mental illnesses/emotional disturbances and technical assistance to the grantees.

Outputs and Outcomes Table

Program: Mental Health System Transformation and Health Reform

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
1.2.11 Increase the number of persons in the mental health and related workforce trained in specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2016: 5,702 Target: 1,540 (Target Exceeded)	4,303	4,303	Maintain
1.2.21 Increase the percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2016: 69 % Target: 52 % (Target Exceeded)	57 %	57 %	Maintain
1.2.22 Increase the percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2016: 60 % Target: 74 % (Target Not Met but Improved)	77 %	77 %	Maintain
1.2.23 Increase the percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2016: 56 % Target: 31 % (Target Exceeded)	32 %	32 %	Maintain

Primary and Behavioral Health Care Integration

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Primary and Behavioral Health Care Integration	$49,877	$49,782	$---	−$49,782
Primary and Behavioral Health Care Integration TTA	$1,991	$1,987	$---	−$1,987
Total PBHCI	**$51,868**	**$51,769**	**$---**	**−$51,769**

Authorizing Legislation……..……Section 520K of the Public Health Service Act
FY 2018 Authorization…….$51,878
Allocation Method ..... Competitive Grants/Cooperative Agreements
Eligible Entities.....Qualified Community Mental Health Programs (FY 2017 Authorization), States or State Agency

Program Description and Accomplishments

The high rates of morbidity and mortality among adults with serious mental illnesses (SMI) such as schizophrenia, bipolar disorder, and major depression are alarming. These rates are due, in large part, to elevated incidence and prevalence of cardiovascular disease, obesity, diabetes, hypertension, and dyslipidemia in people with SMI.[19] Physical health problems among people with SMI affect an individual's quality of life and contribute to premature death. Empirical findings indicate the clear link between early mortality among people with SMI and the lack of access to primary care services.[20]

The Primary and Behavioral Health Care Integration (PBHCI) program began in FY 2009 to address specifically this intersection between primary care and mental disorder treatment. The program supports two activities: grants to community mental health centers and States and the PBHCI Training and Technical Assistance (TTA) Center, which is co-funded through a competitive cooperative agreement with the Health Resources and Services Administration (HRSA). These two activities collectively support the coordination and integration of primary care services and publicly funded community behavioral health settings for individuals with SMI and/or people with co-occurring disorders served by the public mental health system. PBHCI seeks to improve health outcomes for people with SMI by encouraging grantees to engage in necessary collaboration, expand infrastructure, and increase the availability of primary healthcare and wellness services for individuals with mental illness. Collaboration between primary care and behavioral health organizations, as well as information technology entities, is crucial to the success of this program. As of September 2016, SAMHSA has awarded 214 PBHCI grants.

PBHCI activities also include the braided Minority AIDS Initiative HIV Continuum of Care pilot program, which supports behavioral health screening, primary prevention, and treatment for racial/ethnic minority populations with or at high risk for mental illness and drug/alcohol addiction

[19] Forman-Hoffman, Muhuri, Novak, Pemberton, Ault, and Mannix (August 2014) CBHSQ Data Review: Psychological Distress and Mortality among Adults in the U.S. Household Population.
[20] E. Chesney et al., Risks of all-cause and suicide mortality in mental disorders: a meta-review, World Psychiatry; 2014: 13:1153-160.

and HIV/AIDS. This includes HIV/AIDS integrated programs that either can co-locate or have fully integrated HIV/AIDS prevention and medical care services with behavioral health services.

In FY 2016, SAMHSA supported 58 continuation grants, awarded 28 new grants to support the coordination and integration of primary care services into publicly funded community behavioral health settings, and one technical assistance contract that is co-funded with HRSA. In FY 2017, SAMHSA will support 62 continuation grants, award a new cohort of grants to states (a new eligibility requirement of the 21st Century Cures Act) with awards up to $2 million per grant, and support the continuation of the technical assistance contract.

Funding History

Fiscal Year	Amount
FY 2014	$51,868,000
FY 2015	$51,868,000
FY 2016	$51,868,000
FY 2017	$51,769,000
FY 2018	$0

Budget Request

The FY 2018 Budget Request is $0.0, a decrease of $51.8 million from the FY 2017 Annualized CR. SAMHSA has eliminated this program due to other funding source availability for integrated care. SAMHSA will continue to disseminate the lessons learned from this program.

Outputs and Outcomes Table

Program: Primary & Behavioral Health Care Integration (PBHCI)

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
3.2.40 Increase the number of clients served (Output)	FY 2016: 29,705 Target: 56,552 (Target Not Met but Improved)	56,552		Elimination
3.2.41 Increase the percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2016: 55.9 % Target: 49.9 % (Target Exceeded)	57 %		Elimination
3.2.42 Increase the percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2016: 23.8 % Target: 22.1 % (Target Exceeded)	22.1 %		Elimination
3.2.43 Increase the percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up. (Outcome)	FY 2016: 69.7 % Target: 65.7 % (Target Exceeded)	75 %		Elimination

Suicide Prevention Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Suicide Prevention	$60,032	$59,940	$59,940	$---
National Strategy for Suicide Prevention (non-add).	*2,000*	*1,996*	*1,996*	---
Suicide Lifeline (non-add)	*7,198*	*7,184*	*7,184*	---
GLS - Youth Suicide Prevention - States (non-add)	*35,427*	*35,382*	*35,382*	---
Budget Authority (non-add)	*23,427*	*23,382*	*35,382*	*12,000*
Prevention & Public Health Fund (non-add)	*12,000*	*12,000*	---	*-12,000*
GLS - Youth Suicide Prevention - Campus (non-add)	*6,488*	*6,476*	*6,476*	---
GLS - Suicide Prevention Resource Center (non-add)	*5,988*	*5,977*	*5,977*	---
AI/AN Suicide Prevention Initiative (non-add)	*2,931*	*2,925*	*2,925*	---

Program Description and Accomplishments

SAMHSA supports the goals and objectives of the National Strategy for Suicide Prevention (NSSP) through the Suicide Prevention Programs highlighted below. Research has shown that implementing comprehensive public health approaches that make suicide prevention a priority within health and community systems can reduce the rates of death by suicide as well as suicide attempts. The NSSP supports this type of comprehensive approach and is an important step toward reducing suicide.

Approximately 44,193 Americans died by suicide in 2015. One American dies by suicide every 11.9 minutes. In 2008, suicide became the 10th leading cause of death in the United States and has remained so through 2015, the most recent year for which there are available mortality data. The 2015 National Survey on Drug Use and Health reported that approximately 1.4 million Americans age 18 and over attempted suicide, 9.7 million seriously considered suicide, and 2.7 million made a plan. While youth have the highest rate of suicide attempts, middle-aged adults have the highest number of deaths by suicide nationwide, and middle aged and older Americans have the highest rates of death by suicide. The nation's suicide prevention efforts must go beyond youth and address the issues of suicidal thoughts, plans, attempts, and deaths among adults.

National Strategy for Suicide Prevention

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
National Strategy for Suicide Prevention	$2,000	$1,996	$1,996	$---

Authorizing Legislation ..... Section 520L of the Public Health Service Act
FY 2018 Authorization $30,000
Allocation Method ..... Competitive Grants
Eligible Entities.....Community –based primary care or behavioral health entity, Federally Recognized, American Indian/Alaska Native tribe or tribal organizations, State mental health or public health agency

Program Description and Accomplishments

Suicide has been increasing in the United States, particularly in adults and older adults. Suicide is the fifth leading cause of death among middle-aged adults (ages 35 to 64 years).[21] In 2013, suicide among working-aged adults (25 to 64) accounted for almost 70 percent of all suicides, and from 1999 to 2010, the suicide rate among individuals age 35 to 64 increased by nearly 30 percent.[22] Additionally, the highest rates of suicide are seen among men who are 80 or older. With the rising rates of suicide among adults, particularly middle-aged and older adults, focusing on preventing suicide among adults is urgently required in order to reduce suicide nationally. The baby boomer generation is the group that has had high rates of suicide throughout its lifecycle and is entering the stage of life that has historically had the highest rate of suicide. There is a risk that without significant targeted intervention toward this population, the number of suicides in the United States could dramatically increase. The nation's suicide prevention efforts must go beyond youth and address the issues of suicidal thoughts, plans, attempts, and deaths among adults.

The 2012 National Strategy for Suicide Prevention (NSSP) seeks to reduce the overall suicide rate and number of suicides in the U.S. nationally. The NSSP grant program supports states' efforts to implement the NSSP. While the NSSP addresses all age groups and populations with specific needs, the goals and objectives of the NSSP grants are focused on preventing suicide and suicide attempts among working-aged adults, 25 to 64 years old, the age group whose deaths by suicide outnumber all others. In FY 2014, SAMHSA awarded four new grants to support states in implementing the NSSP goals and objectives. States use NSSP funding to support efforts such as raising suicide awareness, establishing emergency room referral processes, and improving clinical care practice standards. These grants focus on preventing suicide and suicide attempts among working-aged adults 25 to 64 years old. In FY 2015 and FY 2016, SAMHSA

[21] Centers for Disease Control and Prevention (CDC) Vital Signs: Suicide among adults aged 35–64 years – United States, 1999–2010. MMWR Morbidity Mortality Weekly Report. 2013; 62 (17):321–325.
[22] Centers for Disease Control and Prevention (CDC) Vital Signs: Suicide among adults aged 35–64 years – United States, 1999–2010. MMWR Morbidity Mortality Weekly Report. 2013; 62 (17):321–325.

provided continuation funds for these four grants. In FY 2017, SAMHSA will award a new cohort of grants.

Funding History

Fiscal Year	Amount
FY 2014	$2,000,000
FY 2015	$2,000,000
FY 2016	$2,000,000
FY 2017	$1,996,000
FY 2018	$1,996,000

Budget Request

The FY 2018 Budget Request is $2.0 million, level with the FY 2017 Annualized CR. Funding will support the continuation of four grants. The grants support states in implementing the NSSP goals and objectives. States use NSSP funding to support efforts such as raising suicide awareness, establishing emergency room referral processes, and improving clinical care practice standards.

Garrett Lee Smith Youth Suicide Prevention – State/Tribal and Campus

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
GLS - Youth Suicide Prevention - States.	$35,427	$35,382	$35,382	$---
Budget Authority (non-add)	*23,427*	*23,382*	*35,382*	*12,000*
Prevention & Public Health Fund (non-add)	*12,000*	*12,000*	---	*-12,000*
GLS - Youth Suicide Prevention - Campus	6,488	6,476	6,476	---
Subtotal	41,915	41,858	41,858	---

Authorizing Legislation .....Sections 520E of the Public Health Service Act
FY 2018 Authorization…….$30,000
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....States and Tribes

Program Description and Accomplishments

In the fall of 2003, Garrett Lee Smith, son of Sen. Gordon and Sharon Smith, died by suicide in his apartment in Utah where he attended college. He was one day shy of 22 years old. Like most suicides, Garrett's came unexpectedly. As many families have tragically experienced,

depression is not rare or peculiar, but can be deadly. It affects one in six Americans at some point. Hardly a family goes untouched.[23]

The Garrett Lee Smith (GLS) Memorial Act (Public Law 108-355) authorizes SAMHSA to manage two significant youth suicide prevention programs and one resource center. The GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program has awarded 180 grants to 50 states and the District of Columbia, 47 tribes or tribal organizations, and one territory. These grants develop and implement youth suicide prevention and early intervention strategies involving public-private collaboration among youth-serving institutions. The GLS Campus Suicide Prevention program has awarded 190 grants to 175 institutions of higher education, including tribal colleges and universities, to prevent suicide and suicide attempts.

Grantees often use their funds to provide suicide prevention training in their communities. As of April 2017, 1,280,249 individuals participated in 34,562 training events or educational seminars provided by grantees. The most common approach was gatekeeper training, designed to help trainees recognize suicide risk in young people, address the immediate needs of these individuals, and refer young people to appropriate services. Over 25 percent of trainees received training through campus-sponsored courses and educational seminars. Seventy percent of trainees participated in state-sponsored training activities and 4.3 percent in tribal-sponsored training activities.

Results from the congressionally mandated cross-site evaluation have shown that counties who implemented GLS supported activities had lower suicide rates than matched counties that did not in the first year following suicide prevention activities.

In FY 2016, SAMHSA provided continuation funds for 38 GLS State/Tribal grants, 37 GLS Campus grants, 4 new GLS State/Tribal grants and 18 new GLS Campus grants as well as the National Suicide Prevention Evaluation. In FY 2017, SAMHSA will support the continuation of 43 GLS State/Tribal grants, 40 GLS Campus grants, a new cohort of GLS State/Tribal grants and GLS Campus grants, and the National Suicide Prevention evaluation.

Funding History

Fiscal Year	Amount
FY 2014	$41,915,000
FY 2015	$41,915,000
FY 2016	$41,915,000
FY 2017	$41,858,000
FY 2018	$41,858,000

[23] http://www.jaredstory.com/garrett_smith.html

Budget Request

The FY 2018 Budget Request is $41.8 million, level with the FY 2017 Annualized CR. SAMHSA requests funding for 42 State grant continuations, 32 campus continuations, and a new campus cohort to continue developing and implementing youth suicide prevention and early intervention strategies involving public-private collaboration among youth serving institutions. In addition, the funding will support prevention of suicide and suicide attempts at institutions of higher education and the National Suicide Prevention Evaluation.

Garrett Lee Smith Suicide Prevention Resource Center

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
GLS - Suicide Prevention Resource Center	$5,988	$5,977	$5,977	$---

Authorizing Legislation ..... Section 520C of the Public Health Service Act
FY 2018 Authorization $5,988
Allocation Method ..... Competitive Grants or Contracts
Eligible Entities ..... Domestic Public and Private Nonprofit Entities, Tribal and Urban Indian Organizations, Community and Faith-Based Organizations

Program Description and Accomplishments

In addition to the above programs that build suicide prevention capacity, SAMHSA also supports the Suicide Prevention Resource Center (SPRC). The purpose of this program is to build national capacity for preventing suicide by providing technical assistance, training, and resources to assist states, tribes, organizations, and SAMHSA grantees to develop suicide prevention strategies (including programs, interventions, and policies that advance the National Strategy for Suicide Prevention (NSSP), with the overall goal of reducing suicides and suicidal behaviors in the nation. This work includes support of the public-private National Action Alliance for Suicide Prevention, and working to advance high-impact objectives of the NSSP.

In FY 2015, SAMHSA awarded a new five-year SPRC grant. In FY 2016, SAMHSA supported the continuation of this grant. In FY 2017, SAMHSA is supporting the continuation of this grant.

Funding History

Fiscal Year	Amount
FY 2014	$5,988,000
FY 2015	$5,988,000
FY 2016	$5,988,000
FY 2017	$5,977,000
FY 2018	$5,977,000

Budget Request

The FY 2018 Budget Request is $6.0 million, level with the FY 2017 Annualized CR. Funding will support one grant continuation to continue to promote the implementation of the NSSP and enhance the nation's mental health infrastructure. The Suicide Prevention Resource Center will provide states, tribes, government agencies, private organizations, colleges and universities, and suicide survivor and mental health consumer groups with access to information and resources that support program development, intervention implementation, and adoption of policies that prevent suicide.

Suicide Lifeline

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Suicide Lifeline	$7,198	$7,184	$7,184	$---

Authorizing Legislation ..... Section 520E-3 of the Public Health Service Act
FY 2018 Authorization ..... …$7,198
Allocation Method ..... Competitive Grants/Contracts
Eligible Entities..... States, Tribes, Community Organizations

Program Description and Accomplishments

To prevent death and injury as the result of suicide attempts, individuals need rapid access to suicide prevention and crisis intervention services. In FY2015, the National Suicide Prevention Lifeline answered calls from over 1.5 million Americans. This helped provide rapid access at any time of the day or night to crisis intervention, and when needed, emergency response.

Launched in FY 2005, the National Suicide Prevention Lifeline (Lifeline), 1-800-273-TALK, coordinates a network of 164 crisis centers across the United States by providing suicide prevention and crisis intervention services for individuals seeking help at any time, day or night. The Lifeline routes calls from anywhere in the country to a network of certified local crisis centers that can then link callers to local emergency, mental health, and social services resources. The Lifeline averaged 123,839 calls per month in FY 2016, including a peak of 129,628 calls in May 2016. SAMHSA evaluation studies have found that when a sample of suicidal callers to the Lifeline are asked, "…to what extent did calling the crisis hotline stop you from killing yourself?" 69 percent respond "a lot" and 21.6 percent respond "a little."

Since FY 2007, SAMHSA has collaborated with the Department of Veterans Affairs (VA) to ensure that veterans, service members, and their families who call the Lifeline and "press 1" have 24/7 access to the VA's Veterans Crisis Line. In FY 2015, more than 40,000 callers per month pressed "1" and were seamlessly connected to the Veterans Crisis Line.

The Lifeline Evaluation is a part of the National Suicide Prevention Evaluation (NSPE), which includes many of the programs in SAMHSA's suicide prevention portfolio. The NSPE is an

evaluation that will assess the impact of SAMHSA's suicide prevention initiatives on reducing suicidal behavior, attempts, and mortality. The NSPE also provides training and technical assistance to grantees related to evaluation, data collection, and surveillance.

Prior Lifeline evaluations have been the primary vehicle for collaborating with the crisis centers to adopt standards and guidelines based on evaluation results. These evaluation-driven standards and guidelines have, to date, focused on suicide risk assessment, imminent risk protocols, emergency intervention, and follow-up procedures and have advanced improvements in practice that are lifesaving.

In FY 2015, SAMHSA awarded 12 crisis center follow-up continuation grants, continued support for the evaluation contract, and awarded a new three-year Lifeline grant. In FY 2016, SAMHSA awarded six new crisis center follow-up grants and the continuation of the Lifeline grant. In FY 2017, SAMHSA is supporting the continuation of six crisis center follow-up grants and the Lifeline grant.

Funding History

Fiscal Year	Amount
FY 2014	$7,198,000
FY 2015	$7,198,000
FY 2016	$7,198,000
FY 2017	$7,184,000
FY 2018	$7,184,000

Budget Request

The FY 2018 Budget Request is $7.2 million, level with the FY 2017 Annualized CR. SAMHSA is requesting funding to award a new grant to continue to support the National Suicide Prevention Lifeline, which routes calls from anywhere in the country to a network of certified local crisis centers that can then link callers to local emergency, mental health, and social services resources. In addition, the funding will support the continuation of six National Suicide Prevention Lifeline Crisis Center grants to focus on providing follow up to suicidal people discharged from emergency rooms and inpatient units, and will support a crisis chat system.

American Indian/Alaska Native Suicide Prevention Initiative

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
American Indian/Alaska Native Suicide Prevention	$2,931	$2,925	$2,925	$---

Authorizing Legislation ..... Section 520A of the Public Health Service Act
Allocation Method ..... Contracts
Eligible Entities..... Not applicable

Program Description and Accomplishments

The Tribal Training and Technical Assistance Center (Tribal TTA Center) is an innovative training and technical assistance project that helps tribal communities facilitate the development and implementation of comprehensive and collaborative community-based prevention plans to reduce violence, bullying, substance abuse, and suicide among American Indian/Alaska Native (AI/AN) youth. These plans mobilize tribal communities' existing social and educational resources to meet their goals. From 2015 to 2017, 126 tribal communities have received specialized technical assistance and support in suicide prevention and related areas. In addition, more than 10,860 members of these communities received training in prevention and mental health promotion.

In FY 2016, SAMHSA supported the continuation of this five-year contract. In FY 2017, SAMHSA will continue support for this activity through the existing contract.

Funding History

Fiscal Year	Amount
FY 2014	$2,931,000
FY 2015	$2,931,000
FY 2016	$2,931,000
FY 2017	$2,925,000
FY 2018	$2,925,000

Budget Request

The FY 2018 Budget Request is $2.9 million, level with the FY 2017 Annualized CR. SAMHSA requests funding to support comprehensive, broad, focused, and intensive training and technical assistance to federally recognized tribes and other AI/AN communities in order to address and prevent mental illness and drug/alcohol addiction, prevent suicide, and promote mental health through the contract continuation.

Outputs and Outcomes Table

Program: Suicide Prevention

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
2.3.59 Increase the total number of individuals trained in youth suicide prevention (Outcome)	FY 2016: 173,564 Target: 154,369 (Target Exceeded)	160,082	160,082	Maintain
2.3.60 Increase the total number of youth screened (Output)	FY 2016: 3,337 Target: 61,626 (Target Not Met)	3,337	3,337	Maintain
2.3.61 Increase the number of calls answered by the suicide hotline (Output)	FY 2016: 1,486,072 Target: 1,308,825 (Target Exceeded)	1,308,825	1,308,825	Maintain
3.1.01 Increase the number of individuals screened for mental health or related interventions (Intermediate Outcome)	FY 2017: Result Expected December 31, 2017 Target: Set Baseline (Pending)	N/A	N/A	Maintain
3.1.02 Increase the number of individuals referred to mental health or related services (Intermediate Outcome)	FY 2017: Result Expected December 31, 2017 Target: Set Baseline (Pending)	N/A	N/A	Maintain
3.1.03 Increase the number of organizations that establish management information/information technology system links across multiple agencies (Intermediate Outcome)	FY 2017: Result Expected December 31, 2017 Target: Set Baseline (Pending)	N/A	N/A	Maintain
3.1.04 Increase the number of organizations or communities that demonstrate improved readiness to change their systems (Intermediate Outcome)	FY 2017: Result Expected December 31, 2017 Target: Set Baseline (Pending)	N/A	N/A	Maintain
3.2.37 Increase the number of youth referred to mental health or related services (Output)	FY 2016: 6,164 Target: 8,850 (Target Not Met but Improved)	9,177	9,177	Maintain

Homelessness Prevention Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Homelessness Prevention Programs	$30,696	$30,638	$30,638	$---
Homelessness	2,296	$2,292	2,292	---

Authorizing Legislation ..... Sections 520A and 506 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Domestic Public and Community Organizations, Private Nonprofit Entities, and Community-based Public or Nonprofit Entities

Program Description and Accomplishments

While significant progress has been made over the last decade to reduce homelessness in specific communities and with specific populations, the number of people experiencing homelessness has remained at unacceptably high levels. Many factors contribute to homelessness including lack of affordable housing, foreclosures, rising housing costs, job loss, underemployment, mental illness, and addiction. Services are needed to link individuals to permanent housing, mainstream benefits, treatment, and supportive services. According to the National Alliance to End Homelessness, over 570,000 individuals experienced homelessness on any given night in the United States, about 15 percent (84,291) of the homeless population is considered "chronically homeless," and about nine percent (49,933) of individuals who are homeless are veterans.[24] Approximately 26 percent of individuals experiencing homelessness have a serious mental illness, 50 percent struggle with substance abuse, and 66 percent of the chronically homeless population has a substance use disorder or other chronic health condition.[25,26]

In FY 2011, SAMHSA initiated the CABHI program, jointly funded by the Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT) to support treatment and the development and expansion of local systems that provide permanent housing and supportive services. This includes integration of treatment and other critical services for individuals with serious mental illness and drug/alcohol addiction. Target populations for this program include veterans and individuals with serious mental illness and/or drug/alcohol addiction. CABHI also supports coordination and planning at the local level with state or local Public Housing Authorities; local mental health, substance misuse, and primary care provider organizations; the local Department of Housing and Urban Development-supported Continuum of Care (CoC) program (designed to promote community-wide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and state and local

[24] Snapshot of Homelessness. (n.d.). Retrieved August 21, 2015, from http://www.endhomelessness.org/pages/snapshot of_homelessness
[25] United State Interagency Council on Homelessness. Substance Abuse. Available at http://usich.gov/issue/substance_abuse
[26] Office of National Drug Control Policy. Integrate Treatment for Substance Use Disorders into Mainstream Health Care and Expand Support for Recovery. Available at: https://www.whitehouse.gov/ondcp/chapter-integrate-treatment-for-substance-use-disorders

governments); the state Medicaid Office; and the state Mental Health and Substance Abuse Authorities. This program expanded to include states as the eligible entity in 2013.

In FY 2015, SAMHSA also supported a national evaluation contract to compare the effectiveness of programs and various models of service delivery that are used across homeless service programs. SAMHSA also supported a technical assistance contract to provide training and support to its homeless services grantees. In FY 2016, SAMHSA supported 17 continuation grants, and awarded 30 new grants to states, local governments, and community-based organizations, and a technical assistance and evaluation contract.

Most recent data show that at six-month follow-up, 71 percent of individuals reported positive functioning, 26 percent were employed, and 84.5 percent had a permanent place to live.

In FY 2017, SAMHSA will support 39 continuation grants, a new cohort of CABHI grants, technical assistance, and evaluation.

Funding History

Fiscal Year	Amount
FY 2014	$32,992,000
FY 2015	$32,992,000
FY 2016	$32,992,000
FY 2017	$32,930,000
FY 2018	$32,930,000

Budget Request

The FY 2018 Budget Request is $32.9 million, level with the FY 2017 Annualized CR. This funding will support 34 continuation grants and a new grant cohort to continue to develop and enhance the infrastructure of states and their treatment service systems to increase capacity to provide accessible, effective, comprehensive, and evidence-based treatment services for individuals with serious mental illness and/or co-occurring disorders, experiencing homelessness. It will also increase access to permanent housing and provide other critical services for those who experience homelessness. In addition, funding is requested to continue to assist providers in delivering housing and recovery support services for individuals who are experiencing homelessness as well as mental illness and drug/alcohol addiction. The budget request will provide services and support for approximately 5,000 individuals.

Outputs and Outcomes Table

Program: Mental Health Homelessness Prevention Programs

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
3.4.01 Increase the number of clients served (Output)	FY 2015: 2,432 Target: 4,959 (Target Not Met)	4,959	4,959	Maintain
3.4.02 Increase the percentage of adults with severe mental illness receiving homeless support services who report positive functioning at 6 month follow-up (Outcome)	FY 2015: 70.8 % Target: 66.1 % (Target Exceeded)	66.1 %	66.1 %	Maintain
3.4.03 Increase the percentage of adults receiving services who were currently employed at 6 month follow-up (Outcome)	FY 2015: 26.5 % Target: 26.0 % (Target Exceeded)	26.0 %	26.0 %	Maintain
3.4.05 Increase the percentage of adults receiving services who had a permanent place to live in the community at 6 month follow-up (Outcome)	FY 2015: 84.5 % Target: 81.2 % (Target Exceeded)	81.2 %	81.2 %	Maintain

Minority AIDS and HIV/AIDS Education

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Minority AIDS	$9,224	$9,206	$4,206	−$5,000
HIV/AIDS Education	771	770	770	---

Authorizing Legislation .....Section 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Community and faith-based organizations, Tribes, Urban, Indian organizations, Hospitals, Public and private universities and colleges

Program Description and Accomplishments

Minority AIDS

The Centers for Disease Control and Prevention (CDC) reports significantly higher rates of HIV/AIDS among racial/ethnic minorities compared with the general population.[27] African Americans accounted for 45 percent and Hispanics accounted for 23 percent of all HIV/AIDS cases diagnosed in 2013.[28] Psychiatric and psychosocial complications are frequently not diagnosed nor addressed at the time of HIV diagnosis or through the course of the disease process. When untreated, these complications are associated with increased morbidity and mortality, impaired quality of life, and numerous medical issues such as non-adherence with the treatment regimen.

The Minority AIDS program enhances and expands the provision of effective, culturally competent, HIV/AIDS-related mental health services in racial and ethnic minority communities for people living with or at high risk for HIV/AIDS. More than 4,600 individuals received services in FY 2015.

In FY 2014, SAMHSA's Centers for Mental Health Services, Substance Abuse Prevention, and Substance Abuse Treatment supported the Minority AIDS Initiative Continuum of Care Pilot (MAI CoC). The MAI CoC supports behavioral health screening, primary prevention, and treatment for racial/ethnic minority populations with or at high risk for mental illness and drug/alcohol addiction and HIV/AIDS. MAI CoC supports substance abuse treatment, primary prevention/treatment service programs, community mental health programs, and HIV/AIDS integrated programs that either can co-locate or have fully integrated HIV/AIDS prevention and medical care services. This program also provides primary prevention services for SUD and HIV/AIDS in local communities served by behavioral health programs. Of those with SMI such as schizophrenia, bipolar disorder, and major depression, approximately 20 percent are infected with the hepatitis C virus and 23 percent are infected with the hepatitis B virus. In addition,

[27] Centers for Disease Control and Prevention. HIV Surveillance Report. (2013); vol. 25. Published February 2015. Accessed May 8, 2015 from http://www.cdc.gov/hiv/library/reports/surveillance.
[28] Centers for Disease Control and Prevention. HIV Surveillance Report. (2013); vol. 25. Published February 2015. Accessed May 8, 2015 from http://www.cdc.gov/hiv/library/reports/surveillance.

between 14 percent and 36 percent of those who misuse alcohol are infected with the hepatitis C virus.[29,30]

SAMHSA supports a consolidated evaluation of its HIV/AIDS programs. This comprehensive process and outcome evaluation will assess the degree to which SAMHSA is providing effective and efficient mental and substance abuse treatment services and prevention programs to those with and at risk of HIV/AIDS. The evaluation results will help inform program development and refine the approach used in SAMHSA's HIV portfolio.

In FY 2015, SAMHSA funded the continuation of 34 HIV Continuum of Care grants, a technical assistance contract, and awarded a new evaluation contract. In FY 2016 and FY 2017, SAMHSA is supporting the continuation of 34 HIV Continuum of Care grants, and evaluation and technical assistance contracts.

The Mental Health Care Provider Education in HIV/AIDS Education
The Mental Health Care Provider Education in HIV/AIDS Education program disseminates knowledge and training on the treatment of the neuropsychiatric and psychological complications of HIV/AIDS. Front-line providers, including psychiatrists, psychologists, social workers, primary care practitioners, and medical students receive this training.

Funding History

Fiscal Year	Amount
FY 2014	$9,995,000
FY 2015	$9,995,000
FY 2016	$9,995,000
FY 2017	$9,976,000
FY 2018	$4,976,000

Budget Request

The FY 2018 Budget Request is $5.0 million, level with the FY 2017 Annualized CR. The requested funding will support a new cohort of grants to continue to enhance and expand the provision of effective, culturally competent, HIV/AIDS-related mental health services in minority communities for people living with HIV/AIDS. In addition, the funding will support continuation of the HIV Continuum of Care grants, evaluation, and technical assistance contracts. The output and outcome measures for the Minority AIDS Initiative are part of the Mental Health - Other Capacity Activities outputs and outcomes table shown on page 80.

[29] Bhattacharya R, Shuhart MC. Hepatitis C and alcohol: interactions, outcomes, and implications. J Clin Gastroenterol. 2003;36(3):242-52.
[30] Rosenberg et al. Prevalence of HIV, Hepatitis B, and Hepatitis C in People With Severe Mental Illness. Am J Public Health. 2001;91:(31–37).

Criminal and Juvenile Justice Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Criminal and Juvenile Justice Programs	$4,269	$4,261	$4,261	$---

Authorizing Legislation .....Sections 520A and G of the Public Health Service Act
FY 2018 Authorization $4,269
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Tribal Court Administrator, the Administrative Office of the Courts, the Single State Agency for Alcohol and Drug Abuse, the State Mental Health Agency, the Designated State Drug Court Coordinator, and Local Governmental Unit

Program Description and Accomplishments

Studies of people involved in the criminal justice system have documented higher rates of co-occurring diagnoses of psychiatric and substance use disorders than those of the general population.[31] Approximately 15 percent of people in the justice system with a diagnosis of substance use disorder and 30 percent with a diagnosed mental illness receive treatment.[32] Inadequate resources to address behavioral health conditions place millions of individuals at greater risk for parole or probation failure and re-incarceration at substantial human, social, and economic cost to society. Of inmates released from prison, 43 percent commit a new crime or a technical violation within three years of release. The costs associated with incarceration are high: state corrections budgets alone account for $39.0 billion in taxpayer costs.[33,34] There is a clear and largely unmet need for effective behavioral health services and supports that are accessible before, during, and after incarceration and continue in the community as needed for this high-risk, population.

In FY 2014, SAMHSA supported a second cohort of four-year Behavioral Health Treatment Court Collaborative grants (BHTCC) in the Mental Health and Substance Abuse Treatment appropriations. BHTCC supports judges and staff of specialty (e.g., drug court) and other courts within a jurisdiction to work together to divert adults with mental illness and/or drug/alcohol addiction from the criminal justice system. The purpose of this grant program is to allow municipal courts more flexibility to collaborate with multiple criminal justice system

[31] Steadman, HJ, Osher, FC, Robbins, PC, Case, BF, & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. Psychiatric Services, 60(6), 761-765.
[32] Cloud, D., (2014). On life support: Public health in the age of mass incarceration. New York: Vera Institute of Justice. http://www.vera.org/sites/default/files/resources/downloads/on-life-support-public-health-mass-incarceration-report.pdf
[33] Pew Center on the States. (2011). State of recidivism: The revolving door of America's prisons. Washington, DC: The Pew Charitable Trusts. http://www.pewtrusts.org/en/research-and-analysis/reports/0001/01/01/state-of-recidivism
[34] Henrichson, C., & Delaney, R. (2012). The price of prisons: What incarceration costs taxpayers. New York: Vera Institute of Justice.

components and local community treatment and recovery providers to address the behavioral health needs of adults who are involved with the criminal justice system. The Court Collaborative focuses on the diversion of adults with behavioral health problems, including serious mental illness, from the criminal justice system, including alternatives to incarceration. The program supports community behavioral health services for individuals with mental and/or substance disorders and includes a focus on veterans involved with the criminal justice system.

SAMHSA completed an evaluation of the first cohort of BHTCC grantees in September 2014. Findings of the evaluation demonstrate that grantees built multi-agency workgroups or collaboratives to oversee programs. Because of the grant funding, all grant recipients expanded access to specialty courts. Most grant recipients anticipated continuing new screening and assessment processes addressing a broader array of behavioral health needs after grant funding ended. Program innovations were divided into four main groups, including court and treatment provider collaboration, court and community case management, unified cross-court screening and referral, and meaningful peer involvement. BHTCC served over 1,400 individuals, with two-thirds of them identified as having co-occurring mental illness and drug/alcohol addiction and with 54 percent reporting significant trauma exposure in their lives. Based on performance data reporting, program participants experienced improvements in mental health and reductions in substance use. Mental health problems declined by 20 percent in the first six months while alcohol and drug use declined by 60 percent over the same period. Nearly 74 percent of participants reported physical health improvements at six months. In addition, employment rates increased from 36 percent to 45 percent over the first six months, with monthly median income increasing by $298.[35]

In FY 2015, SAMHSA provided continuation support for the second year of 17 four-year grants, continued technical assistance, and awarded a new evaluation contract. The new BHTCC evaluation focuses on examining the clinical and functional outcomes of program participants with behavioral health issues. The new BHTCC evaluation is building on the findings from the first cohort and more deeply examine both the features of successful collaborations between the courts and community services as well as the clinical and functional outcomes of program participants. In FY 2016 and FY 2017, SAMHSA is continuing support for 17 grants, and the technical assistance and evaluation contracts.

Funding History

Fiscal Year	Amount
FY 2014	$4,296,000
FY 2015	$4,296,000
FY 2016	$4,269,000
FY 2017	$4,261,000
FY 2018	$4,261,000

[35] Advocates for Human Potential. (2014). *Evaluation of the Adult Treatment Court Collaborative Program: Final evaluation report.* Albany, NY: Author.

Budget Request

The FY 2018 Budget Request is $4.3 million, level with the FY 2017 Annualized CR. SAMHSA's request, through a new grant cohort, will continue to provide comprehensive treatment and recovery support services for adolescents and adults with co-occurring mental illness and drug/alcohol addiction who come into contact with the criminal justice system, as well as offenders re-entering the community.

The output and outcome measures for Criminal and Juvenile Justice Programs are part of the Mental Health - Other Capacity Activities outputs and outcomes table shown on page 80.

Practice Improvement and Training

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Practice Improvement and Training	$7,828	$7,813	$7,813	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... 105 Nationally Recognized Historically Black Colleges and Universities

Program Description and Accomplishments

SAMHSA facilitates health integration by engaging in activities that support mental health system transformation. The Practice Improvement and Training programs address the need for disseminating key information, such as evidence-based mental health practices, to the mental health delivery system through these activities: the Historically Black Colleges and Universities Center for Excellence in Behavioral Health (HBCU-CFE) program, the Rehabilitation Research and Training Centers (RRTCs), the Transforming Lives through Supported Employment Grant Program, the Recovery into Practice, and Programs to Achieve Wellness.

The purpose of the HBCU-CFE program is to network the 105 HBCUs throughout the United States and promote behavioral health workforce development through expanding knowledge of best practices, developing leadership, and encouraging community partnerships that enhance the participation of African Americans in substance abuse treatment and mental health professions. The comprehensive focus of the HBCU-CFE program simultaneously expands service capacity on campuses and in other treatment venues.

In FY 2014, SAMHSA awarded a three-year new HBCU-Center for Excellence grant to a consortium of HBCUs with a lead university. SAMHSA continued this effort in FY 2015 and FY 2016. In FY 2017, SAMHSA is awarding a new one year HBCU-Center for Excellence.

RRTCs seek to advance the current knowledge base by supporting research, training, technical assistance, and knowledge translation activities that help adults with serious mental health illness achieve their life goals. The RRTCs are funded in partnership with the Administration for

Community Living's National Institute on Disability, Independent Living, and Rehabilitation Research. Currently, there are two RRTCs funded for up to five years. The first program, RRTC on Improving Employment Outcomes for Persons with Mental Illness will conduct research activities and evaluation studies on improving employment outcomes of individuals with serious mental illness. The second program, RRTC on Self-Directed Care to Promote Recovery, Health and Wellness for Individuals with Serious Mental Illness, will conduct research and evaluation studies to develop, adapt, and enhance self-directed models of medical, mental health, and nonmedical services designed to improve health, recovery and employment outcomes for individuals with serious mental illness.

In FY 2015, SAMHSA continued funding for the two RRTCs and will continue this funding in FY 2016 and FY 2017.

The Recovery into Practice contract supports the expansion and integration of recovery-oriented care delivered by mental health providers through training and education, policy and analysis, and materials development. The effort crosses professional mental health disciplines (e.g., psychiatry, psychology, nursing, social work, peer specialists, primary care, and substance use and addiction) to provide training on the principles and practices of evidenced-based recovery-oriented care and its implementation, to hold meetings with stakeholders, to establish collaborative relations with provider, consumer, and family leaders, and to conduct research and literature reviews on the current state of recovery-oriented care, knowledge and attitudes.

In FY 2015, SAMHSA supported the continuation of the Recovery into Practice contract. In FY 2016 and FY 2017, SAMHSA will continue support of this contract.

In addition, in FY 2015, SAMHSA awarded a new contract for Programs to Achieve Wellness that promotes and facilitates wellness initiatives for people with mental disorders, including those with the most serious mental illnesses and with co-occurring diagnoses of substance use disorders. Research indicates alarming health disparities between people with serious mental and/or drug/alcohol addiction and the general population. These individuals are likely to die decades earlier, mostly due to preventable, chronic medical conditions. The median reduction in life expectancy among those with mental illness was 10.1 years.[36] The project engages people with mental disorders, national organizations, communities, states, and tribes in the promotion of evidence-based tools for wellness. In FY 2016 and FY 2017, SAMHSA will continue to fund this contract.

[36] Walker ER, McGee RE, Druss BG. Mortality in Mental Disorders and Global Disease Burden Implications: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2015 Feb 11. doi: 10.1001/jamapsychiatry.2014.2502.

Funding History

Fiscal Year	Amount
FY 2014	$7,828,000
FY 2015	$7,828,000
FY 2016	$7,828,000
FY 2017	$7,813,000
FY 2018	$7,813,000

Budget Request

The FY 2018 Budget Request is $7.8 million, level with the FY 2017 Annualized CR. In FY 2018, SAMHSA proposes to expand the HBCU program to include other minority serving institutions, including tribal universities. This request supports the continuation of eight grants. In addition, SAMHSA's funding request will continue to address the need for disseminating key information to the mental health delivery system and engage in activities that support mental health system transformation.

The output and outcome measures for Practice Improvement and Training are part of the Mental Health - Science and Service Activities outputs and outcomes table shown on page 81.

Consumer and Consumer-Supporter TA Centers

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Consumer and Consumer-Supporter Technical Assistance Centers	$1,918	$1,914	$1,914	$---

Authorizing Legislation ..... Section 520A of the Public Health Service Act
Allocation Method ..... Competitive Grants
Eligible Entities ..... Community Organizations

Program Description and Accomplishments

Consumer-centered services and supports such as peer specialists are vital to improving the quality and outcomes of health and behavioral healthcare services for people with mental disorders including serious mental illnesses.

First funded in 1992, the purpose of Consumer and Consumer-Supporter Technical Assistance (TA) Centers is to provide technical assistance to facilitate quality improvement of the mental health system by specific promotion of consumer-directed approaches for adults with serious mental illnesses (SMI). Such approaches maximize consumer self-determination, promote long-term recovery, and assist individuals with serious mental illness to increase their community

involvement through work, school, and social connectedness. This decreases their dependence on a variety of social service programs and reduces unnecessary or inappropriate psychiatric hospitalization. This program also improves collaboration among consumers, families, providers, and administrators. It helps to transform community mental health services into a more consumer and family driven model.

In FY 2014, the Consumer and Consumer-Supporter Technical Assistance Centers provided training to more than 9,500 individuals. Because of this funding, more than 1,700 consumers and family members participated in mental health-related planning and systems improvement.

In the first six months of FY 2015, Consumer and Consumer-Supporter TA Centers facilitated peer-led technical assistance and presentations for over 2,500 participants throughout the U.S. The Centers also facilitated 77 webinars and trainings for over 9,000 participants on a range of topics that included Employment Strategy; Exemplary Peer Groups; Olmstead Implementation and the Americans with Disabilities Act; Engagement Skills; and Strategic Planning.

In FY 2015, SAMHSA awarded a new cohort of five regionally focused Consumer and Consumer-Supporter TA Centers for five years. Through the first two quarters of FY 2017, the Consumer and Consumer-Supporter Technical Assistance Centers provided training to over 2,200 people and helped other consumer-run organizations develop organizational infrastructure and businesses practices.

In FY 2016 and FY 2017, SAMHSA will support the continuation of these grants.

Funding History

Fiscal Year	Amount
FY 2014	$1,918,000
FY 2015	$1,918,000
FY 2016	$1,918,000
FY 2017	$1,914,000
FY 2018	$1,914,000

Budget Request

The FY 2018 Budget Request is $1.9 million, level with the FY 2017 Annualized CR. SAMHSA's funding request will continue support of five grants to provide technical assistance to facilitate the quality improvement of the mental health system by promoting consumer-directed approaches for adults with serious mental illness.

The output and outcome measures for Consumer and Consumer-Supporter TA Centers are part of the Mental Health - Science and Service Activities outputs and outcomes table shown on page 81.

Disaster Response

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Disaster Response	$1,953	$1,949	$1,949	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....Domestic Public or Private Non-Profit Entities

Program Description and Accomplishments

Disasters like Hurricane Sandy, the Oregon and Washington mudslides, the Iowa and Oklahoma tornados, and the Boston Marathon bombing strike without warning. These unexpected disasters leave individuals, families, and whole communities struggling to rebuild.

SAMHSA helps ensure that the nation is prepared to address the behavioral health needs that follow a natural or man-made disaster. SAMHSA focuses on three major programs: the Crisis Counseling Assistance and Training Program (CCP), the Disaster Distress Helpline (DDH), and Disaster Behavioral Health. These programs use allocated supplemental funds to support survivors of natural and man-made disasters.

SAMHSA, through an interagency agreement with the Federal Emergency Management Agency (FEMA), operates the CCP. This program assists individuals and communities in recovering from presidentially declared disasters through the provision of community-based behavioral health outreach and psycho-educational services. SAMHSA provides technical assistance, program guidance and monitoring, and oversight of the CCP. SAMHSA and FEMA jointly fund a Disaster Technical Assistance Center (DTAC) designed to provide additional technical assistance, strategic planning, consultation, and logistical support. SAMHSA provides Disaster Behavioral Health expertise around emerging public health initiatives to develop and disseminate innovative consultation and to technologies to communities, federal partners, and other stakeholders.

SAMHSA's Disaster Distress Helpline is a toll-free, multilingual crisis systems service available 24/7 via telephone (1-800-985-5990) and Short Message Service (SMS) (text 'TalkWithUs' to 66746) to residents in the United States and its territories who are experiencing emotional distress resulting from disasters. In FY 2014, SAMHSA's first Disaster app was created and launched on Apple and Android platforms. The Disaster App provided evidence-informed/based resources in the Disaster Kit, along with additional partner resources, local mental health and substance abuse facilities, the ability to share content anonymously, and functioned with limited Internet connectivity.

Periodically, SAMHSA receives additional funding to help survivors of a particular emergency or disaster.

between 14 percent and 36 percent of those who misuse alcohol are infected with the hepatitis C virus.[37,38]

SAMHSA supports a consolidated evaluation of its HIV/AIDS programs. This comprehensive process and outcome evaluation will assess the degree to which SAMHSA is providing effective and efficient mental and substance abuse treatment services and prevention programs to those with and at risk of HIV/AIDS. The evaluation results will help inform program development and refine the approach used in SAMHSA's HIV portfolio.

In FY 2015, SAMHSA funded the continuation of 34 HIV Continuum of Care grants, a technical assistance contract, and awarded a new evaluation contract. In FY 2016 and FY 2017, SAMHSA is supporting the continuation of 34 HIV Continuum of Care grants, and evaluation and technical assistance contracts.

The Mental Health Care Provider Education in HIV/AIDS Education
The Mental Health Care Provider Education in HIV/AIDS Education program disseminates knowledge and training on the treatment of the neuropsychiatric and psychological complications of HIV/AIDS. Front-line providers, including psychiatrists, psychologists, social workers, primary care practitioners, and medical students receive this training.

Funding History

Fiscal Year	Amount
FY 2014	$9,995,000
FY 2015	$9,995,000
FY 2016	$9,995,000
FY 2017	$9,976,000
FY 2018	$4,976,000

Budget Request

The FY 2018 Budget Request is $5.0 million, level with the FY 2017 Annualized CR. The requested funding will support a new cohort of grants to continue to enhance and expand the provision of effective, culturally competent, HIV/AIDS-related mental health services in minority communities for people living with HIV/AIDS. In addition, the funding will support continuation of the HIV Continuum of Care grants, evaluation, and technical assistance contracts. The output and outcome measures for the Minority AIDS Initiative are part of the Mental Health - Other Capacity Activities outputs and outcomes table shown on page 80.

[37] Bhattacharya R, Shuhart MC. Hepatitis C and alcohol: interactions, outcomes, and implications. J Clin Gastroenterol. 2003;36(3):242-52.
[38] Rosenberg et al. Prevalence of HIV, Hepatitis B, and Hepatitis C in People With Severe Mental Illness. Am J Public Health. 2001;91:(31–37).

Seclusion and Restraint

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Seclusion and Restraint -	$1,147	$1,145	$1,145	$---

Authorizing Legislation ..... Section 520A of the Public Health Service Act
Allocation Method ..... Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

People die because of the inappropriate use of seclusion and restraint practices; countless others are injured; and many are traumatized by coercive practices. Children with emotional and behavioral problems are more frequently subjected to restraints in schools than students with other disabilities, often leading to serious physical injuries and emotional trauma for both students and staff. Coercive practices such as seclusion and restraint impede recovery and well-being.

Through SAMHSA's National Technical Assistance Center: Promoting Alternatives to Seclusion and Restraint Through Trauma-Informed Practices, evidence-based approaches to care have been developed, proven effective, and implemented to reduce or eliminate the use of traumatizing practices. This program provides technical assistance to states/tribes and communities in their efforts to implement best practices to reduce and ultimately eliminate the use of restraints and seclusion in institutional and community-based settings that provide services to individuals with mental illness and/or drug/alcohol addiction. This initiative focuses on the mental health delivery system and other service sectors, including criminal justice systems, schools, and child welfare organizations, that may use coercive practices with people who have mental illness and/or drug/alcohol addiction.

SAMHSA awarded a five-year contract in FY 2013 to design, assess, and implement a technical assistance strategy to assist publicly funded systems, agencies, and organizations across the nation in addressing two high priority and interrelated objectives. The first objective is to promote alternatives to and the elimination of restraint, seclusion, and other coercive practices. The second objective is to develop and implement training and technical assistance on SAMHSA's concept of trauma,[39] key principles, and practice guidance for a trauma-informed approach,[40] and enhance recognition that both organizational and cultural changes are necessary to sustain efforts to eliminate the use of seclusion and restraints. In addition, the contract facilitates dissemination of trauma-informed practices across multiple service settings. In FY 2015, SAMHSA supported the continuation of this contract. In FY 2016 and FY 2017, SAMHSA continues to support this contract.

[39] Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.
[40] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Funding History

Fiscal Year	Amount
FY 2014	$1,147,000
FY 2015	$1,147,000
FY 2016	$1,147,000
FY 2017	$1,145,000
FY 2018	$1,145,000

Budget Request

The FY 2018 Budget Request is $1.1 million, level with the FY 2017 Annualized CR. SAMHSA's funding request will allow continued support of a contract to disseminate trauma-informed practices across multiple service settings. These efforts will help advance the goal of reducing and eliminating the use of seclusion, restraint, and other traumatizing practices in service systems and treatment agencies.

Assisted Outpatient Treatment for Individuals with Serious Mental Illness

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Assisted Outpatient Treatment for Individuals with Serious Mental Illness	$15,000	$14,971	$14,971	$---

Authorizing Legislation ..... ……Section 224 of the Protecting Access to Medicare Act of 2014, as amended
FY 2018 Authorization $20,000
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Communities

Program Description and Accomplishments

Recent data show that one in 25 Americans live with a serious mental illness (SMI), such as schizophrenia, bipolar disorder and/or major depression. Less than half of adults with diagnosable mental health problems receive the treatment they need. Without access to and receipt of evidence-based mental health services, mental health related challenges can negatively affect all areas of a person's life.

In an effort to increase access to evidence-based mental health services for individuals with SMI, in April 2014, Congress passed the Protecting Access to Medicare Act of 2014 (PAMA), which authorized a four year pilot program to award grants for Assisted Outpatient Treatment (AOT) programs for individuals with SMI. AOT is the practice of delivering outpatient treatment under court order to adults with serious mental illness who meet specific criteria such as a prior history of repeated hospitalizations or arrest. AOT involves petitioning local courts through a civil process to order individuals to enter and remain in treatment within the community for a specified period of time. This program will help to identify evidence-based AOT practices that support improved outcomes including outreach and engagement, clinical treatment and supportive services, and due process protections.

In FY 2016, SAMHSA implemented an AOT grant program and awarded 17 grants to eligible entities such as a county, city, mental health system, mental health court, or any other entity with authority under the law of the state in which the grantee is located. This four-year pilot program is intended to implement and evaluate new AOT programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with an SMI. This program is designed to work with families and courts to allow these individuals to obtain treatment while continuing to live in the community and their homes. Grants were awarded to applicants that have not previously implemented an AOT program.

SAMHSA has partnered with the Assistant Secretary for Planning and Evaluation to implement a cross-site evaluation which will assess the effectiveness and impact of the AOT grant program. Additional program outcomes that will be evaluated will include, but are not be limited to, the

rates of incarceration, employment, healthcare utilization, mortality, suicide, substance use, hospitalization, homelessness, and use of services.

SAMHSA will continue to consult with the National Institute of Mental Health, the Attorney General, and the Administration for Community Living on this pilot program. In addition, SAMHSA will work with families and courts in the implementation of this program.

In FY 2017, SAMHSA will provide funding for the continuation of 17 grants, technical assistance, and the evaluation of this program.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	$15,000,000
FY 2017	$14,971,000
FY 2018	$14,971,000

Budget Request

The FY 2018 Budget Request includes $15.0 million, level with the FY 2017 Annualized CR. This funding will support 17 grant continuations to improve the health and social outcomes for individuals with serious mental illness by providing continuation funding for the AOT grants, evaluation, and technical assistance.

Outputs and Outcomes Table

Program: Mental Health – Other Capacity Activities [1]

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
1.2.05 Increase the percentage of clients receiving services who report positive functioning at 6 month follow-up (Outcome)	FY 2016: 72.6 % Target: 55.7 % (Target Exceeded)	55.7 %	55.7 %	Maintain
1.2.82 Increase the percentage of clients receiving services who had a permanent place to live in the community at 6 month follow-up (Outcome)	FY 2016: 47.3 % Target: 70.5 % (Target Not Met)	70.5 %	70.5 %	Maintain
1.2.83 Increase the percentage of clients receiving services who are currently employed at 6 month follow-up (Outcome)	FY 2016: 35.1 % Target: 22.2 % (Target Exceeded)	25.3 %	25.3 %	Maintain
1.2.88 Increase the number of individuals screened for mental health or related interventions (Outcome)	FY 2016: 8,742 Target: 13,775 (Target Not Met)	29,813	29,813	Maintain

[1] includes the following: Law Enforcement and Behavioral health partnership for Early Diversion, Jail Diversion and Trauma Recovery-Priority to Veterans, Minority AIDS Initiative, Targeted Capacity Expansion, and Primary and Behavioral Health Care Integration.

Outputs and Outcomes Table

Program: Mental Health - Science and Service Activities

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
1.4.06 Increase the number of people trained by CMHS Science and Service Programs (Output)	FY 2016: 34,468 Target: 16,271 (Target Exceeded)	20,000	20,000	Maintain
1.4.14 Increase the number of calls answered by the Disaster Distress Hotline (Output)	FY 2016: 8,422 Target: 3,228 (Target Exceeded)	6,000	6,000	Maintain
1.4.15 Increase the number of text messages answered by the Disaster Distress Hotline (Output)	FY 2016: 8,210 Target: 4,131 (Target Exceeded)	10,000	10,000	Maintain

Tribal Behavioral Health Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Tribal Behavioral Health Grants	$15,000	$14,971	$14,971	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Tribes

Program Description and Accomplishments

Suicide is the second leading cause of death among American Indian/Alaska Native (AI/AN) youth ages 8 to 24 years.[6] Further, AI/AN high school students report higher rates of suicidal behaviors than the general population of U.S. high school students.[7] These behaviors include serious thoughts of suicide, suicide plans, suicide attempts, and medical attention for a suicide attempt. However, the risk of suicide is not the same in all AI/AN youth demographic groups. For instance, AI/AN youth raised in urban settings have a smaller risk of suicide than AI/AN youth raised on tribal reservations (21 percent and 33 percent, respectively).[8]

Consistent with the goals of the Tribal Behavioral Health Agenda, the Tribal Behavioral Health Grant (TBHG) program addresses the high incidence of substance use and suicide among AI/AN populations. Starting in FY 2014, this program supports tribal entities with the highest rates of suicide by providing effective and promising strategies that address substance abuse, trauma, and suicide and by promoting the mental health of AI/AN young people.

In FY 2014, SAMHSA's Center for Mental Health Services awarded five-year TBHG grants of up to $0.2 million annually to 20 tribes or tribal organizations with high rates of suicide. These five-year grants help grantees develop and implement a plan that addresses suicide and substance abuse, thereby promoting mental health among tribal youth. In addition, SAMHSA's Tribal Training and Technical Assistance Center (http://www.samhsa.gov/tribal-ttac) provides training and education to AI/AN grantees and organizations serving AI/AN populations to support their ability to achieve their goals. An evaluation component allows grantees and SAMHSA to work collaboratively to monitor progress and learn from each other.

In FY 2016, SAMHSA expanded the TBHG program to include a Native youth initiative focused on removing possible barriers to success for Native youth. This initiative takes a comprehensive, culturally appropriate approach to help improve the lives of and opportunities for AI/AN youth. In addition to the Department of Health and Human Services, multiple agencies, including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing AI/AN youth. This

[6] Centers for Disease Control and Prevention. Fatal injury data, 2010. Web-based Injury Statistics Query and Reporting System. Available at www.cdc.gov/injury/wisqars/fatal.html. Accessed May 27, 2014.
[7] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Available at http://www.cdc.gov/healthyyouth/yrbs/index.htm. Accessed May 27, 2014.
[8] http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2011/AI-AN2011.pdf

funding allows SAMHSA to expand activities through the braided TBHG ($15.0 million in the Substance Abuse Prevention appropriation and $15.0 million in Mental Health appropriation) to allow tribes the flexibility to implement community-based strategies to address trauma, prevent substance abuse, and promote mental health and resiliency among youth in tribal communities. The additional FY 2016 funding expands these activities to approximately 90 tribes and tribal entities. With the expansion of the TBHG program, SAMHSA's goal is to reduce substance use and the incidence of suicide attempts among AI/AN youth and to address behavioral health conditions that affect learning in the Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion, including trauma-informed strategies, and substance use prevention activities for high-risk AI/AN youth and their families, enhance early detection of mental illness and drug/alcohol addiction among AI/AN youth, and increase referral to treatment. In FY 2017, SAMHSA will provide funding to support 81 grant continuations, a new cohort of grants, and the evaluation and technical assistance activities.

Funding History

Fiscal Year	Amount
FY 2014	$4,988,000
FY 2015	$4,988,000
FY 2016	$15,000,000
FY 2017	$14,971,000
FY 2018	$14,971,000

Budget Request

The FY 2018 Budget Request is $15.0 million level with the FY 2017 Annualized CR. This request, combined with $15.0 million $15.0 million in the Substance Abuse Prevention will continue support for 113 grants that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families.

As a braided activity, SAMHSA will track separately any amounts spent or awarded under Tribal Behavioral Health Grants through the distinct appropriations and ensure that funds are used for purposes consistent with legislative direction and intent of these appropriations.

Outputs and Outcomes Table

Program: Tribal Behavioral Health

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
2.4.12 Increase the number of youth age 10 - 24 who received mental health or related services after screening, referral or attempt (Output)	FY 2016: 20 Target: 20 (Baseline)	20	20	Maintain
2.4.13 Increase the number of programs/organizations that implemented specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2016: 296 Target: 296 (Baseline)	296	296	Maintain

Minority Fellowship Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Minority Fellowship Program	$8,059	$8,044	$8,044	$---

Authorizing Legislation ..... Section 516 of the PHS Act
Allocation Method ..... Grants/Contracts
Eligible Entities..... American Nurses Association (ANA), American Psychiatric Association (ApA), American Psychological Association (APA), Council on Social Work Education (CSWE), American Association for Marriage and Family Therapy (AAMFT)

Program Description and Accomplishments

The mental health-related and substance use-related service needs of racial and ethnic minority communities within the United States have been historically under–addressed due to a variety of factors. These include a limited number of trained practitioners who are equipped with the language skills or cultural competency training needed to deliver effective services for this population. SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to funding increases the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance abuse treatment services for minority populations that are underserved. This will result in improved quality of mental and substance abuse prevention and increased treatment delivered to ethnic minorities. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, the program expanded to include marriage and family therapists and later added professional counselors. These individuals often serve in key leadership positions in mental illness and substance abuse treatment services, services supervision, services research, training, and administration. Professional guilds receive competitively awarded grants, and then competitively award the stipends to post-graduate students pursuing a degree in that professional field. In FY 2015 and FY 2016, SAMHSA funded six continuation grants.

Minority Fellowship Program Expansion-Youth (MFP-Y) and Addiction Counselors (MFP-AC)
Begun in FY 2014, MFP-Y is a component of MFP that support master's level trained behavioral health professionals in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing serving children, adolescents, and populations in transition to adulthood (aged 16 to 25). The purpose of the program expansion, the Minority Fellowship Program-Youth (MFP-Y), is to reduce health disparities and improve behavioral healthcare outcomes for racially and ethnically diverse youth and young adults.

To do this, the program aims to increase the number of culturally competent master's level behavioral health professionals serving children, adolescents, and populations in transition to

adulthood (aged 16 to 25) in an effort to increase access to, and the quality of, behavioral health care for this age group. The expansion program uses the existing infrastructure of the MFP to expand the program to support 960 master's level trained behavioral health providers. Grants are competitively awarded to professional guilds, which then competitively award the stipends to post-graduate students pursuing a degree in that professional field.

MFP-AC is a component of MPP to support master's level addiction counselors (MFP-AC) for youth and young adults. The purpose of the four-year grant program is to reduce health disparities and improve behavioral healthcare outcomes for racially and ethnically diverse populations by increasing the number of culturally competent master's level addiction counselors available to underserved minority populations with a specific focus on transition age youth (ages 16 to 25) in public and private non-profit sectors. MFP-AC grants are supporting students pursuing master's level degrees in addiction/substance abuse counseling, with the goal of increasing the number of masters-level addiction counselors across the nation by approximately 300 counselors. As is the case with MFP and MFP-Y, grants are competitively awarded to professional guilds, who then competitively award the stipends to post-graduate students pursuing a degree in that professional field.

Funding History

Fiscal Year	Amount
FY 2014	$7,977,134
FY 2015	$8,058,998
FY 2016	$8,059,000
FY 2017	$8,044,000
FY 2018	$8,044,000

Budget Request

The FY 2018 Budget Request is $8.0 million, level with the FY 2017 Annualized CR. The funds will support six MFPs, five MFP-Y, and one technical assistance and evaluation support contract. Funding will support the training of approximately 300 fellows.

Assertive Community Treatment for Adults with SMI

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Assertive Community Treatment for Individuals with Serious Mental Illness	$---	$---	$5,000	$5,000

Authorizing Legislation ..... Sections 520A and 506 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Domestic Public and Community Organizations, Private Nonprofit Entities, and Community-based Public or Nonprofit Entities

Program Description and Accomplishments

The Assertive Community Treatment (ACT) for Adults with Serious Mental Illness (SMI) program is authorized under the 21st Century Cures Act of 2016. ACT is an evidence-based practice considered one of the most effective approaches to deliver services to people with serious mental illness[9] and has been disseminated by SAMHSA for widespread use through its Evidence Based Toolkit series[10] beginning in 2008. ACT was developed to reduce re-hospitalization and improve outcomes soon after discharge. ACT is designed as a coordinated care approach to provide a comprehensive array of services - including medication management along with other supportive services - directly rather than through referrals. The ACT team is composed of 10-12 transdisciplinary behavioral health staff – including psychiatrists, nurses, peer specialists and others - working together to deliver a mix of individualized, recovery oriented services to approximately 100 people with serious mental illness to help them to integrate into the community. Caseloads are approximately one staff to every 10 individuals. The services are provided 24 hours, 7 days a week and as long as needed, wherever they are needed. Teams often find they can anticipate and avoid crises.

In FY 2018 SAMHSA will award grants, to states, counties, cities, tribes and tribal organizations, mental health systems, health care facilities and entities to establish, maintain or expand ACT programs. Special consideration will be given to applicants that serve those adults with serious mental illness who are high utilizers of health and social services including homeless and justice involved populations. In addition, technical assistance and a program evaluation will be supported. A program evaluation will be conducted to report public health outcomes to include mortality, suicide, substance use, hospitalization; rates of homelessness and involvement with the criminal justice system; patient and family satisfaction with program participation; service utilizations and cost.

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3589962/
[10] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	---
FY 2018	$5,000,000

Budget Request

The FY 2018 Budget Request is $5.0 million, an increase of $5.0 million from the FY 2017 Annualized CR. Funding will support approximately seven grants and technical assistance and evaluation activities.

SAMHSA/Mental Health
PRNS Mechanism Table Summary

(Dollars in thousands)

	FY 2016 Final		FY 2017 Annualized CR		FY 2018 President's Budget	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Programs of Regional & National Significance						
Grants/Cooperative Agreements						
Continuations	420	$226,675	629	$246,210	434	$177,460
New/Competing	302	119,042	107	65,882	114	41,017
Subtotal	722	345,717	736	312,092	548	218,477
Contracts						
Continuations	19	56,100	24	85,302	18	47,423
New/Competing	9	12,792	4	16,449	6	11,520
Subtotal	28	68,892	28	101,751	24	58,943
Total, Mental Health PRNS	**750**	**$414,609**	**764**	**$413,843**	**572**	**$277,419**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
Capacity:						
National Child Traumatic Stress Network						
Grants						
Continuations	---	$ ---	82	$43,283	82	$43,299
New/Competing	82	43,284	---	---	---	---
Subtotal	82	43,284	82	43,283	82	43,299
Contracts						
Continuations	---	3,603	---	2,489	---	3,499
New/Competing	---	---	---	1,025	---	---
Subtotal	---	3,603	---	3,514	---	3,499
Total ,National Child Traumatic Stress Network	**82**	**46,887**	**82**	**46,798**	**82**	**46,798**
Youth Violence Prevention						
Grants						
Continuations	8	19,587	---	---	7	15,160
New/Competing	---	---	7	15,153	---	---
Subtotal	8	19,587	7	15,153	7	15,160
Contracts						
Continuations	1	3,512	---	2,202	1	4,889
New/Competing	---	---	1	5,700	---	3,006
Subtotal	1	3,512	1	7,902	1	7,895
Total, Youth Violence Prevention	**9**	**23,099**	**8**	**23,055**	**8**	**23,055**
Project AWARE						
Grants						
Continuations	89	46,547	96	35,137	---	---
New/Competing	10	10,239	---	4,534	---	---
Subtotal	99	56,786	96	39,671	---	---
Contracts						
Continuations	1	6,009	3	22,160	---	---
New/Competing	1	2,070	---	2,911	---	---
Subtotal	2	8,078	3	25,071	---	---
Total, Project AWARE	**101**	**64,865**	**99**	**64,742**	**---**	**---**
Healthy Transitions						
Grants						
Continuations	17	16,853	16	15,323	---	---
New/Competing	---	---	---	---	---	---
Subtotal	17	16,853	16	15,323	---	---
Contracts						
Continuations	---	2,286	---	4,590	---	---
New/Competing	---	812	---	---	---	---
Subtotal	---	3,098	---	4,590	---	---
Total, Healthy Transitions	**17**	**19,951**	**16**	**19,913**	**---**	**---**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
Children and Family Programs						
Grants						
Continuations	11	4,383	---	---	11	4,560
New/Competing	---	---	11	4,586	---	---
Subtotal	11	4,383	11	4,586	11	4,560
Contracts						
Continuations	---	2,075	---	1,860	---	1,090
New/Competing	---	---	---	---	---	796
Subtotal	---	2,075	---	1,860	---	1,886
Total, Children and Family Programs	**11**	**6,458**	**11**	**6,446**	**11**	**6,446**
Consumer and Family Network Grants						
Grants						
Continuations	14	1,322	44	4,123	30	2,836
New/Competing	37	3,195	---	---	14	1,310
Subtotal	51	4,517	44	4,123	44	4,146
Contracts						
Continuations	---	183	---	821	---	798
New/Competing	---	253	---	---	---	---
Subtotal	---	437	---	821	---	798
Total, Consumer and Family Network Grants	**51**	**4,954**	**44**	**4,945**	**44**	**4,945**
Project LAUNCH						
Grants/Cooperative Agreements						
Continuations	36	28,956	25	17,733	33	22,051
New/Competing	---	---	13	7,600	5	3,536
Subtotal	36	28,956	38	25,333	38	25,588
Contracts						
Continuations	2	5,513	2	5,582	2	6,902
New/Competing	---	86	2	3,574	1	2,000
Subtotal	2	5,599	4	9,156	3	8,902
Total, Project LAUNCH	**38**	**34,555**	**42**	**34,489**	**41**	**34,489**
Mental Health System Transformation and Health Reform						
Grants						
Continuations	7	2,633	7	1,688	7	2,678
New/Competing	---	---	---	---	---	---
Subtotal	7	2,633	7	1,688	7	2,678
Contracts						
Continuations	---	222	---	2,084	---	1,094
New/Competing	---	924	---	---	---	---
Subtotal	---	1,146	---	2,084	---	1,094
Total, Mental Health System Transformation and Health Reform	**7**	**3,779**	**7**	**3,772**	**7**	**3,772**
Primary and Behavioral Health Care Integration						
Grants						
Continuations	53	20,628	62	22,650	---	---
New/Competing	28	25,899	11	23,009	---	---
Subtotal	81	46,527	73	45,659	---	---
Contracts						
Continuations	---	3,350	---	4,123	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	3,350	---	4,123	---	---
Total, PBHCI	**81**	**49,877**	**73**	**49,782**	**---**	**---**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
National Strategy for Suicide Prevention						
Grants						
Continuations	4	1,880	---	---	4	1,886
New/Competing	---	---	4	1,886	---	---
Subtotal	4	1,880	4	1,886	4	1,886
Contracts						
Continuations	---	120	---	111	---	111
New/Competing	---	---	---	---	---	---
Subtotal	---	120	---	111	---	111
Total, National Strategy for Suicide Prevention	**4**	**2,000**	**4**	**1,996**	**4**	**1,996**
GLS - Youth Suicide Prevention - States						
Grants						
Continuations	38	27,590	43	29,728	42	30,802
New/Competing	4	2,942	---	---	---	---
Subtotal	42	30,533	43	29,728	42	30,802
Contracts						
Continuations	1	4,894	1	5,655	1	4,580
New/Competing	---	---	---	---	---	---
Subtotal	1	4,894	1	5,655	1	4,580
Total, GLS - States	**43**	**35,427**	**44**	**35,382**	**43**	**35,382**
GLS - Youth Suicide Prevention - Campus						
Grants						
Continuations	37	3,505	40	3,665	31	3,238
New/Competing	18	1,756	15	1,656	22	2,062
Subtotal	55	5,261	55	5,321	53	5,300
Contracts						
Continuations	---	1,227	---	1,155	---	1,176
New/Competing	---	---	---	---	---	---
Subtotal	---	1,227	---	1,155	---	1,176
Total, GLS - Campus	**55**	**6,488**	**55**	**6,476**	**53**	**6,476**
GLS - Suicide Prevention Resource Center						
Grants						
Continuations	1	5,634	1	5,634	1	5,634
New/Competing	---	---	---	---	---	---
Subtotal	1	5,634	1	5,634	1	5,634
Contracts						
Continuations	---	354	---	343	---	343
New/Competing	---	---	---	---	---	---
Subtotal	---	354	---	343	---	343
Total, GLS - Suicide Prevention Resource Center	**1**	**5,988**	**1**	**5,977**	**1**	**5,977**
Suicide Lifeline						
Grants						
Continuations	1	5,288	7	5,975	6	687
New/Competing	6	690	---	---	1	5,288
Subtotal	7	5,978	7	5,975	7	5,975
Contracts						
Continuations	---	1,220	---	1,210	---	1,210
New/Competing	---	---	---	---	---	---
Subtotal	---	1,220	---	1,210	---	1,210
Total, Suicide Lifeline	**7**	**7,198**	**7**	**7,184**	**7**	**7,184**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
AI/AN Suicide Prevention Initiative						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	2,781	1	2,925	---	153
New/Competing	1	150	---	---	1	2,772
Subtotal	2	2,931	1	2,925	1	2,925
Total, AI/AN	**2**	**2,931**	**1**	**2,925**	**1**	**2,925**
Homelessness Prevention Programs						
Grants						
Continuations	17	14,758	39	18,682	37	14,831
New/Competing	30	9,738	14	4,899	10	10,403
Subtotal	47	24,496	53	23,581	47	25,234
Contracts						
Continuations	2	5,114	2	5,014	2	5,404
New/Competing	1	1,086	---	2,043	---	---
Subtotal	3	6,200	2	7,057	2	5,404
Total, Homelessness Prevention Programs	**50**	**30,696**	**55**	**30,638**	**49**	**30,638**
Minority AIDS						
Grants						
Continuations	34	7,675	34	7,753	---	---
New/Competing	---	---	---	---	34	2,936
Subtotal	34	7,675	34	7,753	34	2,936
Contracts						
Continuations	---	1,549	---	1,453	---	868
New/Competing	---	---	---	---	---	402
Subtotal	---	1,549	---	1,453	---	1,271
Total, Minority AIDS	**34**	**9,224**	**34**	**9,206**	**34**	**4,206**
Criminal and Juvenile Justice Programs						
Grants						
Continuations	17	2,903	17	2,249	---	---
New/Competing	---	---	---	---	17	2,905
Subtotal	17	2,903	17	2,249	17	2,905
Contracts						
Continuations	1	681	2	2,012	2	1,356
New/Competing	1	684	---	---	---	---
Subtotal	2	1,366	2	2,012	2	1,356
Total, Criminal and Juvenile Justice Programs	**19**	**4,269**	**19**	**4,261**	**19**	**4,261**
Seclusion and Restraint						
Grants						
Continuations	---	$---	---	$---	---	$---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	1,147	1	1,145	---	60
New/Competing	---	---	---	---	1	1,085
Subtotal	1	1,147	1	1,145	1	1,145
Total, Seclusion and Restraint	**1**	**1,147**	**1**	**1,145**	**1**	**1,145**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
Assertive Community Treatment for Individuals with Serious Mental Illness						
Grants						
Continuations	---	---	---	---	---	5,000
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	5,000
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Total, Assertive Community Treatment for Individuals with Serious Mental Illness	**---**	**---**	**---**	**---**	**---**	**$5,000**
Assisted Outpatient Treatment for Individuals with Serious Mental Illness						
Grants						
Continuations	---	---	17	13,318	17	13,305
New/Competing	17	13,430	---	---	---	---
Subtotal	17	13,430	17	13,318	17	13,305
Contracts						
Continuations	---	---	---	1,653	1	1,667
New/Competing	1	1,570	---	---	---	---
Subtotal	1	1,570	---	1,653	1	1,667
Total, Assisted Outpatient Treatment for Individuals with Serious Mental Illness	**18**	**15,000**	**17**	**14,971**	**18**	**14,971**
Tribal Behavioral Health Grants						
Grants						
Continuations	20	3,804	81	7,812	113	11,532
New/Competing	70	7,869	32	2,560	---	---
Subtotal	90	11,672	113	10,372	113	11,532
Contracts						
Continuations	---	265	1	3,904	1	3,440
New/Competing	1	3,063	---	696	---	---
Subtotal	1	3,328	1	4,599	1	3,440
Total, Tribal Behavioral Health Grants	**91**	**15,000**	**114**	**14,971**	**114**	**14,971**
Subtotal, Capacity	**722**	**$389,793**	**734**	**$389,075**	**537**	**$254,638**
Science and Service:						
Primary and Behavioral Health Care Integration TA						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	1,938	1	1,987	---	---
New/Competing	---	53	---	---	---	---
Subtotal	1	1,991	1	1,987	---	---
Total, PBHCI TA	**1**	**1,991**	**1**	**1,987**	**---**	**---**
Practice Improvement & Training						
Grants						
Continuations	---	3,156	2	2,137	8	3,158
New/Competing	---	---	---	---	---	---
Subtotal	---	3,156	2	2,137	8	3,158
Contracts						
Continuations	5	3,775	6	5,176	6	3,815
New/Competing	2	897	1	500	2	840
Subtotal	7	4,672	7	5,676	8	4,655
Total, Practice Improvement & Training	**7**	**7,828**	**9**	**7,813**	**16**	**7,813**

SAMHSA/Mental Health
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
Consumer and Consumer-Supporter TA Centers						
Grants						
Continuations	5	1,799	5	1,547	5	1,804
New/Competing	---	---	---	---	---	---
Subtotal	5	1,799	5	1,547	5	1,804
Contracts						
Continuations	---	119	---	368	---	111
New/Competing	---	---	---	---	---	---
Subtotal	---	119	---	368	---	111
Total, CCSTAC	**5**	**1,918**	**5**	**1,914**	**5**	**1,914**
Disaster Response						
Grants						
Continuations	---	923	---	923	---	---
New/Competing	---	---	---	---	---	828
Subtotal	---	923	---	923	---	828
Contracts						
Continuations	1	1,030	1	1,026	1	1,121
New/Competing	---	---	---	---	---	---
Subtotal	1	1,030	1	1,026	1	1,121
Total, Disaster Response	**1**	**1,953**	**1**	**1,949**	**1**	**1,949**
Homelessness						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	1,153	1	2,292	1	2,292
New/Competing	1	1,143	---	---	---	---
Subtotal	1	2,296	1	2,292	1	2,292
Total, Homelessness	**1**	**2,296**	**1**	**2,292**	**1**	**2,292**
Minority Fellowship Program						
Grants						
Continuations	11	6,851	11	6,851	---	---
New/Competing	---	---	---	---	11	6,749
Subtotal	11	6,851	11	6,851	11	6,749
Contracts						
Continuations	1	1,208	1	1,193	---	676
New/Competing	---	---	---	---	1	619
Subtotal	1	1,208	1	1,193	1	1,295
Total, Homelessness	**12**	**8,059**	**12**	**8,044**	**12**	**8,044**
HIV/AIDS Education						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	771	1	770	---	770
New/Competing	---	---	---	---	---	---
Subtotal	1	771	1	770	---	770
Total, HIV/AIDS Education	**1**	**771**	**1**	**770**	**---**	**770**
Subtotal, Science and Service	**28**	**24,816**	**30**	**24,769**	**35**	**22,782**
Total, Mental Health PRNS	**750**	**$414,609**	**764**	**$413,843**	**572**	**$277,419**

Grant Awards Table

(Whole dollars)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	722	736	548
Average Awards	$478,832	$424,039	$389,680
Range of Awards	$15,000 - $6,000,000	$15,000 - $6,000,000	$15,000 - $6,000,000

Children's Mental Health Services

(Dollars in thousands)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Programs of Regional & National Significance				
Budget Authority	$119,026	$118,800	$118,800	---
10% set-aside for youth in prodrome phase of psychosis (non-add)	---	---	*11880*	*11880*

Authorizing Legislation ..... Sections 561 of the Public Health Service Act
FY 2018 Authorization $119,026
Allocation Method .....Competitive Grants/Contracts
Eligible Entities…….States, Tribes, Communities, Territories

Program Description and Accomplishments

It is estimated that over 7.4 million children and youth in the United States have a serious mental disorder. Unfortunately, only 41 percent of those in need of mental health services actually receive treatment.[11] Created in 1992, SAMHSA's Children's Mental Health Initiative (CMHI) addresses this gap by supporting "systems of care" (SOC) for children and youth with serious emotional disturbances and their families to increase their access to evidence-based treatment and supports. The 21st Century Cures Act reauthorized the CMHI through FY 2022. Approximately 9-13 percent of America's youth are estimated to have a serious emotional disturbance (SED). CMHI provides grants to assist states, local governments, tribes, and territories in their efforts to deliver services and supports to meet the needs of children and youth with SED.

CMHI supports the development, implementation, expansion, and sustainability of comprehensive, community-based services that use the SOC approach. SOC is a strategic approach to the delivery of services and supports that incorporates family-driven, youth-guided, strength-based, and culturally and linguistically competent care in order to meet the physical, intellectual, emotional, cultural, and social needs of children and youth throughout the U.S. The SOC approach helps prepare children and youth for successful transition to adulthood and assumption of adult roles and responsibilities. Services are delivered in the least restrictive environment with evidence-supported treatments and interventions. Individualized care management ensures that planned services and supports are delivered with an appropriate, effective, and youth-guided approach. This approach has demonstrated improved outcomes for children at home, at school, and in their communities. For example, CMHI grantee data show that suicide attempt rates fell over 38 percent within 12 months after children and youth accessed CMHI-related SOC services. In addition, school suspensions/expulsions fell over 42 percent and unlawful behavior fell over 40 percent within 18 months of children and youth beginning SOC-related services and supports.

[11] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 144863. Rockville, MD: Substance Abuse and Mental Health Services Administration.

In addition, the CMHI program seeks to address behavioral health disparities for children and youth with SED/Serious Mental Illness (SMI) from racial and ethnic minorities by promoting clear and culturally competent strategies to improve their access, use of services, and outcomes.

SAMHSA funding ensures that grantees will continue to expand and sustain CMHI SOC values, principles, infrastructure, and services throughout their states, tribes, and territories. A central focus of these efforts is ensuring collaboration between the CMHI SOC and other child-and youth-serving systems (e.g., Child Welfare, Juvenile Justice, and Education). SAMHSA also strongly encourages efforts by CMHI SOC to coordinate with other SAMHSA programs, such as those supported by the Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG).

CMHI has an ongoing national evaluation, which is designed to provide information on: 1) the mental health outcomes of children and youth, and their families; 2) the implementation, process, and sustainability of SOC; and 3) critical and emerging issues in children's and youth's mental health. The evaluation includes an SOC assessment that describes the infrastructure and an assessment of outcomes derived from direct SOC services. A service experience study evaluates: 1) change in service use patterns of children and their families; 2) differences in client satisfaction between groups of children (and their families) in the SOC communities who receive an evidence-based treatment and those who do not; and 3) retention in services.

National program evaluation data reported annually to Congress indicate that CMHI SOCs are successful, resulting in many favorable outcomes for children, youth, and their families, including:

- sustained mental disorder improvements for participating children and youth in behavioral health outcomes after as little as six months of program participation;
- improvements in school attendance and achievement;
- reductions in suicide-related behaviors;
- decreases in the use of inpatient care and reduced costs due to fewer days in residential settings; and
- significant reductions in contacts with law enforcement.

In FY 2015, SAMHSA supported 54 continuation grants. SAMHSA also awarded 24 four-year new SOC Expansion and Sustainability Cooperative Agreements that focused on sustainable financing, cross-agency collaboration, the creation of policy and infrastructure, and the development and implementation of services and supports. In addition, SAMHSA supported one new technical assistance contract and one new evaluation contract.

In FY 2016, SAMHSA supported 47 continuation grants, 53 new grants, and five contracts. In FY 2017, SAMHSA will support 64 continuation grants, 8 new grants, and four contracts.

Funding History

Fiscal Year	Amount
FY 2014	$117,026,000
FY 2015	$117,026,000
FY 2016	$119,026,000
FY 2017	$118,800,000
FY 2018	$118,800,000

Budget Request

The FY 2018 Budget Request is $118.8 million, level with the FY 2017 Annualized CR. As part of this budget request, SAMHSA seeks to develop and implement a services research demonstration effort based on the North American Prodrome Longitudinal Study funded by the National Institute of Mental Health. During the prodrome phase, a disease process has begun but is not yet diagnosable or inevitable. The demonstration will address whether community-based intervention during this phase can prevent the further development of serious emotional disturbances and ultimately serious mental illness. The project will examine the extent to which evidence-based early intervention for young people at clinical high risk for psychosis can be scaled up to mitigate or delay the progression of mental illness, reduce disability, and/or maximize recovery. The new effort will be funded from a 10 percent set-aside of the base program, and will focus on youth and young adults who are identified to be at clinical high risk for developing a first episode of psychosis. Funding of this new effort will not affect continuation funding of any CMHI-base funded program. The grantees will focus on this population in order to support the development and implementation of evidence-based programs providing community outreach and psychosocial interventions for youth and young adults in the prodrome phase of psychotic illness. The Budget includes new appropriations language for the 10 percent set-aside.

The budget request will also support funding for 72 continuation grants and four continuation contracts. This funding will provide training to 5,100 people in the mental health and related workforce and serve 13,595 children with serious emotional disturbances.

SAMHSA/Mental Health
Mechanism Table

(Dollars in thousands)

Program Activity	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
Children's Mental Health Services						
Grants/Cooperative Agreements						
Continuations	47	$42,132	64	$77,873	65	$86,878
New/Competing	32	54,379	8	18,348	12	11,326
Subtotal.	79	96,511	72	96,221	77	98,204
Contracts						
Continuations	2	12,561	---	13,380	1	9,278
New/Competing	---	500	---	---	1	2,000
Subtotal	2	13,061	---	13,380	2	11,278
Technical Assistance	2	9,454	---	9,199	2	9,318
Total, Children's Mental Health Services	**83**	**$119,026**	**72**	**$118,800**	**81**	**$118,800**

* Totals may not add due to rounding.

Outputs and Outcomes Table

Program: Children's Mental Health Services

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
3.2.16 Increase the number of children with severe emotional disturbance that are receiving services from the Children's Mental Health Initiative (Output)	FY 2016: 7,830 Target: 6,610 (Target Exceeded)	7,830	7,830	Maintain
3.2.25 Increase the percentage of children receiving services who report positive social support at 6 month follow-up (Outcome)	FY 2016: 86.1 % Target: 87.6 % (Target Not Met)	87.6 %	87.6 %	Maintain
3.2.26 Increase the percentage of children receiving Systems of Care mental health services who report positive functioning at 6 month follow-up (Outcome)	FY 2016: 59.6 % Target: 62.7 % (Target Not Met)	62.7 %	62.7 %	Maintain
3.2.27 Increase the number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the program (Output)	FY 2016: 48,818 Target: 5,101 (Target Exceeded)	48,818	48,818	Maintain

Grant Awards Table

(Whole dollars)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	79	72	77
Average Awards	$1,221,658	$1,336,403	$1,275,373
Range of Awards	$330,000 - $2,000,000	$330,000 - $2,000,000	$330,000 - $2,000,000

Projects for Assistance in Transition from Homelessness

(Dollars in thousands)

Program Activity	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Budget Authority	$64,635	$64,512	$64,512	$---

Authorizing Legislation ..... Section 535(a) of the Public Health Service Act
FY 2018 Authorization $64,635
Allocation Method ..... Formula Grants
Eligible Entities..... States and Territories

Program Description and Accomplishments

On an average night, an estimate of 578,424 individuals experience homelessness.[12] Data suggest that approximately 26 percent of individuals experiencing homelessness have a serious mental illness (SMI), and that 30 percent of the chronically homeless population (individuals or families with a disabling condition who have been experiencing homelessness for longer than one year or more than four times in the past three years) have a serious mental illness.[13,14,15] Mental illness affects individuals' abilities to maintain stable relationships, perform daily living activities, and maintain stable employment. Symptoms of mental disorders also often cause individuals to become estranged from family members and caregivers, leaving them without a support system. As a result, individuals with a mental illness are more likely to experience homelessness than those without mental illness and experience homelessness longer than the rest of the homeless population.[16]

Data show that the PATH program's efforts to identify primary care, behavioral disorder treatment, and housing for individuals who are chronically homeless is two to three times more cost effective than having them in the criminal justice system or treating them via other costly healthcare settings (e.g., emergency rooms, critical care units).

In 1990, the Stewart B. McKinney Homeless Assistance Amendments Act authorized the PATH program to provide services to individuals who are experiencing homelessness and SMI. The

[12] The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2014). The 2014 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. Available at: https://www.hudexchange.info/resources/documents/2014-AHAR-Part1.pdf
[13] The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2010). The 2010 Annual Homeless Assessment Report (AHAR) to Congress. Available at: https://www.hudexchange.info/resources/documents/2010HomelessAssessmentReport.pdf
[14] National Alliance on Mental Illness. Mental Health by the Numbers. Available at: https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
[15] Office of National Drug Control Policy. Integrate Treatment for Substance Use Disorders into Mainstream Health Care and Expand Support for Recovery. Available at: https://www.whitehouse.gov/ondcp/chapter-integrate-treatment-for-substance-use-disorders
[16] National Alliance on Mental Illness (2004). Homelessness. Available at: http://www2.nami.org/Content/ContentGroups/Policy/Fact_Sheets/homelessnessPFS.pdf

PATH program supports 56 grants to the 50 states, the District of Columbia, Puerto Rico, Guam, American Samoa, the United States Virgin Islands, and the Northern Mariana Islands, as well as centralized activities such as technical assistance and evaluation. PATH funds community-based outreach, mental illness and substance abuse treatment services, case management, assistance with accessing housing, and other supportive services. PATH helps to engage people with SMI into mental disorder treatment. PATH outreach workers specialize in engaging those who are most vulnerable in their communities and who are least likely to seek out services on their own. PATH's primary goal is to bring the most vulnerable into the service system and to connect them with the mainstream resources and supportive services that they need in order to access and sustain stable housing, build social connections, and access treatment and services to support their recovery.

In FY 2015, the PATH program outreached to 181,336 individuals experiencing homelessness and enrolled 60 percent of individuals with an SMI into the PATH program (90,054 individuals). Additionally, 53 percent of enrolled individuals were experiencing a co-occurring drug/alcohol addiction. Of those enrolled in PATH, 56,405 individuals received community mental health services. In addition, 10,372 individuals received substance abuse treatment through PATH, while 17,318 individuals were referred by PATH to substance abuse treatment services in the community. In addition, PATH assisted 17,232 individuals with addressing complex housing needs and referred 25,911 individuals to housing assistance agencies in their communities. The services provided by the PATH program fill gaps in existing community resources and play a crucial role in communities' strategic plans to end homelessness. In FY 2016 and FY 2017, SAMHSA continued support for this program.

Funding History

Fiscal Year	Amount
FY 2014	$64,635,000
FY 2015	$64,635,000
FY 2016	$64,635,000
FY 2017	$64,512,000
FY 2018	$64,512,000

Budget Request

The FY 2018 Budget Request is $64.5 million, level with the FY 2017 Annualized CR. This formula-based funding to all states will continue PATH services in over 500 communities that the states provide funding to in order to support outreach workers and mental health specialists that engage with individuals who are living with SMI or those living with both SMI and drug/alcohol addiction and are homeless or at imminent risk of becoming homeless. The services provided by the program help ensure that these individuals have an opportunity to access stable housing, improve their health and wellness, lead self-directed lives, and achieve their full potential.

Outputs and Outcomes Table

Program: Projects for Assistance in Transition from Homelessness

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
3.4.15 Increase the percentage of enrolled homeless persons in the Projects for Assistance in Transition from Homelessness (PATH) program who receive community mental health services (Intermediate Outcome)	FY 2015: 63 % Target: 66 % (Target Not Met)	66 %	66 %	Maintain
3.4.16 Increase the number of homeless persons contacted (Outcome)	FY 2015: 181,336 Target: 191,926 (Target Not Met)	185,524	185,524	Maintain
3.4.17 Increase the percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome)	FY 2015: 60 % Target: 58 % (Target Exceeded)	58 %	58 %	Maintain
3.4.20 Increase the number of Projects for Assistance in Transition from Homelessness (PATH) providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits (Output)	FY 2015: 1,676 Target: 4,360 (Target Not Met)	2,296	2,296	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

State/Territory	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Alabama	$613,371	$611,547	$611,434	−113
Alaska	300,000	300,000	300,000	---
Arizona	1,349,975	1,345,960	1,345,711	−249
Arkansas	304,097	303,192	303,136	−56
California	8,817,598	8,791,370	8,789,750	−1,620
Colorado	1,019,638	1,016,606	1,016,418	−188
Connecticut	799,779	797,401	797,253	−148
Delaware	300,000	300,000	300,000	---
District of Columbia	300,000	300,000	300,000	---
Florida	4,336,545	4,323,649	4,322,850	−799
Georgia	1,670,861	1,665,892	1,665,585	−307
Hawaii	300,000	300,000	300,000	---
Idaho	300,000	300,000	300,000	---
Illinois	2,706,572	2,698,522	2,698,024	−498
Indiana	1,012,019	1,009,009	1,008,822	−187
Iowa	334,729	333,733	333,672	−61
Kansas	377,583	376,460	376,390	−70
Kentucky	469,142	467,747	467,661	−86
Louisiana	733,419	731,238	731,102	−136
Maine	300,000	300,000	300,000	---
Maryland	1,272,182	1,268,399	1,268,164	−235
Massachusetts	1,559,659	1,555,021	1,554,733	−288
Michigan	1,730,447	1,725,301	1,724,982	−319
Minnesota	811,399	808,986	808,837	−149
Mississippi	300,000	300,000	300,000	---
Missouri	894,234	891,575	891,410	−165
Montana	300,000	300,000	300,000	---
Nebraska	300,000	300,000	300,000	---
Nevada	616,251	614,419	614,305	−114
New Hampshire	300,000	300,000	300,000	---

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Projects for Assistance in Transition from Homelessness (PATH)
CFDA # 93.150

State/Territory	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
New Jersey	2,139,241	2,132,879	2,132,485	−394
New Mexico	300,000	300,000	300,000	---
New York	4,225,285	4,212,719	4,211,941	−778
North Carolina	1,380,314	1,376,209	1,375,955	−254
North Dakota	300,000	300,000	300,000	---
Ohio	1,987,508	1,981,597	1,981,231	−366
Oklahoma	453,063	451,716	451,632	−84
Oregon	631,332	629,454	629,338	−116
Pennsylvania	2,368,105	2,361,062	2,360,626	−436
Rhode Island	300,000	300,000	300,000	---
South Carolina	680,567	678,543	678,418	−125
South Dakota	300,000	300,000	300,000	---
Tennessee	910,234	907,527	907,359	−168
Texas	4,998,114	4,983,250	4,982,329	−921
Utah	591,777	590,018	589,909	−109
Vermont	300,000	300,000	300,000	---
Virginia	1,472,964	1,468,584	1,468,312	−272
Washington	1,329,846	1,325,891	1,325,646	−245
West Virginia	300,000	300,000	300,000	---
Wisconsin	837,078	834,589	834,435	−154
Wyoming	300,000	300,000	300,000	---
Puerto Rico	891,574	888,923	888,759	−164
Guam	50,000	50,000	50,000	---
Virgin Islands	50,000	50,000	50,000	---
American Samoa	50,000	50,000	50,000	---
Northern Mariana Islands	50,000	50,000	50,000	---

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Protection and Advocacy for Individuals with Mental Illness (PAIMI)

(Dollars in thousands)

Program Activity	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Budget Authority	$36,146	$36,077	$36,077	$---

Authorizing Legislation ..... The PAIMI Act, 42 U.S.C. 10801 et seq.
FY 2018 Authorization ..... Expired
Allocation Method ..... Formula Grants
Eligible Entities..... States and Territories

Program Description and Accomplishments

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) program is highly effective ensuring that the most vulnerable individuals with serious mental illness, especially those residing in public and private residential care and treatment facilities, are free from abuse, including inappropriate restraint and seclusion, neglect, and rights violations. The program ensures individuals receive the appropriate mental disorder treatment and discharge planning services they will need to facilitate their recovery and subsequent placement into the least restrictive, appropriate, community-based setting.

The Protection and Advocacy for Individuals with Mental Illness Act of 1986, as amended by the Children's Health Act of 2000, extended the protections of the Developmental Disabilities (DD) Assistance Act of 1975 to individuals with significant mental illness (adults) and significant emotional impairments (children/youth) at risk for abuse, neglect, and rights violations while residing in public and private care and treatment facilities. The PAIMI Act authorized the same governor-designated state protection and advocacy (P&A) systems established under the DD Act of 1975 to receive PAIMI Program formula grant awards from SAMHSA. The PAIMI Program supports legal-based advocacy services that are provided by the 57 governor-designated P&A systems located in each state, territory, and the District of Columbia (Mayor). Each system is mandated to: 1) ensure that the rights of individuals with mental illness who are at risk for abuse, neglect, and rights violations while residing in public or private care or treatment facilities are protected; 2) protect and advocate for the rights of these individuals through activities that ensure the enforcement of the Constitution and federal and state statutes; and 3) investigate incidents of abuse and/or neglect of individuals with mental illness.

In FY 2016, the 57 state PAIMI Programs:

- Served 11,197 PAIMI-eligible individuals/clients: 2,520 children and youth (ages 0 to 18), 7,987 adults (ages 19 to 64), and 690 older adults (age 65 and older). These individuals filed 9,344 complaints alleging abuse, neglect, and/or rights violations.

- Resolved 91 percent of abuse allegations, 89 percent of neglect allegations, and 92 percent of rights violations allegations, and attained outcomes that resulted in positive change for the clients served. These positive outcomes included receipt of appropriate medical and mental disorder treatment; safer, cleaner facility environment; discharge into an appropriate community-based setting; and discharge from a nursing facility.

In FY 2016, SAMHSA continued to fund 57 annual grants to states and territories as well as continued technical assistance activities and support for grantees. In FY 2017, SAMHSA is continuing support for this program.

Funding History

Fiscal Year	Amount
FY 2014	$36,146,000
FY 2015	$36,146,000
FY 2016	$36,146,000
FY 2017	$36,077,000
FY 2018	$36,077,000

Budget Request

The FY 2018 Budget Request is $36.1 million, level with the FY 2017 Annualized CR. Funding will support the continuation of the PAIMI grants in order to serve the same number of individuals, approximately 15,000, as in past years. This program will continue to assist individuals with serious mental illness increase access to treatment. These grantees protect and advocate for the rights of individuals with mental illness and investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.

Outputs and Outcomes Table

Program: Protection and Advocacy for Individuals with Mental Illness

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
3.4.12 Increase the number of people served by the PAIMI program (Outcome)	FY 2016: 11,197 Target: 15,925 (Target Not Met)	15,192	15,192	Maintain
3.4.19 Increase the number attending public education/constituency training and public awareness activities (Output)	FY 2016:98,441 Target: 139,427 (Target Not Met but Improved)	139,427	139,427	Maintain
3.4.21 Increase percentage of complaints of alleged abuse, neglect, and rights violations substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, elimination of other barriers to personal decision-making, as a result of Protection and Advocacy for Individuals with Mental Illness (PAIMI) involvement (Outcome)	FY 2016: 91 % Target: 87 % (Target Exceeded)	88 %	88 %	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA # 93.138

State/Territory	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Alabama	$456,202	$453,049	$457,317	4,268
Alaska	428,000	427,200	427,200	---
Arizona	620,810	625,436	632,493	7,057
Arkansas	428,000	427,200	427,200	---
California	3,133,536	3,134,386	3,092,688	−41,698
Colorado	437,326	437,288	442,249	4,961
Connecticut	428,000	427,200	427,200	---
Delaware	428,000	427,200	427,200	---
District of Columbia	428,000	427,200	427,200	---
Florida	1,724,396	1,735,256	1,756,972	21,716
Georgia	924,616	924,065	931,585	7,520
Hawaii	428,000	427,200	427,200	---
Idaho	428,000	427,200	427,200	---
Illinois	1,068,437	1,064,548	1,048,251	−16,297
Indiana	601,509	598,854	591,130	−7,724
Iowa	428,000	427,200	427,200	---
Kansas	428,000	427,200	427,200	---
Kentucky	428,000	427,200	427,200	---
Louisiana	428,000	427,200	427,200	---
Maine	428,000	427,200	427,200	---
Maryland	461,758	465,178	465,787	609
Massachusetts	507,383	506,654	501,621	−5,033
Michigan	900,554	886,029	876,602	−9,427
Minnesota	447,204	445,000	445,042	42
Mississippi	428,000	427,200	427,200	---
Missouri	538,623	536,028	540,838	4,810
Montana	428,000	427,200	427,200	---
Nebraska	428,000	427,200	427,200	---
Nevada	428,000	427,200	427,200	---
New Hampshire	428,000	427,200	427,200	---

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Protection and Advocacy for Individuals with Mental Illness (PAIMI)
CFDA # 93.138

State/Territory	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
New Jersey	684,418	676,962	673,808	−3,154
New Mexico	428,000	427,200	427,200	---
New York	1,522,543	1,519,082	1,503,160	−15,922
North Carolina	900,754	907,663	910,450	2,787
North Dakota	428,000	427,200	427,200	---
Ohio	1,026,130	1,017,456	1,016,749	−707
Oklahoma	428,000	427,200	427,200	---
Oregon	428,000	427,200	427,200	---
Pennsylvania	1,068,002	1,056,446	1,049,098	−7,348
Rhode Island	428,000	427,200	427,200	---
South Carolina	455,079	457,046	459,017	1,971
South Dakota	428,000	427,200	427,200	---
Tennessee	587,219	587,707	588,267	560
Texas	2,268,331	2,274,421	2,315,644	41,223
Utah	428,000	427,200	427,200	---
Vermont	428,000	427,200	427,200	---
Virginia	672,622	670,316	672,260	1,944
Washington	573,924	572,446	575,818	3,372
West Virginia	428,000	427,200	427,200	---
Wisconsin	496,018	493,823	491,960	−1,863
Wyoming	428,000	427,200	427,200	---
Puerto Rico	538,623	527,152	527,535	383
American Samoa	229,300	228,900	228,900	---
Guam	229,300	228,900	228,900	---
American Indian Consortium	229,300	228,900	228,900	---
Northern Mariana Islands	229,300	228,900	228,900	---
Virgin Islands	229,300	228,900	228,900	---

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Community Mental Health Services Block Grant (MHBG)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Community Mental Health Services Block Grant	$532,571	$531,599	$415,539	−$116,060
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*15,539*	*−$5,500*

Authorizing Legislation……Sections 1920 of the Public Health Service Act
FY 2018 Authorization….....$532,571
Allocation Method .....Formula Grant
Eligible Entities.....States, Territories, Freely Associated States, and District of Columbia

Program Description and Accomplishments

Serious mental illnesses are more common in the United States than is generally realized. According to the 2015 Behavioral Health Barometer: United States, approximately 4.1 percent of U.S. adults (an estimated 9.8 million individuals) reported having a serious mental illness (SMI) within the year prior to being surveyed.[17,18] Nearly a third of these individuals did not receive any services in the year before being surveyed.[19]

Since 1992, the Community Mental Health Services Block Grant (MHBG) has distributed funds to 59 eligible states and territories and freely associated states through a formula based upon specified economic and demographic factors.[20] The MHBG distributes funds for a variety of services and for planning, administration, and educational activities. By statute, these services and activities must support community-based mental health services for children with serious emotional disturbances and adults with serious mental illness. MHBG services include: outpatient treatment for serious mental illnesses, such as schizophrenia and bipolar disorders; supported employment and supported housing; rehabilitation services; crisis stabilization and case management; peer specialist and consumer-directed services; wraparound services for children and families; jail diversion programs; and services for vulnerable populations (e.g., individuals, who are homeless, those in rural and frontier areas, military families, and veterans). Through the administration of the MHBG, SAMHSA supports implementation of practices demonstrated and

[17] Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51)
[18] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: United States, 2015*. HHS Publication No. SMA–16–Baro–2015. Rockville, MD: Substance Abuse and Mental Health Services Administration,
[19] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: United States, 2015*. HHS Publication No. SMA–16–Baro–2015. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
[20] Territories include Guam, Puerto Rico, the Northern Mariana Islands, U.S. Virgin Islands and American Samoa. Freely Associated States, which have signed Compacts of Free Association with the United States, include the Republic of Palau, Federated States of Micronesia and Republic of the Marshall Islands. See http://www.doi.gov//oia/islands/index.cfm. Further information about the Block Grant program can be found on SAMHSA's Web site at http://www.samhsa.gov/grants/block-grants

proven effective in the Mental Health Programs of Regional and National Significance (PRNS) portfolio.

The MHBG continues to represent a significant "safety net" source of funding for mental health services for some of the most vulnerable populations across the country. Together, SAMHSA's block grants support the provision of services and related support activities to approximately seven million individuals with mental and substance use conditions in any given year. The Block Grant's "flexibility and stability" have made it a vital support for public mental health systems.

States rely on the MHBG for delivery of services and for an array of non-clinical coordination and support services that are not supported by Medicaid or other third party insurance to strengthen their service systems. The MHBG statute provides for a five percent administrative set-aside that allows SAMHSA to assist the states and territories in the development of their mental health systems through the support of technical assistance, data collection, and evaluation activities. States also use block grant funds, with other funding sources, to support training for staff and implementation of evidence-based practices and other promising practices for the treatment of mental disorders, improved business practices, use of health information technology, and integration of physical and behavioral health services.

SAMHSA's MHBG and Substance Abuse Prevention and Treatment Block Grant (SABG) applications align with changes in federal/state environments and statutes. SAMHSA offers states the opportunity to complete a combined application for mental health and substance abuse services, submit a biennial versus an annual plan, and provide information regarding their efforts to respond to various changes in federal and state law.[21,22] Permitting MHBG recipients to submit the application/plan biennially reduces the burden on states.

There are many individuals, both adolescent and adult, with co-occurring mental illness and drug/alcohol addiction. In recognition of this, SAMHSA strongly encourages coordination between MHBG programs and those supported by the Substance Abuse Prevention and Treatment Block Grant (SABG) as well as other SAMHSA-funded efforts such as the systems of care for children and adolescents supported through the Children's Mental Health Initiative.

Most block grant recipients are currently reporting on National Outcome Measures (NOMS) for public mental health services within their state. State-level outcome data for mental health are currently reported by State Mental Health Authorities. The following outcomes for all people served by the publicly funded mental health system during 2015 show that:

- For the 57 states and territories that reported data in the Employment Domain, 21.7 percent of the mental health consumers were in competitive employment;
- For the 58 states and territories that reported data in the Housing Domain, 76.2 percent of the mental health consumers were living in private residences;

[21] State Plan for Comprehensive Community Mental Health Services for Certain Individuals (Sec. 1912 of Title XIX, Part B, Subpart I of the Public Health Service (PHS) Act (42 USC § 300x-2).
[22] State Plan (Sec. 1932 (b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x-32(b)).

- For the 58 states and territories that reported data in the Access/Capacity Domain, state mental health agencies provided mental health services for approximately 23.07 people per 1,000 population;
- For the 50 states and territories that reported data in the Retention Domain, only 8.2 percent of the patients returned to a state psychiatric hospital within 30 days of state hospital discharge; and
- For the 45 states and territories that reported data in the Perception of Care Domain, 70 percent of adult mental health consumers improved functioning as a direct result of the mental health services they received.

Set-aside for Evidence-based Programs That Address Needs of Individuals with Early Serious Mental Illness

Starting in FY 2014, states were required to set aside five percent of their MHBG funds to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders."[23] SAMHSA is collaborating with the National Institute of Mental Health and states to implement this provision.

The majority of individuals with serious mental illness experience their first symptoms during adolescence or early adulthood, and there are often long delays between the initial onset of symptoms and receiving treatment. The consequences of delayed treatment can include loss of family and social supports, reduced educational achievement, incarceration, disruption of employment, substance abuse, increased hospitalizations, and reduced prospects for long-term recovery.

The five percent set-aside allocated to states totaling approximately $24.2 million per year in FY 2014 and FY 2015 supported implementation of evidenced-based models that seek to address treatment of serious mental illness at an early stage through reducing symptoms and relapse rates, and preventing deterioration of cognitive function in individuals living with psychotic illness. In FY 2016, Congress increased the set-aside to 10 percent; through this funding, the number of states with fully implemented operating first-episode treatment programs is 39 and SAMHSA continues to monitor and ensure that the set-aside program is solely used to address first-episode psychosis. Beginning in September 2016, SAMHSA, in partnership with NIMH, initiated a 3-year evaluation study of such programs funded through the MHBG set-aside to ensure that funds are only used for programs showing strong evidence of effectiveness and target first episode of psychosis. In FY 2017, SAMHSA is continuing support for the MHBG and maintaining the ten percent set-aside.

The table below identifies activities which have been implemented with the 10% set-aside

[23] http://www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

State	10% Set Aside Allotment	Program Description
Alabama	$735,122	Statewide EASA (Early Assessment and Support Alliance) program model is being developed and implemented.
Alaska	$97,223	A CSC (Coordinated Speciality Care) Program model is in the process of being developed and implemented.
American Samoa	$9,815	Training 2-4 peer support specialists to begin FEP outreach.
Arizona	$1,163,988	An EPICENTER FEP program is operational in Phoenix and in Tuscon.
Arkansas	$448,397	Developing portions of CSC model in thirteen locations.
California	$6,918,048	Forty-one CSC programs, from several different models, are in various states of development throughout CA. Thiry-seven are fully operational.
Colorado	$848,285	Implementing three CSC (OnTRACKUSA) programs.
Connecticut	$523,715	State is implementing two programs based on two distinct CSC models (Potential and STEP).
District of Columbia	$105,711	CSC program is being developed and implemented. Training staff on Cognitive Behavioral Therapy for individuals experiencing psychosis.
Delaware	$141,740	A statewide program, PIER, has been implemented
Florida	$126,787	State has implemented two CSC programs; three more are being developed and implemented. All of these programs are based on the Navigate model.
Georgia	$1,717,993	State has implemented three CSC programs; three more are being developed and implemented. All programs are based on the LIGHT-ETP model.
Guam	$28,767	Ongoing training of staff on the OnTRACKNY model.
Hawaii	$263,692	State has implemented a program in Honolulu based on the OnTRACK model.
Idaho	$237,867	Three CSC programs have been implemented.
Illinois	$1,983,932	State is in the process of setting up CSC services in eleven locations.
Indiana	$911,070	State is establishing four programs based on the PARC model and making use of a "hub and spoke" design.
Iowa	$406,786	State has two functioning CSC programs and is in the process of contracting for four additional locations/programs.
Kansas	$377,195	State has one fully functional CSC program in Kansas City and is operationalizing a second program in Topeka.
Kentucky	$662,889	Two EASA CSC program sites are operational and two more are being developed. State is also developing data infrastructure to track outcomes.
Louisana	$618,316	Three sites are in the process of being implemented. These programs are using the Navigate CSC model.
Maine	$200,943	State has implemented one program based on the PIER Model and is developing a second location.
Marshall Islands	$5,501	Marshall Islands is using the set-aside block grant funding to develop first episode outreach practices and protocols for individuals experiencing FEP.
Maryland	$853,207	The state has implemented two CSC programs, one in Baltimore and a second in Gaithersburg. They are continuing to develop staff expertise in the FEP approaches.
Massachusetts	$1,049,346	Massachusetts has developed two CSC programs, one in Boston and a second in western Mass. They are using the PREP model of CSC.
Michigan	$1,601,844	The State has implemented three CSC programs and are in the process of developing three additional locations. They are using the NAVIGATE CSC model.
Federated States of Micronesia	$19,032	Funds are being used to train staff on the OnTrack CSC model in four locations.
Minnesota	$786,276	State is implementing two CSC programs in the Twin Cities area and plan to expand these services throughout MN.

State	10% Set Aside Allotment	Program Description
Mississippi	467,436	State is fully implementing the NAVIGATE CSC programs to provide training and technical assistance to two CSC teams.
Missouri	856,200	State plans is continuing to implement CSC programs that include the empirically-supported interventions of cognitive-behavioral psychotherapy, family education, and supports and has established two CSC sites.
Montana	$149,765	The state is implementing the NAVIGATE model in one site for the state.
Nebraska	$232,531	Nebraska is implementing OnTrackUSA in two of the six behavioral health service regions of the state.
Nevada	$507,552	Nevada will implement an FEP program in northern Nevada using the RAISE TEAM approach. The state will incorporate telemedicine into the service delivery model to reach rural areas, and will support efforts to expand RAISE into the southern part of the state.
New Hampshire	$180,828	The state is using a NAVIGATE training team to train Community Mental Health Centers to establish CSC teams that will continue to expand beyond the training period, using a staged approach.
New Jersey	$1,433,147	New Jersey is funding three CSC teams implementing the RAISE CSC model.
New Mexico	$299,365	New Mexico is expanding access to the NAVIGATE model for specialty coordinated care for individuals with FEP through the University of New Mexico EARLY program.
New York	$3,242,519	New York is spending set-aside funds to expand its existing OnTrackNY program to six new sites with a goal of having eleven sites by the end of 2015. These sites will include rural and less-populated areas.
North Carolina	$1,430,851	North Carolina will continue to support two CSC sites currently operated in the state, and will work to expand services. The state will also look to implement one to two additional CSC sites, and fully implement a Quality Assurance Database developed by the UNC OASIS (Outreach and Support Intervention Services) technical assistance program, which will be utilized by all FEP sites funded through the MHBG (Mental Health Block Grant).
North Dakota	$87,958	The state is using the set-aside funds to identify and contract with a vendor for the implementation of CSC services.
Northern Mariana Islands	$9,178	The Community Guidance Center is implementing a psychoeducation group in FY 2016 geared toward family education, which will help families and the community better identify FEP symptoms in their family or community leading to earlier treatment of the client.
Ohio	$1,629,288	OhioMHAS is continuing to support existing programs that were funded under the 5% set-aside.
Oklahoma	$543,405	Oklahoma is using MHBG set-aside funds to implement NAVIGATE and Transition to Independence (TIP) in five to six CMHCs in Oklahoma, Okmulgee, and Washington Counties by funding training, outreach activities and an employment/education coach. Will also be expanding to Tulsa area.
Oregon	$672,682	Oregon is using the additional funds to initiate FEP services in the remaining ten counties that do not currently offer such services, provide additional support programs for psychosocial and community education.
Palau	$5,000	One CSC team will be supported in a population area of roughly 20,000 with 1% need annually.
Pennsylvania	$1,799,735	Pennsylvania selected eight program sites for fiscal year 2016-2017, including four new sites, increasing geographical coverage to each region of the state.

State	10% Set Aside Allotment	Program Description
Puerto Rico	$653,909	Puerto Rico is using the 10% set-aside of its MHBG for intervention in situations of First Episode Psychosis (FEP). Block grant funds will continue to support the development of the PORTI program in San Juan and replicated in Mayagüez for the fiscal year 2016-2017 beginning in October 2016.
Rhode Island	$186,254	Rhode Island is usingthe entire set-aside amount to serve individuals ages 16-25 experiencing a first episode of psychosis by enhancing the two existing treatment teams so that they will be able to serve an additional ten clients.
South Carolina	$743,578	South Carolina is funding two programs, The existing, or Traditional Program, will be evaluated against the CSC Program in terms of clinical and social outcomes.
South Dakota	$105,107	Southeastern Behavioral Health care (SEBHC) is receiving additional training and/or technical assistance to ensure proficiency in delivering FEP specialty services as well as fidelity to the OnTrackNY model. They will also research the possibility of adding another FEP program, including researching the need and financial viability of an additional program.
Tennessee	$1,032,585	Tennessee is using the additional funds to expand OnTrackTN to two additional sites, create a statewide FEP learning collaborative consisting of all three sites, improve outcomes, provide rapid access to services including services that are linguistically and culturally competent, increase awareness and early detection, provide statewide training for providers and the community, and increase statewide capacity to provide FEP services.
Texas	$4,092,545	Texas is in the process of expanding to eight additional locations in rural and urban areas across the state. These new sites will be able to serve both indigent and Medicaid eligible populations.
Utah	$385,888	The additional funds is supporting two counties, Davis and Weber, to operate their FEP teams to fidelity.
Vermont	$89,609	Vermont is continuing to partner with the Vermont Cooperative for Practice Improvement and Innovation to facilitate the initiative including targeted research, implementation, workforce development, outreach and education.
Virgin Islands	$18,786	Virgin Islands is planning and designing an intervention program and securing the resources necessary to train staff and implement the program.
Virginia	$1,157,845	Developing CSC sites through the state's community service boards (CSBs). The existing programs will continue to receive training and technical assistance to strengthen their clinical service delivery skills and to ensure fidelity to the model.
Washington	$1,160,642	The additional funds are supporting the startup of two Coordinated Specialty Care (CSC) teams and continuing the funding of the current, New Journeys Demonstration Project.. Washington is now implementing the NAVIGATE CSC Model.
West Virginia	$290,608	West Virginia is continuing capacity development for CSC using the OnTrackNY model.
Wisconsin	$844,055	Wisconsin is continuing to fund the CSC model PROPS program operated by JMHC and expand CSC programs by funding two to seven additional programs.
Wyoming	$54,319	There are two programs being piloted in Wyoming to implement and provide FEP services.

Funding History

Fiscal Year	Amount
FY 2009	420,774,000
FY 2010	420,774,000
FY 2011	419,933,000
FY 2012	459,756,000
FY 2013	436,809,376
FY 2014	482,571,000
FY 2015	482,571,000
FY 2016	532,571,000
FY 2017	531,599,000
FY 2018	415,539,000

Budget Request

The FY 2018 Budget Request is $415.5 million, a decrease of $116.1 million from the FY 2017 Annualized CR. With this funding, SAMHSA will continue to address the needs of individuals with SMI and SED through the MHBG. SAMHSA will maintain the ten percent set-aside for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The set-aside funds help reduce costs to society, as intervening early helps prevent deterioration of functioning in individuals experiencing a first episode of serious mental illness. With the decreased level of funding, state set-aside activities will be reduced along with a reduction in infrastructure activities for activities such as outpatient treatment, supported employment, housing services, and crisis counseling.

Outputs and Outcomes Table

Program: Mental Health Block Grant

Note: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
2.3.11 Increase the number of evidence based practices (EBPs) implemented (Output)	FY 2015: 4.8 per State Target: 4.8 per State (Target Not Met but Improved)	4.5 per State	4.5 per State	Maintain
2.3.14 Increase the number of people served by the public mental health system (Output)	FY 2015: 7,448,380 Target: 8,249,930 (Target Not Met but Improved)	7,448,380	7,396,241	-52,139
2.3.15 Increase the rate of consumers (adults) reporting positively about outcomes (Outcome)	FY 2015: 72.3 % Target: 71.8 % (Target Exceeded)	71.8 %	71.8 %	Maintain
2.3.16 Increase the rate of family members (children/adolescents) reporting positively about outcomes (Outcome)	FY 2015: 69.7 % Target: 66.3 % (Target Exceeded)	66.1 %	66.1 %	Maintain
2.3.81 Increase the percentage of service population receiving any evidence based practice (Outcome)	FY 2015: 11.4 % Target: 6.2 % (Target Exceeded)	10.8 %	10.8 %	Maintain

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Alabama	$7,351,221	$7,338,061	$5,788,356	−1,549,705
Alaska	972,230	1,068,158	834,064	−234,094
Arizona	11,639,880	12,202,879	9,778,695	−2,424,184
Arkansas	4,483,965	4,549,014	3,602,265	−946,749
California	69,180,482	70,093,153	55,322,680	−14,770,473
Colorado	8,482,852	8,357,605	6,696,058	−1,661,547
Connecticut	5,237,154	5,289,593	4,169,782	−1,119,811
Delaware	1,417,398	1,521,362	1,205,530	−315,832
District Of Columbia	1,057,109	1,155,933	934,922	−221,011
Florida	33,793,628	34,686,212	27,798,833	−6,887,379
Georgia	17,179,928	16,651,002	13,262,496	−3,388,506
Hawaii	2,636,917	2,818,497	2,236,821	−581,676
Idaho	2,378,674	2,431,683	1,934,130	−497,553
Illinois	19,839,321	19,397,263	15,176,612	-4,220,651
Indiana	9,110,702	9,007,052	7,077,625	−1,929,427
Iowa	4,067,863	4,043,482	3,180,786	−862,696
Kansas	3,771,945	3,804,500	2,999,642	−804,858
Kentucky	6,628,893	6,576,470	5,174,065	−1,402,405
Louisiana	6,183,159	6,170,251	4,977,695	−1,192,556
Maine	2,009,425	2,024,283	1,599,475	−424,808
Maryland	8,532,072	8,626,658	6,849,038	−1,777,620
Massachusetts	10,493,458	10,051,034	7,929,569	−2,121,465
Michigan	16,018,438	15,597,185	12,214,458	−3,382,727
Minnesota	7,862,764	7,537,088	5,919,589	−1,617,499
Mississippi	4,674,359	4,615,012	3,630,976	−984,036
Missouri	8,562,000	8,457,358	6,658,176	−1,799,182
Montana	1,497,654	1,542,944	1,220,302	−322,642
Nebraska	2,325,306	2,333,088	1,844,851	−488,237
Nevada	5,075,524	5,385,069	4,324,301	−1,060,768
New Hampshire	1,808,281	1,810,249	1,430,470	−379,779

Department of Health and Human Services

Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARY STATE/FORMULA GRANTS
Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
New Jersey	14,331,474	13,966,123	11,036,215	−2,929,908
New Mexico	2,995,653	3,074,426	2,401,898	-672,528
New York	32,425,192	31,313,707	24,496,970	−6,816,737
North Carolina	14,308,507	14,319,694	11,430,055	−2,889,639
North Dakota	879,581	887,838	651,646	−236,192
Ohio	16,292,879	15,867,498	12,772,348	−3,095,150
Oklahoma	5,434,052	5,473,044	4,257,666	−1,215,378
Oregon	6,726,815	6,872,776	5,611,552	−1,261,224
Pennsylvania	17,997,348	17,728,079	13,833,367	−3,894,712
Rhode Island	1,862,535	1,853,017	1,457,937	−395,080
South Carolina	7,435,778	7,481,490	5,966,267	−1,515,223
South Dakota	1,051,067	1,081,348	856,388	−224,960
Tennessee	10,325,846	10,291,957	8,117,196	−2,174,761
Texas	40,925,451	41,075,077	32,818,255	−8,256,822
Utah	3,858,877	3,965,020	3,179,640	−785,380
Vermont	896,094	903,361	710,303	−193,058
Virginia	11,578,454	11,223,456	8,937,722	−2,285,734
Washington	11,606,420	11,885,963	9,495,810	−2,390,153
West Virginia	2,906,084	2,883,716	2,235,643	−648,073
Wisconsin	8,440,552	8,251,416	6,473,906	−1,777,510
Wyoming	543,194	606,798	477,800	−128,998
American Samoa	98,148	98,155	77,753	−20,402
Guam	287,665	289,873	231,480	−58,393
Northern Marianas	91,782	92,692	74,893	−17,799
Puerto Rico	6,539,088	6,519,207	5,148,482	−1,370,725
Palau	50,000	50,000	50,000	---
Marshall Islands	125,103	127,801	103,290	−24,511
Micronesia	190,316	190,272	150,542	−39,730
Virgin Islands	187,864	187,552	148,192	−39,360
Territory Subtotal	7,569,966	7,555,552	5,984,632	−1,570,920

SAMHSA

Substance Abuse Prevention
Table of Contents

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Substance Abuse Prevention Appropriation

(Dollars in thousands)

Program Activities	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Programs of Regional and National Significance	$211,219	$222,817	$149,703	−$73,114
Total, Substance Abuse Prevention	**$211,219**	**$222,817**	**$149,703**	**−$73,114**

The FY 2018 Budget Request is $149.7 million, a decrease of $73.1 million from the FY 2017 Annualized CR.

Programs of Regional and National Significance (PRNS)

Substance Abuse Prevention Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Capacity:				
Strategic Prevention Framework	$119,484	$119,257	$58,427	–$60,830
Strategic Prevention Framework Rx (non-add)	*10,000*	*9,981*	*10,000*	
Federal Drug-Free Workplace	4,894	4,885	4,885	---
First Responder Training	---	12,000	12,000	---
Minority AIDS	41,205	41,127	28,843	–$12,284
Sober Truth on Preventing Underage Drinking Act (Stop Act)	7,000	6,986	6,986	---
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths	12,000	11,977	11,977	---
Tribal Behavioral Health Grants	15,000	14,971	14,971	---
Subtotal, Capacity	**199,583**	**211,203**	**138,089**	**–$73,114**
Science and Service:				
Center for the Application of Prevention Technologies	7,493	7,479	7,479	---
SAP Minority Fellowship Program	71	71	71	---
Science and Service Program Coordination	4,072	4,064	4,064	---
Subtotal, Science and Service	**11,636**	**11,614**	**11,614**	---
Total, PRNS	**$211,219**	**$222,817**	**$149,703**	**–$73,114**

Authorizing Legislation .....Sections 516 of the PHS Act
FY 2018 Authorization $211,148
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities……States, political subdivisions of States, Federally Recognized American Indian/Alaska Native tribe or tribal organizations, Indian Health Service-operated and contracted health facilities and programs, public or private nonprofit entities

Strategic Prevention Framework

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Strategic Prevention Framework	$119,484	$119,257	$58,427	−$60,830
Strategic Prevention Framework Rx (non-add)	*10,000*	*9,981*	*10,000*	---

Authorizing Legislation ..... Section 516 of the PHS Act
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities..... States, Tribes, and Territories

Program Description and Accomplishments

Strategic Prevention Framework (SPF)

Drug and alcohol use are significant public health problems. Youth and adolescents who use alcohol and drugs face an increased risk of poor school performance, criminal justice involvement, the development of a drug/alcohol addiction, risky sexual behavior, illnesses such as HIV and hepatitis, depression and anxiety, and injury and death. The immediate and long-term risks and negative outcomes associated with adolescent drug and alcohol use underscore the need for effective prevention and treatment programs.

Youth and adolescents use a variety of substances. In 2015, 27.1 million people aged 12 or older used an illicit drug in the past 30 days, which corresponds to about 1 in 10 Americans (10.1 percent). The illicit drug use estimate for 2015 continues to be driven primarily by marijuana use and the misuse of prescription pain relievers, with 22.2 million individuals who currently use marijuana aged 12 or older (i.e., past 30 day use) and 3.8 million people aged 12 or older who reported current misuse of prescription pain relievers. The 2015 estimate of current marijuana use was similar to the estimate in 2014; but it was higher than the estimates from 2002 to 2013. This increase in marijuana use among people aged 12 or older reflects the increase in marijuana use by adults aged 26 or older and, to a lesser extent, the increase in marijuana use among young adults aged 18 to 25.

The Strategic Prevention Framework – Partnerships for Success program addresses underage drinking among youth and young adults age 12 to 20 and allows states to prioritize their top data driven substance abuse target areas such as marijuana and cocaine.

Data show that states and communities receiving Partnerships for Success funding have made improvements in reducing the impact of substance abuse. The 2015 National Survey on Drug Use and Health (NSDUH) report shows that underage alcohol use (i.e., people aged 12 to 20) and binge and heavy drinking use among young adults aged 18 to 25, have declined over time but remain a concern. In 2015, 20.3 percent of underage people reported current use of alcohol, 13.4 percent reported binge drinking, and 3.3 percent reported heavy alcohol use. The binge-drinking rate declined from 14.2 percent to 13.4 percent, and the rate of heavy drinking declined from 3.7

percent to 3.3 percent.[24] In 2015, 7.0 percent of adolescents aged 12 to 17 were currently using marijuana. This means that approximately 1.8 million adolescents used marijuana in the past month. The percentage of adolescents in 2015 who currently used marijuana was similar to the percentages in most years between 2004 and 2014. [25]

The correlation between perceived risk and substance use informed the design and implementation of SAMHSA's FY 2016 Partnerships For Success program. In 2016, the program addressed underage drinking and prescription drug misuse among youth and young adults and encouraged grantees to address issues related to marijuana and heroin use.

The cross-site evaluation for the Partnerships For Success program will address the following questions:

1) Was the implementation of Partnerships for Success program associated with a reduction in underage drinking and/or prescription drug misuse?
2) Did variability in the total level of funding from all sources relate to outcomes? Did variability in the total level of Partnerships for Success funding relate to outcomes, above and beyond other funding available to communities?
3) What intervention type, combinations of interventions, and dosages of interventions were related to outcomes at the grantee level? What intervention type, combinations of interventions, and dosages of interventions were related to outcomes at the community level?
4) Were some types and combinations of interventions within communities more cost-effective than other interventions?
5) How does variability in factors (strategy selection and implementation, infrastructure, geography, demography, sub-recipient selection, Training/Technical Assistance, barriers to implementation) relate to outcomes across funded communities?

In FY 2016, SAMHSA funded one new Strategic Prevention Framework grant cohort and 65 grant continuations. In FY 2017, SAMHSA plans to support 66 Strategic Prevention Framework grant continuations.

Strategic Prevention Framework for Prescription Drugs (SPF Rx)

Drug overdose death rates have increased five-fold since 1980.[26] Since 2000, the drug overdose death rates have continued to increase and have more than doubled.[27] In 2009, drug overdose deaths outnumbered deaths due to motor vehicle crashes for the first time. In the U.S., misuse of prescription drugs, including opioid-analgesic pain relievers, is responsible for much of the

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[24] Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

[25]https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf

[26] Warner M, Chen LH, Makuc DM, Anderson RN, Miniño AM. Drug poisoning deaths in the United States, 1980–2008. NCHS data brief, no 81. Hyattsville, MD: National Center for Health Statistics. 2011.

[27] Centers for Disease Control and Prevention. NCHS Data on Drug Poisoning Deaths. NCHS Fact Sheet. June 2015. Hyattsville, MD: National Center for Health Statistics. 2015. Available at http://www.cdc.gov/nchs/data/factsheets/factsheet_drug_poisoning.pdf.

recent increase in drug-poisoning deaths.[1] Opioid painkillers Opioids(https://www.cdc.gov/drugoverdose/opioids/index.html) (including prescription opioids(https://www.cdc.gov/drugoverdose/opioids/prescribed.html) and heroin(https://www.cdc.gov/drugoverdose/opioids/heroin.html)) killed more than 33,000 people in 2015, more than any year on record. Nearly half of all opioid overdose deaths involve a prescription opioid.[2]

Funding for SAMHSA and the Centers for Disease Control and Prevention (CDC) in FY 2016 was part of a strategic effort to address non-medical use of prescription drugs as well as opioid overdoses. Leveraging the strengths and capabilities of each agency, SAMHSA and CDC partnered to ensure alignment with HHS's policy and plan for prevention of opioid-related overdoses and deaths involving multiple operating divisions and offices. CDC provided funding to states to address opioid prescribing on multiple fronts, and SAMHSA provided funding to states for the prevention of prescription drug misuse in high priority age groups (including young and middle-aged adults) and the public through the Strategic Prevention Framework – Partnerships for Success program.

In FY 2016, SAMHSA implemented the Strategic Prevention Framework for Prescription Drugs to raise awareness about the dangers of sharing medications and to work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program focuses on raising community awareness and bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients. SAMHSA tracks reductions in opioid overdoses and the incorporation of Prescription Drug Monitoring Program (PDMP) data into needs assessments and strategic plans as indicators of program success. SAMHSA awarded 25 grants in FY 2016. In FY 2017 and FY 2018, SAMHSA will support 25 grant continuations.

Funding History

Fiscal Year	Amount
FY 2014	$109,484,000
FY 2015	$109,484,000
FY 2016	$119,484,000
FY 2017	$119,257,000
FY 2018	$58,427,000

Budget Request

The FY 2018 Budget Request is $58.4 million, a decrease of $60.8 million from the FY 2017 Annualized CR. Funding for the SPF Rx program will be maintained in its entirety ($10.0M). Funding will support 25 Strategic Prevention Framework for Prescription Drugs continuation

[1] Paulozzi LJ. Prescription drug overdoses: A review. J. Safety Res 43(4):283–9. 2012.
[2] Centers for Disease Control and Prevention. Hyattsville, MD: National Center for Health Statistics. 2015. Available at https://www.cdc.gov/drugoverdose/

and overdose prevention efforts, in conjunction with other state and local partners. In FY 2018, in order to ensure that every state receives SPF funding, a new cohort of PFS grants will be awarded to focus on underage drinking and two other substances including but not limited to marijuana and cocaine. Additionally, SAMHSA will also support the continuation at a significantly reduced rate of 49 Strategic Prevention Framework - Partnerships For Success grants to decrease the impact of underage drinking and prescription drug misuse while lessening the progression of emergent issues such as heroin and marijuana use.

Outputs and Outcomes Table

Program: Partnerships for Success

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2018 Target +/– FY 2017 Target
2.3.79 Increase the number of EBPs implemented by sub-recipient communities (Output)	FY 2015: 300 Target: 950 (Target Not Met but Improved)	300	300	Maintain
2.3.80 Increase the number of sub-recipient communities that improved on one or more targeted NOMs indicators (Outcome)	FY 2015: 301 Target: 50 (Target Exceeded)	200	200	Maintain

Outputs and Outcomes Table

Program: Strategic Prevention Framework Rx

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/− FY 2018 Target
3.3.11 Increase the percent of funded states that incorporate PDMP data into their needs assessments in developing their strategic plans (Outcome)	FY 2016: Result Expected August 31, 2017 Target: 100 % (Pending)	100 %	100 %	Maintain
3.3.12 Increase the percent of funded states reporting reductions in opioid overdoses (Outcome)	FY 2016: Result Expected August 31, 2017 Target: 55 % (Pending)	55 %	55 %	Maintain

Federal Drug-Free Workplace

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Federal Drug-Free Workplace	$4,894	$4,885	$4,885	$---

Authorizing Legislation ..... Section 516 of the PHS Act
Allocation Method ..... Inter-Agency Agreements/Contracts
Eligible Entities..... Federal Agencies, Regulated Entities (e.g., Department of Transportation, Nuclear Regulatory Commission), HHS- Certified Laboratories

Program Descriptions and Accomplishments

Alcohol and other drug use are widespread and have a variety of negative consequences, particularly in the workplace. Employers with successful drug-free workplace programs report decreases in absenteeism, accidents, downtime, turnover, and theft; increases in productivity; and overall improved morale. They also report better health status among many employees and family members and decreased use of medical benefits. Some organizations with drug-free workplace programs qualify for incentives, for example, decreased premium costs for certain kinds of insurance, such as Workers' Compensation.

In 1986, the President signed an Executive Order mandating that all Federal agencies be drug-free. In 1988, Congress passed the Drug-Free Workplace Act.

The Federal Drug-Free Workplace Programs (DFWP) ensure employees in national security, public health, and public safety positions are tested for the use of illegal drugs and the misuse of prescription drugs and ensure the laboratories that perform this drug testing are inspected and certified by HHS. Through this program, the federal government is able to avoid lost productivity and reduce absenteeism, injuries, and fatalities.

SAMHSA implements the Federal Drug-Free Workplace Programs, which consist of two principal activities mandated by Executive Order (E.O.) 12564 and Public Law (P.L.) 100-71. These include: 1) oversight of the Federal Drug-Free Workplace Programs, aimed at the elimination of the use of illegal drugs and the misuse of prescription drugs within Executive Branch agencies and the federally-regulated industries, and 2) oversight of the National Laboratory Certification Program (NLCP), which certifies laboratories to conduct forensic drug testing for federal agencies and federally-regulated industries; the private sector also uses the HHS-Certified Laboratories.

First signed on September 15, 1986, E.O. 12564 requires the head of each executive agency to establish a comprehensive Drug-Free Workplace Plan that includes supervisor/employee education, an employee assistance program, and a random testing component to test the use of illegal substances and the misuse of prescription drugs by federal employees in safety-sensitive positions.

The Supplemental Appropriations Act, 1987 (Public Law 100-71) included language which requires HHS to: 1) certify that each Executive Branch agency has developed a plan for achieving a drug-free workplace, and 2) publish mandatory guidelines that establish comprehensive standards for laboratory drug testing procedures, specify the drugs for which federal employees may be tested, and establish standards and procedures for periodic review and certification of laboratories to perform drug testing for federal agencies.

Since FY 2014, SAMHSA has funded the Drug-Free Workplace drug testing activities. These activities will continue in FY 2018 under the NLCP contract. The NLCP oversees the certification of the labs that perform drug testing under the Drug-Free Workplace Programs. The Drug Testing Advisory Board (DTAB) provides recommendations to the Assistant Secretary for Mental Health and Substance Use based on an ongoing review of the direction, scope, balance, and emphasis of SAMHSA's drug testing activities and the NLCP. On January 10, 2012, SAMHSA approved the DTAB's recommendations to revise the mandatory guidelines to include oral fluid as an alternative specimen to urine as well as include additional Schedule II prescription drug medications (e.g., oxycodone, oxymorphone, hydrocodone and hydromorphone). On August 7, 2015, SAMHSA approved the DTAB's recommendations to pursue hair as an alternative specimen in the Mandatory Guidelines for Federal Workplace Drug Testing Programs. CSAP's Workplace Helpline supports the drug-free workplace program. The helpline is a toll-free telephone service (800-WORKPLACE) that answers questions from the public and private sectors about drug testing in the workplace.

Continued funding for the Federal Drug-Free Workplace Programs has ensured the testing of federal employees in national security, public health, and public safety positions for the use of illegal drugs, the misuse of prescription drugs, and the inspection certification of HHS-certified laboratories for the past four years.

Funding History

Fiscal Year	Amount
FY 2014	$4,894,000
FY 2015	$4,894,000
FY 2016	$4,894,000
FY 2017	$4,885,000
FY 2018	$4,885,000

Budget Request

The FY 2018 Budget Request is $4.9 million, level with the FY 2017 Annualized CR. In FY 2018, SAMHSA will continue oversight of the Executive Branch Agencies' Federal Drug-Free Workplace Programs. This includes review of Federal Drug-Free Workplace plans from those federal agencies that perform federal employee testing, random testing of those designed testing positions of national security, public health, and public safety, and testing for illegal drug use and the misuse of prescription drugs. SAMHSA will continue its oversight role for the inspection and certification of the HHS-certified laboratories.

SAMHSA will continue/add the below items to its drug testing portfolio:

- DTAB continued evaluation of the scientific supportability of hair as an alternative specimen to urine and oral fluids in the Mandatory Guidelines for Federal Workplace Drug Testing Programs;
- Continued use of subject matter experts and partnering with other federal agencies to establish the scientific standards set out in the mandatory guidelines;
- Implementation of the final Urine Specimen Mandatory Guidelines;
- Continued development of the final Oral Fluid Specimen Mandatory Guidelines and provide technical assistance on implementation;
- Research of alternative specimens for scientific supportability and inclusion in the Mandatory Guidelines;
- Technical and scientific leadership for federal agencies on marijuana testing; and
- Updates to the DFWP website.

Minority AIDS

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Minority AIDS	$41,205	$41,127	$28,843	−$12,284

Authorizing Legislation ..... Section 516 of the PHS Act
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities.....Local Government Entities, Community-based Organization, Minority Serving Institutions, and Institutions of Higher Education

Program Description and Accomplishments

The update to the 2010 National HIV/AIDS Strategy for the United States reports that there is still an HIV epidemic, which remains a major health issue for the United States. It also notes that people across the nation deserve access to tools and education to prevent HIV transmission.[30] In 1995, 44 percent of the public indicated that HIV/AIDS was the most urgent health problem facing the U.S., compared to only six percent in 2009. Approximately 50,000 people become infected each year. In addition, because HIV and viral hepatitis share common modes of transmission, one third of HIV infected individuals are also infected with hepatitis C.[31]

The Minority AIDS program supports activities that assist grantees in building a solid foundation for delivering and sustaining quality and accessible state-of-the-science substance misuse and HIV prevention services. The program aims to engage community-level domestic public and private non-profit entities, tribes, and tribal organizations in order to prevent and reduce the onset of substance misuse and transmission of HIV/AIDS among at-risk populations, including

[30] National HIV/AIDS Strategy for the United States: Update to 2020
[31] Action Plan for the Prevention, Care and Treatment of Viral Hepatitis, http://www.hhs.gov/ash/initiatives/hepatitis/

racial/ethnic minority youth and young adults, ages 13 to 24. SAMHSA works with college and university clinics/wellness centers and community-based providers that can provide comprehensive substance abuse and HIV prevention strategies. These strategies combine education and awareness programs, social marketing campaigns, and HIV and viral hepatitis testing services in non-traditional settings with substance misuse and HIV prevention programming for the population of focus. Because of the high rate of HIV/AIDS and hepatitis co-morbidity, this program includes viral hepatitis prevention and education training.

SAMHSA helps to prevent HIV and hepatitis infection acquired through substance abuse and other means. SAMHSA's Minority AIDS programs address incidence, care, disparities and coordination, and provide counseling to reduce risk. The program emphasizes that all grantees must be prepared to serve the community in which they are located. The Capacity-Building Initiative (CBI) supports grantees in building a solid foundation for delivering evidence-based substance misuse and HIV prevention services. The program aims to engage community organizations, tribes, and tribal organizations to prevent and reduce the onset of substance use and the transmission of HIV/AIDS among at-risk individuals, including, racial/ethnic minority youth and young adults, ages 13 to 24. SAMHSA's Minority Serving Institutions (MSI) in Partnerships with Community-Based Organizations (MSI CBO) program supports grants to MSIs. The MSI CBO program focuses on preventing and reducing substance use and the transmission of HIV/AIDS and hepatitis C virus infections among minority young adults ages 18 to 24 on campus and in the surrounding communities.

In the FY2015 MAI report, significant improvements were observed between participants' baseline and exit knowledge and attitudes associated with SA and HIV transmission:

25 percent increase in perceived risk of harm from binge drinking;
43 percent increase in perceived risk of harm from weekly marijuana use;
4 percent increase in perceived risk of harm from sharing unsanitized needles;
15 percent increase in perceived risk of harm from unprotected anal sex (adult participants);
23 percent increase in perceived risk of harm from unprotected oral sex (adult participants);
18 percent increase in perceived risk of harm from unprotected vaginal sex (adult participants

In FY 2014, SAMHSA's Centers for Mental Health Services, Substance Abuse Prevention, and Substance Abuse Treatment supported the Minority AIDS Continuum of Care pilot. The Minority AIDS Continuum of Care program supports mental illness and drug/alcohol addiction screening, primary prevention, and treatment for racial/ethnic minority populations with or at high risk for mental illness and drug/alcohol addiction and HIV/AIDS. Minority AIDS Continuum of Care grants support substance abuse treatment, primary prevention/treatment service programs, community mental health programs, and HIV/AIDS integrated programs that either can co-locate or have fully integrated HIV/AIDS prevention and medical care services. This program also provides primary prevention services for substance abuse and HIV/AIDS in local communities served by behavioral health programs. In addition, approximately 20 percent and 23 percent of those with Serious Mental Illness such as schizophrenia, bipolar disorder, and major depression are infected with hepatitis C virus and hepatitis B virus, respectively, while

between 14 percent and 36 percent of those who misuse alcohol are infected with the hepatitis C virus.[32,33]

SAMHSA supports a consolidated evaluation of its HIV/AIDS programs. This comprehensive process and outcome evaluation will assess the degree to which SAMHSA is providing effective and efficient mental illness and substance abuse treatment services and prevention programs to those with and at risk of HIV/AIDS. The evaluation results will help inform program development and refine the approach used in SAMHSA's HIV portfolio.

Under the FY 2017 Annualized CR, SAMHSA will fund an additional 14 new grants under the Prevention Navigator program. These funds support an array of activities to assist grantees in building a solid foundation for delivering and sustaining quality and accessible state of the science substance use and HIV prevention services. In addition to new grant awards, SAMHSA will also support 145 grant continuations as well as grant technical assistance and evaluation efforts.

Funding History

Fiscal Year	Amount
FY 2014	$41,205,000
FY 2015	$41,205,000
FY 2016	$41,205,000
FY 2017	$41,127,000
FY 2018	$28,843,000

Budget Request

The FY 2018 Budget Request of $28.8 million, a decrease of $12.3 million from the FY 2017 Annualized CR. New MAI CoC grants will not be awarded and CBI will be phased out in order to reduce duplication and target funding most effectively in SAMHSA's Prevention Navigator and MSI/CBO programs. SAMHSA will support up to 73 grant continuations to assist grantees in building a solid foundation for delivering integrated evidence-based substance use, HIV and viral hepatitis prevention services that are in alignment with the National HIV/AIDS Strategy. These funds continue to address a critical public health problem and provide lifesaving prevention services, including testing for HIV.

[32] Bhattacharya R, Shuhart MC. Hepatitis C and alcohol: interactions, outcomes, and implications. J Clin Gastroenterol. 2003;36(3):242-52.
[33] Rosenberg et al. Prevalence of HIV, Hepatitis B, and Hepatitis C in People With Severe Mental Illness. Am J Public Health. 2001;91:(31–37).

Outputs and Outcomes Table

Program: Minority AIDS

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
2.3.56 Increase the number of program participants exposed to substance abuse prevention education services (Output)	FY 2015: 3,944 Target: 3,000 (Target Exceeded)	2,580	2,580	Maintain
2.3.83 Increase the percent of program participants who report no use of alcohol at pre-test who remain non-users at post-test (all ages) (Outcome)	FY 2015: 89.4 % Target: 91.2 % (Target Not Met but Improved)	85.7 %	85.7 %	Maintain
2.3.85a Increase the number of persons tested for HIV through the Minority AIDS Initiative prevention activities (Outcome)	FY 2015: 27,731 Target: 11,066 (Target Exceeded)	21,137	21,137	Maintain

Sober Truth on Preventing Underage Drinking Act (STOP Act)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Sober Truth on Preventing Underage Drinking Act (STOP Act)	$7,000	$6,986	$6,986	$---

Authorizing Legislation .....Section 519B of the PHS Act
FY 2018 Authorization $6,000
Allocation Method .....Competitive Grants/Contracts
Eligible EntitiesCurrent and former Drug-Free Communities grantees .....

Program Description and Accomplishments

Underage drinking continues to be a national concern. It disrupts the lives of individuals and families and imposes great costs on communities. Alcohol-related consequences include impairments in cognitive abilities (e.g., decision-making and impulse control) and motor skills (e.g., balance and hand-eye coordination), death, injury, physical and sexual assault, unsafe sex, health problems, suicide attempts, memory loss, and more.[34] Those who report being intoxicated at least once a week have a higher likelihood of becoming injured and needing medical treatment, causing injury in traffic crashes, and being taken advantage of sexually.[35] Twenty-five percent of college students report academic consequences of their drinking, including missing class, falling behind in class, doing poorly on exams, and receiving lower grades overall.[36]

The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 (Public Law 109 - 422) was the nation's first comprehensive legislation on underage drinking. One of the primary components of the STOP Act is the community-based coalition enhancement grant program, which provides up to $50,000 per year over four years to current or former grantees under the Drug Free Communities Act of 1997 to prevent and reduce alcohol use among youth under the age of 21. The STOP Act grant program enables organizations to strengthen collaboration and coordination among stakeholders to achieve a reduction in underage drinking in their communities.

Strong prevention efforts are necessary to continue to address underage drinking. These efforts have proven effective. Over the past decade, a large number of evaluation studies have demonstrated the far-reaching effects of prevention interventions in reducing alcohol, tobacco, and other drug abuse as well as delinquent behaviors; violence; and other mental, emotional, and behavioral health problems.[37]

[34] Chaloupka, Grossman, & Saffer, 2002; O'Brien et al., 2013; A. White & Hingson, 2013.
[35] A. White & Hingson, 2013.
[36] A. White & Hingson, 2013.
[37] e.g., Calear & Christensen, 2010; Lemstra et al., 2010; Ttofi & Farrington, 2011.

In 2015, there were 138.3 million Americans aged 12 or older who reported current use of alcohol, including 66.7 million who reported binge alcohol use in the past month and 17.3 million who reported heavy alcohol use in the past month. Individuals with past month binge drinking and heavy alcohol use represented 24.9 and 6.5 percent of people aged 12 or older, respectively.

In both FY 2011 and FY 2012, SAMHSA conducted program evaluations of the STOP Act grant program. The findings indicated that the program is accomplishing its intended goal of enhancing underage drinking prevention efforts in coalition communities around the country. In mid-2014, SAMHSA began conducting a retrospective national cross-site evaluation of the STOP Act grant program. SAMHSA awarded 97 grant continuations in FY 2015 and awarded 81 new STOP Act grants and 17 continuations in FY 2016. In FY 2017, SAMHSA will continue these grants.

Funding History

Fiscal Year	Amount
FY 2014	$6,983,000
FY 2015	$7,000,000
FY 2016	$7,000,000
FY 2017	$6,986,000
FY 2018	$6,986,000

Budget Request

The FY 2018 Budget Request of $7.0 million, level with the FY 2017 Annualized CR. In FY 2018, SAMHSA will support 95 STOP Act grant continuations. This funding will continue to strengthen SAMHSA's commitment to reduce and prevent underage drinking.

Outputs and Outcomes Table

Program: Sober Truth on Preventing Underage Drinking (STOP Act)
NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
3.3.01 Increase the percent of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades (Outcome)	FY 2015: 81.8 % Target: 62 % (Target Exceeded)	45 %	45 %	Maintain
3.3.02 Increase the percent of coalitions that report improvement in youth perception of risk from alcohol in at least two grades (Outcome)	FY 2015: 50 % Target: 68% (Target Not Met)	45 %	45 %	Maintain

Center for the Application of Prevention Technologies

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Center for the Application of Prevention Technologies	$7,493	$7,479	$7,479	$---

Authorizing Legislation ..... Section 516 of the PHS Act
Allocation Method ..... Contracts
Eligible Entities..... Domestic and Public Entities

Program Description and Accomplishments

SAMHSA's Center for the Application of Prevention Technologies (CAPT) program provides state-of-the-art training and technical assistance to build the capacity of SAMHSA grantees and develop the skills, knowledge, and expertise of the prevention workforce. The program builds capacity and promotes the development of substance abuse prevention professionals in the behavioral health field through three core strategies: 1) establishing technical assistance networks using local experts; 2) developing and delivering targeted training and technical assistance activities; and 3) using communication media such as teleconference and video conferencing, online events, and web-based support. These activities help ensure the delivery of effective prevention programs and practices and the development of accountability systems for performance measurement and management.

During FY 2013, the program completed a comprehensive revision and update of its flagship Substance Abuse Prevention Skills Training (SAPST), which offers participants 31 training hours toward certification as a Substance Abuse Prevention Specialist. The CAPT also developed a Pacific Islander and Native American adaptation of the training for six additional training hour credits. Through FY 2016, the CAPT continued to develop comprehensive training products and technical assistance products. These products focus on shared risk and protective factors to promote collaboration across substance abuse and mental health disciplines within the behavioral health field.

The program is increasing emphasis on virtual or distance forms of service delivery and relying more heavily on webinars and online training. The CAPT program developed a series of self-paced courses to increase the capacity of community-level grantees to use epidemiological data to guide their prevention planning efforts, as well as webinars and coaching consultations to help grantees identify risk and protective factors and appropriate strategies to address emerging prevention needs such as prescription drug misuse and youth marijuana use. In FY 2015, the CAPT supported the organizational capacity of high-need communities to address health disparities and achieve benchmarks identified in SAMHSA's Partnerships for Success program. CAPT continues to strengthen the prevention workforce, overall, by increasing the availability of interactive virtual trainings on using epidemiological data and risk and protective factors to guide implementation of effective prevention strategies.

In FY 2016, CAPT expanded its scope of work by providing technical assistance to new SAMHSA grantees in the SPF Rx program as well as Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths program.

In FY 2017, funding will continue to support the delivery of technical assistance and workforce development to the prevention field.

Funding History

Fiscal Year	Amount
FY 2014	$7,493,000
FY 2015	$7,493,000
FY 2016	$7,493,000
FY 2017	$7,479,000
FY 2018	$7,479,000

Budget Request

The FY 2018 Budget Request is $7.5 million, level with the FY 2017 Annualized CR. The program will continue to provide technical assistance and training to over 9,000 individuals in the prevention field.

Outputs and Outcomes Table

Program: Center for the Application of Prevention Technologies (CAPT)
NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/− FY 2018 Target
1.4.11 Prevention: increase the number of individuals trained by the CAPT (Output)	FY 2015: 8,874 Target: 5,216 (Target Exceeded)	9,000	9,000	Maintain
1.4.12 Increase the percent of participants that agree or strongly agree that the training or TA provided increased their capacity to do substance abuse prevention work (Outcome)	FY 2015: 94 % Target: 90 % (Target Exceeded)	90 %	90 %	Maintain

Science and Service Program Coordination

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Science and Service Program Coordination	$4,072	$4,064	$4,064	$---

Authorizing Legislation ..... Section 516 of the PHS Act
Allocation Method ..... Contracts
Eligible Entities..... Domestic and Public Entities

Program Description and Accomplishments

SAMHSA has made prevention of underage drinking a priority because of its potential impact on the health and well-being of young people and their communities. Over the past decade, there has been a steady decline in past-month, or current drinking by adolescents and young adults. Trend data report similar declines in underage binge and heavy drinking. In fact, among 8th to 12th grade students, rates of current, binge, and heavy drinking have declined to record lows. Yet, alcohol remains the drug of choice for individuals between the ages of 12 to 20 years. Risky and heavy drinking among college students remains unacceptably high.

The Science and Service Program Coordination program funds the provision of technical assistance and training to states, tribes, communities, and grantees around substance abuse prevention. Specifically, the program supports the Tribal Training and Technical Assistance Center and the Underage Drinking Prevention Education Initiatives (UADPEI).

The Tribal Training and Technical Assistance Center is an innovative training and technical assistance project that helps tribal communities facilitate the development and implementation of comprehensive and collaborative community-based prevention plans to reduce violence, bullying, substance abuse, and suicide among American Indian/Alaska Native (AI/AN) youth, in support of the HHS Tribal Health and Well-Being Coordination. These plans mobilize tribal communities' existing social and educational resources to meet their goals. As of FY 2015, 65 tribal communities have received specialized technical assistance and support in suicide prevention and related areas. In addition, more than 9,200 members of these communities received training in prevention and mental health promotion.

The Underage Drinking Prevention Education Initiatives engage parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences. Through this initiative, families, their children, and other youth-serving organizations have been reached through Town Hall Meetings, technical assistance, trainings, and a variety of tools and materials. Efficiencies have been achieved from the growing focus on train-the-trainer models rather than training of individuals.

In FY 2016, community-based organizations registered to host 1,500 events. These events were held in all 50 states, the District of Columbia, and three territories. Approximately 870 individuals

attended live online training webinars and SAMHSA responded to 3,000 requests for technical assistance in planning, promoting, hosting, and evaluating events. In FY 2017, SAMHSA will continue to fund two contracts to support these activities.

Funding History

Fiscal Year	Amount
FY 2014	$4,072,000
FY 2015	$4,072,000
FY 2016	$4,072,000
FY 2017	$4,064,000
FY 2018	$4,064,000

Budget Request

The FY 2018 Budget Request is $4.1 million, level with the FY 2017 Annualized CR. These funds will support SAMHSA's substance abuse prevention efforts and include a focus on preventing underage drinking and providing technical assistance and training to American Indians/Alaska Native communities.

Tribal Behavioral Health Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Tribal Behavioral Health Grants	$15,000	$14,971	$14,971	$---

Authorizing Legislation ..... Section 516 of the PHS Act
Allocation Method ..... Grants/Contracts
Eligible Entities..... Tribes

Program Description and Accomplishments

Suicide is the second leading cause of death among American Indian/Alaska Native (AI/AN) youth ages eight to 24 years.[38] Further, AI/AN high school students report higher rates of suicidal behaviors than the general population of U.S. high school students.[39] These behaviors include having serious thoughts of suicide, making suicide plans, attempting suicide, and getting medical attention for a suicide attempt. However, the risk of suicide is not the same in all AI/AN youth

[38] Centers for Disease Control and Prevention. Fatal injury data, 2010. Web-based Injury Statistics Query and Reporting System. Available at http://www.cdc.gov/injury/wisqars/fatal.html.
[39] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Available at http://www.cdc.gov/healthyyouth/yrbs/index.htm.

The Tribal Behavioral Health Grants (TBHG) program addresses the high incidence of substance abuse and suicide among AI/AN populations. Starting in FY 2014, this program supports tribal entities with the highest rates of suicide by providing effective and promising strategies that address substance abuse, trauma, and suicide and by promoting the mental health of AI/AN young people.

In FY 2014, SAMHSA's Center for Mental Health Services awarded Tribal Behavioral Health grants up to $0.2 million annually for a total of five years to 20 tribes or tribal organizations with high rates of suicide. These five-year grants help grantees develop and implement a plan that addresses suicide and substance abuse, thereby promoting mental health among tribal youth. In addition, SAMHSA's Tribal Training and Technical Assistance Center (http://www.samhsa.gov/tribal-ttac) provides technical assistance to AI/AN grantees, organizations, and providers serving AI/AN populations to support their ability to achieve their goals. An evaluation component allows grantees and SAMHSA to work collaboratively to monitor progress and learn from each other. SAMHSA has incorporated lessons learned to enhance this program and other national efforts to reduce suicide and substance abuse and support positive mental health among AI/AN youth. SAMHSA continued the support of this program in FY 2015. Grantees completed their needs assessments in FY 2015 and are working with SAMHSA to implement action plans based on these assessments. These action plans will report baseline data by the end of FY 2017.

In FY 2016, SAMHSA proposed an expansion of its TBHG program. This initiative takes a comprehensive, culturally appropriate approach to help improve the lives of and opportunities for AI/AN youth. In addition to HHS, multiple agencies, including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing AI/AN youth. This funding allows SAMHSA to expand activities through the braided TBHG ($15.0 million in Prevention; $15.0 million in Mental Health) to allow tribes the flexibility to implement community-based strategies to address trauma, prevent substance abuse, and promote mental health and resiliency among youth in tribal communities. The additional FY 2016 funding expanded these activities to approximately 75 tribes and tribal entities. With the expansion of the TBHG program, SAMHSA's goal is to reduce substance use and the incidence of suicide attempts among AI/AN youth and to address behavioral health conditions that affect learning in the Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion, including trauma informed care, and substance use prevention activities for high-risk AI/AN youth and their families, enhance early detection of mental illness and drug/alcohol addiction among AI/AN youth, and increase referral to treatment. In FY 2017, this activity will continue at the same level with grant continuations and a new cohort of TBHG grantees.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	$15,000,000
FY 2017	$14,971,000
FY 2018	$14,971,000

Budget Request

The FY 2018 Budget Request for the Tribal Behavioral Health Grant program is $15.0 million is level with the FY 2017 Annualized CR. This will be combined with the $15.0 million in the Mental Health appropriation for a total of $30.0 million. This request will continue support for programs that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families. In FY 2018, SAMHSA will fund TBHG continuation grants.

Outputs and Outcomes Table

Program: Tribal Behavioral Health
NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
2.4.12 Increase the number of youth age 10 - 24 who received mental health or related services after screening, referral or attempt (Output)	FY 2016: 20 Target: 20 (Baseline)	20	20	Maintain
2.4.13 Increase the number of programs/organizations that implemented specific mental-health related practices/activities as a result of the grant (Outcome)	FY 2016: 296 Target: 296 (Baseline)	296	296	Maintain

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Grants to Prevent Prescription Drug/ Opioid Overdose Related Deaths	$12,000	$11,977	$11,977	$---

Authorizing Legislation ..... Section 516 and Section 546 of the PHS Act
FY 2018 Authorization $12,000
Allocation Method .....Competitive Grants, Contracts
Eligible Entities.....States, local government entities, Federally Recognized American Indian/Alaska Native tribe or tribal organizations

Program Description and Accomplishments

Opioid overdose is a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids (including synthetics), such as fentanyl).[1] Opioids include illegal drugs such as heroin, as well as prescription medications used to treat pain. These prescription medications include morphine, codeine, methadone, oxycodone (Oxycontin, Percodan, Percocet), hydrocodone (Vicodin, Lortab, Norco), fentanyl (Duragesic, Fentora), hydromorphone (Dilaudid, Exalgo), and buprenorphine (Subutex, Suboxone). Opioids bind to specific receptors in the brain, spinal cord, and gastrointestinal tract and reduce the body's perception of pain. As opioids reduce pain, they induce a slight sense of euphoria, which can lead to overuse.

In 2013, SAMHSA released the Opioid Overdose Prevention Toolkit to help reduce the number of opioid-related overdose deaths and adverse events. Developed by SAMHSA, the Association of State and Territorial Health Officials, the National Association of State Alcohol and Drug Abuse Directors, and the American Association for the Treatment of Opioid Dependence, the Toolkit was the first federal resource that includes safety and prevention information for individuals at risk for overdose. The toolkit provides information on how to recognize and respond appropriately to overdose, identifies specific drug-use behaviors to avoid, and describes the role of overdose reversing drugs in preventing death from an overdose. Naloxone is an opioid antagonist that reverses the effects of opioids, including respiratory depression. A growing evidence base suggests that naloxone is a cost-effective method to reduce opioid overdose deaths.

As the rates of prescription drug abuse, heroin abuse, illicit synthetic opioid abuse, overdoses, and opioid-related overdose deaths increase, communities are searching for ways to reduce the death rate from opioid-related overdoses.
The Grants to Prevent Prescription Drug and Opioid Overdose-related Deaths program helps states identify communities of high need and provide education, training, and resources necessary to

[1] National Institute on Drug Use (NIDA). America's Addiction to Opioids: Heroin and Prescription Drug Abuse. (2014) Available from URL: http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2015/americas-addiction-to-opioids-heroin-prescription-drug-abuse#_ftnref4

tailor the overdose kits to meet their specific needs. The grant funds can be used for purchasing overdose reversing drugs, equipping first responders with them, providing training on it and other overdose-related death prevention strategies, and providing materials to assemble and disseminate overdose kits.

These grantees are required to develop a dissemination plan and a training course tailored to meet the needs of first responders in the communities within their state. The course uses SAMHSA's Opioid Overdose Prevention Toolkit as a guide and includes a comprehensive prevention program that will focus on prevention, treatment, and recovery services in order to decrease the likelihood of drug overdose recurrence.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	$12,000,000
FY 2017	$11,977,000
FY 2018	$11,977,000

Budget Request

The FY 2018 Budget Request is $12.0 million, level with the FY 2017 Annualized CR. This funding will provide continuation grants to 12 states to reduce the number of opioid overdose-related deaths. Funding will help states purchase overdose reversing drugs, equip first responders in high-risk communities, support education on the use of naloxone and other overdose-related death prevention strategies, provide the necessary materials to assemble overdose kits, and cover expenses incurred from dissemination efforts.

First Responder Training

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
First Responder Training (CARA)	$---	$12,000	$12,000	$---

Authorizing Legislation…….....Section 546 of the Public Health Service Act
FY 2018 Authorization…….$12,000
Allocation Method…….....Competitive Grants
Eligible entities…….States, local government entities, Federally Recognized American Indian/Alaska Native tribe or tribal organizations

Program Description and Accomplishments

Under Section 202 of the Comprehensive Addiction and Recovery Act (CARA), SAMHSA is authorized to support additional efforts to prevent opioid overdose-related deaths by providing grants to train first responders. In FY 2017, SAMHSA will fund up to 11 grants for the First Responder Training program. The purpose of this program is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals at risk for opioid abuse. Applicants will train first responders and members of other key community sectors at the local government and tribal levels to implement secondary prevention strategies, such as the administration of naloxone through FDA-approved delivery devices to reverse the effects of opioid overdose.

In 2013, SAMHSA released the Opioid Overdose Prevention Toolkit to help reduce the number of opioid-related overdose deaths and adverse events. The grant program will utilize this toolkit and other resources to help grantees develop a comprehensive prevention program that educates the public about the dangers of sharing medications, raises awareness among pharmaceutical and medical communities on the risks of overprescribing, and implements overdose death prevention strategies, such as naloxone distribution and the purchase of overdose reversing drugs for first responders, in communities of high need. Grantees will develop a naloxone distribution plan and a training course for first responders and others on the use of overdose reversing drugs tailored to meet the needs of their communities. The grant program also will work to strengthen communities in developing policies and practices that prevent and respond appropriately to prescription drug/opioid-related overdoses.

Training, technical assistance, and evaluation activities are also being supported to assist grantees, determine best practices, and assess program outcomes.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$12,000,000
FY 2018	$12,000,000

Budget Request

The FY 2018 Budget Request is $12.0 million, level with the FY 2017 Annualized CR. This funding will provide continuation grants to 11 grantees to address the opioid crisis in this country.

Minority Fellowship Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Minority Fellowship Program	$71	$71	$71	$---

Authorizing Legislation ..... Section 516 of the PHS Act
Allocation Method ..... Grants/Contracts
Eligible Entities..... American Nurses Association (ANA), American Psychiatric Association (ApA), American Psychological Association (APA), Council on Social Work Education (CSWE), American Association for Marriage and Family Therapy (AAMFT), and professional organization representing addictions counselors

Program Description and Accomplishments

The mental health-related and substance use-related service needs of racial and ethnic minority communities within the United States have been historically under–addressed due to a variety of factors. These include a limited number of trained practitioners who are equipped with the language skills or cultural competency training needed to deliver effective services for this population. SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to funding increases the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance abuse treatment services for minority populations that are underserved. This will result in improved quality of mental and substance abuse prevention and increased treatment delivered to ethnic minorities. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, the program expanded to include marriage and family therapists and later added professional counselors. These

individuals often serve in key leadership positions in mental illness and substance abuse treatment services, services supervision, services research, training, and administration. Professional guilds receive competitively awarded grants, and then competitively award the stipends to post-graduate students pursuing a degree in that professional field. In FY 2015 and in FY 2016, SAMHSA funded six continuation grants.

Minority Fellowship Program Expansion-Youth (MFP-Y) and Addiction Counselors (MFP-AC)
Begun in FY 2014, MFP-Y is a component of MFP that support master's level trained behavioral health professionals in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing serving children, adolescents, and populations in transition to adulthood (aged 16 to 25). The purpose of the program expansion, the Minority Fellowship Program-Youth (MFP-Y), is to reduce health disparities and improve behavioral healthcare outcomes for racially and ethnically diverse youth and young adults.

To do this, the program aims to increase the number of culturally competent master's level behavioral health professionals serving children, adolescents, and populations in transition to adulthood (aged 16 to 25) in an effort to increase access to, and the quality of, behavioral health care for this age group. The expansion program uses the existing infrastructure of the MFP to expand the program to support 960 master's level trained behavioral health providers. Grants are competitively awarded to professional guilds, which then competitively award the stipends to post-graduate students pursuing a degree in that professional field.

MFP-AC is a component of MPP to support master's level addiction counselors (MFP-AC) for youth and young adults. The purpose of the four-year grant program is to reduce health disparities and improve behavioral healthcare outcomes for racially and ethnically diverse populations by increasing the number of culturally competent master's level addiction counselors available to underserved minority populations with a specific focus on transition age youth (ages 16 to 25) in public and private non-profit sectors. MFP-AC grants are supporting students pursuing master's level degrees in addiction/substance abuse counseling, with the goal of increasing the number of masters-level addiction counselors across the nation by approximately 300 counselors. As is the case with MFP and MFP-Y, grants are competitively awarded to professional guilds, who then competitively award the stipends to post-graduate students pursuing a degree in that professional field.

Funding History

Fiscal Year	Amount
FY 2014	$71,000
FY 2015	$71,000
FY 2016	$71,000
FY 2017	$71,000
FY 2018	$71,000

Budget Request

The FY 2018 Budget Request is $71 thousand, level with the FY 2017 Annualized CR. The funding will provide continued support for both base and expansion activities. The funds will support one MFP and one technical assistance and evaluation support contracts.

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table Summary

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
Grants						
Continuations	215	$125,302	386	$158,842	343	$107,674
New/Competing	198	41,857	37	21,990	15	5,114
Subtotal	413	167,159	423	180,832	358	112,788
Contracts						
Continuations	22	37,707	3	28,248	23	31,720
New	14	6,353	33	13,738	6	5,195
Subtotal	36	44,060	36	41,986	29	36,915
Total, Substance Abuse Prevention PRNS	**449**	**$211,219**	**459**	**$222,817**	**387**	**$149,703**

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
Capacity:						
Strategic Prevention Framework						
Grants						
Continuations	66	$92,927	89	$106,308	73	$43,884
New/Competing	21	11,815	---	---	15	5,048
Supplements	---	---	---	---	---	---
Subtotal	87	104,742	89	106,308	88	48,932
Contracts						
Continuations	8	13,582	13	12,849	8	9,494
New	6	1,160	---	100	---	---
Subtotal	14	14,742	13	12,949	8	9,494
Total, Strategic Prevention Framework	**101**	**119,484**	**102**	**119,257**	**96**	**58,426**
Federal Drug-Free Workplace						
Contracts						
Continuations	3	4,880	4	4,735	3	746
New	1	14	---	150	1	4,138
Subtotal	4	4,894	4	4,885	4	4,885
Total, Federal Drug-Free Workplace	**4**	**4,894**	**4**	**4,885**	**4**	**4,885**
Minority AIDS						
Grants						
Continuations	132	31,504	137	31,136	73	25,714
New/Competing	19	3,957	---	5,597	---	---
Subtotal	151	35,461	137	36,733	73	25,714
Contracts						
Continuations	4	5,221	4	3,594	1	2,076
New	1	522	---	800	3	1,052
Subtotal	5	5,744	4	4,394	4	3,128
Total, Minority AIDS	**156**	**41,205**	**141**	**41,127**	**77**	**28,843**
Sober Truth on Preventing Underage Drinking Act						
Grants						
Continuations	17	804	78	3,898	95	4,634
New/Competing	78	3,780	17	766	---	---
Subtotal	95	4,584	95	4,664	95	4,634
Contracts						
Continuations	2	2,416	2	1,336	2	2,353
New	---	---	---	987	---	---
Subtotal	2	2,416	2	2,323	2	2,353
Total, Sober Truth on Preventing Underage Drinking Act	**97**	**7,000**	**97**	**6,987**	**97**	**6,987**

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths						
Grants						
Continuations	---	---	12	10,529	12	10,477
New	10	10,546	---	---	---	---
Subtotal	10	10,546	12	10,529	12	10,477
Contracts						
Continuations	---	---	2	1,448	2	1,500
New	3	1,454	---	---	---	---
Subtotal	3	1,454	2	1,448	2	1,500
Total, Grants to Prevent Prescription Drug/ Opioid Overdose Related Deaths	**13**	**12,000**	**14**	**11,977**	**14**	**11,977**
Tribal Behavioral Health Grants						
Grants						
Continuations	---	---	70	6,904	70	12,593
New/Competing	70	11,759	---	5,204	---	---
Subtotal	70	11,759	70	12,108	70	12,593
Contracts						
Continuations	---	---	4	2,313	3	2,378
New/Competing	2	3,241	---	550	---	---
Subtotal	2	3,241	4	2,863	3	2,378
Total, Tribal Behavioral Health Grants	**72**	**15,000**	**74**	**14,971**	**73**	**14,971**
Comprehensive Addiction and Recovery Act						
Grants						
Continuations	---	---	---	---	20	10,371
New/Competing	---	---	20	$10,423	---	---
Subtotal			20	$10,423	20	10,371
Contracts						
Continuations	---	---	---	---	2	1,629
New/Competing	---	---	2	1,577	---	---
Subtotal	---	---	2	1,577	2	1,629
Total, Comprehensive Addiction and Recovery Act	**---**	**---**	**22**	**12,000**	**22**	**12,000**
Subtotal, Capacity	**443**	**$199,583**	**432**	**$199,203**	**361**	**$126,089**

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount
Science and Service:						
Center for the Application of Prevention Technologies						
Contracts						
Continuations	1	$7,705	1	$359	1	$7,479
New/Competing	1	-212	---	7,119	---	---
Subtotal	2	7,493	1	7,479	1	7,479
Technologies	2	7,493	1	7,479	1	7,479
SAP Minority Fellowship Program						
Grants						
Continuations	1	66,582	1	66	---	---
New/Competing	---	---	---	---	1	66
Subtotal	1	66,582	1	66,301	1	66,301
Contracts						
Continuations	1	4	---	5	---	---
New/Competing	---	---	---	---	1	5
Subtotal	1	4,418	---	4,699	1	4,699
Total, SAP Minority Fellowship Program	**2**	**71,000**	**1**	**71,000**	**2**	**71,000**
Science & Service Program Coordination						
Contracts						
Continuations	4	3,899	3	1,610	3	4,064
New	---	173	---	2,454	---	---
Subtotal	4	4,072	3	4,064	3	4,064
Total, Science & Service Program Coordination	**4**	**4,072**	**3**	**4,064**	**3**	**4,064**
Subtotal, Science and Service	**6**	**11,636**	**4**	**11,614**	**4**	**11,614**
Total, Substance Abuse Prevention	**449**	**$211,219**	**458**	**$222,817**	**387**	**$149,703**

Grant Awards Table

(Whole dollars)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	413	423	358
Average Award	$470,421	$486,500	$386,828
Range of Awards	$50,000 – $2,300,000	$50,000 – $2,300,000	$50,000 – $2,300,000

SAMHSA
Substance Abuse Treatment
Table of Contents

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Substance Abuse Treatment Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Programs of Regional and National Significance	$337,345	$341,708	$341,738	30
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*2,000*	---
Substance Abuse Prevention and Treatment Block Grant	1,858,079	1,854,697	1,854,697	---
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	---
State Targeted Response to the Opioid Crisis Grants	---	*500,000*	*500,000*	---
Total, Substance Abuse Treatment	**$2,195,424**	**$2,696,405**	**$2,696,435**	**30**

The Substance Abuse Treatment FY 2018 Budget Request is $2.7 billion, an increase of $0.03 million from the FY 2017 Annualized CR. The request includes $2.6 billion in Budget Authority and $81.2 million in Public Health Service (PHS) Evaluation funds.

Substance Abuse Treatment Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Capacity:				
Opioid Treatment Programs/Regulatory Activities	$8,724	$8,708	$8,708	---
Screening, Brief Intervention and Referral to Treatment	46,889	46,804	46,804	---
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*2,000*	---
Targeted Capacity Expansion-General	36,303	36,234	36,234	---
Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (non-add)	*25,000*	*24,952*	*24,952*	---
Pregnant and Postpartum Women	15,931	19,901	19,931	30
Recovery Community Services Program	2,434	2,429	2,429	---
Children and Families	29,605	29,549	29,549	---
Treatment Systems for Homeless	41,304	41,225	41,225	---
Minority AIDS	65,570	65,445	65,445	---
Criminal Justice Activities	78,000	77,852	77,852	---
SAT Minority Fellowship Programs	3,539	3,532	3,532	---
Building Communities of Recovery		1,000	1,000	---
Subtotal, Capacity	**328,299**	**332,679**	**332,709**	**30**
Science and Service:				---
Addiction Technology Transfer Centers	9,046	9,029	9,029	---
Subtotal, Science and Service	**9,046**	**9,029**	**9,029**	**---**
Total, PRNS	**$337,345**	**$341,708**	**$341,738**	**$30**

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2018 Authorization $333,806
Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities…… …… ……..States, local governments, Communities, Federally Recognized American Indian/Alaska Native tribe or tribal organizations, Indian Health Service-operated and contracted health facilities and programs, public or private nonprofit entities

Opioid Treatment Programs/Regulatory Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Opioid Treatment Programs/Regulatory Activities	$8,724	$8,708	$8,708	---

Authorizing Legislation .....Section 509 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Medical Association, American Osteopathic Association, American Psychiatric Association, American Dental Association

Program Description and Accomplishments

The misuse of prescription opioid pain relievers and illicit opioids such as heroin is causing suffering, sickness, overdose, and death in the United States at epidemic levels.[77] Communities across the nation also face the risk that individuals who inject opioids will contract and spread HIV and hepatitis C.[78] The underlying cause of these problems is increasing rates of opioid abuse.[79,80]

With increasing incidence of opioid abuse, there is a corresponding increase in admissions for treatment of opioid use disorder diagnoses.[81] Medication-assisted treatment (MAT), which is the use of FDA-approved medications (i.e., buprenorphine, methadone, extended-release injectable naltrexone), in combination with counseling and behavioral therapies to provide a whole-patient approach to the treatment of substance abuse, including opioid abuse. MAT is a safe and effective strategy for decreasing the frequency and quantity of opioid use and reducing the risk of overdose and death.

Approximately one million Americans need, but do not access treatment for an opioid addiction.[82] A search of SAMHSA's behavioral health treatment locator reveals only 20 percent of surveyed facilities offer MAT for individuals with opioid addiction. The majority of the approximately 1,500 opioid treatment programs (OTPs) which provide supervised dosing of methadone - and

[77] U.S. Department of Health and Human Services. Addressing prescription drug abuse in the United States: current activities and future opportunities. 2013. Retrieved from http://www.cdc.gov/homeandrecreationalsafety/overdose/hhs_rx_abuse.html
[78] Substance Abuse and Mental Health Services Administration. Associations of nonmedical pain reliever use and initiation of heroin use in the United States. 2013. Retrieved from http://samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.html
[79] Johnson EM, Lanier WA, Merrill RM, et al. Unintentional prescription opioid-related overdose deaths: description of decedents by next of kin or best contact, Utah, 2008-2009. J Gen Intern Med. 2013;28(4): 522-9.
[80] Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA.* 2011;305(13):1315-1321. doi:10.1001/jama.2011.370.
[81] Paulozzi LJ, Jones CM, Mack KA, Rudd RA. Vital signs: overdoses of prescription opioid pain relievers – United States, 1999-2008. MMWR Morb Mortal Wkly Rep. 2011;60(43): 1487-92.
[82] Jones, C. M. (2013). Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers, United States, 2002-2004 and 2008-2010. Drug and Alcohol Dependence, 132(1-2):95-100.

sometimes buprenorphine - are at or near capacity. OTPs are the only means of providing medication assisted treatment (MAT) with methadone. Buprenorphine can be prescribed in an office setting by physicians who have received a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000) provision of the Controlled Substances Act. Most physicians with a waiver to prescribe buprenorphine do not treat the maximum allowable number of patients. Some physicians willing to attempt to fill the unmet need for treatment by serving more individuals are prevented from doing so due to the patient limit on prescribing buprenorphine.

On July 8, 2016, HHS/SAMHSA published a final rule, "Medication Assisted Treatment for Opioid Use Disorders," which allows practitioners who have had a waiver to prescribe buprenorphine for up to 100 patients for a year or more, to now obtain a waiver to treat up to 275 patients.

SAMHSA is responsible for regulating and certifying approximately 1,500 OTPs to use opioid agonist treatment medications and processing waivers for physicians and mid-level practitioners who wish to treat opioid abuse with buprenorphine. SAMHSA reviews new and renewal applications for OTPs and oversees their accreditation. OTPs are required to be accredited as a condition of certification. SAMHSA's regulation of OTPs plays a critical role in expanding access and maintaining quality. Accrediting organizations must be approved by SAMHSA to fulfill this function and this approval must be renewed every five years. SAMHSA monitors the accrediting bodies for quality assurance and improvement by making 10 to 20 site visits to recently-accredited programs each year, and conducts unannounced OTP site visits to investigate complaints from members of the public, state and local jurisdictions, and others. In addition to regulating OTPs, SAMHSA provides training and technical support through a contract entitled Opioid Treatment Program Quality (OTP-Q) which was re-competed and awarded in 2016. The goal is to provide trainings for OTP staff, on-site consultations for programs with deficiencies or unique challenges, and annual training for State Opioid Treatment Authorities. The Federal Guidelines for Opioid Treatment Programs are available to the field and describe SAMHSA's expectation of how the federal opioid treatment standards found in Title 42 of the Code of Federal Regulations Part 8 are to be satisfied by OTPs.

SAMHSA also implements DATA 2000 in coordination with the Drug Enforcement Agency. This includes approving waivers for qualified practitioners to provide medication-assisted treatment in office-based settings. More than 37,000 practitioners have been granted waivers since 2001. Waiver processing is conducted under a contract entitled DATA Waiver Processing and Support Project. This contract was modified in FY 2016 to update and upgrade the database of information about waivered practitioners and to modernize the system to handle the expected increase in volume. From August 2016 through March 2017, SAMHSA has processed over 7,365 waiver applications of which 3,211 physicians were certified to treat 30 patients, 1,107 were certified to treat 100 patients, and 3,047 were certified to treat 275 patients.

On November 17, 2016, the Department of Health and Human Services (HHS) announced that nurse practitioners (NPs) and physician assistants (PAs) can immediately begin taking the 24 hours of required training to prescribe buprenorphine for the treatment of opioid addiction. This was based on Section 303 of the Comprehensive Addiction and Recovery Act (CARA), which made several changes to the law regarding office-based opioid addiction treatment with buprenorphine.

One of these changes was that prescribing privileges have been expanded to NPs and PAs for five years (until October 1, 2021). NPs and PAs who complete the required training and seek to prescribe buprenorphine for up to 30 patients were able to begin applying for a waiver in February 2017. SAMHSA supports a cooperative agreement with the American Academy of Addiction Psychiatry which provides education, training, and mentors to behavioral healthcare providers. The Providers Clinical Support Services for Medication Assisted Treatment (PCSS-MAT) focuses on medication-assisted treatment for opioid abuse.

Through the Behavioral Health Information Technology and Standards (BHITS) contract, SAMHSA funded a competition that resulted in three new mobile applications for overdose prevention in FY 2015. In FY 2016, SAMHSA conducted another challenge to promote the development of recovery support applications for patients receiving medication-assisted treatment. Also through BHITS, in FY 2015, an Opioid Treatment Program Service continuity Project was conducted, and successfully demonstrated the ability to assure continuity of care for OTP patients via a health information exchange while fully respecting patient privacy. In FY 2016, a second such pilot began using a different software vendor and programs in a different geographic area in order to increase the number of health information exchange organizations incorporating substance use and mental disorder treatment data using Health Level 7 (HL7) standards.

SAMHSA's Preventing Prescription Drug Abuse and Overdose technical assistance contract has provided live, free, continuing medical education (CME) across the country on safe and appropriate opioid prescribing making a special effort to reach isolated areas. CME courses are offered in conjunction with annual meetings of various national organizations. Since 2011, PPDAO recorded 64,063 online CME completions and 72 live CME trainings, attracting almost 10,812 participants. This contract supported the publication of two brief guides for clinicians: "Clinical Use of Extended-Released Injectable Naltrexone in the Treatment of Opioid Use Disorder" and "Alcohol Brief Guide – Medication for the Treatment of Alcohol Use Disorder" which SAMHSA developed in coordination with the National Institutes of Health. Both of these were released as "pocket" versions in FY 2016. This contract was also used to develop SAMHSA's guidance document on the management of pregnant and parenting opioid dependent women and their infants. In 2015, the Rand-UCLA Appropriateness Method was used to review the evidence and formulate recommendations. In 2016, a report of this activity was released for public comment. The findings are being converted into a patient-centered, multi-disciplinary clinical guide. Additional activities for FY 2016, under this contract included CME training in Indiana, Virginia, Minnesota, Vermont, California, and Alabama and at two large meetings. The first was a Telebehavioral health for Medication-Assisted Treatment Providers and the second was a Non-Agonist Pharmacotherapies Scientific Review. The contract was competed and awarded for FY 2016 as Addressing Opioid Misuse and Overdose (AOMO). Subsequent to the passage of the Comprehensive Addiction and Recovery Act, AOMO organized a public meeting where stakeholders discussed the training requirements for midlevel practitioners to prescribe buprenorphine for an opioid addiction. Under AOMO, SAMHSA plans to implement training in addiction medicine to providers, including NP and PA, with the ECHO model, and to evaluate whether the ECHO training model results in clinician practice change for addiction providers.

SAMHSA developed the MATx, a public domain app for healthcare practitioners to support medication-assisted treatment of opioid abuse. This is a significant step forward in efforts to

improve access to MAT, making it easier for patients living with addiction to access effective, evidence-based treatment. This public domain app puts the most critical information to support the delivery of MAT in one place—the latest on treatment approaches, medications, and clinical support tools, plus helplines and access to SAMHSA's Treatment Locators. Since, the launch date of October 2016, there has been 9,247 downloads of the app.

In FY 2017, SAMHSA plans to fund one continuation grant, one new supplement and three new contracts and four continuing contracts.

Funding History

Fiscal Year	Amount
FY 2014	$8,724,000
FY 2015	$8,724,000
FY 2016	$8,724,000
FY 2017	$8,708,000
FY 2018	$8,708,000

Budget Request

The FY 2018 Budget Request is $8.7 million, level with the FY 2017 Annualized CR. In FY 2018, SAMHSA intends to continue funding two continuation grants and three contracts and plans to support two new contracts.

Screening, Brief Intervention and Referral to Treatment

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Screening, Brief Intervention and Referral to Treatment	$46,889	$46,804	$46,804	---
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*2,000*	---

Authorizing Legislation .....Section 509 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Single State Authority and Health Departments in States, Territories, the District of Columbia, Federally Recognized American Indian/Alaska Native Tribe or Tribal Organizations, Domestic Public and Private Non-Profit Entities, and Public and Private Universities Colleges

Program Description and Accomplishments

A high number of individuals misuse illicit drugs and alcohol. Of all individuals age 12 or older, 27.1 million (10.1 percent) use illicit drugs, 66.7 million (24.9 percent) binge drink, and 17.3 million (6.5 percent) drink heavily.[83] This increases the cost to society by compromising individual health and potentially causing injury to others. Misuse of illicit drugs and alcohol costs society $488.0 billion each year.[84] Of the individuals who need treatment for drug/alcohol addiction, only 10.8 percent receive treatment in a specialty treatment facility.[85] The vast majority of those meeting criteria for having a diagnosable substance use disorder (SUD) have not been diagnosed with an SUD.

In 2003, SAMHSA started the Screening, Brief Intervention and Referral to Treatment (SBIRT) program, which is intended to help primary care physicians identify individuals who misuse substances and help them intervene early with education, brief treatment, or referral to specialty treatment. The program's goal is to increase the number of individuals who receive treatment and

[81] Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/
[82] National Institute on Drug Abuse (2016), *Trends and Statistics*, http://www.drugabuse.gov/related-topics/trends-statistics.
[83] Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/

reduce the rate of substance misuse. Studies have shown that this approach is effective in helping reduce harmful alcohol consumption.[86,87,88]

The SBIRT program seeks to increase the use of SBIRT in medical settings by promoting wide dissemination and adoption of the practice across the spectrum of primary care services. To achieve this, SAMHSA awards state implementation grants to encourage adoption of SBIRT by healthcare providers in each state. SAMHSA also supports the SBIRT Student Training grant programs.

The SBIRT program requires state grant recipients to implement the model in all primary care settings, as well as hospitals, trauma centers, federally qualified health centers, and other relevant health care settings. Recipients may use funds to screen for substance abuse and co-occurring mental illness and drug/alcohol addiction. They can support evidence-based client-centered interventions such as motivational interviewing, brief treatment, and referral to specialty care for individuals exhibiting SUD symptoms.

The SBIRT training program helps train a wide range of medical providers to incorporate SBIRT as part of their ongoing practice. This includes physicians, nurses, counselors, social workers, health promotion advocates, health educators, and others. A SAMHSA-funded cross-site evaluation found that allied health professionals, rather than the physicians themselves, were more likely to implement SBIRT with their patients.[89] The SBIRT Student Training and Health Professionals Training grant programs support SBIRT training efforts for medical students, medical residents, nurses, social workers, psychologists, pharmacists, dentists, and physician assistants. These efforts aim to develop further the primary healthcare workforce in substance abuse treatment and services.

SAMHSA has demonstrated the effectiveness of SBIRT and continues to disseminate SBIRT practices. As of 2016, SAMHSA data show roughly 2.7 million individuals have received screening and/or intervention through this initiative.[1] Of those screened, roughly, 11.5 percent were determined to be at risk, another 1.9 percent were referred for brief treatment, and an additional 2.2 percent are referred to specialty treatment.[2]

In FY 2017, SAMHSA continued funding for 11 state cooperative agreements and 80 training grant continuations. SAMHSA also supported funding of three contracts, which support training

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[86] Bertholet, N., Daeppen, J.-B., Wietlisbach, V., Fleming, M., & Burnand, B. (2005). *Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis*. Archives of Internal Medicine 165, 986–995.

[87] Kahan, M., Wilson, L., & Becker, L. (1995). *Effectiveness of physician-based interventions with problem drinkers: A review*. Canadian Medical Association Journal, *152*, 851–859.

[88] Wilk, A.I., Jensen, N.M., and Havighurst, T.C. (1997*). Meta-analysis of randomized control trails addressing brief interventions in heavy alcohol drinkers*. Journal of General Medicine, 12 (5), 274-283.

[89] RTI International (2009). *RTI International to Evaluate Comprehensive Substance Abuse Intervention Programs for SAMHSA.* Retrieved from http://www.rti.org/newsroom/news.cfm?obj=070E322D-5056-B172-B8E8D0FB9C898DB7

[1] *Services Accountability Improvement System*, (2016)

[2] *Services Accountability Improvement System*, (2016)

and technical assistance and the evaluation of the SBIRT program. SAMHSA projects to fund one new training grant in FY 2017.

Funding History

Fiscal Year	Amount
FY 2014	$46,889,000
FY 2015	$46,889,000
FY 2016	$46,889,000
FY 2017	$46,804,000
FY 2018	$46,804,000

Budget Request

The FY 2018 Budget Request is $46.8 million, the same level as the FY 2017 Annualized CR. SAMHSA intends to fund a new SBIRT program utilizing a tiered evidence design. The new effort will utilize a two-tiered approach, in which a portion of the funds will be utilized to fund innovative approaches and the evaluation of such to broaden the program's reach and scalability in a variety of settings. The remaining funds will support more traditional approaches to program implementation. Using this approach, along with robust cross-site evaluation, will enable innovation and assessment of targeted screening for drug use for specific populations in specific setting, i.e., young adults outside of healthcare settings. This design will allow for new approaches to brief intervention for drug abuse to develop and refine knowledge of what works and what does not; the tiered approach allows for the continued promotion and scaling up of SBIRT in primary care, school-based health programs, and emergency departments. SAMHSA also intends to fund 20 continuations grants (12 SBIRT Student Training and eight SBIRT State) and support two contracts that include technical assistance and evaluation.

Outputs and Outcomes Table

Program: Screening, Brief Intervention and Referral to Treatment

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/− FY 2018 Target
1.2.40 Increase the number of clients served (Output)	FY 2016: 291,025 Target: 143,783[1] (Target Exceeded)	300,000	300,000	Maintain
1.2.41 Increase the percentage of clients receiving services who had no past month substance use (Outcome)	FY 2016: 29.5 % Target: 36 % (Target Not Met)	36 %	36 %	Maintain

[1]Increase in target from previously reported.

Targeted Capacity Expansion-General

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Targeted Capacity Expansion-General	$36,303	$36,234	$36,234	---
Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (non-add)	*25,000*	*24,952*	*24,952*	---

Authorizing Legislation ..... Sections 509 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Domestic Public and Private Non-Profit Entities, States, Opioid Medication-Assisted Treatment Service Providers, Outpatient Substance Abuse Providers, Community Mental Health Centers, Federally Qualified Health Centers, SAMHSA Certified Opioid Treatment Programs, and Licensed Outpatient Substance Abuse Treatment Programs

Program Description and Accomplishments

Urgent, unmet, and emerging substance abuse treatment and recovery support service capacity needs remain a critical issue for the nation. When these needs are not being addressed, there are a host of individual, societal, and community consequences. In an effort to assist communities in overcoming these barriers, SAMHSA initiated the Targeted Capacity Expansion (TCE) program. The program provides rapid, strategic, comprehensive, and integrated community-based responses to gaps in and capacity for SUD treatment and recovery support services. Examples of such needs include limited or no access to medication-assisted treatment (MAT) for opioid addiction; lack of resources needed to adopt and implement health information technologies (HIT) in treatment settings; and short supply of trained and qualified peer recovery coaches to assist individuals in the recovery process.

Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT PDOA)
MAT refers to the use of the Food and Drug Administration-approved pharmacotherapies (i.e., buprenorphine products, methadone, and naltrexone products) in combination with evidence-based psychosocial interventions for treatment of opioid addiction. MAT is a safe and effective strategy for decreasing the frequency and quantity of opioid use and reducing the risk of overdose and death.

Drug overdose is the leading cause of accidental death in the U.S., with 52,404 lethal drug overdoses in 2015, an increase from 47,055 in 2014; among these deaths, 33,091 (63.1 percent) involved an opioid, an increase from 28,647 in 2014. Opioid addiction is driving this alarming trend, with 20,101 overdose deaths related to prescription pain relievers, and 12,990 overdose deaths related to heroin in 2015.[90] Overdose deaths involving opioid pain relievers quadrupled from 1999 to 2014. Heroin overdose death rates increased by 20.6 percent from 2014 to 2015 and

[90] Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep 2016;65:1445–1452. DOI: http://dx.doi.org/10.15585/mmwr.mm655051e1

have more than tripled since 2010, from 1.0 per 100,000 in 2010 to 3.4 per 100,000 in 2014. Despite these troubling statistics, significant gaps persist between treatment needs and capacity. In 2012, 48 states and the District of Columbia reported levels of opioid addiction that were higher than their rates of MAT capacity. Furthermore, 38 states reported that at least 75 percent of their opioid treatment programs (OTPs) were operating at 80 percent or greater capacity.[91]

MAT PDOA addresses treatment needs of individuals who have an opioid addiction by expanding/enhancing treatment system capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based MAT and recovery support services. Recovery support services include linking patients and families to social, legal, housing, and other supports to improve the probability of positive outcomes.

In FY 2016, SAMHSA funded 11 continuation state grants, 11 new state grants, as well as one contract. In FY 2017, SAMHSA plans to fund 22 continuation state grants, and one technical assistance contract. The 22 grantees in FY 2016 represent all 10 HHS regions in the U.S. To date, approximately 2,470 individuals with opioid addiction are being served through the grant program. In FY 2017, SAMHSA plans to fund 22 continuation MAT PDOA grants and one continuing technical assistance contract.

Targeted Capacity Expansion-Technology Assisted Care (TCE-TAC)

Access to treatment still remains inadequate for underserved populations living with drug/alcohol addiction and/or co-occurring mental illness and drug/alcohol addiction, such as those living in rural and extremely rural areas. A key component of this access challenge relates to a lack of dependable transportation and many organizations experience significant financial constraints in serving these rural populations. SAMHSA believes that behavioral healthcare providers who use health information technology (HIT) can help patients improve their access to necessary care and prevention services. For example, tele-health and tele-psychiatry can bring addiction medicine providers to clients in areas without local specialists. Web-based tools can improve communication and help deliver much-needed support and education. Health information technology approaches can also enable providers to document and coordinate better mental and substance abuse treatment services directly or via tele-psychiatry or telemedicine with families and other providers and specialists.

SAMHSA established the TCE-TAC grant program to address the lack of resources in the field necessary to adopt and implement health information technologies including electronic health records (EHRs), smart phones, tablets, web-based technologies and applications to support tele-psychiatry and telemedicine. The program also addresses the behavioral healthcare providers' need to expand and/or enhance their ability to communicate effectively with individuals in treatment, as well as monitor their health to ensure treatment and prevention services are available when and where needed.

TCE-TAC and the predecessor program, Targeted Capacity Expansion-Health Information Technology (TCE-HIT), have improved care delivery in 48 behavioral healthcare organizations

[91]Jones, C. M., Campopiano, M., Baldwin, G., McCance-Katz, E. (2015). National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health*, 105(8), e55-c63.

across 23 states. In FY 2017, the TCE-TAC program will include 12 additional grantees; bringing to total since 2011 to 60 behavioral healthcare organizations. Grantees have deployed all of the above mentioned technologies to provide substance abuse treatment services directly or via remote service delivery (i.e., tele-psychiatry and telemedicine). In FY 2015, the TCE-TAC and TCE- HIT programs served roughly 1,195 individuals. Health information technology clearly holds great potential for increasing access to treatment services and providing reliable exposure to meaningful health information for underserved individuals with mental illness and drug/alcohol addiction. Providing the means to sustain this technology is likely to be an ongoing challenge for these and similarly-situated organizations. For example, River Edge Behavioral Health Center, Macon, GA, used funds from SAMHSA's TCE-TAC grant to establish an "I-Care Network" and promoted its successes at the 2014 American Telemedicine National Conference. The I-Care Network uses innovative technology including a HIPAA compliant product called "Veamea" to expand access to tele-health and advance service delivery for individuals with substance drug/alcohol addiction. In addition, a web portal and computer lab called "Smoke Signal" is used to enhance access to counseling and treatment for any client with s disorders within River Edge Behavioral Health Center areas of responsibility. The combined use of both technologies helped to improve overall access for clients in rural and remote areas across more than 10 counties in central and northeast Georgia with transportation challenges.[92]

In FY 2016, SAMHSA funded 13 new TCE-TAC grants to enhance or expand the capacity of treatment providers to serve individuals who are traditionally underserved and to help achieve and maintain recovery and to improve the overall quality of life for those being served.

In FY 2017, SAMHSA plans to support continued funding for the 12 TCE-TAC grant awards. These awards support the continuous development and deployment of unique advanced technology solutions to serve more clients with fewer resources. These adaptable and scalable HIT solutions use common technical requirements and components, making interoperability possible across various health domains of mental health services, substance abuse prevention, and substance abuse treatment services. In addition, these state-of-the-art innovative solutions supports integrated behavioral healthcare delivery across rural and extremely rural communities.

Targeted Capacity Expansion-Peer to Peer (TCE-PTP)

Peer support is built on the premise that individuals in recovery from substance drug/alcohol addiction can be of great value through the sharing of their recovery experiences with those attempting to achieve and sustain recovery. Peer recovery support services, as an adjunct to clinical treatment, extends the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery from substance drug/alcohol addiction. Peer support and peer recovery support services have been shown to reduce healthcare costs. Additionally, the overall message from limited research studies conducted to date is that recovery support service adjuncts appear to be helpful over and above treatment alone

[92] Monroe County Reporter (2014). River Edge to present successes in telemedicine at national conference. Retrieved from http://www.mymcr.net/news/river-edge-to-present-successes-in-telemedicine-at-national-conference/article_f448ca2c-26c1-5c96-adf4-d1c37f7195f1.html

There is currently a short supply of adequately trained peer support providers to work both in treatment and community-based settings. There is also a growing need to train and certify existing peer providers to address the increasing demand and diverse settings in which peer providers are employed. Since 2002, SAMHSA has awarded over 105 grants to community-based organizations to provide peer recovery support services to individuals in or seeking recovery from substance drug/alcohol addiction and their families. The primary objective of these services is to help individuals and families in search of recovery to obtain much needed support, sustain clinical treatment gains, engage in healthy community living, and improve overall quality of life. This grant program incorporates a peer-to-peer model, which capitalizes on the expertise of those individuals with similar lived experience.

The TCE-PTP program has reached over 5,800 individuals and their families. Significant strides have been made in increasing abstinence, work and educational opportunities, social connectedness, housing stability, housing support, and decreasing criminal justice involvement. In FY 2016, the percentage of people who were employed or currently attending school increased from 27.5 percent at intake to 47.1 percent at six-month follow-up and abstinence in the past 30 days from alcohol and drug use improved from 63.6 percent at intake to 82.1 percent at six-month month follow-up. In addition, the percentage of individuals reporting stability in housing improved from 45.2 percent at intake to 55.6 percent at six-month follow-up. In FY 2017, SAMHSA plans to fund 17 continuation TCE peer-to-peer grants and two contracts.

Funding History

Fiscal Year	Amount
FY 2014	$13,223,000
FY 2015	$23,223,000
FY 2016	$36,303,000
FY 2017	$36,234,000
FY 2018	$36,234,000

Budget Request

The FY 2018 Budget Request is $36.2 million, level with the FY 2017 Annualized CR. SAMHSA intends to fund 11 new MAT PDOA grants, 11 continuation MAT PDOA grants, 12 TCE-TAC continuation grants, and 17 TCE-PTP continuation grants, as well as support two contracts.

Outputs and Outcomes Tables

Program: Treatment Prescription Drug and Opioid Addiction

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
1.3.01 Increase the number of admissions for Medication Assisted Treatment (Output)	FY 2016: 1,616 Target: 1,400 (Target Exceeded)	1,400	1,400	Maintain
1.3.02 Increase number of clients receiving integrated care (Output)	FY 2016: 1,280 Target: 1,100 (Target Exceeded)	1,100	1,100	Maintain
1.3.03 Decrease illicit drug use at 6-month follow-up (Outcome)	FY 2016: 61% Target: 61% (Baseline)	60%	60%	Maintain

Pregnant and Postpartum Women

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Pregnant and Postpartum Women	$15,931	$19,901	$19,931	$30

Authorizing Legislation…….Section 508 of the Public Health Service Act
FY 2018 Authorization…… $16,900
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

From 1992 to 2012, a steady four percent of women admitted to treatment were pregnant. From FY 2003 through FY 2015, 28.4 percent of pregnant and postpartum women who had custody of their children at intake reported any illegal drug use in the past 30 days.[93] Since many traditional substance abuse treatment programs do not allow for the inclusion of children, a woman may be torn between the need to care for her dependent children and the need for treatment.[94] The nation's opioid crisis has also added to this challenge for many pregnant and parenting women. The proportion of pregnant women entering treatment who reported any prescription opioid misuse increased substantially from two percent in 1992 to 28 percent in 2012, an increase of 173 percent, from 351 to 6,087 women.[95] The proportion of pregnant women who entered treatment and reported prescription opioids as their primary substance use increased from one percent in 1992 to 19 percent in 2012, an increase of 344 percent, from 124 to 4,268 women.[96]

Since 2003, SAMHSA has supported comprehensive residential substance abuse treatment, prevention, and recovery support services for pregnant and postpartum women, their minor children, and services for other family members (e.g., fathers of the children) through the Pregnant and Postpartum Women program (PPW). SAMHSA has successfully implemented a family-centered approach in the PPW program, which has evolved over time. This approach includes partnering with others to leverage diverse funding streams, encouraging the use of evidence-based practices, supporting innovation, and developing workforce capacity to meet the needs of these families.

The PPW family-centered approach includes a variety of services and case management for women, children, and families. Services provided to women include: outreach; engagement; pre-treatment; screening and assessment; detoxification; substance misuse education; treatment; relapse-prevention; healthcare services, including mental health services; postpartum health care, including attention to depression, anxiety, and medication needs; parenting education and

[93] Services Accountability Improvement System.
[94] Women and Treatment, Office of National Drug Control Policy. Retrieved from http://www.whitehouse.gov/ondcp/women-treatment
[95] *Journal of Substance Abuse Treatment*, *48*(1), 37–42.
[96] Martin, Longinaker, & Terplan, 2014.

interventions; home management and life skills training, education, testing, and counseling; and treatment of hepatitis, HIV/AIDS, and other sexually transmitted diseases. Services available to children include screening and developmental diagnostic assessments regarding social, emotional, cognitive, and physical well-being prevention assessments; and interventions related to mental, emotional, and behavioral wellness. Services for families include family-focused programs to support family strengthening, including, involvement with the child's other parent. The PPW program also supports tobacco use counseling and interventions, screening and assessment for Fetal Alcohol Syndrome Disorders, and a trauma-informed approach.

The PPW program provides essential services not covered under most public and private insurance. Based on an in-depth review of cross-site evaluation and performance data in FY 2014, SAMHSA built the current PPW program model on an evidence-based approach for serving pregnant and post-partum women in need of residential substance abuse treatment.

In FY 2015, SAMHSA developed and began implementing a two-year action plan to inform and guide the development of the PPW program in FY 2017 to ensure a wider uptake of a family-centered approach. Since FY 2015, SAMHSA has placed an increased focus on studying sustained models of care and developing training curricula.

In FY 2016, SAMHSA funded two new residential treatment grants, 25 residential treatment grant continuations, and one Addiction Technology Transfer Center (ATTC) supplement grant continuation.

In FY 2016, SAMHSA convened a PPW Family-Centered Summit. The Summit's purpose was to elicit recommendations from experts in the area of women's substance abuse treatment services and family-centered care to inform the expansion of CSAT's PPW program to incorporate a wider range of family-centered services for pregnant and postpartum women and their minor children. This includes the expansion of treatment modalities to go beyond residential treatment and include intensive outpatient and outpatient treatment with or without housing components. SAMHSA has reviewed the recommendations from the Summit and is taking them into consideration in determining the future direction of the PPW Program, including the development of service requirements for the PPW program expansion effort to support wide-scale adoption of the family-centered approach.

In FY 2017, SAMHSA plans to fund 19 new residential treatment grants, seven residential treatment grant continuations, and three contracts. In 2017, SAMHSA will fund additional PPW grants consistent with the new Comprehensive Addiction and Recovery Act (CARA) authority.

<u>Pregnant and Postpartum Women Pilot</u>

A major aim of the Comprehensive Addiction and Recovery Act (CARA) is to address substance use and addiction across the country through the implementation of prevention, treatment, and recovery programs. In FY 2017, SAMHSA received funding to support two of these programs through its Substance Abuse Treatment Appropriation.

Historically, the PPW program has only supported the provision of residential treatment services. In order to ensure increased accessibility and availability of services for pregnant women, CARA

authorizes the provision of outpatient and intensive outpatient services for pregnant women through the PPW Pilot program.

In FY 2017, SAMHSA plans on funding three new state PPW pilot grants to: 1) support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid disorders; 2) help state substance abuse agencies address the continuum of care, including services provided to women in nonresidential-based settings; and 3) promote a coordinated, effective and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery. An evaluation of this program will be conducted to determine the effectiveness of the pilot.

In addition to this Pilot, the Substance Abuse Treatment appropriation supports one other program with the additional funding to implement CARA programs.

Funding History

Fiscal Year	Amount
FY 2014	$15,931,000
FY 2015	$15,931,000
FY 2016	$15,931,000
FY 2017	$19,901,000
FY 2018	$19,931,000

Budget Request

The FY 2018 Budget Request is $19.9 million, level with the FY 2017 Annualized CR. SAMHSA intends to fund five new residential treatment grants and 21 continuation residential treatment grants. These funds also support the continuation of the PPW Pilot ($4.0 million) to provide an array of services and supports to pregnant women and their children.

Recovery Community Services Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Recovery Community Services Program	$2,434	$2,429	$2,429	---

Authorizing Legislation .....Section 509 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Family/Consumer Controlled Organizations, Domestic Public and Private Non-Profit Organizations in States, Territories, and Tribes, Recovery Community Organizations of Domestic Private Non-Profit Entities in States, Territories, and Tribes

Program Description and Accomplishments

An estimated 23 million people in the United States are in recovery from addiction to alcohol and other drugs.[97] As public education increases, we have witnessed a broader acknowledgement of addiction as a treatable condition that needs to be managed over the course of a lifetime. More people in recovery are now willing to be open about their own recovery and to share their experience to help others attempting to achieve recovery. Through the use of their lived experience, individuals in recovery can provide support and hope to those newly seeking recovery.

Since 1998, SAMHSA has recognized the value of supporting recovery through peers and other recovery supports, and has provided funding through the Recovery Community Services Program (RCSP). RCSP was designed to assist recovery communities strengthen their infrastructure and provide peer recovery support services to those in or seeking recovery from drug/alcohol addiction across the nation. The delivery of recovery support services by people in recovery is known as peer recovery support services (PRSS). PRSS are a strong component in helping individuals and families address substance abuse in the context of chronic disease management, especially when delivered by a Peer (often known as a Recovery Coach, Peer Specialist, or Peer Mentor). SAMHSA initiated RCSP to help build an infrastructure for PRSS programs to support the development and expansion of peer recovery services. These peer services are most frequently offered by Recovery Community Organizations (RCOs), that now number over one hundred in the US alone.

Though the RCSP was a services program from 2002-2010, it was evident that this approach needed to be taken system-wide to have a larger effect. Many states recognize the value of addiction peer recovery services; however, further efforts are required to realize the potential of these services and supports at a system-wide level. The infusion of these services into state systems is critical in ensuring the wide scale adoption of peer recovery support. By developing a workforce of trained and certified peers and engaging recovery community organizations in the full continuum of treatment and recovery services, states have the ability to enhance their systems to ensure holistic approaches to care. SAMHSA supports this state system development effort

[97] Partnership for Drug Free Kids, March, 2015. Retrieved from http://www.drugfree.org/newsroom/survey-ten-percent-of-american-adults-report-being-in-recovery-from-substance-abuse-or-addiction

through the RCSP Statewide Network grant program. Since the inception of the RCSP, over 120 grants have been awarded to RCOs to expand PRSS locally and lay the groundwork for a national network of PRSS programs.

Recovery Community Services Program Statewide Network (RCSP-SN)

The RCSP-SN grant program supports a statewide approach to enhance the presence of people with lived experience in recovery from drug/alcohol addiction as key partners in state systems, as well as building a peer workforce. Key activities include collaborating on local and state workforce-development, developing linkages with other organizations that promote recovery throughout the state, and participating in policy, planning, and program development discussions at the state, community, and local level. Involving recovery community leaders and key stakeholders in decision making helps states to design peer services and PRSS programs that are authentic to the recovery experience, complementary to clinical practice, demonstrate strong recovery outcomes, and are sustainable over time. Additionally, the statewide networks help to ensure the development of a trained, qualified, and aptly supervised peer workforce.

Key workforce outcomes for the program include the amount of training provided, the number of people trained, trainee satisfaction, and the usefulness of information presented. Other key outcomes include: the number of RCOs that have been linked across the state; the number of state-sponsored events where participation of the statewide network occurred; the effects of linkages with behavioral health and other health systems; the outcomes of program activities on raising awareness about addiction peer recovery support; and the number of policy/program discussions which included addiction peer recovery support as a result of project efforts.

In FY 2017, SAMHSA plans to fund a new cohort of up to 10 RCSP-SN grants, three contracts, as well as a statewide peer network development activity to foster collaboration between the addiction recovery and mental health consumer and family network communities. This effort is also supported by a contract designed to strengthen the development and expansion of the recovery support work of the RCSP-SN grantees and other related SAMHSA recovery support efforts.

Funding History

Fiscal Year	Amount
FY 2014	$2,434,000
FY 2015	$2,434,000
FY 2016	$2,434,000
FY 2017	$2,429,000
FY 2018	$2,429,000

Budget Request

The FY 2018 Budget Request is $2.4 million, level with the FY 2017 Annualized CR. SAMHSA intends to fund the continuation of 10 RCSP Statewide Network grants and two technical assistance contacts to continue the efforts of building addiction recovery networks throughout the

nation and the collaboration among peer-run organizations working toward mental illness and substance abuse treatment service integration.

Children and Families

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Children and Families	$29,605	$29,549	$29,549	---

Authorizing Legislation .....Section 509 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Single State Agencies in States, Territories, District of Columbia, Federally Recognized American Indian/Alaska Native Tribes, and Tribal Organizations

Program Description and Accomplishments

Substance abuse plays a significant role in the lives of many children and youth (ages 12 to 25) throughout the nation. In 2014, approximately nine percent of adolescents between the ages of 12 and 17 and 22 percent of youth between the ages of 18 and 25 reported current illicit drug use. Five percent of adolescents and 16 percent of youth between the ages of 18 and 25 reported alcohol and/or illicit drug abuse or dependence. Many of these youth have co-occurring mental illness and drug/alcohol addiction. In 2014, among those adolescents who had a diagnosable substance use disorder in the past year, approximately 28 percent had a co-occurring major depressive episode. Approximately seven percent of admissions to substance abuse treatment facilities were adolescents in 2012. Most substance abuse begins during adolescence, making this developmental period a critical time for intervention.[98] Sixty-one percent of infants and 41 percent of older children involved in the child welfare system have at least one parent who is using drugs or alcohol.

On average, 31 percent of children are removed from home care resulting from parental alcohol or drug use; this rate increases to 41 percent for children under the age of one. SAMHSA's Children and Families programs make appropriate treatment available to youth and their families/caregivers to reduce the impact of substance abuse and/or co-occurring substance abuse and mental disorders on America's communities.[99]

Substance Abuse Treatment for Youth

In 2013, less than 10 percent of youth (ages 12 to 25) with an illicit drug or alcohol use problem received the needed treatment at a specialty facility. Although data show that the number of youth with illicit drug or alcohol use problems has declined since 2002, there is still a significant percent that need but are not receiving treatment.[100] Adolescents constitute 7.4 percent of total admissions to the public substance abuse treatment system.[101] Youth have psychological, developmental, and

[98] 2014 National Survey on Drug Use and Health (NSDUH)
[99] Wulczyn, F., Ernst, M., & Fisher, P. (2011). Who are the children in out-of-home care? An epidemiological and developmental snapshot.
[100] 2013 National Survey on Drug Use and Health (NSDUH)
[101] 2012 TEDS Report, CBHSQ

emotional needs that are distinct from adults. The neurological and developmental differences between youth and adults require tailored treatment and recovery approaches for youth with drug/alcohol addiction.

SAMHSA's programs to treat youth with addiction and/or co-occurring substance abuse and mental disorders address gaps in service delivery by providing services for youth and their families and primary caregivers using effective evidence-based, family-centered practices. SAMHSA supports a youth treatment grant initiative at the state, territorial, and tribal levels. The populations of focus for the initiatives are adolescents (ages 12 to 17), transitional-aged youth (ages 18 to 25), and their families and caregivers.

The initiative helps to further the use of, and access to, effective evidence-based family-centered treatment approaches for youth with drug/alcohol addiction. The initiative includes statewide training and collaboration between local community-based providers and their state, tribal, or territorial infrastructure. The services provided include evidence-based assessment and treatment interventions appropriate for adolescents and transitional age youths.

From FY 2013 to FY 2015, these programs served approximately 3,870 individuals. Of those served from intake to six-month follow-up from intake, there was a: 50 percent increase in abstinence from substance use, 11 percent increase in no alcohol-related or illegal drug-related health, behavioral, or social consequences, and 5 percent increase in no arrests in the past 30 days[102]. Since FY 2012, the initiative has assisted in developing or strengthening the infrastructures in 37 states, territories, and tribes, which resulted in the development of policies to increase access to treatment for youth with drug/alcohol addiction, an expanded trained workforce, the dissemination of evidence-based family centered practices, and the implementation of financial mechanisms to fund treatment for youth with drug/alcohol addiction.

In FY 2015, SAMHSA began a new five-year evaluation to assess the effectiveness of the initiative, document best practices, disseminate lessons learned, and guide programmatic and policy changes. SAMHSA also restructured the initiative into two separate approaches in order to distinguish planning and implementation efforts. With this change, SAMHSA is supporting a two-year youth treatment planning grant and a three-year youth treatment implementation grant. The planning grant is designed to support infrastructure development only; it does not have a direct service component. It supports states, territories, and tribes in strengthening the existing infrastructure to ensure that youth have access to evidence-based assessments, treatment, and recovery support services. The implementation grant includes infrastructure and direct services. It further strengthens the existing state, territorial, and tribal infrastructure and provides direct treatment services for adolescents and/or transitional aged youth and their families/care givers with SUDs.

<u>Addressing Child Abuse and Neglect</u>

SAMHSA and the Administration for Children and Families collaborate to address child abuse and neglect by supporting a National Center on Substance Abuse and Child Welfare (NCSACW). NCSACW works across agencies to provide technical assistance and training to professionals in order to meet the needs of families affected by parental substance abuse. From September 2016

[102] Services Accountability Improvement System.

through March 2017, NCSACW disseminated nearly 8000 informational materials, which include reports, guidance documents, presentations from conferences and webinars, research articles, toolkits, and grantee site-specific tools. NCSACW facilitated 30 events, attended by an estimated 4,000 participants, with an average of 130 attendees per event. NCSACW monitored and provided support to trainees on web-based tutorials. Since 2007, 71,141 users have completed the NCSACW's tutorials and the current completion rate is 97 percent. The content of the tutorials was updated in 2015 to infuse the latest research and evidence-based practices and to offer a more interactive and engaging user experience. NCSACW's activities have assisted professionals throughout the nation in improving cross-system collaboration and being better prepared to meet child welfare mandates requirements for timely child permanency decisions.

NCSACW continues to provide support and technical assistance and training to tribes, state agencies, and communities to developing collaborative approaches to the treatment of pregnant women with opioid addiction. Since its publication in August 2016, NCSACW has disseminated the SAMHSA publication A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers to child welfare, substance abuse treatment, dependency court, and medical professionals. The publication has been downloaded 13,000 times from the NCSACW website. Since the passage of the Comprehensive Addiction and Recovery Act of 2016 (CARA), Section 503, Infant Plan of Safe Care Act, NCSACW has responded to 440 TA requests on Plans of Safe Care and the provisions on prenatal substance exposure in the Child Abuse and Prevention Treatment Act (CAPTA). Launched in September 2014, NCSACW provides the Substance Exposed Infant In-Depth Technical Assistance Program (SEI-IDTA) to strengthen collaboration linkages across child welfare, substance abuse treatment, and the courts, as well as medical communities, early care and education systems, home visiting, and other key partners to improve outcomes for infants and their families.

In FY 2016, SAMHSA funded 32 grant continuations (11 for youth treatment grants, 10 for youth treatment planning grants, and 11 for youth treatment implementation grants), and five contracts. SAMHSA also funded two new youth treatment implementation grants to support treatment for youth with SUD.

In FY 2017, SAMHSA plans to fund 10 new youth treatment implementation grants and one new contract. SAMHSA also plans to fund 14 grant continuations and two continuing contracts.

Funding History

Fiscal Year	Amount
FY 2014	$29,605,000
FY 2015	$29,605,000
FY 2016	$29,605,000
FY 2017	$29,549,000
FY 2018	$29,549,000

Budget Request

The FY 2018 Budget Request is $29.5 million, level with the FY 2017 Annualized CR. In FY 2018, SAMHSA intends to fund 12 new youth treatment implementation grants. SAMHSA also intends to fund 15 grant continuations. These funds will continue to address the gaps in substance abuse treatment by providing services for youth, their families, and caregivers.

Treatment Systems for Homeless

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Treatment Systems for Homeless	$41,304	$41,225	$41,225	---

Authorizing Legislation .....Section 506 of the Public Health Service Act
FY 2018 Authorization $41,304
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Domestic Public and Community Organizations, Private Nonprofit Entities, and Community-based Public or Nonprofit Entities

Program Description and Accomplishments

SAMHSA's Treatment Systems for Homeless portfolio supports services for those with drug/alcohol addiction and who are experiencing homelessness, including veterans, and those experiencing chronic homelessness.

Between 2007 and 2014, homelessness in the United States declined by 11 percent, while chronic homelessness declined by 31 percent.[103] Chronic homelessness is defined as individuals or families with a disabling condition who have been without housing for longer than one year or more than four times in the past three years. Despite this progress, the number of people experiencing homelessness remains at unacceptably high levels. On a given night in January 2015,

[103] The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2014). The 2014 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. Retrieved from https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf

564,708 individuals were experiencing homelessness. Of these individuals, 96,275 were experiencing chronic homelessness, 104,083 had severe mental illness, 103,888 were affected by chronic substance abuse, and 47,725 were veterans.[104]

Many factors contribute to the problem of homelessness, including lack of affordable housing, foreclosures, rising housing costs, job loss, underemployment, mental illness, and drug/alcohol addiction. The progress made to date in reducing homelessness points to improvement in services, as well as the effectiveness of collaboration across all levels, from the federal government to state governments and community systems. The U.S. Interagency Council on Homelessness, in which HHS participates, has set aggressive goals to prevent and end homelessness. These goals include: preventing and ending homelessness among veterans; preventing and ending chronic homelessness; preventing and ending homelessness for families, youth, and children; and setting a path to ending homelessness for all individuals. The services and support offered through SAMHSA's Treatment Systems for Homeless programs are crucial to achieving these goals. SAMHSA's homelessness programs are a component of its Recovery Support Strategic Initiative. One of the goals of this Strategic Initiative is to increase access to permanent housing for individuals with mental illness and/or substance drug/alcohol addiction and their families. SAMHSA manages the following Treatment Systems for Homelessness grant programs:

Cooperative Agreements to Benefit Homeless Individuals (CABHI)

In FY 2011, SAMHSA initiated the Cooperative Agreements to Benefit Homeless Individuals (CABHI) program, jointly funded by Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS) to support treatment and the development and/or expansion of local systems that provide permanent housing and supportive services. This includes integration of treatment and other critical services for individuals with serious mental illness and drug/alcohol addiction. Target populations for this program include veterans and individuals with serious mental illness and/or drug/alcohol addiction. CABHI also supports coordination and planning at the local level with state or local Public Housing Authorities, local mental health, substance misuse, and primary care provider organizations, the local Department of Housing and Urban Development-supported Continuum of Care (CoC) program, the state Medicaid Office, and the state Mental Health and Substance Abuse Authorities.

Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States)

In FY 2013, SAMHSA initiated the CABHI-States program, funded jointly by CSAT and CMHS, which builds on the CABHI program by working with states to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services. CABHI-States supports services for individuals with serious mental illness and/or drug/alcohol addiction who experience chronic homelessness and/or veterans who experience homelessness. It also provides peer supports and enhancement or development of a statewide plan to ensure sustained collaboration across public health and housing systems that will result in short-term and long-term strategies to support behavioral health services for individuals who experience chronic homelessness. The grantees work with state and local Public Housing Authorities and state Medicaid agencies to develop systematic, cost-effective, and integrated approaches to housing and

[104] U.S. Department of Housing and Urban Development (HUD) 2014 Continuum of Care (CoC) Homeless Assistance Programs-Homeless Populations and Subpopulations Report. Retrieved from https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2015.pdf

behavioral disorder treatment and services for individuals with mental illness and/or drug/alcohol addiction experiencing homelessness. This program was further enhanced in FY 2015 with the implementation of CABHI State Enhancement grants, which enabled CABHI-States grantees to build upon their programs.

Grants for the Benefit of Homeless Individuals (GBHI)

In FY 2017, CSAT plans to fund the GBHI program (last funded in FY 2010). The purpose of this program is to support the development and/or expansion of local implementation of a community infrastructure that integrates behavioral health treatment and services for drug/alcohol addiction and co-occurring mental illness and drug/alcohol addiction, permanent housing, and other critical services for individuals (including youth) and families experiencing homelessness.

Based on FY 2016 data for CSAT funded programs, 58 percent of clients in Treatment Systems for Homeless-supported programs report abstinence from substance use at a six-month follow up, while approximately 25.3 percent of clients report being employed or engaged in productive activities and 54.4 percent of clients report having a permanent place to live in the community.[105]

In FY 2016, SAMHSA funded 30 new CABHI grants to states, local governments, and community based organizations and 50 continuation grants (33 GBHI-SSH, seven CABHI-States Enhancements, and 10 CABHI-States). Additional funds support up to two contracts including cross-center contracts for national evaluation and technical assistance.

In FY 2017, SAMHSA plans to fund 14 new CABHI grants, 24 new GBHI grants, and 46 continuation grants (30 CABHI, seven GBHI-SSH, and nine CABHI-States) as well as supporting two contracts for national evaluation and technical assistance.

Funding History

Fiscal Year	Amount
FY 2014	$41,386,000
FY 2015	$41,386,000
FY 2016	$41,304,000
FY 2017	$41,225,000
FY 2018	$41,225,000

Budget Request

The FY 2018 Budget Request is $41.2 million, level with the FY 2017 Annualized CR. SAMHSA plans to support annual Cooperative Agreements to Benefit Homeless Individuals for States-Enhancement (CABHI-States Enhancement) and Grants for the Benefit of Homeless Individuals (GBHI) grant continuations and continue to expand programs and support homeless programs through the support of new grants. SAMHSA intends to fund 68 continuation grants; 44 for CABHI and 24 GBHI. SAMHSA also plans to award nine new CABHI grants, and 10 new GBHI

[105] Services Accountability Improvement System. (2014). Retrieved from www.samhsa-gpra.samhsa.gov.

grants. Additional funds will support two contracts including the continuation of cross-center contracts for national evaluation and technical assistance.

Outputs and Outcomes Table

Program: Treatment System for Homelessness (GBHI)

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
3.4.22 Increase the percentage of clients receiving services who had no past month substance use (Outcome)	FY 2016: 58.0 % Target: 65.0 % (Target Not Met)	65.0 %	65.0 %	Maintain
3.4.23 Increase the number of clients served (Output)	FY 2016: 4,694 Target: 5,800 (Target Not Met but Improved)	5,100	5,100	Maintain
3.4.24 Increase the percentage of homeless clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2016: 25.3 % Target: 31.7 % (Target Not Met)	30 %	30 %	Maintain
3.4.25 Increase the percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2016: 54.4 % Target: 33 % (Target Exceeded)	33 %	33 %	Maintain

Minority AIDS

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Minority AIDS	$65,570	$65,445	$65,445	---

Authorizing Legislation .....Section 509 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

An estimated 287,400 women were living with HIV at the end of 2013, representing 23 percent of all Americans living with the virus; a disproportionate percent of the women living with HIV are Black/African American and Hispanic/Latina women.[106] In 2014, gay and bisexual men accounted for 83 percent (29,418) of the estimated new HIV diagnoses among all males aged 13 and older and 67 percent of the total estimated new diagnoses in the United States.[107] In addition, the Department of Health and Human Services' National Viral Hepatitis Action Plan cites people living with HIV and viral hepatitis co-infection as a priority population. Among the 1.2 million people in the United States living with HIV, approximately one in 10 is co-infected with HBV and one in five is co-infected with HCV.

Three of SAMHSA's Minority AIDS Initiative (MAI) programs address HIV and hepatitis infection by facilitating the development and expansion of culturally competent and effective community-based treatment systems for substance drug/alcohol addiction and co-occurring mental illness and substance abuse treatment within racial and ethnic minority communities. The goals of the MAI program are to reduce the impact of behavioral health issues, reduce the risk for and incidence of HIV and hepatitis, and increase access to HIV and hepatitis testing and treatment for these individuals in states with the highest HIV prevalence rates (at or above 299.5 per 100,000). By region, the prevalence rates were highest in the Northeast at 419.5 per 100,000 and the South at 352.5 per 100,000. [108]

[106] Center for Disease Control and Prevention. (2017). HIV Among Women. Retrieved from https://www.cdc.gov/hiv/group/gender/women/index.html
[107] Center for Disease Control and Prevention. (2016). HIV Among Gay and Bisexual Men Retrieved from https://www.cdc.gov/hiv/group/msm/index.html
[108] Centers for Disease Control and Prevention. (2016). HIV in the United States by Geographic Distribution Retrieved from https://www.cdc.gov/hiv/pdf/statistics/cdc-hiv-geographic-distribution.pdf

Targeted Capacity Expansion Program (TCE): Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS (TCE-HIV): High Risk Populations)

Under SAMHSA's TCE-HIV program, grantees are required to provide substance use and/or co-occurring substance use and mental disorder treatment, recovery support services, and HIV/AIDS testing and case management services. In addition, grantees must enhance infrastructure and capacity to improve their community's response to HIV/AIDS by increasing access to care and services for racial and ethnic minorities at high risk for or living with HIV/AIDS. Target populations include young men who have sex with men, ages 18 to 29, adult heterosexual women and men, and men who have sex with men, ages 30 and older.

In FY 2016, SAMHSA funded 78 TCE-HIV High Risk continuation grants and supported three contracts. In FY 2017, SAMHSA plans to fund 52 new grants, 26 grant continuations and three contracts. These grants are expected to reduce the negative impact of behavioral health problems; increase access to and retention in treatment for behavioral health conditions; reduce the risk of HIV; reduce new HIV and viral hepatitis infections by increasing HIV and viral hepatitis testing and diagnosis; and increase provisions of or linkage to HIV care including antiretroviral therapy. In FY 2017, SAMHSA plans to support 58 new and 25 continuation grants.

Targeted Capacity Expansion: Substance Abuse Treatment for Racial/Ethnic Minority Women at High Risk for HIV/AIDS (TCE-HIV: Minority Women)

The populations of focus for this program are African American, Hispanic/Latina, and other racial/ethnic minority women ages 18 years and older who have substance use or co-occurring substance use and mental disorders and are living with or at risk for HIV/AIDS and hepatitis. Grantees are expected to address the impact of violence and trauma on women's increased risk of SUD and HIV infection, and provide comprehensive evidence-based trauma-informed care services that consider the individuals adverse life experiences within the context of their culture, history, and experience of traumatic events.

In FY 2016, SAMHSA supported 22 new TCE-HIV: Minority Women grants, and five grant continuations. In FY 2017, SAMHSA intends to support 23 continuations.

Minority AIDS Initiative Continuum of Care Pilot- Integration of HIV Prevention and Medical Care into Mental Health and Substance Abuse Treatment Programs for Racial/Ethnic Minority Populations at High Risk for Mental and Substance Use Disorders and HIV (MAICoC Pilot: Integration of HIV Medical Care into BH Programs or "MAI-CoC")

SAMHSA's Centers for Mental Health Services, Substance Abuse Prevention, and Substance Abuse Treatment supported the MAI Continuum of Care Pilot (MAI CoC). This grant supports substance use and mental disorder treatment and substance abuse and HIV primary prevention programs that either can co-locate or have fully integrated HIV/AIDS and hepatitis prevention and medical care services for racial/ethnic minority populations.

This program also provides primary prevention services for drug/alcohol addiction and HIV/AIDS in local communities served by behavioral health programs. People with drug/alcohol addiction and mental disorders are at high risk for hepatitis, as over 60 percent of the estimated 3.9 million individuals in the U.S. currently chronically infected with HCV became infected through substance use (70-90 percent HCV prevalence for people who inject drugs). [109]

By the third year, 2017, over 5,700 consumers were engaged in services for mental and substance abuse treatment. Across the program, 13 percent reported improved housing status and 47 percent with improvement in social connectedness; 24 percent reported improvements with 'no illicit drug use' and 20 percent with reduced psychological distress. Overall, there was a 66 percent reduction in emergency room use, with a decline from 4.5 to 2.0 percent. Over 13,000 individuals were tested for HIV, and over 10,000 were tested for hepatitis. For those testing positive, 61 percent were linked to HIV medical care, and 76 percent for hepatitis treatment. In addition, thirteen grantees were supplemented to engage or strengthen a partnership in their community with a syringe services program for supportive linkages to behavioral health care and HIV and hepatitis testing and care.

In FY 2017, SAMHSA plans to support up to 34 HIV CoC continuation grants.

Funding History

Fiscal Year	Amount
FY 2014	$65,570,000
FY 2015	$65,570,000
FY 2016	$65,570,000
FY 2017	$65,445,000
FY 2018	$65,445,000

Budget Request

The FY 2018 Budget Request is $65.5 million, level with the FY 2017 Annualized CR. SAMHSA intends to fund two new TCE-HIV/AIDS grants, and up to 34 HIV MAI CoC grants. SAMHSA also plans to fund 59 continuation TCE-HIV/AIDS grants, 23 HIV Women's continuation grants, one Addiction Technology Transfer Center Network supplemental grant, and three new contracts.

[109] Services Accountability Improvement System. (2016)

Criminal Justice Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Criminal Justice Activities	$78,000	$77,852	$77,852	---

Authorizing Legislation .....Section 509 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities, Operational Individual Misdemeanor and Felony Adult Criminal Courts, Municipal Courts, Tribal, State, Local Government Proxies, Government with Direct Involvement with Adult Criminal Courts, Tribal Organizations and Individual Adult Tribal Healing to Wellness Courts, and Individual Juvenile Treatment Drug Courts

Program Description and Accomplishments

SAMHSA's Criminal Justice portfolio includes several grant programs that focus on diversion, alternatives to incarceration, drug courts, and re-entry from incarceration for adolescents and adults with drug/alcohol addiction and/or co-occurring drug/alcohol addiction and mental illness.

Drug Courts

According to a 2006 Bureau of Justice Statistics report, approximately 74 percent of state prisoners, 63 percent of federal prisoners, and 76 percent of jail inmates met the criteria for a mental disorder. An estimated 42 percent of state prisoners and 49 percent of jail inmates met the criteria for both a mental illness and drug/alcohol addiction. Studies have found that for youth in the juvenile justice system, 50 to 70 percent met criteria for a mental disorder and 60 percent met criteria for a substance use disorder. Of those youth with co-occurring mental and substance use disorders, almost 30 percent experienced severe disorders that impaired their ability to function.[110] The criminal justice system was the major source of referrals to substance abuse treatment, with probation or parole referrals representing the largest proportion of criminal justice system referrals to treatment.[111] Most probation or parole referrals to treatment were males between the ages of 18 and 44.[112] The most common substances reported by these referrals were alcohol, marijuana, and methamphetamine. Similarly, in SAMHSA's adolescent substance abuse treatment grant programs, juvenile justice is the most frequent referring agency. Although the prevalence of substance use disorders is high, only about 10 percent of those involved in the justice system received treatment and recovery services.

Drug courts are designed to combine the sanctioning power of courts with effective treatment services for a range of populations with circumstances such as alcohol and/or drug use, child

[110] Teplin, Linda et al, (2005) Major mental disorders, substance use disorders, comorbidity and HIV-AIDS risk behaviors in juvenile detainees. *Psychiatric Services*, 56,: 7, pp 823-28.
[111] Client Level Data/TEDS CBHSQ (2012). Retrieved from http://www.samhsa.gov/data/client-level-data-teds
[112] SAMHSA. (2015). *Criminal and Juvenile Justice*. Retrieved from http://www.samhsa.gov/criminal-juvenile-justice

abuse/neglect or criminal behavior, veterans or people with mental illness. Drug courts represent the coordinated efforts of the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities to intervene and break the cycle of substance misuse, addiction, and crime. Stakeholders work together to give individual clients the opportunity to improve their lives, including recovery from substance drug/alcohol addiction, and develop the capacity and skills to become fully-functioning parents, employees, and citizens.

Many drug courts lack sufficient funding or the ability to implement evidence based practices for substance abuse treatment and recovery services.[113] Through its Treatment Drug Court grant programs, SAMHSA seeks to reduce this gap in treatment services while also improving treatment services by requiring that evidence-based practices be used. SAMHSA's interest is to support and shape treatment drug courts that serve clients with drug/alcohol addiction in the respective problem-solving court models as long as the court meets all the elements required for drug courts. The intent is to meet the treatment needs of clients using evidence-based practices consistent with the disease model and the problem-solving model, rather than with the traditional court case-processing model. A long-term goal of this program is to build sustainable systems of care for individuals needing treatment drug court services.

SAMHSA's Adult Drug Court programs support a variety of services including direct treatment services for diverse populations, wraparound/recovery support services designed to improve access and retention, drug testing for illicit substances, education support, relapse prevention and long-term management, pharmacotherapy, and HIV testing conducted in accordance with state and local requirements. The program seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use, and outcomes among the racial and ethnic minority populations served.

These grant programs use existing evidence from numerous studies to support current programs and new proposals. There have been more than 125 evaluation and research studies of the effectiveness of drug courts in addition to Government Accountability Office reports. SAMHSA's funding opportunity announcements require evidence-based practices to be used from federal inventories, including SAMHSA's National Registry of Evidence-Based Programs and Practices. SAMHSA also has regular communications with the National Association of Drug Court Professionals to obtain and incorporate the latest findings and field expertise.

Performance data show that these grant programs are effective in improving the lives of drug court participants. In FY 2015, 5,497 clients received services through the Drug Court Programs. Of these, 85.1 percent had no past month substance use, 91.8 percent had no involvement with the criminal justice system thirty days prior to intake, 58.9 percent of adult clients were either employed or engaged in productive activities, and 43.8 percent had a permanent place to live in the community.

In FY 2015, SAMHSA supported the continuation of 103 drug court grants, 110 new family drug court grants, and 48 new Treatment Drug Courts; including 10 new Bureau of Justice Assistance jointly funded drug court grants. Additionally, SAMHSA conducted a performance evaluation of

[113] SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. (n.d.). *Adult Mental Health Treatment Courts Database*. Retrieved from http://gainscenter.samhsa.gov/judgescourts/courtsjudges.asp

the FY 2015 Family Treatment Drug Court (FTDC) grant program. The purpose of this evaluation is to measure the performance of each FY 2015 FTDC grantee, including assessing the progress of children, parents, and family functioning after receiving SAMHSA funding.

In FY 2015, FY 2016 and FY 2017, SAMHSA's Adult Drug Court grant programs were required to ensure that drug courts funded by SAMHSA could not deny the use of FDA-approved medications for opioid addiction to drug court clients. Drug court judges, however, retained judicial discretion in cases where specified conditions for pharmacotherapy provisions were not met.

In FY 2016, SAMHSA funded 122 drug court grant continuations, 60 new drug court grants including new BJA jointly funded drug court grants, and four contracts. In FY 2017, SAMHSA plans to fund 103 drug court grant continuations, 71 new drug court grants and two contracts.

Criminal Justice Other/Offender Reentry Program

In addition to the drug court portfolio, SAMHSA supports Offender Reentry Program (ORP) grants, as well as other criminal justice activities such as evaluation and behavioral health contracts.

Studies show that only about 10 percent of individuals involved with the criminal justice system who are in need of substance abuse treatment receive it as part of their justice system supervision. Approximately one-half of the institutional treatment provided is educational programming.[114] Over the past decade, awareness of the need for a continuum of care of services for adult offenders has grown as states and local communities have struggled with the increasing number of these individuals returning to the community after release from correctional confinement. ORP grants provide screening, assessment, comprehensive treatment, and recovery support services for individuals reentering the community from incarceration. ORP services include screening, comprehensive individual assessment for substance use and/or co-occurring mental disorders, case management, program management, alcohol and drug treatment, wraparound services, drug testing, relapse prevention and long-term support.

In FY 2016, SAMHSA funded 10 ORP grant continuations, one contract, and 20 new ORP grants that will implement the Risk-Needs- Responsivity Simulation Tool to implement best practices and opioid overdose prevention programs.[115] In FY 2017, SAMHSA plans to fund 13 new ORP grants 27 ORP grant continuations.

Behavioral Health Treatment Court Collaborative Program

In FY 2014, SAMHSA supported a second cohort of four-year Behavioral Health Treatment Court Collaborative grants (BHTCC) in the Mental Health and Substance Abuse Treatment appropriations. BHTCC supports judges and staff of specialty (e.g., drug court) and other courts within a jurisdiction to work together to divert adults with mental illness and/or drug/alcohol addiction from the criminal justice system. The purpose of this grant program is to allow municipal

[114] Taxman FS, Perdoni ML, Harrison LD. (2007). Drug treatment services for adult offenders: The state of the state. Journal of Substance Abuse Treatment 32(3), 239-254.

[115] George Mason University (2011). *Risk-Needs-Responsivity (RNR) Simulation Tools*. Retrieved from: Center for Advancing Correctional Excellence!: http://www.gmuace.org/research_rnr.html

courts more flexibility to collaborate with multiple criminal justice system components and local community treatment and recovery providers to address the behavioral health needs of adults who are involved with the criminal justice system. The court collaborative focuses on adults with behavioral health problems, including serious mental illness, from the criminal justice system, including alternatives to incarceration. The program supports community behavioral health services for individuals with mental and/or substance disorders and includes a focus on veterans involved with the criminal justice system.

SAMHSA completed an evaluation of the first cohort of BHTCC grantees in September 2014. Findings of the evaluation demonstrate that grantees built multi-agency workgroups or collaboratives to oversee programs. Because of the grant funding, all grant recipients expanded access to specialty courts. Most grant recipients anticipated continuing new screening and assessment processes addressing a broader array of behavioral health needs after grant funding ended. Program innovations were divided into four main groups, including court and treatment provider collaboration, court and community case management, unified cross-court screening and referral, and meaningful peer involvement. Over 1,400 individuals were served through the BHTCC, with two-thirds of them identified as having co-occurring mental illness and substance abuse treatment services, trauma-specific treatment, peer support, and more. Based on performance data reporting, program participants experienced improvements in mental health and reductions in substance use. Alcohol and drug use declined by 60 percent in the first six months while mental health symptoms declined by 20 percent over the same period and 74 percent of participants reported physical health improvements at six months. In addition, employment rates increased from 36 percent to 45 percent over the first six months, with monthly median income increasing by $298.[116]

In FY 2016, SAMHSA provided continuation support for the third year of 17 four-year grants, continued technical assistance, and support one evaluation contract. The new BHTCC evaluation focuses on examining the clinical and functional outcomes of program participants with behavioral health issues. The new BHTCC evaluation is building on the findings from the first cohort and more deeply examines both the features of successful collaborations between the courts and community services as well as the clinical and functional outcomes of program participants. In FY 2017, SAMHSA intends to fund 17 continuation grants and the evaluation contract.

[116] Advocates for Human Potential. (2014). *Evaluation of the Adult Treatment Court Collaborative Program: Final evaluation report.* Albany, NY: Author.

Funding History

Fiscal Year	Amount
FY 2014	$74,816,000
FY 2015	$78,000,000
FY 2016	$78,000,000
FY 2017	$77,852,000
FY 2018	$77,852,000

Budget Request

The FY 2018 Budget Request is $77.9 million ($60.0 million for Drug Courts and $17.9 million for Other Criminal Justice Activities), level with the FY 2017 Annualized CR.

SAMHSA intends to support 115 Drug Court continuations grants, 70 new drug court grants, and three contracts. SAMHSA intends to fund 17 new Offender Reentry Program (ORP) new grants, and 13 continuation ORP grants.

Outputs and Outcomes Table

Program: Criminal Justice - Drug Courts

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
1.2.72 Increase the percentage of adult clients receiving services who were currently employed or engaged in productive activities (Outcome)	FY 2016: 64.3 % Target: 55 % (Target Exceeded)	60 %	60 %	Maintain
1.2.73 Increase the percentage of adult clients receiving services who had a permanent place to live in the community (Outcome)	FY 2016: 50.6 % Target: 41 % (Target Exceeded)	45 %	45 %	Maintain
1.2.74 Increase the percentage of adult clients receiving services who had no involvement with the criminal justice system (Outcome)	FY 2016: 94.3 % Target: 91 % (Target Exceeded)	92 %	92 %	Maintain
1.2.76 Increase the percentage of adult clients receiving services who had no past month substance use (Outcome)	FY 2016: 87.5 % Target: 71 % (Target Exceeded)	85 %	85 %	Maintain
1.2.79 Increase the number of adult clients served (Output)	FY 2016: 8,539 Target: 4,369 (Target Exceeded)	5,500	5,500	Maintain

Outputs and Outcomes Table

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

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
1.2.80 Increase the number of clients served. (Outcome)	FY 2016: 1,366 Target: 2,000 (Target Not Met)	2,500[1]	2,500	Maintain
1.2.81 Increase the percentage of clients who had no past month substance use. (Outcome)	FY 2016: 73.2 % Target: 74 % (Target Not Met)	80 %[2]	80 %	Maintain
1.2.84 Increase the percentage of clients receiving services who had no involvement with the criminal justice system. (Outcome)	FY 2016: 92.2 % Target: 94 % (Target Not Met)	95 %	95 %	Maintain

[1] Decrease in target from prior year level reflects a decrease in funding and changes in data trends.

[2] Decrease in target from prior year level reflects a decrease in funding and changes in data trends.

Building Communities of Recovery

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Building Communities of Recovery	$---	$1,000	$1,000	---

Program Description and Accomplishments

In FY 2017, SAMHSA is planning to support a new cohort of grants through the Building Communities of Recovery program. The purpose of this program is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery support from drug/alcohol addiction. These grants are intended to support the development, enhancement, expansion, and delivery of recovery support services (RSS) as well as promotion of and education about recovery. Programs will be principally governed by people in recovery from SUDs who reflect the community served.

Grants support linkages between recovery networks and a variety of other organizations, systems, and communities, including: primary care, other recovery networks, child welfare system, criminal justice system, housing services and employment systems. Grantees will also work to reduce negative attitude, discrimination, and prejudice around addiction and addiction recovery.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$1,000,000
FY 2018	$1,000,000

Budget Request

The FY 2018 budget request is $1.0 million, level with the FY 2017 Annualized CR. These funds will be used to support the Building Communities of Recovery Program to develop, expand, and enhance recovery support services.

Minority Fellowship Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Minority Fellowship Program (MFP)	$3,539	$3,532	$3,532	---

Authorizing Legislation .....Section 509 of the Public Health Service Act
Allocation Method ..... Grants/Contracts
Eligible Entities.....American Nurses Association (ANA), American Psychiatric Association (ApA), American Psychological Association (APA), Council on Social Work Education (CSWE), American Association for Marriage and Family Therapy (AAMFT)

Program Description and Accomplishments

The mental health-related and substance abuse-related service needs of racial and ethnic minority communities within the United States have been historically under–addressed due to a variety of factors. These include a limited number of trained practitioners who are equipped with the language skills or cultural competency training needed to deliver effective services for this population. SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to funding increases the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance abuse treatment services for minority populations that are underserved. This will result in improved quality of mental illness and substance abuse prevention and increased treatment delivered to ethnic minorities. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. In 2006, the program expanded to include marriage and family therapists and later added professional counselors. These individuals often serve in key leadership positions to deliver mental illness and substance abuse treatment services, services supervision, services research, training, and administration. Professional guilds receive competitively awarded grants, and then competitively award the stipends to post-graduate students pursuing a degree in that professional field. In FY 2015 and FY 2016, SAMHSA funded six continuation grants.

Minority Fellowship Program Expansion-Youth (MFP-Y) and Addiction Counselors (MFP-AC)
Begun in FY 2014, MFP-Y is a component of MFP that support master's level trained behavioral health professionals in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing serving children, adolescents, and populations in transition to adulthood (aged 16 to 25). The purpose of the program expansion, the Minority Fellowship Program-Youth (MFP-Y), is to reduce health disparities and improve behavioral healthcare outcomes for racially and ethnically diverse youth and young adults.

To do this, the program aims to increase the number of culturally competent master's level behavioral health professionals serving children, adolescents, and populations in transition to

adulthood (aged 16 to 25) in an effort to increase access to, and the quality of, behavioral health care for this age group. The expansion program uses the existing infrastructure of the MFP to expand the program to support 960 master's level trained behavioral health providers. Grants are competitively awarded to professional guilds, which then competitively award the stipends to post-graduate students pursuing a degree in that professional field.

MFP-AC is a component of MPP to support master's level addiction counselors (MFP-AC) for youth and young adults. The purpose of the four-year grant program is to reduce health disparities and improve behavioral healthcare outcomes for racially and ethnically diverse populations by increasing the number of culturally competent master's level addiction counselors available to underserved minority populations with a specific focus on transition age youth (ages 16 to 25) in public and private non-profit sectors. MFP-AC grants are supporting students pursuing master's level degrees in addiction/substance abuse counseling, with the goal of increasing the number of masters-level addiction counselors across the nation by approximately 300 counselors. As is the case with MFP and MFP-Y, grants are competitively awarded to professional guilds, who then competitively award the stipends to post-graduate students pursuing a degree in that professional field.

Funding History

Fiscal Year	Amount
FY 2014	$2,107,265
FY 2015	$2,920,045
FY 2016	$3,539,000
FY 2017	$3,532,000
FY 2018	$3,532,000

Budget Request

The FY 2018 Budget Request is $3.5 million, level with the FY 2017 Annualized CR. The funding will provide continued support for both base and expansion activities. The funds will support six MFPs, four MFP Addiction Counselors, and two technical assistance and evaluation support contracts.

Addiction Technology Transfer Centers

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Addiction Technology Transfer Centers	$9,046	$9,029	$9,029	---

Authorizing Legislation .....Section 509 of the Public Health Service Act
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

Misuse of, and addiction to alcohol, tobacco, and illicit drugs cost Americans more than $700 billion a year in increased healthcare costs, crime, and lost productivity.[117, 118] Recently the nation's attention has been on the increase misuse of opioids. The majority of drug overdose deaths (more than six out of ten) involved an opioid.[119] Drug/alcohol addiction is treatable and research has led to development of medications and evidence-based psychosocial interventions that help people achieve recovery and resume productive lives. One critical need is to help recruit, train, and support treatment providers in the use of evidence-based practices.

The Addiction Technology Transfer Center Network (ATTC Network) is one of SAMHSA's proven models for building behavioral health capacity in health systems and communities through the sharing and transfer of expertise. SAMHSA supports the ATTC Network to develop and provide low or no cost training opportunities using evidence-based teaching, technologies, implementation, coaching, and information dissemination to behavioral health professionals. During the last cycle of the ATTC program (FY 2011 - 2016), the ATTC network supported the completion of over 430 events (technical assistance, webinars, onsite training, presentations etc.) benefiting over 128,000 health professionals. Overall, over 94 percent of the participants reported satisfaction with the quality of the training or technical assistance they received from the ATTC Network.

There is a critical and rising need for practitioners to reflect the diversity of their client population in terms of characteristics such as age, race/ethnicity, and sexual orientation. Existing diversity requires recruitment of new professionals from a variety of backgrounds.[120]

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[117] National Institute for Drugs and Alcohol. (2015). *Trends and Statistics*. Retrieved from NIH/NIDA: http://www.drugabuse.gov/related-topics/trends-statistics

[118] National Institute for Drugs and Alcohol. (2015). *Trends and Statistics*. Retrieved from NIH/NIDA: http://www.drugabuse.gov/related-topics/trends-statistics

[119] Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep. ePub: 16 December 2016

[120] Ryan, O., Murphy, D., Krom, L. (2012). Vital Signs: Taking the Pulse of the Addiction Treatment Workforce, A National Report, Version 1. Kansas City, MO: Addiction Technology Transfer Center National Office in residence at the University of Missouri-Kansas City. Retrieved from http://www.attcnetwork.org/documents/VitalSignsReport.pdf

Treating persons with drug/alcohol addiction is difficult and challenging. Pay and benefits often do not fully reflect the difficulty of this work. Burnout and turnover are significant challenges for providers and their employing organizations and may impede patient recovery.

Faced with an average annual staff turnover rate of 18.5 percent, substance abuse treatment programs deal with significant challenges to fill open positions.[121] Common hurdles for many substance abuse treatment facilities include difficulty retaining and recruiting qualified individuals, the need for a diverse racial/ethnic workforce capable of working in integrated settings, and the perception that substance abuse is not a valid health issue (i.e., that addiction is a 'choice').[122]

To address the gaps in workforce, the ATTC Network supports national and regional activities focused on improving the skills of substance abuse treatment and other healthcare professionals. The ATTC Network decreases the gap in time between the release of new scientific findings and the adoption of these interventions by front-line substance abuse treatment clinicians. This program disseminates evidence-based and promising practices to addiction treatment/recovery professionals, public health/mental health personnel, institutional and community corrections professionals, nurses, and other health professions. The ATTC Network dissemination models include technical assistance, training and an extensive array of web-based resources created to translate the latest science for adoption into practice by the substance abuse treatment workforce. Using a systems change approach, the goal is to improve organizations and systems of care, enhancing access, engagement, and outcomes based in a continuous quality improvement framework; not limited to training and knowledge enhancement alone.

The ATTC Network currently includes 10 Regional Centers, four National Focus Area Centers, and a Network Coordinating Office. In FY 2017, a new ATTC Network will be awarded and will consist of 10 Regional Centers and one Coordinating Center. The National Center will take on an enhanced coordination function. Together, the members of the ATTC Network will continue to provide technical assistance, workforce training, support meetings, and the collaboration with other HHS agencies, the SAMHSA Regional Administrators, and other partners.

[121] Ryan, O., Murphy, D., Krom, L. (2012). Vital Signs: Taking the Pulse of the Addiction Treatment Workforce, A National Report, Version 1. Kansas City, MO: Addiction Technology Transfer Center National Office in residence at the University of Missouri-Kansas City. Retrieved from http://www.attcnetwork.org/documents/VitalSignsReport.pdf

[122] Ryan, O., Murphy, D., Krom, L. (2012). Vital Signs: Taking the Pulse of the Addiction Treatment Workforce, A National Report, Version 1. Kansas City, MO: Addiction Technology Transfer Center National Office in residence at the University of Missouri-Kansas City. Retrieved from http://www.attcnetwork.org/documents/VitalSignsReport.pdf

Funding History

Fiscal Year	Amount
FY 2014	$9,024,000
FY 2015	$9,046,000
FY 2016	$9,046,000
FY 2017	$9,029,000
FY 2018	$9,029,000

Budget Request

The FY 2018 Budget Request is $9.0 million, level with the FY 2017 Annualized CR. In FY 2018, SAMHSA plans to fund up to 11 continuation grants. SAMHSA expects the ATTC grantees to sponsor over 1,000 events involving more than 30,000 unique participants in FY 2018. In addition to the number of participants, event topics and contact hours, other metrics to be collected include participant satisfaction measures and self-assessed improvement skill levels. Funding will allow the ATTC grantees to disseminate evidence-based, promising practices to addiction treatment and recovery professionals, public health and mental health personnel, institutional and community corrections professionals, and other related disciplines.

State Targeted Response to the Opioid Crisis

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
State Response to the Opioid Abuse Crisis	$---	$500,000	$500,000	---

Authorizing Legislation .....Section 1003 of the 21st Century Cures Act
FY 2018 Authorization $500,000
Allocation Method .....Grants
Eligible Entities.....States

Program Description and Accomplishments

Opioid abuse continues to causa significant crisis across the nation. Opioid-overdose related deaths numbered 33,000 in 2015. As abuse continues to rise, Americans are dealing with the devastating consequences that accompany this use including: loss of employment, social connectedness, increased criminal justice involvement, injury, and death.

The State Targeted Response to the Opioid Crisis Grant Program (Opioid STR) was authorized under Section 1003 of the 21st Century Cures Act. The program aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid addiction (including prescription opioids as well as illicit drugs such as heroin).

Grantees will be required to do the following: use epidemiological data to demonstrate the critical gaps in availability of treatment for opioid addiction in geographic, demographic, and service level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly address the gaps in their systems of care; implement prevention strategies; deliver evidence based treatment interventions including medication and psychosocial interventions; deliver recovery support services; and report progress toward increasing availability of treatment for opioid addiction and reducing opioid-related overdose deaths.

In FY 2017, grants were awarded via formula to all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Northern Marianas, Micronesia, Palau, and American Samoa. Funds will also be used to support a cross-site evaluation to demonstrate program effectiveness and technical assistance activities.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$500,000,000
FY 2018	$500,000,000

Budget Request

In FY 2018, SAMHSA requests $500.0 million, level with the FY 2017 Annualized CR. These funds will support the Opioid STR Program. During the first year of the program, lessons learned will be utilized to determine if resource allocations and priorities need to be adjusted in the second year of the program.

Substance Abuse Prevention and Treatment Block Grant

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Substance Abuse Prevention and Treatment Block Grant	$1,858,079	$1,854,697	$1,854,697	$---
PHS Evaluation Funds (non-add).	*79,200*	*79,200*	*79,200*	---

Authorizing Legislation . .....Section 1935 of the Public Health Service Act
FY 2018 Authorization $1,858,079
Allocation Method ..... Formula Grants
Eligible Entities.....States, Territories, Freely Associated States, District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota

Program Description and Accomplishments

The authorizing legislation and implementing regulation governing the Substance Abuse Prevention and Treatment Block Grant (http://www.samhsa.gov/grants/block-grants) includes a number of prescriptive performance and expenditure requirements as well as explicit expenditure prohibitions. The states and jurisdictions have the flexibility to plan, carry out, and evaluate substance abuse treatment and recovery services that reflect comments received from individuals, families and communities during the development of their respective biennial plans and the results of such plans are reflected in their respective annual reports. The legislation and regulation prioritizes two populations to be served with SABG funds: (1) substance using pregnant women and women with dependent children; and (2) persons who inject drugs. Although the legislation and regulation prioritizes such individuals, the states and jurisdictions have the flexibility to prioritize other underserved populations as determined by anecdotal and empirical data. For example, most states and jurisdictions prioritize substance abuse treatment and recovery services for adolescents and transitional age youth. Some states and jurisdictions are also developing peer-to-peer recovery services to facilitate individuals' entry to substance abuse treatment services and to promote and support individuals in early recovery. States and jurisdictions frequently partner with other executive branch departments, e.g., education, human services, justice and public health, to coordinate services for individuals and families impacted by substance abuse.

The Massachusetts Bureau of Substance Abuse Services uses Substance Abuse Prevention and Treatment funds to collaborate with the state's Medicaid agency, Mass Health, in developing a Centralized Navigation System. The substance abuse treatment availability information is collected multiple times a day and reflected to the public. The website provides information, facilitated support, and referral to the public to access the treatment system and other recovery resources. The website is expanding its capacity by adding more treatment modalities over time and will soon release an improved user interface.

The Georgia Department of Behavioral Health and Developmental Disabilities, Office of Addictive Diseases in collaboration with the Office of Behavioral Health Prevention utilizes SABG funds to support three innovative and unique prevention clubhouses designed to provide prevention services to at-risk adolescents residing in Norcross, LaGrange, and Dawson, Georgia.

Participation is limited to adolescents at risk for or involved in underage drinking and illicit drug use, engaged in ongoing detention and/or alternative school, residing with a parent(s) with a drug/alcohol addiction or in recovery or a sibling(s) receiving substance abuse treatment, or experiencing education or social issues. The clubhouses use peer mentors, evidence based prevention curricula, and interactive youth activities to build coping, decision making, and life skills. Each clubhouse includes family activities/participation, community service, education and employment services, nutrition, and physical activities.

Texas is committed to focusing efforts on improving recovery services, principles and best practices. Texas currently funds 22 Recovery Support Service providers responsible for integrating recovery support services throughout their system of care, strengthening the alignment of treatment services with a recovery oriented approach, and expanding the community supports available to assist individuals in successfully integrating into their communities. Evaluation results for participants include increases in stable housing, employment, and wages earned. In addition, healthcare utilization decreased with an estimated cost savings of $3.4 million.

The Utah Department of Human Services, Division of Substance Abuse and Mental Health provides the Southwest Regional Behavioral Health Center with SABG funds to support a residential facility for women, Desert Haven, in the five county area that is serviced by the Southwest Regional Behavioral Health Center local treatment authority. The facility is licensed for up to 7-10 adult women and up to 6-9 children (ages eight and under) belonging to the women. The women in the program attend substance abuse treatment in the daytime, while day care services are provided to their children. The treatment offered combines group and individual therapy, education classes, anger management, communication skill building, parenting skills, life skills education, and relapse prevention.

In addition to the states' and jurisdictions' plans and reports, the authorizing legislation provides SAMHSA with significant resources to support targeted technical assistance to the SABG grantees and their respective sub-recipients, i.e., community- and faith-based organizations approved by the states and jurisdictions to provide substance abuse treatment and recovery services. SAMHSA's Knowledge Application Program (KAP) (http://www.samhsa.gov/kap) produces the Technical Assistance Public Series that provide practical guidance and information related to the delivery of substance abuse treatment services and related public health services to individuals and families. The KAP also produces the Treatment Improvement Protocol Series, a growing library of best practice guidelines, which are produced by a consensus-development process based on the experience and knowledge of clinical, research, and administrative experts.

The Substance Abuse Prevention and Treatment Block Grant (SABG) program distributes funds to 60 eligible states, territories and freely associated states[123], the District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota (referred to collectively as states) to plan, carry out, and evaluate substance abuse prevention, treatment, and recovery support services for individuals, families, and communities impacted by substance abuse. The SABG's overall goal is

[123] Territories include Guam, Puerto Rico, the Northern Mariana Islands, U.S. Virgin Islands and American Samoa. Freely Associated States, which have signed Compacts of Free Association with the United States, include the Republic of Palau, Federated States of Micronesia and Republic of the Marshall Islands. Retrieved from http://www.doi.gov//oia/islands/index.cfm

to support and expand substance abuse prevention and treatment services while providing maximum flexibility to grantees.

The SABG is critically important because it provides the states and their respective SABG sub-recipients, including, but not limited to, administrative service organizations, county and municipal governments, and prevention and treatment providers, the flexibility to respond to local and/or regional emergent issues impacting health, public health, and public safety through a consistent federal funding stream. SABG accounts for approximately 32 percent of total state substance abuse agency funding and 23 percent of total state substance abuse prevention and public health funding.[124] Individuals and families without health coverage or whose health insurance benefit will not cover certain services (e.g., recovery support) rely on services funded by the SABG. Block grant funds are being leveraged by states, along with other funding sources, to support training for staff and implementation of evidence-based practices for the prevention of substance misuse and the treatment of drug/alcohol addiction, improved business practices such as facilitating enrollment in appropriate health coverage and use of health information technology and integration of physical and behavioral health.[125] SAMHSA encourages states to use block grant resources to support and not supplant services that are covered through commercial and public insurer plans.

SAMHSA Block Grant funds are directed toward four purposes: to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; to fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery; to fund primary prevention for individuals not identified as needing treatment (universal programs that reach everyone in a group being served regardless of risk, selective interventions that serve people at elevated risk of substance misuse or a drug/alcohol addiction, and indicated prevention interventions that serve people who exhibit some symptoms of a clinical substance use disorder, but do not yet meet criteria for a diagnosis); and to collect performance and outcome data to determine the ongoing effectiveness of behavioral disorder treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.

SAMHSA also encourages the states to use their Block Grants to: allow recovery to be pursued through personal choice and many pathways; encourage providers to assess performance based on outcomes that demonstrate client successes; and expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services.

Funding Allocations and Requirements

SABG funds are distributed[126] through a formula grant that provides funding based on specified economic and demographic factors and is administered by SAMHSA's Centers for Substance Abuse Treatment (CSAT) and Substance Abuse Prevention (CSAP). Of the amounts appropriated

[124] SABG State Agency Reported Expenditures by Target Activity Within Source of Funds, State/Jurisdiction Selection: All States/Jurisdictions (2015)

[125] Case Studies of Three Policy Areas and Early State Innovators: 2014 State Profiles of Mental Health and Substance Use Disorder Agencies. HHS Publication In Press. Rockville, MD: Substance Abuse and Mental Health Services Administration. (2015).

[126] Block Grants and Formula Grants: A Guide for Allocation Calculations; 2007 Department of Health and Human Services, SAMHSA.

for the SABG program, 95 percent are distributed to states through a formula included in the authorizing legislation. Factors used to calculate the allotments include total personal income, state population data by age groups (total population data for territories), total taxable resources, and a cost of services index factor. The SABG also includes "hold harmless" provisions that limit fluctuations in allotments as the total block grant appropriation changes from year to year.

Maintenance of Effort: The SABG requires states to maintain its expenditures for certain substance abuse prevention and treatment activities at a level that is no less than the state's average expenditures for the previous two-years. While maintenance of effort (MOE) requirements can be important tools for maximizing the effectiveness of Federal funds, the way the SABG requirement is currently structured makes it a challenge for SAMHSA to administer. For example, timing requirements on when penalties must be assessed precede when SAMHSA receives final State data that demonstrates compliance. In addition, States are currently unable to claim credit for substance abuse prevention and treatment efforts that occur outside of the Single State Agency (defined as the agency within the State that has primary responsibility for administering SABG funds). For example, substance abuse prevention and treatment activities conducted by State Education Agencies and State Departments of Justice do not count toward the MOE. Finally, the State penalties for non-compliance with the MOE can exceed the size of the State SABG allotment.

Funding Set-Asides and Other Requirements: The authorizing legislation and implementation regulation for the SABG includes specific funding set-asides, including 20 percent for primary prevention (see below), and five percent for early intervention service for HIV for designated states.[127] The statute also includes performance requirements for the treatment of substance-using pregnant women and women with dependent children, and provides states with the flexibility to expend a combination of federal and non-federal funds. There are also requirements and potential penalty reduction of the Block Grant allotment if the recipient fails to prohibit and enforce sale of tobacco products to individuals under the age of 18.

Coordination of Efforts: SAMHSA emphasizes that Block Grant recipients should coordinate and partner with government agencies, nonprofit organizations, consumers and families and providers to support integrated and coordinated services and programs. SAMHSA provides targeted technical assistance for SABG grantees through a technical assistance contract.

Recent Updates: Guidance to states regarding the use of SABG funds for naloxone was sent out on April 2, 2014. Additionally, in July 2014, the Centers for Medicare & Medicaid Services, in collaboration with SAMHSA, the Centers for Disease Control and Prevention and the National Institutes of Health disseminated an Informational Bulletin, "Medication Assisted Treatment for Substance Use Disorders."[128]

<u>Performance and Evaluation</u>
SAMHSA is undertaking a series of agency-wide efforts designed to develop a set of common performance, quality, and cost measures to demonstrate the impact of SAMHSA's programs.

[127] Substance Abuse and Mental Health Services Administration. (2015). *Block Grant Laws and Regulations.* Retrieved from http://www.samhsa.gov/grants/block-grants/laws-regulations.
[128] Centers for Medicare & Medicaid. (n.d.). *Federal Policy Guidance.* Retrieved from http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html

Ultimately, SAMHSA and its state partners will collaborate to develop a streamlined behavioral health data system that complements other existing systems (e.g., Medicaid administrative and billing data systems, and state mental health and substance abuse treatment data systems), ensures consistency in the use of measures, and provides a more complete perspective of the delivery of mental illness and substance abuse treatment services.

An independent evaluation of the SABG demonstrated how states have leveraged the statutory requirements of this Block Grant program to expand existing or establish new treatment capacity in underserved areas of states and territories and to improve coordination of services with other state systems.[129] SAMHSA data show that the SABG has been successful in expanding treatment capacity by supporting approximately two million[130] admissions to treatment programs receiving public funding. Outcome data for the Block Grant program show positive results as reported through Behavioral Health Services Information System/Treatment Episode Data Set (TEDS) administered by SAMHSA's Center for Behavioral Health Statistics and Quality. In FY 2015, at discharge, clients demonstrated high abstinence rates from both illegal drug (70 percent) and alcohol (83 percent) use. State substance abuse authorities reported the following outcomes for services provided during FY 2015, the most recent year for which data is available:

- For the 50 states[3] and the District of Columbia that reported data concerning abstinence from alcohol use, all 51 identified improvements in client abstinence;
- Similarly, for the 50 states and D.C. that reported data concerning the abstinence from drug use, 50 of 51 identified improvements in client abstinence;
- For the 50 states and D.C. that reported employments data, 47 of 50 identified improvements in client employment;
- For the 50 states and D.C. that reported criminal justice data, 47 of 51 reported an increase in clients with no arrests based on data reported to TEDS; and
- For the 49 states and D.C. that reported housing data, 48 of 50 identified improvements in stable housing for clients based on data reported to TEDS.
- For the 51 states that reported recovery support data, 49 states out of 51 identified improvements in client engagement in recovery support programs. At intake clients who were engaged in recovery support programs increased from 28 percent to 43.9 percent at discharge.

20 Percent Prevention Set-Aside

SAMHSA is responsible for managing the 20 percent prevention set-aside of the SABG. The 20 percent set-aside requires SABG grantees to spend at least 20 percent of their SABG award to develop and implement a comprehensive prevention program, which includes a broad array of prevention strategies directed at individuals not identified to be in need of treatment.[131] The prevention set-aside is one of SAMHSA's main vehicles for supporting SAMHSA's Strategic Initiative for the Prevention of Substance Abuse and Mental Illness. The 20 percent set-aside is

[129] Substance Abuse and Mental health Administration. Retrieved from http://tie.samhsa.gov/SAPT2010.html#Evaluation.

[130] Substance Abuse and Mental Health Services Administration (2015). *Clients Level Data / TEDS.* Retrieved from http://www.samhsa.gov/data/client-level-data-teds

[3] Source: West Virginia numbers have been included in the text, but they appear lower than expected.

[131] Substance Abuse and Mental Health Services Administration (2015). *Substance Abuse Prevention and Treatment Block Grant.* Retrieved from http://www.samhsa.gov/grants/block-grants/sabg

focused only on substance use prevention. States use these funds to develop infrastructure and capacity and to fund programs specific to primary substance abuse prevention. Some states rely solely on the 20 percent set-aside to fund their prevention systems while others use the funds to target gaps and enhance existing program efforts.

States are encouraged to make prevention a top priority, taking advantage of recent science, best practices in community coordination, proven planning processes, and the findings articulated by the Institute of Medicine report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People.*[132] SAMHSA regularly works with states to improve their accountability systems for prevention and to establish necessary reporting capacities.

Synar

The Synar program is the set of actions put in place by states, with the support of the federal government, to implement the requirements of the Synar Amendment. The Synar Amendment requires states to ensure tobacco is not sold to individuals under age 18.[133] The Amendment was developed in the context of a growing body of evidence about the health problems related to tobacco use by youth, as well as evidence about the ease with which youth could purchase tobacco products through retail sources. The Synar program is a critical component of the success of youth tobacco use prevention efforts. SAMHSA is charged with overseeing states' implementation of the Synar requirements and provides technical assistance to states on both the Synar requirements and youth tobacco access issues in general.

While the national weighted retailer violation rate declined steadily from the program's baseline year in FY 1997 through FY 2011, the rate has increased slightly since FY 2012. One of the greatest predictors of a state's retailer violation rate is the amount and reach of their enforcement efforts. As states have faced budget shortfalls, some have scaled back on their enforcement programs and this may be contributing to the increase in the rate of tobacco sales to youth. Also, under the Synar program, SAMHSA encourages states to include in their inspections the types of tobacco products most often used by youth in their states. As states have expanded the types of tobacco products included in their Synar inspections, some states are reporting that retailers are sometimes more likely to sell non-cigarette tobacco products, including smokeless tobacco, to youth. These factors are likely contributing to the overall increase in the national weighted retailer violation rate. SAMHSA is addressing this increase by providing technical assistance to states, as well as examining Synar data in order to provide states with guidance on best practices including enforcement, merchant education, and community mobilization.

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[132] "Front Matter." *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington, DC: The National Academies Press, 2009. Retrieved from http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx.

[133] Substance Abuse and Mental Health Services Administration (2015). *Synar Program.* Retrieved from http://www.samhsa.gov/synar

Funding History

Fiscal Year	Amount
FY 2009	1,778,591,000
FY 2010	1,454,713,000
FY 2011	1,782,528,000
FY 2012	1,800,332,000
FY 2013	1,710,306,376
FY 2014	1,815,443,000
FY 2015	1,819,856,000
FY 2016	1,858,079,000
FY 2017	1,854,697,000
FY 2018	1,854,697,000

Budget Request

The FY 2018 Budget Request is $1.9 billion, the same level from the FY 2017 Annualized CR. SABG funds will continue to serve as a source of safety net funding and will continue to support certain services (e.g., recovery support services) not covered by commercial insurance and non-clinical activities and services that address the critical needs of state substance abuse prevention and treatment service systems.

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2018 DISCRETIONARY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

State/Territory	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Alabama	$23,089,486	$23,045,458	$22,751,632	−$293,826
Alaska	5,889,074	5,877,844	5,802,903	−$74,941
Arizona	40,187,732	40,111,100	39,599,681	−$511,409
Arkansas	13,524,497	13,498,708	13,326,602	−$172,106
California	254,414,759	253,929,625	250,692,065	−$3,237,560
Colorado	28,777,345	28,722,471	28,356,265	−$366,206
Connecticut	18,212,225	18,177,497	17,945,737	−$231,760
Delaware	6,967,796	6,954,509	6,865,840	−$88,669
District Of Columbia	6,967,796	6,954,509	6,865,840	−$88,669
Florida	111,379,297	111,166,912	109,749,553	−$1,417,359
Georgia	57,152,217	57,043,236	56,315,945	−$727,291
Hawaii	8,469,866	8,453,715	8,345,932	−$107,783
Idaho	8,535,838	8,519,561	8,410,938	−$108,623
Illinois	67,645,777	67,516,786	66,655,959	−$860,827
Indiana	32,246,086	32,184,597	31,774,249	−$410,348
Iowa	13,093,348	13,068,381	12,901,761	−$166,620
Kansas	11,899,663	11,876,972	11,725,543	−$151,429
Kentucky	20,378,373	20,339,514	20,080,189	−$259,325
Louisiana	25,026,431	24,978,709	24,660,235	−$318,474
Maine	6,967,796	6,954,509	6,865,840	−$88,669
Maryland	34,079,985	34,014,999	33,581,314	−$433,685
Massachusetts	39,845,084	39,769,105	39,262,056	−$507,049
Michigan	56,052,853	55,945,968	55,232,667	−$713,301
Minnesota	24,102,039	24,056,080	23,749,369	−$306,711
Red Lake Indians	594,027	592,894	585,335	−$7,559
Mississippi	13,803,562	13,777,241	13,601,584	−$175,657
Missouri	26,548,475	26,497,851	26,160,008	−$337,843
Montana	6,967,796	6,954,509	6,865,840	−$88,669
Nebraska	7,641,241	7,626,670	7,529,431	−$97,239
Nevada	16,890,047	16,857,840	16,642,906	−$214,934

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
FY 2018 DISCRETIONARY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

State/Territory	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
New Hampshire	6,967,796	6,954,509	6,865,840	−$88,669
New Jersey	48,064,193	47,972,541	47,360,900	−$611,641
New Mexico	9,565,114	9,546,875	9,425,154	−$121,721
New York	111,830,061	111,616,817	110,193,722	−$1,423,095
North Carolina	44,991,909	44,906,116	44,333,571	−$572,545
North Dakota	6,533,547	6,521,088	6,437,945	−$83,143
Ohio	64,535,736	64,412,675	63,591,425	−$821,250
Oklahoma	17,149,341	17,116,640	16,898,406	−$218,234
Oregon	20,578,346	20,539,106	20,277,236	−$261,870
Pennsylvania	59,100,201	58,987,505	58,235,425	−$752,080
Rhode Island	7,598,476	7,583,987	7,487,293	−$96,694
South Carolina	23,717,773	23,672,546	23,370,725	−$301,821
South Dakota	6,041,710	6,030,189	5,953,305	−$76,884
Tennessee	31,978,247	31,917,269	31,510,329	−$406,940
Texas	144,708,674	144,432,735	142,591,243	−$1,841,492
Utah	16,588,581	16,556,949	16,345,851	−$211,098
Vermont	6,459,874	6,447,556	6,365,351	−$82,205
Virginia	41,979,903	41,899,853	41,365,637	−$534,216
Washington	37,784,663	37,712,613	37,231,784	−$480,829
West Virginia	8,432,680	8,416,600	8,309,290	−$107,310
Wisconsin	27,197,983	27,146,120	26,800,012	−$346,108
Wyoming	4,197,559	4,189,555	4,136,139	−$53,416
American Samoa	342,788	342,799	339,035	−$3,764
Guam	1,004,691	1,012,363	1,009,343	−$3,020
Northern Marianas	320,555	323,721	326,563	$2,842
Puerto Rico	22,838,224	22,767,940	22,449,405	−$318,535
Palau	132,231	133,216	132,668	−$548
Marshall Islands	436,931	446,336	450,385	$4,049
Micronesia	664,690	664,515	656,421	−$8,094
Virgin Islands	656,127	655,013	646,177	−$8,836

Outputs and Outcomes Tables

Program: Treatment Activities

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
1.2.43 Increase the number of admissions to substance abuse treatment programs receiving public funding (Output)	FY 2015: 1,806,941 Target: 1,937,960 (Target Not Met)	1,880,000	1,880,000	Maintain
1.2.48 Percentage of clients reporting no drug use in the past month at discharge (Outcome)	FY 2016: 69.6 % Target: 74 % (Target Not Met)	74 %	74 %	Maintain
1.2.49 Increase the percentage of clients reporting no alcohol use in the past month at discharge (Outcome)	FY 2016: 83.1 % Target: 78 % (Target Exceeded)	78 %	78 %	Maintain
1.2.50 Increase the percentage of clients reporting being employed/in school at discharge (Outcome)	FY 2015: 35.7 % Target: 43 % (Target Not Met)	40 %	40 %	Maintain
1.2.51 Increase the percentage of clients reporting no involvement with the Criminal Justice System (Outcome)	FY 2015: 93.2 % Target: 92 % (Target Exceeded)	92 %	92 %	Maintain
1.2.85 Increase the percentage of clients receiving services who had a permanent place to live in the community (Outcome)	FY 2015: 88.9 % Target: 92 % (Target Not Met)	92 %	92 %	Maintain

Outputs and Outcomes Tables

Program: Synar Amendment

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
2.3.49 Increase the number of States (including Puerto Rico) whose retail sales violations is at or below 20% (Outcome)	FY 2015: 52 Target: 52 (Target Met)	52	52	Maintain
2.3.62 Increase the number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% (Outcome)	FY 2015: 27 Target: 34 (Target Not Met)	33	33	Maintain

Outputs and Outcomes Tables

Program: Prevention Set-Aside

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/– FY 2018 Target
2.3.63 Increase the 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 2014: 35 % (Historical Actual)	22 %	22 %	Maintain
2.3.65 Increase the 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 2015: 73 % Target: 67.5 %[1] (Target Exceeded)	67.5 %	67.5 %	Maintain
2.3.67 Increase the 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 2014: 49 % Target: 59 % (Target Not Met)	63 %	63 %	Maintain
2.3.68 Increase the 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 2014: 24 % Target: 37 % (Target Not Met)	43 %	43 %	Maintain

[1] Change from previously reported to reflect average of FY 2011 result and FY 2014 target.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table Summary

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final		FY 2017 Annualized CR		FY 2018 President's Budget		FY 2018 +/– FY 2017	
	No.	**Amount**	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Grants/Cooperative Agreements:								
Continuations	493	194,371	421	176,076	395	181,772	−26	5,696
New/Competing	200	85,342	234	111,755	253	108,459	19	−3,296
Subtotal	693	279,713	655	287,831	648	290,230	−7	2,399
Contracts:								
Continuations	15	37,985,980	23	34,415,973	27	40,040,207	4	5,624
New/Competing	21	19,646,497	15	19,460,908	4	11,467,095	−11	−7,994
Subtotal	36	57,632	38	53,877	31	51,507	−7	−2,370
Total, Substance Abuse Treatment	**729**	**$337,345**	**693**	**$341,708**	**679**	**$341,738**	−14	−30

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount	FY 2018 +/– FY 2017 No.	FY 2018 +/– FY 2017 Amount
Capacity:								
Opioid Treatment Programs/Regulatory Activities								
Grants								
Continuations	11	$1,391	1	$1,000	1	$1,393		**393**
New/Competing	1	999	1	1,400	1	1,000		**−400**
Subtotal	12	2,391	2	2,400	2	2,393		**−7**
Contracts								---
Continuations	2	1,685	4	4,589	3	4,004		**−585**
New/Competing	5	4,649	3	1,718	2	2,311		**592**
Subtotal	7	6,333	7	6,308	5	6,315		**7**
Total, Opioid Treatment Programs/Regulatory Activities	**19**	**8,724**	**9**	**8,708**	**7**	**8,708**		**---**
Screening, Brief Intervention and Referral to Treatment								---
Grants								---
Continuations	63	22,246	81	39,316	20	16,607		**−22,709**
New/Competing	21	17,459	1	870	59	22,324		**21,454**
Subtotal	84	39,705	82	40,186	79	38,931		**−1,255**
Contracts								---
Continuations	1	6,051	3	5,306	4	7,554		**2,248**
New/Competing	3	1,132	---	1,312	---	318		**-994**
Subtotal	4	7,184	3	6,618	4	7,872		**1,255**
Total, Screening, Brief Intervention and Referral to Treatment	**88**	**46,889**	**85**	**46,804**	**83**	**46,804**		**-**
Targeted Capacity Expansion								---
Grants								---
Continuations	13	11,013	52	29,046	43	19,223		**−9,823**
New/Competing	39	18,673	2	800	11	11,392		**10,592**
Subtotal	52	29,686	54	29,846	54	30,615		**769**
Contracts								---
Continuations	2	5,272	2	3,180	1	3,171		**-9**
New/Competing	3	1,344	2	3,208	1	2,448		**−761**
Subtotal	5	6,617	4	6,388	2	5,619		**−769**
Total, Targeted Capacity Expansion	**57**	**36,303**	**58**	**36,234**	**56**	**36,234**		**---**
Pregnant and Postpartum Women								---
Grants								---
Continuations	26	11,504	7	3,559	21	11,170		**7,610**
New/Competing	2	1,035	19	10,134	5	2,366		**−7,769**
Subtotal	28	12,540	26	13,694	26	13,535		**-159**
Contracts								---
Continuations	---	2,481	2	2,055	1	2,395		**341**
New/Competing	---	911	---	152	---	---		**−152**
Subtotal	---	3,391	2	2,207	1	2,395		**189**
Total, Pregnant and Postpartum Women	**28**	**$15,931**	**28**	**$15,901**	**27**	**$15,931**		**30**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount	FY 2018 +/− FY 2017 No.	FY 2018 +/− FY 2017 Amount
Recovery Community Services Program								
Grants								
Continuations	10	900	---	---	10	1,500		**1,500**
New/Competing	8	350	10	1,500	---	---		**−1,500**
Subtotal	18	1,250	10	1,500	10	1,500		---
Contracts								---
Continuations	1	1,006	---	117	2	774		**657**
New/Competing	1	178	3	813	---	156		**−657**
Subtotal	2	1,184	3	929	2	929		---
Total, Recovery Community Services Program	**20**	**2,434**	**13**	**2,429**	**12**	**2,429**		---
Children and Families								---
Grants								---
Continuations	32	$20,668	14	$10,921	12	$11,954		**1,033**
New/Competing	2	1,264	10	10,600	15	11,708		**1,108**
Subtotal	34	21,933	24	21,521	27	23,663		**2,141**
Contracts								---
Continuations	3	5,009	2	3,702	3	4,922		**1,220**
New/Competing	2	2,664	1	4,325	---	964		**−3,361**
Subtotal	5	7,672	3	8,027	3	5,886		**−2,141**
Total, Children and Families	**39**	**29,605**	**27**	**29,549**	**30**	**29,549**		---
Treatment Systems for Homeless								---
Grants								---
Continuations	50	26,222	46	22,207	68	24,022		**1,816**
New/Competing	31	10,538	38	14,345	16	12,533		**−1,812**
Subtotal	81	36,760	84	36,552	84	36,556		**3**
Contracts								---
Continuations	---	2,734	2	3,703	2	3,741		**38**
New/Competing	2	1,811	---	971	---	929		**−41**
Subtotal	2	4,544	2	4,673	2	4,670		**−3**
Total, Treatment Systems for Homeless	**83**	**41,304**	**86**	**41,225**	**86**	**41,225**		---
Minority AIDS								---
Grants								---
Continuations	116	46,776	82	30,315	81	40,332		**10,017**
New/Competing	23	12,489	58	28,916	59	18,901		**−10,015**
Subtotal	139	59,265	140	59,231	140	59,233		**2**
Contracts								---
Continuations	3	5,969	2	4,638	3	4,769		**131**
New/Competing	---	336	1	1,576	---	1,444		**−133**
Subtotal	3	6,305	3	6,214	3	6,212		**-2**
Total, Minority AIDS	**142**	**65,570**	**143**	**65,445**	**143**	**65,445**		---

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2016 Final No.	FY 2016 Final Amount	FY 2017 Annualized CR No.	FY 2017 Annualized CR Amount	FY 2018 President's Budget No.	FY 2018 President's Budget Amount	FY 2018 +/− FY 2017 No.	FY 2018 +/− FY 2017 Amount
Criminal Justice Activities								
Grants								
Continuations	149	42,964	130	37,604	128	43,043		**5,438**
New/Competing	71	21,721	84	29,805	87	25,156		**−4,649**
Subtotal	220	64,685	214	67,409	215	68,198		**789**
Contracts								**---**
Continuations	1	6,695	4	6,267	4	6,861		**594**
New/Competing	5	6,621	3	4,176	1	2,792		**−1,384**
Subtotal	6	13,315	7	10,442	5	9,653		**−789**
Total, Criminal Justice Activities	**226**	**78,000**	**221**	**77,852**	**220**	**77,852**		**---**
Subtotal, Capacity	**702**	**324,760**	**670**	**324,147**	**664**	**324,177**		**30**
Science and Service:								**---**
Addiction Technology Transfer Centers								**---**
Grants								**---**
Continuations	15	8,579	---	---	11	8,468		**8,468**
New/Competing	---	---	11	8,528	---	---		**−8,528**
Subtotal	15	8,579	11	8,528	11	8,468		**-60**
Contracts								**---**
Continuations	---	599	---	434	---	473		**39**
New/Competing	---	-131	---	67	---	88		**21**
Subtotal	---	467	---	501	---	561		**60**
Total, Addiction Technology Transfer Centers	**15**	**9,046**	**11**	**9,029**	**11**	**9,029**		**---**
Subtotal, Science and Service	**15**	**9,046**	**11**	**9,029**	**11**	**9,029**		**---**
Minority Fellowship Program (MFP)								
Grants								
Continuations	8	2,107	8	2,107	---	---		**−2,107**
New/Competing	2	813	2	796	11	3,078		**2,283**
Subtotal	10	2,920	10	2,903	11	3,078		**175**
Contracts								**---**
Continuations	2	486	2	427	2	436		**9**
New/Competing	---	133	---	202	---	18		**−184**
Subtotal	2	619	2	629	2	454		**−175**
Total, Minority Fellowship Program (MF)	**12**	**3,539**	**12**	**3,532**	**13**	**3,532**		**---**
Subtotal, Capacity	**729**	**38,658**	**693**	**61,512**	**688**	**54,374**		**−7,138**
Science and Service:								**---**
Comprehensive Addiction and Recovery Act (CARA)								**---**
Grants								**---**
Continuations	---	---	---	---	8	4,060		**4,060**
New/Competing	---	---	8	4,060	---	---		**−4,060**
Subtotal	---	---	8	4,060	8	4,060		**---**
Contracts								**---**
Continuations	---	---	---	---	2	940		**940**
New/Competing	---	---	2	940	---	---		**−940**
Subtotal	---	---	2	940	2	940		**---**
Total, Comprehensive Addiction and Recovery Act (CARA)	**---**	**---**	**10**	**5,000**	**10**	**5,000**		**---**
Subtotal, Science and Service	**---**	**---**	**10**	**5,000**	**10**	**5,000**		**---**
Total, Substance Abuse Treatment PRNS [1]	**729**	**$337,345**	**703**	**$341,708**	**698**	**$341,738**		**30**

Grant Awards Table

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Number of Awards	691	654	647	−7
Average Award	$403,618	$438,573	$447,033	8
Range of Awards	$300,000–$600,000	$300,000–$600,000	$300,000–$600,000	$300,000–$600,000

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SAMHSA
Health Surveillance and Program Support
Table of Contents

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Health Surveillance

(Dollars in thousands)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/– FY 2017
Health Surveillance	$47,258	$47,226	$33,842	-$13,384
Budget Authority (non-add)	*16,830*	*16,798*	*11,414*	*-5,384*
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*22,428*	*-8,000*
Data Request and Publication User Fees	$1,500	$1,500	$1,500	---

Authorizing Legislation ..... Sections 501 and 505 of the Public Health Service Act
FY 2018 Authorization ..... Expired
Allocation Method ..... Federal/Intramural, Contracts, Other
Eligible Entities..... Not Applicable

Program Description and Accomplishments

The Health Surveillance funding primarily supports the activities of the Center for Behavioral Health Statistics and Quality (CBHSQ). The detailed funding for each activity along with a detailed narrative description of each project follows.

Health Surveillance
Resources by Activity/Program

(Dollars in thousands)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Health Surveillance and Program Support Appropriation				
Health Surveillance				
Population Data Collection, Analysis, and Dissemination	$10,987	$17,886	$10,284	-$7,602
National Survey on Drug Use and Health (NSDUH)	*10,987*	*17,886*	*10,284*	*-7,602*
Community Behavioral Health Surveillance	2,525	3,000	---	-3,000
Community Early Warning and Monitoring System (CEM-S)	*2,525*	*3,000*	---	*-3,000*
Evidence-Based Programs/Practices	2,348	2,044	---	-2,044
National Registry for Evidence Based Programs and Practices (NREPP)	*2,348*	*2,044*	---	*-2,044*
Emergency Department Data Collection, Analysis, and Dissemination	---	125	---	-125
SAMHSA's Emergency Department Surveillance System (SEDSS)	---	*125*	---	*-125*
Treatment Services Data Collection, Analysis, and Dissemination	16,073	11,125	13,696	2,572
Behavioral Health Services Information System (BHSIS)	*16,073*	*11,125*	*13,696*	*2,572*
Behavioral Health Research and Dissemination	3,084	3,810	1,880	-1,930
Substance Abuse and Mental Health Data Archive (SAMHDA)	---	*425*	*372*	*-52*
Analytic Support Center (ASC)	*1,741*	*2,698*	*1,507*	*-1,190*
Center for Financing Reform & Innovations (CFRI)	*1,344*	*688*	---	*-688*
Performance Measurement/Systems	*912*	---	---	---
WebBGAS	*912*	---	---	---
Program Evaluations	---	696	---	-696
Primary and Behavioral Health Care Integration (PBHCI)	---	*696*	---	*-696*
Content Management	26	---	---	---
Innovation and Logistical Services Support	*1,953*	---		---
Support	9,351	8,540	7,982	-558
Operations	*3,460*	*2,560*	*1,912*	*-648*
Payroll	*5,892*	*5,980*	*6,070*	*90*
Total Health Surveillance	**$47,258**	**$47,226**	**$33,842**	**-$13,384**

Overview

SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) is the government's lead agency for behavioral health statistics. As detailed in the 21st Century Cures Act, CBHSQ performs activities that: (1) coordinate SAMHSA's integrated data strategy, including by collecting data each year; (2) provide statistical and analytical support for SAMHSA's activities; (3) recommend a core set of performance metrics to evaluate activities supported by SAMHSA; (4) coordinate with the Assistant Secretary, the Assistant Secretary for Planning and Evaluation, and the Chief Medical Officer, as appropriate, to improve the quality of services and evaluations. CBHSQ activities are integrated and cross over multiple funding lines.

CBHSQ receives budget for Health Surveillance (HS) and Performance and Quality Information Systems (PQIS) within the Health Surveillance and Program Support appropriation (HSPS) funding sources and the Substance Abuse Treatment appropriation from Block Grant Set Aside (SABG) funding sources. Programs are often funded from several sources. (A table detailing All Funding Sources follows the PQIS section). Under Health Surveillance, CBHSQ work includes Population Data Collection, Analysis, and Dissemination; Treatment Services Data Collection, Analysis, and Dissemination; Emergency Services Data Collection, Analysis, and Dissemination; Behavioral Health Surveillance; and Behavioral Health Research and Dissemination. Under PQIS, CBHSQ activities include Performance Measurement/Systems, Program Evaluations, and Evidence-Based Programs/Practices.

The total funding amount requested for CBHSQ (from all sources) in FY 2018 is $102.3 million, including $46.7 million from Health Surveillance and Program Support (HSPS) Appropriation and $55.6 million from the Substance Abuse Treatment (SAT) Appropriation. The CBHSQ overall FY 2018 budget reflects a decrease of $16.0 million from the FY 2017 Annualized CR. Funding has been prioritized to continue the NSDUH survey at its current sample size and to maintain NREPP activities at the current funding level.

Population Data Collection, Analysis, and Dissemination

Section 505 of the Public Health Service Act (42 USC 290aa-4) requires SAMHSA, on an annual basis, to collect data on the prevalence of substance use and mental illness. To accomplish this, SAMHSA administers the National Survey on Drug Use and Health (NSDUH). NSDUH is an annual collection of behavioral health data on approximately 67,500 persons aged 12 or older of the U.S. civilian, non-institutionalized population. NSDUH is the nation's primary source of statistical information on the use of illegal drugs, alcohol, and tobacco, certain mental disorders, co-occurring substance use and mental disorders, and treatment for substance use and mental health problems. NSDUH data provide estimates at the national, state, and sub-state level. NSDUH can be used to determine the prevalence of substance use and mental illness among demographic or geographic subgroups and provides trend estimates over time. NSDUH data provide states the opportunity to focus on their leading public health challenges through the release of state-specific data. Each year, three simultaneous NSDUH activities are ongoing: planning for future surveys, collecting data on over 67,500 persons in the current year survey, and analysis and dissemination of data from previous collections.

The prevalence of substance use from the FY 2015 NSDUH estimates that 27.1 million Americans aged 12 or older, or 10.1 percent were current (past month) illicit drug users.[134] From the FY 2015 NSDUH, 17.9 percent of adults ages 18 and older had any mental illness in the past year (43.4 million) and 4 percent (9.8 million) of adults had serious mental illness.[135]

The FY 2015 NSDUH included changes to the data collection equipment, respondent contact materials, and survey questions. The changes made to the survey questions were intended to improve the quality of the data collected and address changing substance use (e.g., misuse of prescription drugs) and mental health policy and research needs. All of the FY 2015 NSDUH changes were evaluated in field tests during FY 2012 and FY 2013, with appropriate adjustments made to the FY 2015 NSDUH based on field test findings.[136] The current NSDUH contract supports annual surveys through FY 2017; the contract was re-competed in FY 2016 and was awarded in early FY 2017 for survey years FY 2018 through FY 2021.

CBHSQ has partnered with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Research Council (NRC) for guidance on how to collect data on other behavioral health issues (including trauma, recovery, and serious emotional disturbance among children) through extramural data collection initiatives. SAMHSA also continues to explore opportunities for a future NSDUH redesign to ensure the survey is clinically up-to-date through alignment of questions to the DSM-5. Other potential areas for the next possible redesign include, but are not limited to, electronic cigarettes, synthetic marijuana, and alignment of treatment questions for substance use and mental health. In FY 2018, a total of $54.9 million is available for NSDUH ($10.2 million from HSPS and $44.7 million from SAT) to continue survey activities without reducing sample size, representing a decrease of $2.6 million from FY 2017. SAMHSA will plan to roll out the results of the 2017 survey, field the 2018 survey, plan for the 2019 survey, and will continue to explore options for a future NSDUH redesign.

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[134] Substance Abuse and Mental Health Services Administration, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. See:
http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1- 2014.pdf.

[135] Substance Abuse and Mental Health Services Administration, *Behavioral Health Trends in the United States: Results from the 2015 National Survey on Drug Use and Health*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. See:
http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1- 2014.pdf.

[136] The following report provides a summary of the changes made to the 2014 NSDUH sample design and 2015 NSDUH redesign, including data collection equipment, respondent contact materials, and the survey questionnaire. http://www.samhsa.gov/data/sites/default/files/NSDUH-RedesignChanges-2015.pdf

NSDUH data are disseminated through public-use files made available on the Substance Abuse and Mental Health Data Archive (SAMHDA). Data are also disseminated through annual reports.[137,138,139] Collectively, in FY 2015 and FY 2016, approximately 200 reports and articles were written by external researchers using NSDUH, TEDS, N-SSATS, and DAWN data. In FY 2017, 30,000 NSDUH downloaded events are anticipated. CBHSQ staff also responded to over 600 requests for NSDUH data in FY 2016.

Treatment Services Data Collection, Analysis, and Dissemination

Section 505 of the Public Health Service Act (42.U.S.C. 290aa-4) requires SAMHSA to collect data on substance use and mental disorder treatment services. For this purpose, SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) developed the Behavioral Health Services Information System (BHSIS). Data collected through the BHSIS provide information to the public on treatment services through the Behavioral Health Treatment Services Locator, a portion of the National Treatment Referral Service. The Locator provides accurate, timely, and regularly updated information on mental and substance abuse treatment facilities across the country.

BHSIS includes multiple data collection programs and information resources to support the Locator. BHSIS data collections comprise: (1) the National Mental Health Services Survey (N-MHSS) which provides information on all specialty mental disorder treatment facilities in the United States; in FY 2016, the overall response rate was 92.1 percent; (2) the National Survey of Substance Abuse Treatment Services (N-SSATS) which provides information on all public and private substance abuse treatment facilities in the United States; in FY 2016, the overall response rate was 92.4 percent; (3) the Treatment Episode Data Set (TEDS) which provides demographic and services information on publicly funded admissions and discharges from substance abuse treatment; (4) the Mental Health Treatment Episode Data Set (MH-TEDS) and the Mental Health Client Level Data (MH-CLD) which provide demographic and services information on publicly funded admissions and discharges of clients in mental disorder treatment; and (5) the Uniform Reporting System (URS) which provides a set of standardized data tables submitted annually by states and territories as part of their Mental Health Block Grant (MHBG) annual implementation reports.

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[137] Substance Abuse and Mental Health Services Administration, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. See: http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1- 2014.pdf.

[138] Substance Abuse and Mental Health Services Administration. *Suicidal Thoughts and Behavior among Adults: Results from the 2014 National Survey on Drug Use and Health* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. See http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR2-2014/NSDUH-FRR2-2014.pdf

[139] Substance Abuse and Mental Health Services Administration. *Risk and Protective Factors and Initiation of Substance Use: Results from the 2014 National Survey on Drug Use and Health.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. See: http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR4-2014v1/NSDUH-DR-FRR4-2014.pdf

One important element of the BHSIS is the Inventory of Behavioral Health Services (I-BHS) which provides a listing of all known mental disorder and substance abuse treatment facilities. As of March 2017, I-BHS had identified 19,529 active substance abuse treatment facilities and 14,263 active mental disorder treatment facilities in the United States and its territories.

In FY 2015, the Behavioral Health Treatment Services Locator was accessed more than 2.8 million times by individuals, families, community groups, and organizations to identify appropriate treatment services. Also in FY 2016, for the months of May through October that SAMHDA was operational, researchers downloaded over 2,000 BHSIS public-use datasets, and it is projected, based on increasing downloads and an expanding repository of datasets available, that in FY 2017, researchers will download over 10,000 BHSIS public use datasets. CBHSQ staff responded to over 100 requests for BHSIS data. In February 2017, data users accessed over 380 web pages for URS tables.

In FY 2016, SAMHSA awarded a new BHSIS contract for four cycles of the annual N-SSATS and N-MHSS. The Behavioral Health Treatment Services Locator is part of the National Treatment Referral Routing Service, which is required through Section 9006 of the 21st Century Cures Act. In FY 2017, SAMHSA continued each of the BHSIS data programs and is coordinating with states to develop Mental Health-Treatment Episode Data Set/Mental Heath-Client Level Data (MH-TEDS/MH-CLD) further. In FY 2018, a total of $18.9 million is requested for BHSIS ($13.7 million in HSPS and $5.2 million from SAT). Additional funds totaling $8.5 million are provided by CMHS and CSAT from the MH and SAT Appropriations to support state payment for data collection.

Emergency Department Data Collection, Analysis, and Dissemination

Section 505 of the Public Health Service Act (42.U.S.C. 290aa-4) requires SAMHSA to collect and publish data on Emergency departments (ED) visits related to the use of alcohol and drugs.

Emergency departments (EDs) are a robust source of information about substance use and mental disorder-related morbidity; an ongoing collection of data allows monitoring of patterns, trends, and the identification of emergent drugs of use.

In late FY 2011, SAMHSA began collaborating with the National Center for Health Statistics (NCHS) to obtain data from the National Hospital Care Survey (NHCS) on ED visits related to substance use and mental illness for the SAMHSA Emergency Department Surveillance System (SEDSS). The NHCS is a survey that describes national patterns of healthcare delivery in hospital-based settings, including inpatient, emergency, and outpatient departments. With SEDSS data, national level estimates of drug-related ED visits and mental illness can be published.

In FY 2017, efforts focus on challenges that include recruiting hospitals to participate in the survey, developing an infrastructure to collect electronic health record (EHR) data for surveillance purposes, and developing methods to identify information about drug-related ED visits in EHR data. SAMHSA also worked with NCHS to fund a NCHS research data center to help prepare for analysis of the EHR data.

In FY 2018, no funding is requested for SEDSS, representing a decrease of $4.0 million from FY 2017. SAMHSA plans to continue the partnership with NCHS to explore the viability of this approach to collect emergency department data in future years.

Community Behavioral Health Surveillance

SAMHSA coordinates public health response data efforts to create opportunities for cross-agency and public-private partnerships to address critical public health questions and use existing or decreasing resources more effectively. Surveillance of health conditions is critical to track aberrations, changes over time, impact of public health interventions, and national and regional differences. Currently, no such surveillance system exists for behavioral health data; national surveillance systems do exist, though, for 52 infectious diseases.

In FY 2016, SAMHSA funded support for the Community Early Warning and Monitoring System (C-EMS), a cooperative initiative in which national level behavioral health indicators are being developed. In FY 2017, SAMHSA provided funding for a pilot program, establishing infrastructure and reporting mechanisms for data collection using this national behavioral health surveillance system. The pilot will be completed in FY 2017 and the results will be available for review.

In FY 2016 and FY 2017, SAMHSA supported and reported on field investigations by deploying staff to New Mexico, Baltimore, and Flint, Michigan to assess the capacity of the local community to respond to behavioral health public health concerns. Additionally, SAMHSA supported and reported on field investigations related to suicide, opioid-overdose deaths, and an opioid-related HIV outbreak in Indiana.

SAMHSA has also developed a community assessment tool (CAST)[1] that provides a modeled "gold standard" for local-level community behavioral health infrastructure compared to an on-the-ground asset mapping. CAST allows for a local-level evaluation of gaps and overages in programmatic coverage, and facilitates community level discussions about resource management. The CAST tool, within the context of public health, can be used as a preparation, mitigation, response, or recovery tool.

In FY 2018, no funding is requested for C-EMS, representing a decrease of $3.0 million from FY 2017. SAMHSA plans to continue a partnership with state and territorial epidemiologists to explore the viability of this approach to collect local behavioral health indicators in future years.

Behavioral Health Research and Dissemination

OMB's Open Data Policy Memorandum (M-13-13) requires the Federal Government to make data it collects accessible and usable through dissemination activities. CBHSQ conducts epidemiological and health services research in the area of behavioral health. Results of these research studies inform policymakers, service providers, program developers, and the public about important behavioral health findings.

[1] Green B, Lyerla R, Stroup DF, Azofeifa A, High PM. A Tool for Assessing a Community's Capacity for Substance Abuse Care. Prev Chronic Dis 2016;13:160190. DOI: http://dx.doi.org/10.5888/pcd13.160190

CBHSQ is completing a research framework to feed into a broader SAMHSA learning agenda for research, statistical studies, and program evaluation. CBHSQ categorizes its research activities into four major portfolio areas: substance use, mental health, community behavioral health surveillance, and methodological studies. Additionally, several portfolio topic areas, subsets of the portfolio areas, have been identified to represent a snapshot of current and past CBHSQ research endeavors. The portfolio topic areas allow CBHSQ to optimize resources and balance priorities. This approach is moving CBHSQ, and SAMHSA, toward finalizing a research framework to reflect the principles of the learning agenda as envisioned by OMB and the Department.

From FY 2012 – FY 2016, CBHSQ produced 64 articles; these articles were across the four Portfolio areas in the CBHSQ Research Framework. CBHSQ is projected to produce 64 articles in FY 2017 and 16 articles in FY 2018. Additionally, CBHSQ disseminates information through short reports and data spotlights using CBHSQ and other data sources that focus on topics impacting the behavioral health of the nation. Short reports describe trends in substance use, treatment, and mental health topics with in-depth analysis by age, gender, substance use initiation, socioeconomic status, and national and state estimates. Spotlights focus on a single topic with one chart or graph and a descriptive paragraph delineating public health significance. These are published on the SAMHSA website and at the National Library of Medicine. During the period FY 2012 – FY 2016, CBHSQ staff authored over 200 such reports. CBHSQ staff are projected to produce approximately 50 short reports and spotlights in FY 2017. Due to reductions in resources over the past two years, CBHSQ projects a reduction of at least 50 percent in the number of short reports and spotlights in FY 2018.

The Analytical Support Contract will continue to provide support for these activities as well as support for ad hoc requests, short- and long-term analyses, special requests, and evaluation activities, a total of $3.4 million is requested for this contract, which is provided from a variety of sources (HSPS [HS and PQIS] and SAT).

The Substance Abuse and Mental Health Data Archive (SAMHDA) serves as SAMHSA's primary means for dissemination of data through Public-Use Files (PUF). From May 23, 2016 to October 2016, users downloaded over 17,000 PUFs from SAMHDA and generated over 8,000 tables utilizing a web-based analytic tool launched September 15, 2016. Through SAMHDA, CBHSQ provides limited, no-cost, public access to confidential data for researcher analysis. A restricted version of the current web-based analytic tool is anticipated to launch in April, 2017, and will allow researchers to generate tables based on confidential data. After SAMHDA reopened in May 2016, an increase in visitors to the website reflected 30 percent returning visitors and 70 percent new visitors, with a total of 1,081 download events processed.

In FY 2017, web-based analytic tool improvements were implemented; and, projected FY 2017 SAMHDA usage is over 50,000 public-use datasets downloaded by researchers and over 100,000 tables generated using online analytic tools. Estimates include supporting over 100 research groups (with up to 10 researchers per group) in the Data Portal, which allows researchers to apply for access to micro-level confidential data for statistical research purposes. CBHSQ will continue to incorporate SAMDHA improvements in FY 2018. SAMHSA anticipates increased SAMHDA

usage in FY 2018 as the website becomes fully operational. In FY 2018, a total of $0.74 million is requested for SAMHDA ($0.37 from HSPS and $0.37 from SAT), representing a decrease of $0.1 million from FY 2017 reflecting savings realized in the fourth option year of its contract.

Funding History

Fiscal Year	Amount
FY 2014	$47,258,000
FY 2015	$47,258,000
FY 2016	$47,258,000
FY 2017	$47,226,000
FY 2018	$33,842,000

Budget Request

The FY 2018 Budget Request is $33.8 million, a decrease of $13.3 million from the FY 2017 Annualized CR. This funding will support the continuation of the NSDUH, NREPP, BHSIS, and the Analytic Support Center contracts. The funding will also support $1.0 million to continue a collaboration between HRSA and SAMHSA to collect and analyze data to examine the Behavioral Health Workforce.

Mechanism Table for Health Surveillance

(Dollars in thousands)

	FY 2016 Final		FY 2017 Annualized CR		FY 2018 President's Budget		FY 2018 +/ FY 2017	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Health Surveillance								
Contracts								
Continuations	3	$40,669	5	$40,027	3	$33,842	---	-$6,185
New/Competing	---	6,589	1	7,199	---	---	---	-$7,199
Subtotal	3	47,258	6	47,226	3	33,842	---	-13,384
Total, Health Surveillance	**3**	**$47,258**	**6**	**$47,226**	**3**	**$33,842**	**---**	**-$13,384**

Performance and Quality Information Systems

(Dollars in thousands)

Program Activity	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/ FY 2017
Performance and Quality Information Systems	$12,918	$12,893	$12,893	$

Authorizing Legislation ..... Sections 501, 509, 516, and 520A of the Public Health Service Act
FY 2018 Authorization ..... Expired
Allocation Method ..... Contracts
Eligible Entities ..... Not Applicable

Program Description and Accomplishments

The Performance and Quality Improvement Systems (PQIS) funding primarily supports the activities of the Center for Behavioral Health Statistics and Quality (CBHSQ). The detailed funding for each activity along with a detailed narrative description of each project follows.

Performance and Quality Information Systems
Resources by Activity/Program

(Dollars in thousands)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Performance and Quality Information Systems				
Performance Measurement/Systems	$11,167	$9,872	$7,375	-$2,497
SAMHSA Performance Accountability Reports System	*10,988*	*9,872*	*7,375*	*-2,497*
WebBGAS	*179*	---	---	---
Program Evaluations	---	696	---	-696
Primary and Behavioral Health Care Integration	---	*696*	---	*-696*
Evidence-Based Programs/Practices	794	770	2,814	2,044
National Registry for Evidence Based Programs and Practices	*794*	*770*	*2,814*	2,044
Behavioral Health Research and Dissemination	---	---	1,360	1,360
Analytic Support Center (ASC)	---	---	1,360	1,360
Content Management	51	---	---	---
Innovation and Logistical Services Support	16	---	---	---
Support	890	1,554	1,344	-210
Operations	*890*	*1,554*	*1,344*	*-210*
Total Performance and Quality Information Systems	**$12,918**	**$12,893**	**$12,893**	**$---**

Performance Measurement and Performance Systems

SAMHSA collects data on key output and outcome measures to monitor and manage grantee performance, improve the quality of services provided, and inform program evaluations.

These data previously were collected by legacy systems, including Data Collection, Analyses, and Reporting (DCAR); Prevention Management Reporting and Training System (PMRTS); Services Accountability Improvement System (SAIS); and the Transformation Accountability System (TRAC). These legacy systems were migrated to a single system, the SAMHSA Performance

Accountability Reports System (SPARS), in FY 2017, to meet SAMHSA's vision of a more efficient, holistic approach to its performance data collection.

In FY 2016, the SPARS contract was awarded. In FY 2017, SPARS was deployed as a real-time data entry and reporting system for all of SAMHSA's discretionary grant programs. In FY 2018, a total of $7.4 million is requested for SPARS, representing a decrease of $2.5 million from FY 2017 reflecting savings realized in the second option year of its contract. In FY 2018, SPARS will continue to provide data entry, data validation and verification, data management, data analysis support, automated reporting, and additional ad-hoc data analysis to SAMHSA, SAMHSA grantees, and others.

Program Evaluations

In FY 2012, SAMHSA established a policy for the development and management of evaluation and performance monitoring, with a specific focus on implementing a rigorous and consistent process of program evaluation within SAMHSA. During the fall of 2016, CBHSQ developed an updated Evaluation Policy and Procedure (P&P) document to guide SAMHSA in developing a long-term evaluation plan based on the selection and use of the best methods for answering specific evaluation questions. The objectives of the Evaluation P&P are: to put into place a policy and a consistent business practice to: match the type of evaluation activity to the maturity of the program and to the nature of the research questions, determine the degree of independence of evaluation activities for different types of programs, incorporate these practices and considerations into the contract planning process, collect and disseminate meaningful and critical findings to colleagues and to the behavioral health and scientific fields, and develop a learning agenda to identify priorities for future evaluation activities. The updated Evaluation P&P will be finalized and fully implemented for the FY 2018 planning cycle.

SAMHSA program evaluations are primarily funded by SAMHSA's other three programmatic appropriations. In FY 2017, the program Centers are funding over a dozen evaluations covering a variety of programs (e.g., Strategic Prevention Framework for Prescription Drugs; Screening, Brief Intervention, and Referral to Treatment; Pregnant and Postpartum Women; Children's Mental Health Initiative; etc.). CBHSQ has directly funded the Primary and Behavioral Health Care Integration (PBHCI) evaluation since FY 2015. In FY 2018, no funding is requested to continue the evaluation of the PBHCI as the program is being eliminated.

In FY 2017, CBHSQ entered into several Center Collaboration Agreements (CCAs) with CSAT and CMHS to conduct small-scale, time-limited assessments and evaluations. These include three CCAs with CSAT to conduct a community assessment for the Medication-Assisted Therapy Prescription Drug Overdose Program (MAT-PDOA), to develop and execute the CARA-required evaluation of the Pregnant and Post-Partum Women and Pilot (PPWP), and to evaluate the State Targeted Response to Opioid Crisis (Opioid STR) program authorized by the 21st Cures Act. Activities also include three CCAs with CMHS to conduct an assessment of barriers and facilitators to implementing the Resiliency in Communities After Stress and Trauma (ReCAST) grants, an analysis of the facilitators to successful implementation of Assisted Outpatient Treatment (AOT) programs, and a study of state's adoption of quality measures for behavioral health clinics. CBHSQ plans to continue these activities in FY 2018.

Evidence-based Programs and Practices

The National Registry of Evidence-based Programs and Practices (NREPP) was established over the past decade to provide decision support to behavioral health service providers as they seek to adopt evidence-based programs for improving the quality of their prevention efforts and behavioral health services. The Learning Center provides its users with tools and information to select programs that will best improve the quality of their behavioral health services. The NREPP serves to meet the requirements of Section 7002 of the 21st Century Cures Act in that SAMHSA shall, as appropriate, improve access to reliable and valid information on evidence-based programs and practices, including information on the strength of evidence associated with such programs and practices related to mental illness and drug/alcohol addiction for states, local communities, non-profit entities, and other stakeholders, by posting on the Internet website of the Administration information on evidence-based programs and practices that have been reviewed.

During the early years of the Registry, efforts were made to attract programs via an open submission process which allowed the developer to identify studies and outcomes to be reviewed and to decline posting of the results. Beginning in FY 2014, the NREPP process was significantly revamped to move toward more rigorous review criteria, an effort to address comments from stakeholders regarding the rigor of NREPP reviews.

With the new process, developers may participate in open submission; but, an external, objective review of the literature is conducted, a range of behavioral health outcomes are reviewed, and an effect size is calculated. Reviewed programs come from three sources: voluntary submissions, programs identified through literature searches, and re-reviews of the 356 legacy programs listed on NREPP prior to incorporation of the new review criteria. Due to the increased rigor and streamlining of the review process, NREPP increased the number of new programs reviewed annually.

In FY 2016 (contract period June 2016 – June 2017), approximately 230 program reviews will be conducted, including a mixture of re-reviews and new program reviews; approximately 30 literature reviews will also be completed. This work included programs that addressed pregnant and post-partum women, co-occurring disorders, medication-assisted treatment, assertive community treatment, prescription drug misuse and overdose prevention, drug courts, and mental health courts, among others. Additionally, a substantial revision of the Learning Center is underway to provide information on developing, implementing, and sustaining programs while bolstering support for emerging practices, particularly with underserved populations.

In FY 2017, it is anticipated CBHSQ will complete approximately 230 program reviews, along with an additional 10 literature reviews, and will continue to build out the Learning Center.

In FY 2018, $2.8 million is requested for NREPP, including the Learning Center, reflecting level funding for these activities). CBHSQ will continue to work to improve access to reliable and valid information on evidence-based programs and practices related to mental illness and drug/alcohol addiction for states, local communities, non-profit entities, and other stakeholders.

Behavioral Health Quality Measures

Behavioral health quality activities are housed within CBHSQ; the Center provides oversight of the agency's quality improvement efforts, including the identification of gaps in behavioral health quality measurement and the adoption and implementation of behavioral health quality measures. Oversight of the agency's measure development efforts includes current re-specification work funded by CSAT, re-specification of measures for HEDIS adoption, measures-conceptualization development work in suicide prevention in CMHS, and ongoing partnerships with CMS and ASPE, among other Federal partners, in quality measure work. CBHSQ serves as the SAMHSA lead to the National Quality Forum as well as participates as a Federal advisor for other agencies conducting measure development work, including CMS and ASPE. CBHSQ also represents SAMHSA on the HHS Measurement Policy Council, leading discussions related to behavioral health metrics and contributing to discussions focused on broader healthcare metrics. CBHSQ also participates on the Measures Application Partnership, a group convened to guide CMS on measure adoption.

In response to the National Quality Strategy, SAMHSA developed its own specific quality strategy, the National Behavioral Health Quality Framework, a stand-alone document that recommends core and supplemental measures to be utilized at the payer, provider, and population level to track meaningful service delivery process and outcome measures in behavioral health. This document is often referenced by the National Quality Forum (NQF) as a foundational document used to guide its behavioral health quality measures work.

To date, a significant amount of behavioral health quality measure development has occurred; but gaps remain. A critical issue is field implementation; therefore, SAMHSA is focused on implementation issues since NQF measures have three years to demonstrate use by the field, after which they are retired. Challenges in implementation are frequently encountered due to the lack of infrastructure or personnel for collection and reporting in behavioral health programs. SAMHSA is jointly advancing behavioral health quality measure implementation by co-leading an HHS Behavioral Health Coordinating Council (BHCC) subcommittee on quality measures with ASPE and CMS which will resulted in recommendations about the uptake of consistent behavioral health quality measures capturing alcohol misuse, tobacco cessation, depression measurement and management, and medication reconciliation, across HHS programs, including CMS, HRSA, SAMHSA, and others. CBHSQ will continue to engage in these types of activities going forward.

CBHSQ staff provides internal collaborations across SAMHSA, advising on quality measure issues and identifying key next steps. Additionally, CBHSQ staff continues to serve as advisors for NQF projects jointly funded by ASPE and CMS and focused on a broad range of quality activities. CBHSQ staff regularly consults with other Federal agencies, the NQF, and other key stakeholders regarding behavioral health quality indicators, including barriers to and facilitators of data collection, tracking, and reporting. SAMHSA must continue its key leadership role around behavioral health quality measure activities through ongoing identification of behavioral health measurement gaps and the capacity to address such gaps.

Funding History

Fiscal Year	Amount
FY 2014	$12,918,000
FY 2015	$12,918,000
FY 2016	$12,918,000
FY 2017	$12,893,000
FY 2018	$12,893,000

Budget Request

The FY 2018 Budget Request is $12.9 million, level with the FY 2017 Annualized CR. SAMHSA will use these funds to continue support for NREPP, SPARS, and other program evaluation and quality improvement efforts. This funding will ensure that SAMHSA continues a strong focus on developing and implementing evidence-based practices and programs and continues its emphasis on performance management for quality improvement and program monitoring.

Mechanism Table for Performance and Quality Information Systems

(Dollars in thousands)

	FY 2016 Final		FY 2017 Annualized CR		FY 2018 President's Budget		FY 2018 +/ FY 2017	
Program Activity	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Performance and Quality Information Systems								
Contracts								
Continuations	1	$2,313	2	$12,893	3	$12,893	---	$
New/Competing	1	10,605	---	---	---	---	---	---
Subtotal	2	12,918	2	12,893	3	12,893	---	
Total, Performance and Quality Information Systems	**2**	**$12,918**	**2**	**$12,893**	**3**	**$12,893**	**---**	**$**

The following table provides a detailed description of all funding sources supporting CBHSQ activities.

SAMHSA
Center for Behavioral Health Statistics and Quality
Breakout by Activity/Program (all sources)

(Dollars in thousands)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Substance Abuse Treatment Appropriation				
Substance Abuse Block Grant Set Aside				
Population Data Collection, Analysis, and Dissemination	$40,627	$39,701	$44,655	$4,955
PHS Evaluation (non add)	*39,929*	*39,003*	*44,655*	*5,652*
Treatment Services Data Collection, Analysis, and Dissemination	6,782	7,193	5,162	-2,032
PHS Evaluation (non add)	*6,628*	*7,193*	*5,162*	*-2,032*
Emergency Department Data Collection, Analysis, and Dissemination	1,375	3,875	---	-3,875
PHS Evaluation (non add)	*1,375*	*3,875*	---	*-3,875*
Behavioral Health Research and Dissemination	1,992	1,802	892	-909
PHS Evaluation (non add)	*1,992*	*1,802*	*892*	*-909*
Program Evaluations	1,699	---	---	---
PHS Evaluation (non add)	*1,699*	---	---	---
Innovation and Logistical Services Support	*233*	---	---	---
PHS Evaluation (non add)	*233*	---	---	---
Support	5,604	5,690	4,849	-841
PHS Evaluation (non add)	*5,604*	*5,690*	*4,849*	*-841*
Total Substance Abuse Block Grant Set Aside	**58,313**	**58,261**	**55,558**	**-2,703**
Total Substance Abuse Treatment PHS Evaluation	*57,460*	*57,564*	*55,558*	*-2,006*
Health Surveillance and Program Support Appropriation				
Health Surveillance				
Population Data Collection, Analysis, and Dissemination	10,987	17,886	10,284	-7,602
PHS Evaluation (non add)	*1,040*	*6,443*	*1,333*	*-5,110*
Treatment Services Data Collection, Analysis, and Dissemination	16,073	11,125	13,696	2,572
PHS Evaluation (non add)	*16,073*	*11,125*	*13,696*	*2,572*
Emergency Department Data Collection, Analysis, and Dissemination	---	125	---	-125
PHS Evaluation (non add)	---	*125*	---	*-125*
Community Behavioral Health Surveillance	2,525	3,000	---	-3,000
PHS Evaluation (non add)	*2,525*	*3,000*	---	*-3,000*
Behavioral Health Research and Dissemination	3,084	3,810	1,880	-1,930
PHS Evaluation (non add)	---	*425*	*372*	*-52*
Program Evaluations	912	696	---	-696
PHS Evaluation (non add)	---	*696*	---	*-696*
Evidence-Based Programs/Practices	2,348	2,044	---	-2,044
PHS Evaluation (non add)	*1,695*	*1,412*	---	*-1,412*
Innovation and Logistical Services Support	1,953	---	---	---
PHS Evaluation (non add)	*1,327*	---	---	---
Content Management	26	---	---	---
PHS Evaluation (non add)	---	---	---	---
Support	9,351	8,482	7,982	-500
PHS Evaluation (non add)	*7,617*	*7,144*	*7,026*	*-118*
Total Health Surveillance	**47,258**	**47,168**	**33,842**	**-13,326**
Performance and Quality Information Systems				
Performance Measurement/Systems	11,167	9,872	7,375	-2,497
Program Evaluations	---	696	---	-696
Evidence-Based Programs/Practices	794	770	2,814	2,044
Behavioral Health Research and Dissemination	---	---	1,360	1,360
Innovation and Logistical Services Support	16	---	---	---
Content Management	51	---	---	---
Support	890	1,554	1,344	-210
Total Performance and Quality Information Systems	**12,918**	**12,893**	**12,893**	**---**
Agency Wide				
Behavioral Health Workforce Data Development	1,000	998	998	---
PHS Evaluation (non add)	*1,000*	*998*	*998*	---
Total Agency-Wide	1,000	998	998	---
Total Health Surveillance and Program Support	**61,176**	**61,059**	**47,733**	**-13,326**
Total Health Surveillance and Program Support PHS Evaluation	31,276	31,368	23,426	-7,942
Total Substance Abuse Block Grant Set Aside and Health Surveillance and Program Support	**$119,489**	**$119,320**	**$103,291**	**-$16,029**

Outputs and Outcomes Table

Program: Performance and Quality Information Systems

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
4.4.10 Increase the combined count of webpage hits, hits to the locator, and hits to Substance Abuse and Mental Health Data Archive (SAMHDA) for SAMHSA-supported data sets (Output)	FY 2016: 95,378[1] Target: 1,700,000 (Target Not Met)	1,700,000	1,700,000	Maintain
4.4.11 Increase the number of evidence-based programs or practices in review (Output)	FY 2016: 119 Target: 55 (Target Exceeded)	55	55	Maintain

[1] Website relaunched end of 2016. Site still under development and will not be fully launched until FY 2017.

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Program Support

(Dollars in thousands)

Program Activity	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/ FY 2017
Program Support	$79,559	$79,409	$73,043	-$6,366

Authorizing Legislation ..... Section 501 of the Public Health Service Act
FY 2018 Authorization ..... Expired
Allocation Method ..... Direct Federal/Intramural, Contracts, Other
Eligible Entities ..... Not Applicable

Program Description and Accomplishments

The Program Support budget supports the majority of SAMHSA staff who plan, direct, and administer SAMHSA's programs, as well as business operations and processes, information technology, and overhead expenses, such as rent, utilities, and miscellaneous charges. In addition, this budget supports the Unified Financial Management System, which covers administrative activities such as human resources, information technology, and the centralized services provided by HHS and the Program Support Center.

SAMHSA supported 620 Full Time Equivalents (FTEs) in FY 2016; in FY 2017, in order to support staffing for areas such as the Office of the Chief Medical Officer and Cures implementation, SAMHSA projects support of 615 FTEs. Staff positions that are not covered through the Health Surveillance and Program Support appropriation are funded with Substance Abuse Prevention and Treatment and Mental Health Block Grant set-asides for activities associated with technical assistance, data collection, and evaluation.

SAMHSA applies an estimated internal administrative charge for overhead expenses to all programs, projects, and activities.

Funding History

Fiscal Year	Amount
FY 2014	$72,002,000
FY 2015	$72,002,000
FY 2016	$79,559,000
FY 2017	$79,409,000
FY 2018	$73,043,000

Budget Request

The FY 2018 Budget Request is $73.0 million, a decrease of $6.3 million from the FY 2017 Annualized CR. This level of funding will continue to cover personnel, overhead costs associated with 5600 Fishers Lane, including rent, the Federal Acquisition Service loan repayment program, and security charges. Funding in FY 2016 and FY 2017 reflected an increase due to the agency's

relocation; given that these expenses will not be incurred in FY 2018, the funding request has been decreased.

In FY 2018, SAMHSA plans to support 610 FTEs with funding from the Mental Health, Substance Abuse Treatment, and Health Surveillance and Program Support appropriations. Funding types include Budget Authority, PHS Evaluation, and other reimbursables.

Mechanism Table for Program Support

(Dollars in thousands)

	FY 2016 Final		FY 2017 Annualized CR		FY 2018 President's Budget		FY 2018 +/ FY 2017	
Program Activity	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Program Support								
Contracts								
Continuations	---	$79,559	---	$79,409	---	$73,043	---	-$6,366
New/Competing	---	---	---	---	---	---	---	---
Subtotal	---	79,559	---	79,409	---	73,043	---	-6,366
Total, Program Support	**---**	**$79,559**	**---**	**$79,409**	**---**	**$73,043**	**---**	**-$6,366**

Public Awareness and Support

(Dollars in thousands)

Program Activity	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/ FY 2017
Public Awareness and Support	$15,571	$15,541	$11,572	-$3,969

Authorizing Legislation ..... Sections 501, 509, 516, and 520A of the Public Health Service Act
FY 2018 Authorization ..... Expired
Allocation Method ..... Grants and Contracts
Eligible Entities ..... Not Applicable

Program Description and Accomplishments

The behavioral healthcare system is critical to the overall health of the nation. A study funded by the National Institutes of Health and SAMHSA[2] estimated that at some point in their lives, almost half of all Americans will experience symptoms of a clinical mental and/or substance use disorder. In addition, half of all lifetime cases of mental illness and/or drug addiction begin by age 14 and three-fourths by age 24.[3] For these reasons, it is important to identify issues early and help individuals get the treatment they need as soon as possible. Communities are increasingly engaging in prevention, treatment, and recovery that are effective in supporting the behavioral health and wellness of their residents, particularly children and young adults. An important part of SAMHSA's mission is to raise the public's understanding of mental illness and drug/alcohol addiction, serve as an expert on behavioral health issues, and lead public health efforts to advance the behavioral health of the nation.

Collaborating Across Agencies

In FY 2017, SAMHSA worked with the Office of the Surgeon General and other HHS agencies to release the *Facing Addiction in America: Surgeon General's Report on Alcohol, Drugs, and Health*, the first ever Surgeon General's report on this topic, to bring national attention to substance misuse and addiction. The report called on people throughout the U.S. to take action to end the public health crisis of addiction and discuss the importance of taking a comprehensive approach to the problem of substance abuse. In FY2018, through the Materials Development and Marketing Support (MDMS) contract, SAMHSA will continue to promote the Surgeon General's Report through communication products such as fact sheets and infographics. SAMHSA also will promote the Report through conferences, grantee meetings, webinars, and social media.

SAMHSA's Public Awareness and Support effort utilizes the Behavioral Health Coordinating Council (BHCC) Communications Subcommittee to improve communications and collaboration. Co-led by SAMHSA and the Office of the Assistant Secretary for Public Affairs (ASPA), the BHCC comprises representatives from HHS agencies and meets monthly. Through the BHCC

[2] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), 593-602.
[3] Ibid.

Communications Subcommittee, SAMHSA will be able to collaborate and cross-promote campaigns, initiatives, events, and products.

Providing Critical Resources to the Behavioral Health Community

SAMHSA's strategic communications plan ensures that the vital information and training materials produced through SAMHSA's Centers and Offices are available to the behavioral and healthcare community through the Public Engagement Platform (PEP) contract, which manages SAMHSA's print and online information resources. The PEP contract is a resource for the public as well as the behavioral health workforce; it provides a warehouse of publications and access to the National Helpline. The PEP contract provides a customer-oriented order fulfillment system, including an online store, call-in contact center (the National Helpline), warehouse, and e-blasts to thousands of subscribers. The current opioid crisis has increased a demand for treatment services. The National Helpline provides free confidential treatment referral and information services in English and Spanish for individuals and families facing mental illness and/or drug/alcohol addiction. It is operational every day, 24/7. The PEP contract is experiencing unprecedented levels of call volume. In FY 2016, SAMHSA's Helpline responded to over 2.5 million calls. Although SAMHSA has instituted new technologies such as text messaging (SMS) and an interactive voice response system as cost-effective solutions, SAMHSA needs to continue to explore innovative solutions to avoid any service disruption and to ensure callers get referred to treatment services.

SAMHSA is also responsible for managing the Disaster Distress Helpline to provide information and counseling referral to the public after tragic events. SAMHSA quickly mobilizes in the aftermath of a disaster to deliver behavioral health information and support services for responders and survivors. SAMHSA has adopted a rapid response practice which it will continue to do in FY 2018. When a disaster occurs, SAMHSA quickly disseminates an e-blast featuring the SAMHSA's Disaster Distress Helpline, links to many of SAMHSA's resources, and a link to SAMHSA's behavioral health treatment locator.

Over the last several years, SAMHSA has leveraged mobile technology to increase the reach of its resources by launching multiple mobile apps. Each app has had a greater reach than the ones that preceded it. In FY 2015, SAMHSA launched the "Suicide Safe" app for primary care and behavioral health providers. The Suicide Safe app is designed to help primary care and behavioral health providers address suicide risk and integrate suicide prevention strategies in patient care. Suicide Safe has been downloaded 46,811 times since its March 2015 launch. In FY 2017, SAMHSA launched MATx, an app that provides healthcare practitioners with immediate access to vital information about medication assisted treatment (MAT) for opioid addiction. The MATx app includes information on medications approved by FDA for use in treatment of opioid use disorders and treatment approaches for practitioners, a buprenorphine prescribing guide, clinical support tools, and access to critical helplines and SAMHSA treatment locators. MATx is available free for Apple and Android mobile devices. MATx has been downloaded 9,432 since October 2016.

In FY 2017, SAMHSA also published the Decisions in Recovery: Treatment for Opioid Use Disorder, an online interactive tool and handbook to help people who want information about the role of medication in treating opioid addiction. The tool is primarily designed for individuals in,

or seeking recovery from, opioid addiction and their service providers. It can also be used by health officials, policy makers, and other members of the communities involved in addressing the problem of opioid addiction.

In FY 2018, SAMHSA will examine its current suite of opioid related products to identify gaps, to cross-promote, and to maximize promotional opportunities.

Leveraging SAMHSA's Online Presence

Available 24/7, SAMHSA.gov is the public's primary access point for behavioral health information from the federal government. SAMHSA's website and social media presence on channels such as Facebook, Twitter, and YouTube are critical to efforts to engage with citizens about behavioral health. In addition to print and traditional media, social media is now incorporated in communications plans and is employed daily to communicate behavioral health messages and resources. The increasingly effective reach of these online channels is demonstrated by the fact that the number of people following SAMHSA on Twitter is 71,179 (an increase from 7,000 in 2013); the "likes" of SAMHSA's Facebook page is 72,976 (an increase from 20,000 in 2013); and the subscribers on SAMHSA's YouTube is 5,758 (an increase from 800 in 2013).

In the course of prioritizing the internet as a strategic business initiative and communications asset, SAMHSA consolidated and modernized its web presence. In FY 2016, SAMHSA managed a significant increase in web visits from the previous year: a 16% growth in annual web visits (over 33 million visits) and a 50% increase in unique visits (almost 9 million new visitors).

Leading in Dissemination of Behavioral Health Data and Surveillance

A key goal of SAMHSA's Public Awareness and Support effort is to make certain that valuable behavioral health data reach the widest number of Americans, enabling them to make informed decisions about the health and wellbeing of their loved ones and themselves. SAMHSA shares this vital information through the aforementioned vehicles (e.g., MDMS, PEP, the Web, and social media) and other program operations. These include press releases issued by SAMHSA to highlight recent findings from the National Survey on Drug Use and Health and SAMHSA's Behavioral Health Barometer. These surveys provide data on behavioral health trends at the national level, by geographic region, and for each of the 50 states and the District of Columbia.

As part of an effort undertaken to change social norms related to behavioral health, SAMHSA charged the National Academy of Sciences, Engineering and Medicine (NASEM) Board on Behavioral, Cognitive, and Sensory Sciences to research the current state of social norms regarding behavioral health and to create a consensus report including recommendations on positively impacting those norms. This effort, "Science of Changing Social Norms: Building the Evidence Base" laid fundamental groundwork in FY 2015. In FY 2016, SAMHSA awarded a one-year contract with NASEM to undertake Phase 2 of the Science of Changing Social Norms project, which will produce a communications toolkit and a pilot public awareness campaign. A committee of experts in the field of behavioral health and health communications has been formed and engaged to discuss campaign themes.

Funding History

Fiscal Year	Amount
FY 2015	$13,482,000
FY 2015	$13,482,000
FY 2016	$15,571,000
FY 2017	$15,541,000
FY 2018	$11,572,000

Budget Request

The FY 2018 Budget Request is $11.6 million, a decrease of $4.0 million from the FY 2017 Annualized CR. Funds for Public Awareness and Support will allow SAMHSA to maintain and update its web presence, manage critical helplines, deliver publications and resources, expand its presence on social media, and provide other resources to support behavioral health and other health. SAMHSA will continue to collaborate with other agencies. These efforts will allow SAMHSA to broaden the reach of its four key messages: behavioral health is essential to health, prevention works, treatment is effective, and people recover. SAMHSA will discontinue support for the Science of Changing Social Norms effort but will continue to disseminate lessons learned from the project.

Mechanism Table for Public Awareness and Support

(Dollars in thousands)

	FY 2016 Final		FY 2017 Annualized CR		FY 2018 President's Budget		FY 2018 +/ FY 2017	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Public Awareness and Support								
Contracts								
Continuations	5	$13,107	6	$15,515	3	$4,063	---	-$11,452
New/Competing	2	2,464	---	26	1	7,509	---	7,483
Subtotal	7	15,571	6	15,541	4	11,572	---	-3,969
Total, Public Awareness and Support	**7**	**$15,571**	**6**	**$15,541**	**4**	**$11,572**	**---**	**-$3,969**

Outputs and Outcomes Table

Program: Public Awareness and Support

NOTE: SAMHSA makes grant awards toward the end of the year and therefore, bases the FY 2018 targets on the FY 2017 Annualized CR and the FY 2019 targets are based on the FY 2018 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/- FY 2018 Target
4.4.12 Increase the number of individuals referred for behavioral health treatment resources. (Output)	FY 2015: 565,925 Target: 310,000 (Target Exceeded)	600,000	600,000	Maintain
4.4.13 Increase the total number of interactions through phone inquiries, e-blasts, dissemination of SAMHSA publications, and total website hits (Output)	FY 2015: 34,151,612 Target: 30,325,334 (Target Exceeded)	33,430,000	33,430,000	Maintain

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Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

(Dollars in millions)

Resource Summary	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Drug Resources by Decision Unit and Function			
Programs of Regional and National Significance			
Substance Abuse Prevention	$211.219	$222.817	$149.703
Substance Abuse Treatment	337.345	341.708	341.738
Total Programs of Regional and National Significance	548.564	564.525	491.441
State Targeted Response to the Opioid Crisis Grants	---	500,000	500,000
Substance Abuse Prevention and Treatment Block Grant[1]			
Prevention	371.616	370.939	370.939
Treatment	1,486.463	1,483.758	1,483.758
Total, Substance Abuse Prevention and Treatment Block Grant	1,858.079	1,854.697	1,854.697
Health Surveillance and Program Support[2]			
Prevention	25.416	26.58	19.419
Treatment	101.663	106.319	77.677
Total, Health Surveillance and Program Support	127.078	132.898	97.096
Total Funding	**$2,533.721**	**$3,052.12**	**$2,943.234**
Drug Resources Personnel Summary			
Total FTEs	416	437	461
Drug Resources as a Percent of Budget			
Total Agency Budget	$3,781.436	$4,291.527	$3,892.333
Drug Resources Percentage	67.0%	71.12%	75.6%

[1] The Substance Abuse Prevention and Treatment Block Grant is split 20% to the Prevention function and 80% to the Treatment function.

[2] The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health and Substance Abuse as follows: Program Support, Health Surveillance and PQIS are split the same percentage split as between MH/SA appropriations. PAS, Agency-wide, and Data Request and Publication User Fees are split 50/50 between MH/SA. The resulting Substance Abuse total is then divided between Prevention (20%) and Treatment (80%).

Drug Budget Split between Prevention and Treatment

(Dollars in thousands)

Substance Abuse Prevention	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Programs of Regional and National Significance (PRNS)			
Strategic Prevention Framework	$119,484	$119,257	$58,427
Strategic Prevention Framework Rx (non-add)	*10,000*	*9,981*	*10,000*
Budget Authority (non-add)	*109,484*	*109,276*	*48,427*
PHS Evaluation Funds (non-add)	---	---	---
Federal Drug-Free Workplace	4,894	4,885	4,885
Minority AIDS	41,205	41,127	28,843
Sober Truth on Preventing Underage Drinking	7,000	6,986	6,986
Center for the Application of Prevention Technologies	7,493	7,479	7,479
Budget Authority (non-add)	*7,493*	*7,479*	*7,479*
PHS Evaluation Funds (non-add)	---	---	---
Science and Service Program Coordination	4,072	4,064	4,064
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths	12,000	11,977	11,977
Tribal Behavioral Health Grants	15,000	14,971	14,971
First Responder Training (Comprehensive Addiction and Recovery Act- CARA)	---	12,000	12,000
SAP Minority Fellowship Program	71	71	71
Total, Substance Abuse Prevention PRNS	**211,219**	**222,817**	**149,703**
Substance Abuse Prevention and Treatment Block Grant[1]	371,616	370,939	370,939
PHS Evaluation Funds (non-add)	*15,840*	*15,840*	*15,840*
Total, Substance Abuse Prevention and Treatment Block Grant	**371,616**	**370,939**	**370,939**
Health Surveillance and Program Support[2]			
Health Surveillance	6,293	6,697	5,089
Prevention and Public Health Fund (non-add)	---	---	---
Budget Authority (non-add)	*2,241*	*2,382*	*1,716*
PHS Evaluation Funds (non-add)	*4,052*	*4,315*	*3,373*
Program Support	10,595	11,260	10,984
Public Awareness and Support	1,557	1,554	1,157
PHS Evaluation Funds (non-add)	---	---	---
Performance and Quality Information Systems	1,720	1,828	1,939
PHS Evaluation Funds (non-add).	---	---	---
Agency-wide Initiatives	5,100	5,091	100
PHS Evaluation Funds (non-add)	*100*	*100*	*100*
Data Request/Publication User Fees	150	150	150
Total, Health Surveillance and Program Support	**25,416**	**26,580**	**19,419**
Total, Substance Abuse Prevention	**$608,250**	**$620,336**	**$540,062**

[1] The Substance Abuse Prevention and Treatment Block Grant is split 20% to the Prevention function and 80% to the Treatment function.

[2] The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health and Substance Abuse as follows: Program Support, Health Surveillance and PQIS are split the same percentage split as between MH/SA appropriations. PAS, Agency-wide, and Data Request and Publication User Fees are split 50/50 between MH/SA. The resulting Substance Abuse amount is then divided between Prevention (20%) and Treatment (80%).

Drug Budget Split between Prevention and Treatment (Continued)

(Dollars in thousands)

Substance Abuse Treatment	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Programs of Regional and National Significance (PRNS)			
Opioid Treatment Programs/Regulatory Activities	$8,724	$8,708	$8,708
Prescription Drug and Opioid Medication-Assisted Treatment	---	---	---
Screening, Brief Intervention and Referral to Treatment	46,889	46,804	46,804
Budget Authority (non-add)	*44,889*	*44,804*	*44,804*
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*2,000*
Targeted Capacity Expansion	36,303	36,234	36,234
Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (non-add)	*25,000*	*24,952*	*24,952*
Pregnant and Postpartum Women	15,931	19,901	19,931
Comprehensive Addiction and Recovery Act (non-add)	---	*4,000*	*4,000*
Recovery Community Services Program	2,434	2,429	2,429
Children and Family Programs	29,605	29,549	29,549
Treatment Systems for Homeless	41,304	41,225	41,225
Minority AIDS	65,570	65,445	65,445
SAP Minority Fellowship Program	3,539	3,532	3,532
Criminal Justice Activities	78,000	77,852	77,852
Addiction Technology Transfer Centers	9,046	9,029	9,029
Building Communities of Recovery	---	1,000	1,000
Total, Substance Abuse Treatment PRNS	**337,345**	**341,708**	**341,738**
State Targeted Response to the Opioid Crisis Grants	---	500,000	500,000
Substance Abuse Prevention and Treatment Block Grant[1]	1,486,463	1,483,758	1,483,758
PHS Evaluation Funds (non-add)	*63,360*	*63,360*	*63,360*
Total, Substance Abuse Prevention and Treatment Block Grant	**1,486,463**	**1,483,758**	**1,483,758**
Health Surveillance and Program Support[2]			
Health Surveillance	25,173	26,787	20,357
Prevention and Public Health Fund (non-add)	---	---	---
Budget Authority (non-add)	*13,464*	*13,438*	*9,131*
PHS Evaluation Funds (non-add)	*16,208*	*17,259*	*13,491*
Program Support	42,380	45,041	43,937
Public Awareness and Support	6,228	6,216	4,629
PHS Evaluation Funds (non-add)	---	---	---
Performance and Quality Information Systems	6,881	7,313	7,755
PHS Evaluation Funds (non-add)	---	---	---
Agency-wide Initiatives	20,400	20,362	399
PHS Evaluation Funds (non-add)	*400*	*400*	*399*
Data Request/Publication User Fees	600	600	600
Total, Health Surveillance and Program Support	**101,663**	**106,319**	**77,677**
Total, Substance Abuse Treatment	**$1,925,471**	**$2,431,784**	**$2,403,172**

[1] The Substance Abuse Prevention and Treatment Block Grant is split 20% to the Prevention function and 80% to the Treatment function.

[2] The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health and Substance Abuse as follows: Program Support, Health Surveillance and PQIS are split the same percentage split as between MH/SA appropriations. PAS, Agency-wide, and Data Request and Publication User Fees are split 50/50 between MH/SA. The resulting Substance Abuse amount is then divided between Prevention (20%) and Treatment (80%).

Mission
The Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA supports the *President's National Drug Control Strategy* through a broad range of programs focusing on prevention, treatment and recovery from substance abuse. Major programs for FY 2018 will include the Substance Abuse Prevention and Treatment Block Grant, the new mandatory State Targeted Response Cooperative Agreements**,** competitive grant programs reflecting Programs of Regional and National Significance (PRNS) and Health Surveillance and Program Support. SAMHSA's Centers for Substance Abuse Prevention (CSAP) and Substance Abuse Treatment (CSAT) as well as through SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) and the Office of Communications administer these programs.

Methodology
SAMHSA distributes drug control funding into two functions: prevention and treatment. Both functions include a portion of funding from the Health Surveillance and Program Support (HSPS) appropriation.

The portion of the Health Surveillance and Program Support account attributed to the Drug Budget uses the following calculations:

- The Health Surveillance, Program Support, and PQIS portions of the HSPS appropriation are divided between Mental Health and Substance Abuse using the same percentages splits as between the Mental Health and Substance Abuse (Prevention and Treatment) appropriation amounts.
    - The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

- The PAS and Agency-wide portions of the HSPS appropriation are divided evenly between Mental Health and Substance Abuse.
    - The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

The prevention function also includes all of the Substance Abuse Prevention appropriation, including the Substance Abuse Prevention Programs of Regional and National Significance, and 20 percent of the Substance Abuse Prevention and Treatment Block Grant funds specifically appropriated for prevention activities from the Substance Abuse Treatment appropriation.

The treatment function also includes the Substance Abuse Treatment appropriation, including the Substance Abuse Treatment Programs of Regional and National Significance, 80 percent of the Substance Abuse Prevention and Treatment Block Grant funds, and the State Targeted Response to the Opioid Crisis funding.

Budget Summary
In FY 2018, SAMHSA requests a total of $2.9 billion for drug control activities, a decrease of $108.9 million from the FY 2017 Annualized CR. The budget directs resources to activities that have demonstrated improved health outcomes and that increase service capacity. SAMHSA has

three major drug-related decision units: Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support. Each decision unit is discussed below:

Substance Abuse Prevention

Substance Abuse Prevention Programs of Regional and National Significance
FY 2018 Request: $149.7 million
(Reflects -$73 million below level funding from the FY 2017 Annualized CR)
The Substance Abuse Prevention Programs of Regional and National Significance support states and communities in carrying out an array of activities to improve the quality and availability of services in priority areas. The FY 2018 President's Budget request for SAMHSA's Substance Abuse Prevention Programs of Regional and National Significance includes $149.7 million for eight programmatic activities, which is $73 million below the FY 2017 Annualized CR. The request includes: $58.4 million for Strategic Prevention Framework, $4.9 million for the Federal Drug-Free Workplace Program, $28.8 million for Minority AIDS, $7 million for Sober Truth on Preventing Underage Drinking, $7.5 million to continue provision of technical assistance to maximize effectiveness through the Centers for the Application of Prevention Technologies, $4.1 million for Science and Service Program Coordination, $12.0 million for Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths, $14.9 million for Tribal Behavioral Health Grants, $0.1 million for SAP Minority Fellowship Program, and $12.0 million for First Responder Training (Comprehensive Addiction and Recovery Act).

Strategic Prevention Framework (PRNS non-add)
FY 2018 Request: $58.4 million
(Reflects $60.8 million below level funding from the FY 2017 Annualized CR)
SAMHSA's Strategic Prevention Framework (SPF) grant programs support activities to help grantees build a solid foundation for delivering and sustaining effective substance abuse prevention services and reducing substance abuse problems. The Strategic Prevention Framework – Partnerships for Success program addresses one of the nation's top substance use prevention priorities: underage drinking among youth and young adults age 12 to 20 and allows states to prioritize their top data driven substance use target areas such as marijuana and cocaine.

See page 129 in the CSAP chapter for the start of the full description of this program.

Strategic Prevention Framework for Prescription Drugs (PRNS non-add)
Due to alarming trends related to prescription drug misuse and overdoses involving opioids, SAMHSA is prioritizing efforts to address prescription drug misuse. SAMHSA implemented the Strategic Prevention Framework for Prescription Drugs to raise awareness about the dangers of sharing medications and to work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program focuses on raising community awareness and bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients. SAMHSA tracks reductions in opioid overdoses and the incorporation of Prescription Drug Monitoring Program (PDMP) data into needs assessments and strategic plans as indicators of program success. SAMHSA awarded 25 grants in FY 2016. In FY 2017 and FY 2018, SAMHSA will support 25 grant continuations.

See page 130 in the CSAP chapter for the start of the full description of these efforts.

Budget Request
The FY 2018 Budget Request is $58.4 million, a decrease of $60.8 million from the FY 2017 Annualized CR. Funding for the SPF Rx program will be maintained in its entirety ($10.0M). Funding will support 25 Strategic Prevention Framework for Prescription Drugs continuation grants, technical assistance, and evaluation to build capacity to address prescription drug misuse and overdose prevention efforts, in conjunction with other state and local partners. In FY 2018, in order to ensure that every state receives SPF funding, a new cohort of PFS grants will be awarded to focus on underage drinking and two other substances including but not limited to marijuana and cocaine. Additionally, SAMHSA will also support the continuation at a significantly reduced rate of 49 Strategic Prevention Framework - Partnerships For Success grants to decrease the impact of underage drinking and prescription drug misuse while lessening the progression of emergent issues such as heroin and marijuana use.

Federal Drug-Free Workplace (PRNS non-add)
FY 2018 Request: $4.9 million
(Reflects level funding from the FY 2017 Annualized CR)
SAMHSA's activities related to the Federal Drug-Free Workplace support two principal activities mandated by Executive Order (E.O.) 12564 and Public Law (P.L.) 100-71. This include: 1) oversight of the Federal Drug-Free Workplace, aimed at the elimination of illicit drug use within Executive Branch agencies and the federally-regulated industries; and 2) oversight of the National Laboratory Certification Program (NLCP), which certifies laboratories to conduct forensic drug testing for federal agencies, federally-regulated industries; the private sector also uses the HHS-Certified Laboratories.

See page 134 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $4.9 million, level with the FY 2017 Annualized CR. In FY 2018, SAMHSA will continue oversight of the Executive Branch Agencies' Federal Drug-Free Workplace Programs. This includes review of Federal Drug-Free Workplace plans from those federal agencies that perform federal employee testing, random testing of those designed testing positions of national security, public health, and public safety, and testing for illegal drug use and the misuse of prescription drugs. SAMHSA will continue its oversight role for the inspection and certification of the HHS-certified laboratories.

Minority AIDS (PRNS non-add)
FY 2018 Request: $28.8 million
(Reflects -$12.3 million below level funding from FY 2017 Annualized CR)
The Minority AIDS program supports activities that assist grantees in building a solid foundation for delivering and sustaining quality and accessible state-of-the-science substance misuse and HIV prevention services. The program aims to engage community-level domestic public and private non-profit entities, tribes, and tribal organizations in order to prevent and reduce the onset of substance misuse and transmission of HIV/AIDS among at-risk populations, including racial/ethnic minority youth and young adults, ages 13 to 24. SAMHSA works with college and

university clinics/wellness centers and community-based providers that can provide comprehensive substance misuse and HIV prevention strategies. These strategies combine education and awareness programs, social marketing campaigns, and HIV and viral hepatitis testing services in non-traditional settings with substance misuse and HIV prevention programming for the population of focus. Because of the high rate of HIV/AIDS and hepatitis co-morbidity, this program includes viral hepatitis prevention and education training.

See page 136 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request of $28.8 million, a decrease of $12.3 million from the FY 2017 Annualized CR. New MAI CoC grants will not be awarded and CBI will be phased out in order to reduce duplication and target funding most effectively in SAMHSA's Prevention Navigator and MSI/CBO programs. SAMHSA will support up to 73 grant continuations to assist grantees in building a solid foundation for delivering integrated evidence-based substance use, HIV and viral hepatitis prevention services that are in alignment with the National HIV/AIDS Strategy. These funds continue to address a critical public health problem and provide lifesaving prevention services, including testing for HIV.

SAP Minority Fellowship Program
FY 2018 Request: $0.1 million
(Reflects level funding from the FY 2017 Annualized CR)
SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to funding increases the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance abuse treatment services for minority populations that are underserved.

See page 153 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $71 thousand, level with the FY 2017 Annualized CR The funding will provide continued support for both base and expansion activities. The funds will support one MFP and one technical assistance and evaluation support contracts.

First Responder Training (Comprehensive Addiction and Recovery Act)
FY 2018 Request: $12.0 million
(Reflects level funding from the FY 2017 Annualized CR)
Comprehensive Addiction and Recovery Act (CARA), SAMHSA is authorized to support additional efforts to prevent opioid overdose-related deaths by providing grants to train first responders. In FY 2017, SAMHSA will fund up to 11 grants for the new First Responder Training program. The purpose of this program is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals at risk for opioid addiction. Applicants will train first responders and members of other key community sectors at the state, local government, and tribal levels to implement secondary prevention strategies, such as the

administration of Naloxone through FDA approved delivery devices to reverse the effects of opioid overdose.

See page 152 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $12 million, level with the FY 2017 Annualized CR. This funding will provide continuation grants to 11 grantees to further address the opioid crisis in this country.

Sober Truth on Preventing Underage Drinking (PRNS non-add)
FY 2018 Request: $7.0 million
(Reflects level funding from the FY 2017 Annualized CR)
The Sober Truth on Preventing Underage Drinking Act (STOP Act) of 2006 (Public Law 109-422) was the nation's first comprehensive legislation on underage drinking. One of the primary components of the STOP Act is the community-based coalition enhancement grant program aimed at preventing and reducing alcohol use among youth under age 21.

See page 140 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request of $7.0 million, level with the FY 2017 Annualized CR. In FY 2018, SAMHSA will support 95 STOP Act grant continuations. This funding will continue to strengthen SAMHSA's commitment to reduce and prevent underage drinking.

Centers for the Application of Prevention Technologies (PRNS non-add)
FY 2018 Request: $7.5 million
(Reflects level funding from the FY 2017 Annualized CR)
The Center for the Application of Prevention Technologies (CAPT) program provides state-of-the-art training and technical assistance to build the capacity of SAMHSA grantees and develop the skills, knowledge, and expertise of the prevention workforce. The program builds capacity and promotes the development of substance abuse prevention professionals in the behavioral health field through three core strategies: 1) establishing technical assistance networks using local experts; 2) developing and delivering targeted training and technical assistance activities; and 3) using communication media such as teleconference and video conferencing, online events, and web-based support. These activities help ensure the delivery of effective prevention programs and practices and the development of accountability systems for performance measurement and management.

See page 143 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $7.5 million, level with the FY 2017 Annualized CR. The program will continue to provide technical assistance and training to over 7,500 individuals in the prevention field.

Science and Service Program Coordination (PRNS non-add)
FY 2018 Request: $4.1 million
(Reflects level funding from the FY 2017 Annualized CR)
The Science and Service Program Coordination program funds the provision of technical assistance and training to states, tribes, communities, and grantees around substance abuse prevention. Specifically, the program supports the Tribal Training and Technical Assistance Center and the Underage Drinking Prevention Education Initiatives (UADPEI).

See pages 146 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $4.1 million, level with the FY 2017 Annualized CR. These funds will support SAMHSA's substance abuse prevention efforts and include a focus on preventing underage drinking and providing technical assistance and training to American Indians/Alaska Native communities.

Tribal Behavioral Health Grants (PRNS non-add)
FY 2018 Request: $15.0 million
(Reflects level funding from the FY 2017 Annualized CR)
SAMHSA's Tribal Behavioral Health Grants (TBHG) program addresses the high incidence of substance abuse and suicide among AI/AN populations.

See page 147 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request for the Tribal Behavioral Health Grant program is $30.0 million, including $15.0 million in the Mental Health appropriation and $15.0 million in the Substance Abuse Prevention appropriation. This is level with the FY 2017 Annualized CR. This request will continue support for programs that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families. In FY 2018, SAMHSA will fund TBHG continuation grants.

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths (PRNS non-add)
FY 2018 Request: $12.0 million
(Reflects level funding from the FY 2017 Annualized CR)
Opioid overdose is a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids (including synthetics), such as fentanyl). SAMHSA's Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths program seeks to help states identify communities of high need, and provide education, training, and resources necessary to tailor the overdose kits to meet their specific needs. Grantees can use the funds to purchase overdose reversing drugs, equip first responders with naloxone and other overdose death

prevention strategies, support education on these strategies, provide materials to assemble and disseminate overdose kits.

See page 150 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $12.0 million, level with the FY 2017 Annualized CR. This funding will provide continuation grants to 12 states to reduce the number of opioid overdose-related deaths.

Substance Abuse Treatment

Substance Abuse Treatment Programs of Regional and National Significance
FY 2018 Request: $341.7 million
(Reflects level funding from the FY 2017 Annualized CR)
The Substance Abuse Treatment Programs of Regional and National Significance (PRNS) support states and communities in carrying out an array of activities to improve the quality and availability of services in priority areas. The FY 2018 Budget Request for SAMHSA's Substance Abuse Treatment PRNS includes $341.7 million, level with the FY 2017 Annualized CR. Specific PRNS activities are described below.

Opioid Treatment Programs/Regulatory Activities (PRNS non-add)
FY 2018 Request: $8.7 million
(Reflects level funding from the FY 2017 Annualized CR)
As part of its regulatory responsibility, SAMHSA certifies Opioid Treatment Programs that use methadone, buprenorphine, or buprenorphine/naloxone to treat patients with opioid dependence. SAMHSA carries out this responsibility by enforcing regulations established by an accreditation-based system. This is accomplished in coordination with the Drug Enforcement Administration, states, territories, and the District of Columbia. SAMHSA also funds the Opioid Treatment Programs Medical Education and Supporting Services project aimed at preparing Opioid Treatment Programs to achieve accreditation and providing technical assistance and clinical training to enhance program clinical activities. Additionally, SAMHSA funds grants and contracts that support the regulatory oversight and monitoring activities of Opioid Treatment Programs.

See page 165 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $8.7 million, level with the FY 2017 Annualized CR. In FY 2018, SAMHSA intends to continue funding two continuation grants and three contracts and plans to support two new contracts.

Screening, Brief Intervention and Referral to Treatment (PRNS non-add)
FY 2018 Request: $46.8 million
(Reflects level funding from the FY 2017 Annualized CR)

The Screening, Brief Intervention and Referral to Treatment (SBIRT) program requires state grant recipients to implement the model in all primary care settings, as well as hospitals, trauma centers, federally qualified health centers, and other relevant health care settings. The program's goal is to increase the number of individuals who receive treatment and reduce the rate of substance misuse. Studies have shown that this approach is effective in helping reduce harmful alcohol consumption. The SBIRT training program helps train a wide range of medical providers to incorporate SBIRT as part of their ongoing practice. This includes physicians, nurses, counselors, social workers, health promotion advocates, health educators, and others.

See page 169 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $46.8 million, level with the FY 2017 Annualized CR.

Targeted Capacity Expansion (PRNS non-add)
FY 2018 Request: $36.2 million
(Reflects level funding from the FY 2017 Annualized CR)
The Targeted Capacity Expansion (TCE) program provides rapid, strategic, comprehensive, and integrated community-based responses to gaps in and capacity for SUD treatment and recovery support services. Examples of such needs include limited or no access to medication-assisted treatment (MAT) for opioid addiction; lack of resources needed to adopt and implement health information technologies (HIT) in substance abuse treatment settings; and short supply of trained and qualified peer recovery coaches to assist individuals in the recovery process.

See page 173 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $36.2 million, level with the FY 2017 Annualized CR. SAMHSA intends to fund 11 new MAT PDOA grants, 11 continuation MAT PDOA grants, 12 TCE-TAC continuation grants, and 17 TCE-PTP continuation grants, as well as support two contracts.

Treatment Systems for Homeless (PRNS non-add)
FY 2018 Request: $41.2 million
(Reflects level funding from the FY 2017 Annualized CR)
SAMHSA's Treatment Systems for Homeless portfolio supports services for those with drug/alcohol addiction and who are experiencing homelessness, including veterans, and those experiencing chronic homelessness.

See page 186 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $41.2 million, level with the FY 2017 Annualized CR. SAMHSA plans to support annual Cooperative Agreements to Benefit Homeless Individuals for States-Enhancement (CABHI-States Enhancement) and Grants for the Benefit of Homeless Individuals (GBHI) grant continuations and continue to expand programs and support homeless programs through the support of new grants.

Minority AIDS – Treatment (PRNS non-add)
FY 2018 Request: $65.4 million
(Reflects level funding from the FY 2017 Annualized CR)
The purpose of the Minority AIDS grant program is to facilitate the development and expansion of culturally competent and effective community-based treatment systems for substance use and co-occurring substance use and mental disorders within racial and ethnic minority communities. The goals of the program are to reduce the impact of behavioral health problems, reduce HIV risk and incidence, and increase access to treatment for individuals with co-existing behavioral health, HIV, and Hepatitis conditions.

See page 191 in the CSAT chapter for the start of the full description of this program.

Budget Request

The FY 2018 Budget Request is $65.4 million, level with the FY 2017 Annualized CR. SAMHSA intends to fund two new TCE-HIV/AIDS grants, and up to 34 HIV MAI CoC grants. SAMHSA also plans to fund 59 continuation TCE-HIV/AIDS grants, 23 HIV Women's continuation grants, one Addiction Technology Transfer Center Network supplemental grant, and three new contracts.

SAT Minority Fellowship Program
Total FY 2018 Request: $3.5 million
(Reflects level funding from the FY 2017 Annualized Continuing Resolution)
SAMHSA's Minority Fellowship Program (MFP) increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations. The program provides stipends to funding increases the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance abuse treatment services for minority populations that are underserved.

See page 202 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $3.5 million, level with the FY 2017 Annualized CR. The funding will provide continued support for both base and expansion activities. The funds will support six MFPs, five MFP-Y, two MFP-AC grants, and three technical assistance and evaluation support contracts.

Pregnant and Postpartum Women and Comprehensive Addiction and Recovery Act
Total FY 2018 Request: $19.9 million
(Reflects level funding from the FY 2017 Annualized CR)
The Pregnant and Postpartum Women and Comprehensive Addiction and Recovery Act (CARA) address the substance use and addiction across the country through the implementation of prevention, treatment, and recovery programs. In FY 2017, SAMHSA received funding to support two of these programs through its Substance Abuse Treatment Appropriation.

In FY 2017, SAMHSA plans on funding three new state PPW pilot grants to: 1) support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid disorders; 2) help state substance abuse agencies address the continuum of care, including services provided to women in nonresidential-based settings; and 3) promote a coordinated, effective and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery. An evaluation of this program will be conducted to determine the effectiveness of the pilot.

See page 178 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2018 budget request is $19.9 million, level with the FY 2017 Annualized CR. These funds will be used to fund five new residential treatment grants and 21 continuation residential treatment grants and support the continuation of the PPW Pilot ($4.0 million) to provide an array of services and supports to pregnant women and their children.

Building Communities of Recovery
Total FY 2018 Request: $1.0 million
(Reflects level funding from the FY 2017 Annualized CR)
In FY 2017, SAMHSA is planning to support a new cohort of grants through the Building Communities of Recovery program. The purpose of this program is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery support from drug/alcohol addiction. These grants are intended to support the development, enhancement, expansion, and delivery of recovery support services (RSS) as well as promotion of and education about recovery.

See page 201 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2018 budget request is $1.0 million, level with the FY 2017 Annualized CR. These funds will be used to the Building Communities of Recovery Program to develop, expand, and enhance recovery support services.

Criminal Justice Activities (PRNS non-add)
FY 2018 Request: $77.9 million
(Reflects level funding from the FY 2017 Annualized CR)
SAMHSA's Criminal Justice portfolio includes several grant programs that focus on diversion, alternatives to incarceration, drug courts, and re-entry from incarceration for adolescents and adults with drug/alcohol addiction and/or co-occurring drug/alcohol addiction and mental illness. This includes Treatment Drug Courts and the Offender Re-Entry Programs.

See page 194 in the CSAT chapter for the start of the full description of this program.

Drug Court Activities
FY 2018 Request: $60.0 million
(Reflects level funding from the FY 2017 Annualized Continuing Resolution)
SAMHSA's Adult Drug Court programs support a variety of services including direct treatment services for diverse populations, wraparound/recovery support services designed to improve access and retention, drug testing for illicit substances, education support, relapse prevention and long-term management, pharmacotherapy), and HIV testing conducted in accordance with state and local requirements. The program seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use, and outcomes among the racial and ethnic minority populations served.

See page 194 in the CSAT chapter for the start of the full description of this program.

Ex-Offender Re-Entry Program
FY 2018 Request: $17.9 million
(Reflects level funding from the FY 2017 Annualized Continuing Resolution)
SAMHSA plans to support 27 Offender Reentry Program continuation grants and one contract.

See page 196 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $77.9 million ($60.0 million for Drug Courts and $17.9 million for Other Criminal Justice Activities), level with the FY 2017 Annualized CR. SAMHSA intends to support 115 Drug Court continuations grants, 70 new drug court grants, and three contracts. SAMHSA intends to fund 17 new Offender Reentry Program (ORP) new grants, and 13 continuation ORP grants.

Other PRNS Treatment Programs (PRNS non-add)
FY 2018 Request: $40.9 million
(Reflects level funding from the FY 2017 Annualized CR)
The FY 2018 budget includes resources of $40.9 million for several other Treatment Capacity programs including: Recovery Community Services Program; Children and Families; and Addiction Technology Transfer Centers. The FY 2018 Budget includes funds for continuing grants and contracts in these programs. Grant funding will enhance overall drug treatment quality by incentivizing treatment and service providers to achieve specific performance targets. Examples of grant awards could include supplements for treatment and service providers who are

able to connect higher proportions of detoxified patients with continuing recovery-oriented treatment; or for outpatient providers who are able to successfully retain greater proportions of patients in active treatment participation for longer periods.

State Targeted Response to the Opioid Crisis Grants
FY 2018 Request: 500.0 million
(Reflects level funding from the FY 2017 Annualized CR)
The State Targeted Response to the Opioid Crisis Grant Program (STR) was authorized under Section 1003 of the 21st Century Cures Act. The program aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid addiction (including prescription opioids as well as illicit drugs such as heroin).

Grantees will be required to do the following: use epidemiological data to demonstrate the critical gaps in availability of treatment for opioid addiction in geographic, demographic, and service level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly address the gaps in their systems of care; implement prevention strategies; deliver evidence based treatment interventions including medication and psychosocial interventions; deliver recovery support services; and report progress toward increasing availability of treatment for opioid addiction and reducing opioid-related overdose deaths.

See page 207 in the CSAT chapter for the start of the full description of this program.

Budget Request
In FY 2018, SAMHSA requests $500.0 million, level with the FY 2017 Annualized CR. These funds will support the Opioid STR Program. During the first year of the program, lessons learned will be utilized to determine if resource allocations and priorities need to be adjusted in the second year of the program.

Substance Abuse Prevention and Treatment Block Grant
FY 2018 Request: $1.9 billion
(Reflects level funding from the FY 2017 Annualized CR)
The Substance Abuse Prevention and Treatment Block Grant (SABG) program distributes funds to 60 eligible states, territories and freely associated states, the District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota (referred to collectively as states) to plan, carry out, and evaluate substance abuse prevention, treatment, and recovery support services for individuals, families, and communities impacted by substance abuse. The SABG's overall goal is to support and expand substance abuse prevention and treatment services while providing maximum flexibility to grantees.

See page 209 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $1.9 billion, level with the FY 2017 Annualized CR. SABG funds will continue to serve as a source of safety net funding and will continue to support certain services (e.g., recovery support services) not covered by commercial insurance and non-clinical activities

and services that address the critical needs of state substance abuse prevention and treatment service systems.

Health Surveillance and Program Support Appropriation

The FY 2018 Budget Request is $97.0 million, which represents the Substance Abuse portion of the Health Surveillance and Program Support appropriation and supports staffing and activities to administer SAMHSA programs as described below.

Health Surveillance and Program Support (PRNS non-add)
FY 2018 Request: $80.3 million
(Reflects a $6.1 million decrease from the FY 2017 Annualized CR)
Health Surveillance and Program Support (HSPS) provides funding for personnel costs, building and facilities, equipment, supplies, administrative costs, and associated overhead to support SAMHSA programmatic activities, as well as provide funding for SAMHSA national data collection and survey systems, funding to support the Center for Disease Control and Prevention's National Health Information Survey, and the data archive. This request represents the total funding available for these activities first divided between Mental Health and Substance Abuse using the same percentages splits that exist between the Mental Health and Substance Abuse (Prevention and Treatment) appropriation amounts. The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

See page 229 and page 245 in the HSPS chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $80.2 million, a decrease of $6.2 million from the FY 2017 Annualized CR. Health Surveillance funding will support the continuation of the NSDUH, NREPP, BHSIS, C-EMS, and the Analytic Support Center contracts as well as operations and payroll Program Support funding will continue to cover overhead costs associated with 5600 Fishers Lane, including rent, the Federal Acquisition Service loan repayment program, and security charges.

Public Awareness and Support
FY 2018 Request: $5.8 million
(Reflects $0.9 million decrease from the FY 2017 Annualized CR)
Public Awareness and Support provides funding to support the unified communications approach to increase awareness of behavioral health, mental disorders and substance abuse issues. This represents the total funding available for these activities first divided evenly between Mental Health and Substance Abuse. The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

See page 247 in the HSPS chapter for the start of the full description of this program.

Budget Request
The FY 2018 request of $5.8 million will support the President's initiative and will allow SAMHSA to continue to streamline its web presence, develop innovative mobile apps, expand its presence on social media, and provide other critical resources to support behavioral health and other health.

Performance and Quality Information Systems
FY 2018 Request: $9.7 million
(Reflects a $0.8 million increase from the FY 2017 Annualized CR)
Performance and Quality Information Systems provides funding to support SAMHSA's Performance Accountability and Reporting System (SPARs) related activities, as well as provide support for the National Registry of Evidence-based Programs and Practices that will reduce the backlog of interventions accepted but not reviewed under the previous contract. SPARS will provide a common data and reporting system for all SAMHSA discretionary grantees and allow programmatic technical assistance (TA) on use of the data to enhance grantee performance monitoring and improve quality of service delivery. This request represents the total funding available for these activities first split into Mental Health and Substance Abuse using the same percentages splits as between the Mental Health and Substance Abuse (Prevention and Treatment) appropriation amounts. The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

See page 237 in the HSPS chapter for the start of the full description of this program.

Budget Request
The FY 2018 Budget Request is $9.7 million, an increase of $0.8 million from the FY 2017 Annualized CR. SAMHSA will use these funds for system development, training and TA to support operations, National Registry of Evidence-Based Programs (NREPP) and SPARS.

Data Request and Publication User Fees
FY 2018 Request: $0.8 million
(Reflects level funding from the FY 2017 Annualized CR)
The FY 2018 Budget Request is $0.8 million and is equal to the FY 2017 Annualized CR. SAMHSA will collect and retain fees for extraordinary data and publications requests. This represents the total funding estimated for these activities first divided evenly between Mental Health and Substance Abuse. The Substance Abuse portion is then split 20 percent/80 percent into the two functions, prevention and treatment, respectively.

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SAMHSA
Supplementary Tables
Table of Contents

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Budget Authority by Object Classification Tables

Substance Abuse and Mental Health Services Administration
Total Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2,3]	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$46,503	$47,248	$47,721	+$473
Other than full-time permanent (11.3)	2,643	2,685	2,713	+28
Other personnel compensation (11.5)	532	541	546	+5
Military personnel (11.7)	3,889	3,863	3,935	+73
Special personnel services payments (11.8)	24	24	25	+
Subtotal personnel compensation:	**53,592**	**54,361**	**54,940**	**+579**
Civilian benefits (12.1)	15,490	15,738	15,908	+170
Military benefits (12.2)	2,019	2,005	2,043	+38
Subtotal Pay Costs:	**71,100**	**72,103**	**72,891**	**+788**
Travel and transportation of persons (21.0)	1,297	1,233	1,253	+20
Transportation of things (22.0)	26	36	35	-1
Rental payments to GSA (23.1)	9,583	6,116	6,147	+31
Rental payments to Others (23.2)	1	---	---	---
Communication, utilities, and misc. charges (23.3)	374	392	412	+20
Printing and reproduction (24.0)	792	1,063	1,089	+27
Other Contractual Services:				
Advisory and assistance services (25.1)	29,661	32,430	32,949	+519
Other services (25.2)	184,243	171,667	174,414	+2,747
Purchase of Goods & Svcs. from Govt. Accts (25.3)	92,460	65,072	8,023	-57,050
Operation and maintenance of facilities (25.4)	865	983	999	+16
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	108	257	261	+4
Subtotal Other Contractual Services:	**307,337**	**270,409**	**216,645**	**-53,764**
Supplies and materials (26.0)	125	704	716	+11
Equipment (31.0)	670	393	399	+6
Grants, subsidies, and contributions (41.0)	3,254,849	3,803,910	3,471,082	-332,828
Interest and dividends (43.0)	113	---	---	---
Subtotal Non-Pay Costs	**3,575,168**	**4,084,257**	**3,697,778**	**-386,479**
Total Direct Obligations	**$3,646,269**	**$4,156,360**	**$3,770,668**	**-$385,692**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds in FY 2016 and FY 2017.

[3] Reflects the transfer of funding associated with the Behavioral Health Workforce Expansion and Training program from SAMHSA to HRSA. HRSA and SAMHSA will continue to work together to implement this program.

Substance Abuse and Mental Health Services Administration
Mental Health Services
Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2,3]	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$865	$879	$894	+$16
Other than full-time permanent (11.3)	38	38	39	+1
Other personnel compensation (11.5)	7	7	7	---
Military personnel (11.7)	---	---	---	---
Special personnel services payments (11.8).	---	---	---	---
Subtotal personnel compensation:	**910**	**924**	**941**	**+16**
Civilian benefits (12.1)	292	297	302	+5
Military benefits (12.2)	---	---	---	---
Subtotal Pay Costs:	**1,202**	**1,221**	**1,243**	**+22**
Travel and transportation of persons (21.0)	163	176	179	+3
Transportation of things (22.0)	2	---	---	---
Rental payments to GSA (23.1)	1,215	1,715	1,507	-208
Rental payments to Others (23.2)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	320	110	101	-9
Printing and reproduction (24.0)	526	300	303	+3
Other Contractual Services:				
Advisory and assistance services (25.1)	14,121	18,051	18,340	+289
Other services (25.2)	67,494	60,190	61,153	+963
Purchase of Goods & Svcs. from Govt. Accts (25.3)	16,335	3,509	1,967	-1,542
Operation and maintenance of facilities (25.4)	794	770	782	+12
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	57	47	48	+1
Subtotal Other Contractual Services:	**98,801**	**82,567**	**82,290**	**-277**
Supplies and materials (26.0)	32	25	25	+
Equipment (31.0)	216	106	108	+2
Grants, subsidies, and contributions (41.0)	1,036,620	1,057,571	811,052	-246,519
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**1,137,894**	**1,142,570**	**895,565**	**-247,005**
Total Direct Obligations	**$1,139,097**	**$1,143,792**	**$896,808**	**-$246,983**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

[3] The Minority Fellowship Program budget appears in the Health Surveillance and Program Support appropriation, Agency-wide Initiatives Workforce program. This is consistent with the FY 2017 Budget Request.

Substance Abuse and Mental Health Services Administration
Substance Abuse Prevention
Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2,3]	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$---	$---	$---	$---
Other than full-time permanent (11.3)	---	---	---	---
Other personnel compensation (11.5)	---	---	---	---
Military personnel (11.7)	---	---	---	---
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	---	---	---	---
Civilian benefits (12.1)	---	---	---	---
Military benefits (12.2)	---	---	---	---
Subtotal Pay Costs:	---	---	---	---
Travel and transportation of persons (21.0)	---	---	---	---
Transportation of things (22.0)	---	5	5	---
Rental payments to GSA (23.1)	63	641	514	-127
Rental payments to Others (23.2)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	49	41	34	-7
Printing and reproduction (24.0)	---	457	465	+7
Other Contractual Services:				
Advisory and assistance services (25.1)	5,114	4,366	4,436	+70
Other services (25.2)	29,824	33,535	34,072	+537
Purchase of Goods & Svcs. from Govt. Accts (25.3)	8,440	826	671	-155
Operation and maintenance of facilities (25.4)	---	69	70	+1
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	---	146	148	+2
Subtotal Other Contractual Services:	**43,377**	**38,942**	**39,397**	**+455**
Supplies and materials (26.0)	---	4	4	---
Equipment (31.0)	99	140	143	+2
Grants, subsidies, and contributions (41.0)	167,565	182,587	109,141	-73,446
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**211,152**	**222,817**	**149,703**	**-73,114**
Total Direct Obligations	**$211,152**	**$222,817**	**$149,703**	**-$73,114**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

[3] The Minority Fellowship Program budget appears in the Health Surveillance and Program Support appropriation, Agency-wide Initiatives Workforce program. This is consistent with the FY 2017 Budget Request.

Substance Abuse and Mental Health Services Administration
Substance Abuse Treatment
Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2,3]	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$2,140	$2,174	$2,209	+$35
Other than full-time permanent (11.3)	239	243	247	+4
Other personnel compensation (11.5)	16	17	17	---
Military personnel (11.7)	130	132	135	+2
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	**2,525**	**2,566**	**2,607**	**+41**
Civilian benefits (12.1)	822	835	860	+25
Military benefits (12.2)	53	54	56	+2
Subtotal Pay Costs:	**3,400**	**3,454**	**3,522**	**+68**
Travel and transportation of persons (21.0)	234	237	241	+4
Transportation of things (22.0)		1	---	−1
Rental payments to GSA (23.1)	994	3,126	3,622	+497
Rental payments to Others (23.2)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	5	200	243	+42
Printing and reproduction (24.0)	258	262	266	+4
Other Contractual Services:				
Advisory and assistance services (25.1)	8,119	8,249	8,381	+132
Other services (25.2)	41,773	42,645	43,327	+682
Purchase of Goods & Svcs. from Govt. Accts (25.3)	16,376	4,025	4,728	+703
Operation and maintenance of facilities (25.4)	69	70	71	+1
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	32	37	38	+1
Subtotal Other Contractual Services:	**66,369**	**55,026**	**56,545**	**+1,519**
Supplies and materials (26.0)		49	50	+1
Equipment (31.0)	325	2	2	+
Grants, subsidies, and contributions (41.0)	2,039,719	2,552,847	2,550,743	−2,105
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**2,107,904**	**2,611,751**	**2,611,713**	**−38**
Total Direct Obligations	**$2,111,304**	**$2,615,205**	**$2,615,235**	**+$30**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds.

[3] The Minority Fellowship Program budget appears in the Health Surveillance and Program Support appropriation, Agency-wide Initiatives Workforce program. This is consistent with the FY 2017 Budget Request.

Substance Abuse and Mental Health Services Administration
Health Surveillance and Program Support
Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2,3]	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/− FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$43,499	$44,195	$44,618	+$423
Other than full-time permanent (11.3)	2,367	2,404	2,427	---
Other personnel compensation (11.5)	509	517	522	---
Military personnel (11.7)	3,759	3,730	3,801	+70
Special personnel services payments (11.8)	24	24	25	---
Subtotal personnel compensation:	**50,157**	**50,871**	**51,392**	**+521**
Civilian benefits (12.1)	14,376	14,606	14,746	+140
Military benefits (12.2)	1,966	1,951	1,987	+37
Subtotal Pay Costs:	**66,498**	**67,427**	**68,125**	**+698**
Travel and transportation of persons (21.0)	900	820	833	+13
Transportation of things (22.0)	24	30	30	+
Rental payments to GSA (23.1)	7,311	634	503	−131
Rental payments to Others (23.2)	1	---	---	---
Communication, utilities, and misc. charges (23.3)	---	41	34	−7
Printing and reproduction (24.0)	8	43	55	+12
Other Contractual Services:				
Advisory and assistance services (25.1)	2,308	1,764	1,792	+28
Other services (25.2)	45,153	35,297	35,861	+565
Purchase of Goods & Svcs. from Govt. Accts (25.3)	51,310	56,713	657	−56,056
Operation and maintenance of facilities (25.4)	2	75	76	+1
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	18	26	27	+
Subtotal Other Contractual Services:	**98,790**	**93,874**	**38,413**	**−55,462**
Supplies and materials (26.0)	93	627	637	+10
Equipment (31.0)	30	145	147	+2
Grants, subsidies, and contributions (41.0)	10,946	10,904	145	−10,760
Interest and dividends (43.0)	113	---	---	---
Subtotal Non-Pay Costs	**118,218**	**107,118**	**40,797**	**−66,321**
Total Direct Obligations	**$184,716**	**$174,546**	**$108,922**	**−$65,623**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds and Mandatory Funds.

[3] Reflects the transfer of funding associated with the Behavioral Health Workforce Expansion and Training program from SAMHSA to HRSA in FY 2016 and FY 2017.

Substance Abuse and Mental Health Services Administration
Total PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation Funds	FY 2016 Final	FY 2017 Annualized CR	FY 2018 Current Services	FY 2018 +/− FY 2017
Personnel Compensation:				
Full Time Permanent (11.1)	$9,535	$9,204	$9,238	+$33
Other than Full-Time Permanent (11.3)	679	634	631	−3
Other Personnel Compensation (11.5)	99	95	95	+
Military Personnel Compensation (11.7)	1,113	1,219	1,242	+23
Special personnel services payments (11.8)	28	---	---	---
Subtotal Personnel Compensation:	**11,454**	**11,152**	**11,205**	**+53**
Civilian Personnel Benefits (12.1)	3,012	2,902	2,928	+25
Military Personnel Benefits (12.2)	581	638	652	+13
Subtotal Pay Costs:	**15,048**	**14,693**	**14,785**	**+92**
Travel (21.0)	105	124	121	−3
Transportation of things (22.0)		---	---	---
Rental payments to GSA (23.1)	---	---	---	---
Communications, Utilities and Misc. Charges (23.3)	---	---	---	---
Printing and Reproduction (24.0)	288	391	394	+3
Other Contractual Services:	---	---	---	
Advisory and assistance services (25.1)	---	---	---	---
Other services (25.2)	113,649	113,806	100,139	−13,667
Purchase of Goods & Svcs. from Govt. Accts (25.3)	1,069	1,086	1,104	+17
Operation and maintenance of equipment (25.7)	2	5	5	---
Subtotal Other Contractual Services:	**114,720**	**114,898**	**101,248**	**−13,650**
Supplies and Materials (26.0)	11	8	7	−1
Equipment (31.0)	16	20	20	+
Grants, Subsidies, and Contributions (41.0)	3,479	3,534	3,591	+57
Subtotal Non-Pay Costs	**118,619**	**118,974**	**105,380**	**−13,594**
Total Reimbursable Obligations	**$133,667**	**$133,667**	**$120,165**	**−$13,502**

Substance Abuse and Mental Health Services Administration
Mental Health Services
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$1,936	$1,967	$2,002	+$35
Other than full-time permanent (11.3)	71	72	74	+1
Other personnel compensation (11.5)	15	16	16	+
Military personnel (11.7)	262	354	361	+7
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	**2,284**	**2,409**	**2,452**	**+43**
Civilian benefits (12.1)	638	649	660	+11
Military benefits (12.2)	141	190	194	+4
Subtotal Pay Costs:	**3,063**	**3,248**	**3,307**	**+58**
Travel and transportation of persons (21.0)	16	38	38	+1
Transportation of things (22.0)		---	---	---
Rental payments to GSA (23.1)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---	---
Printing and reproduction (24.0)	22	28	25	-3
Other Contractual Services:				
Advisory and assistance services (25.1)	---	---	---	---
Other services (25.2)	17,936	17,718	12,163	-5,555
Purchase of Goods & Svcs. from Govt. Accts (25.3)	---	---	---	---
Operation and maintenance of equipment (25.7)	---	---	---	---
Subtotal Other Contractual Services:	**17,936**	**17,718**	**12,163**	**-5,555**
Supplies and materials (26.0)	2	8	7	-1
Equipment (31.0)		---	---	---
Grants, subsidies, and contributions (41.0)	---	---	---	---
Subtotal Non-Pay Costs	**17,976**	**17,791**	**12,233**	**-5,558**
Total Reimbursable Obligations	**$21,039**	**$21,039**	**$15,539**	**-$5,500**

Substance Abuse and Mental Health Services Administration
Substance Abuse Treatment
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$3,792	$3,853	$3,915	+$62
Other than full-time permanent (11.3)	171	174	$177	+3
Other personnel compensation (11.5)	37	37	$38	+1
Military personnel (11.7)	235	238	$243	+4
Special personnel services payments (11.8)	28	---	---	---
Subtotal personnel compensation:	**4,263**	**4,303**	**4,372**	**+69**
Civilian benefits (12.1)	1,130	1,148	1,182	+34
Military benefits (12.2)	125	127	130	+4
Subtotal Pay Costs:	**5,518**	**5,577**	**5,684**	**+107**
Travel and transportation of persons (21.0)	9	5	---	-5
Transportation of things (22.0)	---	---	---	---
Rental payments to GSA (23.1)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---	---
Printing and reproduction (24.0)	266	363	369	+6
Other Contractual Services:				
Advisory and assistance services (25.1)	---	---	---	---
Other services (25.2)	74,229	74,071	73,944	-127
Purchase of Goods & Svcs. from Govt. Accts (25.3)	---	---	---	---
Operation and maintenance of equipment (25.7	2	2	2	---
Subtotal Other Contractual Services:	**74,231**	**74,073**	**73,946**	**-127**
Supplies and materials (26.0)	3	---	---	---
Equipment (31.0)	12	2	2	-
Grants, subsidies, and contributions (41.0)	1,162	1,181	1,199	+19
Subtotal Non-Pay Costs	**75,683**	**75,623**	**75,515**	**-107**
Total Reimbursable Obligations	**$81,200**	**$81,200**	**$81,200**	**+$**

Substance Abuse and Mental Health Services Administration
Health Surveillance and Program Support
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$3,807	$3,384	$3,321	-$63
Other than full-time permanent (11.3)	436	388	$380	-7
Other personnel compensation (11.5)	47	42	$41	-1
Military personnel (11.7)	616	626	$638	+12
Special personnel services payments (11.8)	---	---	$---	---
Subtotal personnel compensation:	**4,907**	**4,440**	**4,381**	**-59**
Civilian benefits (12.1)	1,244	1,106	1,085	-21
Military benefits (12.2)	316	321	327	+6
Subtotal Pay Costs:	**6,467**	**5,868**	**5,794**	**-74**
Travel and transportation of persons (21.0)	80	82	83	+1
Transportation of things (22.0)		---	---	---
Rental payments to GSA (23.1)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	---	---	---	---
Printing and reproduction (24.0)	---	---	---	---
Other Contractual Services:				
Advisory and assistance services (25.1)	---	---	---	---
Other services (25.2)	21,484	22,017	14,032	-7,985
Purchase of Goods & Svcs. from Govt. Accts (25.3)	1,069	1,086	1,104	+17
Operation and maintenance of equipment (25.7)	---	4	4	---
Subtotal Other Contractual Services:	**22,553**	**23,107**	**15,140**	**-7,968**
Supplies and materials (26.0)	7	---	---	---
Equipment (31.0)	3	18	18	+
Grants, subsidies, and contributions (41.0)	2,317	2,354	2,391	+38
Subtotal Non-Pay Costs	**24,961**	**25,560**	**17,632**	**-7,928**
Total Reimbursable Obligations	**$31,428**	**$31,428**	**$23,426**	**-$8,002**

Substance Abuse and Mental Health Services Administration
Salaries and Expenses Tables
Direct Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2,3]	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$46,503	$47,248	$47,721	+$473
Other than full-time permanent (11.3)	2,643	2,685	2,713	+28
Other personnel compensation (11.5)	532	541	546	+5
Military personnel (11.7)	3,889	3,863	3,935	+73
Special personnel services payments (11.8)	24	24	25	+
Subtotal personnel compensation	**53,592**	**54,361**	**54,940**	**+579**
Civilian benefits (12.1)	15,490	15,738	15,908	+170
Military benefits (12.2)	2,019	2,005	2,043	+38
Subtotal Pay Costs:	**71,100**	**72,103**	**72,891**	**+788**
Travel (21.0)	1,297	1,233	1,253	+20
Transportation of things (22.0)	26	36	35	-1
Rental payments to Others (23.2)	1	---	---	---
Communication, utilities, and misc. charges (23.3)	374	392	412	+20
Printing and reproduction (24.0)	792	1,063	1,089	+27
Other Contractual Services:				
Advisory and assistance services (25.1)	29,661	32,430	32,949	+519
Other services (25.2)	184,243	171,667	174,414	+2,747
Purchase of Goods & Svcs. from Govt. Accts (25.3)	92,460	65,072	8,023	-57,050
Operation and maintenance of facilities (25.4)	865	983	999	+16
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	108	257	261	+4
Subtotal Other Contractual Services:	**307,337**	**270,409**	**216,645**	**-53,764**
Supplies and materials (26.0)	125	704	716	+11
Subtotal Non-Pay Costs	**309,953**	**273,838**	**220,150**	**-53,688**
Total Salary and Expenses	**381,053**	**345,941**	**293,041**	**-52,900**
Rental Payments to GSA (23.1)	9,583	6,116	6,147	+31
Grand Total, Salaries & Expenses and Rent	**$390,636**	**$352,057**	**$299,188**	**-$52,869**
Direct FTE	504	503	499	-

[1] Does not include PHS EVAL Funds.
[2] Includes Prevention and Public Health Funds in FY 2016 and FY 2017.
[3] Reflects the transfer of funding associated with the Behavioral Health Workforce Expansion and Training program from SAMHSA to HRSA in FY 2016 and FY 2017.

Substance Abuse and Mental Health Services Administration
Salaries and Expenses Tables
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class[1]	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Personnel compensation:				
Full-time permanent (11.1)	$9,535	$9,204	$9,238	+$33
Other than full-time permanent (11.3)	679	634	631	-3
Other personnel compensation (11.5)	99	95	95	+
Military personnel (11.7)	1,113	1,219	1,242	+23
Special personnel services payments (11.8)	28	---	---	---
Subtotal personnel compensation	**11,454**	**11,152**	**11,205**	**+53**
Civilian benefits (12.1)	3,012	2,902	2,928	+25
Military benefits (12.2)	581	638	652	+13
Subtotal Pay Costs:	**15,048**	**14,693**	**14,785**	**+92**
Travel (21.0)	105	124	121	-3
Transportation of things (22.0)		---	---	---
Rental payments to Others (23.2)	---	---	---	---
Communication, utilities, and misc. charges (23.3).	---	---	---	---
Printing and reproduction (24.0)	288	391	394	+3
Other Contractual Services:				
Advisory and assistance services (25.1)	---	---	---	---
Other services (25.2)	113,649	113,806	100,139	-13,667
Purch. Goods & Svcs. Govt. Accts (25.3)	1,069	1,086	1,104	+17
Operation and maintenance of facilities (25.4)	---	---	---	---
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	2	5	5	---
Subtotal Other Contractual Services:	**114,720**	**114,898**	**101,248**	**-13,650**
Supplies and materials (26.0)	11	8	7	-1
Subtotal Non-Pay Costs	**115,125**	**115,420**	**101,769**	**-13,651**
Total Salary and Expenses	**130,173**	**130,113**	**116,554**	**-13,559**
Rental Payments to GSA (23.1)	---	---	---	---
Grand Total, Salaries & Expenses and Rent	**$130,173**	**$130,113**	**$116,554**	**-13,559**
Reimbursable FTE[1]	116	112	111	-

[1] Does not include Other reimbursable FTEs (30) and associated Object Class cost.

Detail of Full Time Equivalent Employee (FTE)

	FY 2016 Final Civilian	FY 2016 Final Military	FY 2016 Final Total	FY 2017 Est. Civilian	FY 2017 Est. Military	FY 2017 Est. Total	FY 2018 Est. Civilian	FY 2018 Est. Military	FY 2018 Est. Total
Health Surveillance and Program Support									
Direct:	431	39	470	431	38	469	428	38	466
Reimbursable:	32	7	39	28	7	35	27	7	34
Total:	463	46	509	459	45	504	455	45	500
Mental Health Services									
Direct:	9	0	9	9	0	9	9	0	9
Reimbursable:	18	4	22	18	4	22	18	4	22
Total:	27	4	31	27	4	31	27	4	31
Substance Abuse Prevention									
Direct:	0	0	0	0	0	0	0	0	0
Reimbursable:	21	0	21	18	2	20	18	2	20
Total:	21	0	21	18	2	20	18	2	20
Substance Abuse Treatment									
Direct:	23	1	24	23	1	24	23	1	24
Reimbursable:	32	3	35	32	3	35	32	3	35
Total:	55	4	59	55	4	59	55	4	59
SAMHSA FTE Total	**567**	**53**	**620**	**560**	**55**	**615**	**555**	**55**	**610**

Detail of Positions

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Executive Level IV	1	1	1
Subtotal	1	1	1
Total - Exec Level Salaries	**$155,500**	**$155,500**	**$155,500**
SES	13	13	13
Subtotal	13	13	13
Total, SES salaries	**$3,939,509**	**$3,979,416**	**$4,019,847**
GM/GS-15/EE	72	73	73
GM/GS-14	128	125	125
GM/GS-13	209	209	208
GS-12	54	55	55
GS-11	19	19	19
GS-10	1	2	2
GS-09	15	13	12
GS-08	20	18	17
GS-07	19	18	17
GS-06	10	10	9
GS-05	4	4	4
GS-04	0	0	0
GS-03	0	0	0
GS-02	0	0	0
GS-01	0	0	0
Subtotal	551	546	541
Total, GS salaries	**$77,314,646**	**$77,309,014**	**$78,042,708**
CC-08/09	1	1	1
CC-07	0	0	0
CC-06	15	15	15
CC-05	18	18	18
CC-04	16	16	16
CC-03	5	5	5
CC-02	0	0	0
CC-01	0	0	0
Subtotal	55	55	55
Total, CC salaries	**$7,601,413**	**$8,129,435**	**$8,283,973**
Total Positions	**620**	**615**	**610**
Average ES level	ES	ES	ES
Average ES salary	$155,500	$155,500	$155,500
Average SES level	SES	SES	SES
Average SES salary	$303,039	$306,109	$309,218.99
Average GS grade	13.5	13.6	13.6
Average GS salary	$140,317.0	$141,591.6	$144,256.4
Average CC level	5.2	5.2	5.2
Average CC salaries	$138,208	$147,808	$150,618

Programs Proposed for Elimination

The following table shows the programs proposed for elimination in the FY 2018 Budget Request. Terminations of these programs total $186.3 million across the three appropriations: Mental Health, Substance Abuse Prevention, and Health Surveillance and Program Support.

The following is a brief summary of the program and rational for the elimination proposal.

(Dollars in thousands)

Program	FY 2017 Annualized CR
Project AWARE	$64,742
Healthy Transitions	19,913
Primary and Behavioral Health Care Integration	51,769
Behavioral Health Workforce Education and Traning	49,905
Total	186,329

Project AWARE

SAMHSA awarded these grants to 20 State Education Authorities (SEAs) to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services. Mental Health First Aid (MHFA), supports widespread dissemination of the MHFA curriculum. The MHFA curriculum prepares teachers and other individuals who work with youth to help schools and communities understand, recognize, and respond to signs of mental illness and/or drug/alcohol addiction in children and youth, including how to talk to adolescents and families experiencing these problems so that they are more willing to seek treatment.

SAMHSA is proposing an elimination of Project Advancing Wellness and Resiliency in Education (AWARE) ($64.0M). This program is being proposed for elimination to reduce duplication of school-based programs. This program is very similar in nature to the programs funded under the Youth Violence Prevention line. Additionally, SAMHSA has developed significant knowledge and evidence for states to begin implementing and bringing to scale these efforts; SAMHSA will continue to ensure this knowledge is disseminated.

Healthy Transitions

The Healthy Transitions program awarded five-year grants to 17 states to improve access to mental disorder treatment and related support services for young people aged 16 to 25 who either have, or are at risk of developing, a serious mental health condition. Individuals who are 16 to 25 years old are at high risk of developing a mental illness or drug/alcohol addiction and are at high risk for

suicide. Unfortunately, these youth are among the least likely to seek help. Through this program, states are expanding services, developing family and youth networks for information sharing and peer support, and disseminating best practices for services for these young individuals.
SAMHSA is proposing an elimination of the Healthy Transitions initiative ($20.0M) to avoid duplication with other programs such as the Children's Mental Health Services program. SAMHSA has developed significant knowledge and evidence for states to begin implementing and bringing to scale these efforts; SAMHSA will continue to ensure this knowledge is disseminated.

Primary and Behavioral Health Care Integration

The Primary and Behavioral Health Care Integration (PBHCI) program began in FY 2009 to address specifically this intersection between primary care and mental disorder treatment. The program supports two activities: grants to community mental health centers and the PBHCI Training and Technical Assistance (TTA) Center, which is co-funded through a competitive cooperative agreement with the Health Resources and Services Administration (HRSA). These two activities collectively support the coordination and integration of primary care services into publicly funded community behavioral health settings for individuals with SMI and/or people with co-occurring disorders served by the public mental health system. PBHCI seeks to improve health outcomes for people with SMI by encouraging grantees to engage in necessary collaboration, expand infrastructure, and increase the availability of primary healthcare and wellness services for individuals with mental illness

The Primary and Behavioral Healthcare Integration ($52M) program is being proposed for elimination, as this program is potentially fundable through other sources of funds including the Substance Abuse Block Grant and Certified Community Behavioral health Center funding. SAMHSA will continue to disseminate the lessons learned from this program.

Behavioral Health Workforce Education and Training

In FY 2014, as part of the President's *Now is the Time* initiative, SAMHSA and the Health Resources and Services Administration (HRSA) began collaboration on the Behavioral Health Workforce Education and Training Grant Program. The purpose of this program is to increase the clinical service capacity of the behavioral health workforce by supporting training for masters-level social workers, professional counselors, psychologists, marriage and family therapists, psychology doctoral interns, as well as behavioral health paraprofessionals.

SAMHSA is proposing an elimination of the BHWET ($50M) from SAMHSA's budget to prioritize targeted efforts to provide direct health care services. For example, the National Health Service Corps administered by the Health Resources and Services Administration directly hires behavioral health professionals serving in communities with shortages, directly responding to public health needs.

Physicians' Comparability Allowance (PCA) Worksheet
Substance Abuse and Mental Health Services Administration

(Whole dollars)

		CY 2016 (Estimates)	BY 2017 (Estimates)	BY 2018 (Estimates)
1) Number of Physicians Receiving PCAs		3	3	5
2) Number of Physicians with One-Year PCA Agreements		---	---	---
3) Number of Physicians with Multi-Year PCA Agreements		3	3	5
4) Average Annual PCA Physician Pay (without PCA payment)		$141,000	$141,000	$142,851
5) Average Annual PCA Payment		$14,667	$14,667	$14,000
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	---	---	---
	Category II Research Position	---	---	---
	Category III Occupational Health	---	---	---
	Category IV - A Disability Evaluation	---	---	---
	Category IV - B Health and Medical Admin.	3	3	3

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

N/A

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

$30,000.00 - based on years of education, experience, and the position held by the incumbent. Amount is required to retain the employee.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist.

SAMHSA is projecting two medical officer vacancies for FY 2018 and we have to offer PCAs because our salaries are not competitive with the private sector.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

We have to offer PCAs because our salaries are not competitive with the private sector (e.g., we might offer 75% of a physician's salary on the outside). In addition, physicians of interest to SAMHSA often have income from consulting as well. The PCA is the only way to raise the government income so as to make the offer acceptable.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

Substance Abuse and Mental Health Services Administration
SIGNIFICANT ITEMS IN OMNIBUS, HOUSE, AND SENATE REPORTS

FY 2017 Senate Appropriations Committee, Labor/HHS/Education Subcommittee
(Senate Report 114-274)

MENTAL HEALTH

Project Aware.—The Committee strongly supports Project AWARE which increases awareness of mental health issues and connects young people that have behavioral health issues and their families with needed services. The Committee recommendation reflects the administration's proposal to reallocate funding from Youth Violence Prevention to Project AWARE. This shift will allow SAMHSA to avoid program duplication. The increase provided will support a new cohort of Project AWARE State Education Agency awards. Of the amount provided for Project AWARE, the Committee directs SAMHSA to use $10,000,000 for discretionary grants to support efforts in high-crime, high-poverty areas and, in particular, communities that are seeking to address relevant impacts and root causes of civil unrest. These grants should maintain the same focus as fiscal year 2016 grants and continue to be coordinated with the Department of Education grants. The Committee requests a report on progress of fiscal year 2016 grantees 180 days after the enactment of this act. *[Senate Report, pg 117]*

Action taken or to be taken
In FY 2016, SAMHSA issued a Funding Opportunity Announcement (FOA), Resiliency in Communities After Stress and Trauma (ReCAST), and awarded eight grants for communities and surrounding areas that have recently faced civil unrest. The grantees are focusing on high risk youth and family populations that have experienced significant exposure to trauma, and requires grantees to provide evidence-based violence prevention and community youth engagement programs as well as linkages to trauma-informed behavioral health services. In FY 2017, SAMHSA will support the continuation of eight grants and award a new cohort of grants. SAMHSA coordinated with ED on the administration of the funding announcements, activities, oversight of the grant program and will continue this collaboration in FY 2017.

Primary and Behavioral Healthcare Integration.—The Committee directs SAMHSA to require grantees of the Primary and Behavioral Health Care Integration program to include in their biannual National Outcome Measures report a summary of the policies that serve as barriers to the provision of integrated care and the specific steps the grantee has taken or will take to address such barriers. *[Senate Report, page 117]*

Action taken or to be taken

SAMHSA has and continues to require Primary and Behavioral Healthcare Integration (PBHCI) grantees to report their National Outcome Measures (NOMS) client level services data into

SAMHSA's data collection system each quarter of the year. In the quarterly narrative reports, grantees describe new policy developments and changes to improve integration activities and discuss barriers and solutions for the successful provision of integrated care. In the final reports, grantees describe the challenges encountered when providing integrated care and the steps taken to address them. SAMHSA will continue to monitor the reporting requirements to ensure that grantees address barriers to the provision of integrated care and the specific steps taken to overcome them. SAMHSA will also continue to provide technical assistance to grantees on barriers to improve the provision of integrated care.

Community Mental Health Services Block Grant.—The Committee recommendation continues bill language requiring that at least 10 percent of the funds for the MHBG program be set-aside for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The Committee commends SAMHSA for its collaboration with NIMH on the implementation of this set-aside. The Committee notes that it usually takes 17 years to translate research findings into practice and hopes that this joint effort between NIMH and SAMHSA may be a model for how to reduce this timeframe. The Committee directs SAMHSA to continue its collaboration with NIMH to ensure that funds from this set-aside are only used for programs showing strong evidence of effectiveness and that target the first episode of psychosis. SAMHSA shall not expand the use of the set-aside to programs outside of the first episode psychosis. The Committee directs SAMHSA to include in the fiscal year 2018 CJ a detailed table showing at a minimum each State's allotment, name of the program being implemented, and a short description of the program. *[Senate Report, page 118]*

Action taken or to be taken

SAMHSA in collaboration with NIMH has and continues to provide technical assistance to states for implementation of evidence-based Coordinated Specialty Care (CSC) programs that specifically address treatment, services, and supports to individuals who are diagnosed with first-episode psychosis. Since the set-aside was enacted in FY 2014, the number of states with fully implemented operating CSC treatment programs has steadily increased and SAMHSA continues to monitor and ensure that the set-aside program is solely used to address first-episode psychosis. Beginning in September 2016, SAMHSA, in partnership with NIMH, initiated a three year evaluation study of CSC programs funded through the MHBG set-aside to ensure that funds are only used for programs showing strong evidence of effectiveness and target first episode of psychosis. SAMHSA developed a "snapshot" of all the First Episode Psychosis programs, detailing each State's allotment, name of the program being implemented, and a short description of the program. The requested table is part of SAMHSA's FY 2018 CJ.

SUBSTANCE ABUSE TREATMENT

Addiction Technology Transfer Centers [ATTCs].—The Committee again rejects the administration's proposal to reduce funding for the ATTCs and instead provides the same funding level as fiscal year 2016. The Committee directs SAMHSA to ensure that ATTCs maintain a primary focus on addiction treatment and recovery services. *[Senate Report, page 120]*

Action taken or to be taken

On December 7, 2016, SAMHSA, through the Center for Substance Abuse Treatment released a Funding Opportunity Announcement seeking applications for fiscal year (FY) 2017 Addiction Technology Transfer Centers (ATTC) Cooperative Agreements. The FOA specifically states that the purpose of the ATTC program is to develop and strengthen the specialized behavioral healthcare and primary healthcare workforce that provides substance abuse treatment and recovery support services.

Combating Opioid Abuse.—Of the amount provided for Targeted Capacity Expansion, the Committee includes $60,000,000 for discretionary grants to States for the purpose of expanding treatment services to those with heroin or opioid dependence. The Committee directs CSAT to ensure that these grants include as an allowable use the support of medication assisted treatment and other clinically appropriate services. These grants should target States with the highest age adjusted rates of admissions and that have demonstrated a dramatic age adjusted increase in admissions for the treatment of opioid addiction. *[Senate Report, page 120]*

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment, is working with the Targeted Capacity Expansion Medication-Assisted Treatment Prescription Drug and Opioid Addiction grantees to ensure use of medication assisted treatment and other clinically appropriate services and have informed the grantees that they should prioritize treatment regimens that are less susceptible to diversion for illicit purposes.

Drug Courts.—SAMHSA is directed to ensure that all Drug Treatment Court funding is allocated to serve people diagnosed with a drug/alcohol addiction as their primary condition. SAMHSA is further directed to ensure that all drug treatment court grant recipients work directly with the corresponding State substance abuse agency in the planning, implementation, and evaluation of the grant. SAMHSA should expand training and technical assistance to drug treatment court grant recipients to ensure evidence-based practices are fully implemented. *[Senate Report, page 120]*

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment, ensures that all funding appropriated for Drug Treatment Courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. In addition, grantees in the program are expected to work with the state substance abuse agency in planning, implementation and evaluation of the grants. SAMHSA also continues to provide training and technical assistance to Drug Treatment Court grantees.

Screening, Brief Intervention, and Referral to Treatment [SBIRT].—The Committee is pleased that SAMHSA recently included language in the SBIRT Request for Proposal to allow grantees to focus 20 percent of the funding on individuals between the ages of 12 and 18 who are seeking medical services. This will expand opportunities for health care and youth service practitioners to engage young people in preventative conversations about substance use, as well as identify and address risky use before it progresses to addiction. The Committee expects SAMHSA to continue to encourage applicants to take advantage of this allowable use of funds for 12- to 18-year-olds. *[Senate Report, page 121]*

Action taken or to be taken

In Fiscal Year 2016, SAMHSA, through the Center for Substance Abuse Treatment, provided funding to eight states for SBIRT program and these grantees are allowed to allocate 20 percent of their population of focus on youth and young adults aged 12 to 18 years old. One of the states, Massachusetts, is implementing an initiative as part of the SBIRT grant which requires school guidance counselors to use the SBIRT model in counseling their students about substance misuse.

Viral Hepatitis Screening.—The Committee applauds SAMHSA for encouraging grantees to screen for viral hepatitis, including the use of innovative strategies like rapid testing and urges SAMHSA to continue these efforts. The Committee notes the disproportionate impact of viral hepatitis among minority populations and the co-infection rate among individuals with HIV/AIDS. The Committee urges SAMHSA to work with minority AIDS grantees to incorporate hepatitis screening into programmatic activities. *[Senate Report, page 121]*

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment, implements the Department of Health and Human Services' Hepatitis Action Plan which notes that people with HIV are disproportionally affected by viral hepatitis and related adverse conditions. Through the Center for Substance Abuse Treatment's Minority AIDS program, grantees are required to implement hepatitis screening as a condition of the award.

SUBSTANCE ABUSE PREVENTION

Oral Fluid Guidelines.—The Committee is pleased with SAMHSA's recommendation of oral fluid as an alternative specimen for drug testing and commends SAMSHA for the progress made on issuing oral fluid guidelines for the Federal Workplace Drug Testing Programs. The Committee urges SAMSHA to publish the guidelines expeditiously and to implement the guidelines in partnership with stakeholders and other agencies. *[Senate Report, page 121]*

Action taken or to be taken

The Proposed Oral Fluid Mandatory Guidelines for the Federal Workplace Drug Testing Programs (OFMG) were published in the Federal Register in May 2015.

The Committee notes that youth drug use continues to be a major issue and that perceptions of harm are significantly waning. Therefore, the Committee directs that all of the money appropriated explicitly for Substance Abuse Prevention purposes both in CSAP's PRNS lines as well as the funding from the 20 percent prevention set-aside in the SAPT Block Grant be used only for bona fide substance abuse prevention activities and not for any other purpose. *[Senate Report, page 122]*

Action taken or to be taken

SAMHSA ensures that all of the money appropriated explicitly for Substance Abuse Prevention purposes both in CSAP's PRNS lines as well as the funding from the 20 percent prevention set-aside in the SAPT Block Grant be used only for bona fide substance abuse prevention activities and not for any other purpose

Combating Opioid Abuse.—The Committee provides $26,000,000 for grants to prevent opioid overdose related deaths. Part of the initiative to Combat Opioid Abuse, this program will help States equip and train first responders and other community partners with the use of devices that rapidly reverse the effects of opioids. Of this amount, the Committee provides $8,000,000 to prevent opioid overdose-related deaths in rural areas. People in rural communities are especially vulnerable and more likely to overdose on prescription pain killers than people in urban areas, according to the CDC. The Committee encourages SAMHSA to work with HRSA in the administration of these resources to rural areas. The Committee directs SAMHSA to ensure applicants outline how proposed activities in the grant would work with treatment and recovery communities in addition to first responders. Furthermore, the Committee provides $10,000,000 for the Strategic Prevention Framework Rx program to increase awareness of opioid abuse and misuse in communities. *[Senate Report, page 122]*

Action taken or to be taken

SAMHSA ensures that the Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths grantees develop a dissemination plan and a training course tailored to meet the needs of their community. The course uses SAMHSA's Opioid Overdose Prevention Toolkit as a guide, and includes a comprehensive prevention program, which focuses on prevention, treatment and recovery services to decrease the likelihood of drug overdose recurrence. Grantees are also equipping and training first responders with the use of devices that rapidly reverse the effects of opioids.

In addition, SAMHSA's Strategic Prevention Framework for Prescription Drugs (SPF-Rx) program assists grantees in developing capacity and expertise in the use of data from state run prescription drug monitoring programs (PDMP). Grantees are strategically planning and strengthening their current prescription drug misuse efforts through the use of PDMP data. The SPF Rx grant program is also intended to identify communities by geography and high-risk population (e.g., age group), as well as target those communities that are in need of primary and secondary prevention.

SAMHSA is continuing its collaboration with CDC to implement the most effective outreach strategies and reduce any duplication of activities. The two agencies are coordinating to ensure that the efforts are aligned with HHS's recently established policy and plan for prevention of Opioid-Related Overdoses and Deaths involving multiple Operating Divisions and offices.

Strategic Prevention Framework State Incentive Grant and Partnerships for Success.—The Committee intends that these two programs continue to focus exclusively on: addressing State- and community-level indicators of alcohol, tobacco, and drug use; targeting and implementing appropriate universal prevention strategies; building infrastructure and capacity; and preventing substance use and abuse. *[Senate Report, page 123]*

Action taken or to be taken

SAMHSA's Strategic Prevention Framework State Incentive Grants (SPF-SIG) and Strategic Prevention Framework Partnerships for Success (SPF-PFS) programs continue to address the nation's top emerging substance abuse priorities including underage drinking and prescription drug misuse. SAMHSA continues to focus exclusively on: addressing State- and community-level indicators of alcohol, tobacco, and drug use; targeting and implementing appropriate universal prevention strategies; building infrastructure and capacity; and preventing substance use and abuse. SAMHSA provides support for grantees to strengthen substance abuse prevention infrastructure and capacity using the strategic prevention framework.

STOP Act.—The Committee directs that all funds appropriated for STOP Act community-based coalition enhancement grants shall be used for making grants to eligible communities and not for any other purposes or activities. *[Senate Report, page 123]*

Action taken or to be taken

The STOP Act program continues to address alcohol use among youth and young adults ages 12-20 in communities throughout the United States. STOP Act recipients are expected to: 1) Enhance the ability of established community organizations to create community-level change regarding underage drinking; 2) Strengthen collaboration among communities, the federal government, state, local, and tribal governments to reduce alcohol use among youth and young adults in current and former DFC recipient communities; 3) Enhance intergovernmental cooperation and coordination on the issue of alcohol use among youth and young adults; 4) Address the barriers to collaboration with institutions of higher education, local education agencies, and state counterparts of the members of the federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) and their Single State Authority (SSA) or tribal equivalent; 5) Host sites for local Town Hall Meetings to address underage drinking issues; and 6) Develop an action plan to address underage drinking. SAMHSA project officers routinely (e.g. reporting requirements and site visits) review grantees work to ensure it remains in compliance with only those allowable grant activities as articulated in the funding announcement and terms of the award.

FY 2017 House Appropriations Committee, Labor/HHS/Education Subcommittee
(House Report 114-699)

MENTAL HEALTH

Mental Health Block Grant—The Committee recommends a total of $532,571,000 for the Mental Health Block Grant, which is the same as the fiscal year 2016 enacted program level and the fiscal year 2017 budget request program level. The block grant provides funds to States to support mental illness prevention, treatment, and rehabilitation services. Funds are allocated according to a statutory formula among the States that have submitted approved annual plans. The Committee continues the ten percent set-aside within the Mental Health Block Grant for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The Committee expects SAMHSA to continue its collaboration with the National Institute of Mental Health to encourage States to use this block grant funding to support programs that demonstrate strong evidence of effectiveness. *[House Report, page 82]*

Action taken or to be taken

Through collaborations and an Interagency Agreement (IAA), NIMH and SAMHSA have worked together since 2014 to develop guidance, training, and technical assistance to states and territories to implement evidence-based programs for early serious mental illness focusing on first-episode psychosis through a set-aside in the Community Mental Health Services Block Grant (MHBG). SAMHSA, in partnership with NIMH, has supported, guided, and monitored the development of evidence-based programs throughout the nation. SAMHSA provides oversight and ongoing technical support through its training and technical assistance functions. Every state and territory has a program underway and the majority has fully implemented programs while a few are in earlier stages of development. SAMHSA has developed a "snapshot" of all the First Episode Psychosis (FEP) programs, detailing each State's allotment, name of the program being implemented, and a short description of the program.

SUBSTANCE ABUSE TREATMENT

Targeted Capacity Expansion.—The Committee recommends $61,303,000 for Targeted Capacity Expansion activities. Of this amount, $50,080,000 is for services that address prescription drug abuse and heroin use in high-risk communities. This funding level will provide funding for 45 States. SAMHSA should target States with the highest rates of admissions and that have demonstrated a dramatic increase in admissions for the treatment of opioid addiction. The United States has seen a 500 percent increase in admissions for treatment for prescription drug abuse since 2000. Moreover, according to a recent study, in the past two years, 28 States saw an increase in admissions for treatment for heroin dependence. The Center for Substance Abuse Treatment is directed to include as an allowable use medication-assisted treatment and other clinically

appropriate services to achieve and maintain abstinence from all opioids and heroin and prioritize treatment regimens that are less susceptible to diversion for illicit purposes. *[House Report, page 83]*

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment, is working with the Targeted Capacity Expansion Medication-Assisted Treatment Prescription Drug and Opioid Addiction grantees to ensure use of medication assisted treatment and other clinically appropriate services and have informed the grantees that they should prioritize treatment regimens that are less susceptible to diversion for illicit purposes.

Drug Treatment Courts.—The Committee continues to direct SAMHSA to ensure that all funding appropriated for Drug Treatment Courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. SAMHSA is directed to ensure that all drug treatment court grant recipients work directly with the corresponding State substance abuse agency in the planning, implementation, and evaluation of the grant. The Committee further directs SAMHSA to expand training and technical assistance to drug treatment court grant recipients to ensure evidence-based practices are fully implemented. *[House Report, page 83]*

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment, ensures that all funding appropriated for Drug Treatment Courts is allocated to serve people diagnosed with a substance use disorder as their primary condition. In addition, grantees in the program are expected to work with the state substance abuse agency in planning, implementation and evaluation of the grants. SAMHSA also continues to provide training and technical assistance to Drug Treatment Court grantees.

Drug Testing for Opioid Treatment Programs.—Drug testing plays a key role in the delivery of safe and effective substance abuse treatment programs. Providers utilize these tests to identify the type of substance abuse, to determine a proper treatment plan, to continue on-going evaluations, and to prevent drug diversion. The Committee requests SAMHSA ensure that all opioid treatment programs are implementing drug tests at a frequency necessary to implement a safe and an effective program. *[House Report, page 84]*

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment's Division of Pharmacologic Therapies, works with all certified opioid treatment programs (OTPs) to ensure that requisite drug testing is implemented across the treatment episode for all clients of opioid abuse treatment at OTPs in an evidence-based fashion.

Overdose Fatality Prevention.—The agreement reflects strong concerns about the increasing number of unintentional overdose deaths attributable to prescription and nonprescription opioids.

SAMHSA is urged to take steps to encourage and support the use of Substance Abuse and Prevention Block Grant funds for opioid safety education and training, including initiatives that improve access for licensed healthcare professionals, including paramedics, to emergency devices used to rapidly reverse the effects of opioid overdoses. Such initiatives should incorporate robust evidence based intervention training, and facilitate linkage to treatment and recovery services. *[House Report, page 84]*

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment, is working with Substance Abuse Prevention and Treatment Block Grant recipients to ensure the provision of evidence-based training and technical assistance in the area of opioid safety, including training supporting access to life saving devices used to rapidly reverse the effects of opioid overdose.

Viral Hepatitis Screening.—The Committee applauds SAMHSA for encouraging grantees to screen for viral hepatitis including the use of innovative strategies like rapid testing. The Committee notes the disproportionate impact of viral hepatitis among minority populations and the co-infection rate among individuals with HIV/AIDS. The committee urges SAMHSA to work with Minority AIDS grantees to incorporate hepatitis screening into programmatic activities. *[House Report, page 84]*

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment, implements the Department of Health and Human Services' Hepatitis Action Plan which notes that people with HIV are disproportionally affected by viral hepatitis and related adverse conditions. Through the Center for Substance Abuse Treatment's Minority AIDS program, grantees are required to implement hepatitis screening as a condition of the award.

Comprehensive Opioid Response.—The Committee recommends $500,000,000 for Comprehensive Opioid Response grants. SAMHSA, in coordination with CDC, may award funds to eligible states, units of local government, territories or Indian Tribes, which may, in turn, sub-grant to non-governmental organizations as appropriate. Funds may be used to plan for and implement an integrated opioid abuse response initiative that incorporates prevention and education, treatment, and recovery services. Eligible activities are as follows: (1) Prevention and education efforts concerning heroin and opioid use, treatment, and recovery; (2) Education of physicians, residents, medical students, and other medical providers who prescribe controlled substances on the prescription drug monitoring program of the State, on the CDC Guideline for Prescribing Opioids for Chronic Pain, and on the treatment of addiction; (3) Expanding prescription drug and opioid addiction treatment programs of the State. This includes the expansion of abstinence-based and medication assistance treatment programs that incorporate training for treatment and recovery support providers; behavioral health therapy for individuals who are in treatment for prescription drug and opioid addiction; screening for and clinically appropriate treatment of hepatitis C and HIV; and screening, early intervention, and referral to treatment for teenagers and young adults in primary care, middle schools, high schools, universities, school-based health centers, and other community-based health care settings; and (4)

Developing, implementing, and expanding programs to prevent overdose death from prescription medications and opioids that incorporate a referral to treatment services. Priority shall be given to States with the highest burden of opioid-related overdoses. SAMHSA is directed to brief the Committee no less than 30 days before issuing a funding announcement regarding the criteria for grant awards. In addition, SAMHSA is directed to brief the Committee no less than 30 days before awarding a grant. *[House Report, pg 85]*

Action taken or to be taken

On December 14, 2016, SAMHSA released a Funding Opportunity Announcement in line with the State Response to the Opioid Abuse Crisis program authorized in Section 1003 of the 21st Century Cures Act and Section 195 of the Further Continuing and Security Assistance Appropriations Act, 2017 which appropriated the $500,000,000 for the State Response to the Opioid Abuse Crisis program. The program aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities (including prescription opioids as well as illicit drugs such as heroin). These grants will be awarded to states and territories via formula based on unmet need for opioid abuse treatment and drug poisoning deaths. SAMHSA would be pleased to brief the Committee at its convenience regarding this important program.

SUBSTANCE ABUSE PREVENTION

Strategic Prevention Framework State Incentive Grant and Partnerships for Success.—The Committee intends that the Strategic Prevention Framework State Incentive Grant and Partnerships for Success programs continue to focus exclusively on: addressing State- and community-level indicators of alcohol, tobacco, and drug use; targeting and implementing appropriate universal prevention strategies, building infrastructure and capacity, and preventing substance use and abuse. *[House Report, page 85]*

Action taken or to be taken

The Strategic Prevention Framework State Incentive Grant and Strategic Prevention Framework Partnerships for Success (SPF-PFS) programs continue to address the nation's top emerging substance abuse priorities including underage drinking and prescription drug misuse. SAMHSA continues to focus exclusively on: addressing State- and community-level indicators of alcohol, tobacco, and drug use; targeting and implementing appropriate universal prevention strategies; building infrastructure and capacity; and preventing substance use and abuse. SAMHSA provides support for grantees to strengthen substance abuse prevention infrastructure and capacity using the strategic prevention framework.

Grants to Prevent Prescription Drug and Opioid Overdose Related Deaths.—The Committee recommends $12,000,000 for discretionary grants to States to prevent prescription drug and opioid overdose related deaths. This program will help States equip and train first responders with the use of devices that rapidly reverse the effects of opioids. SAMHSA is directed to ensure applicants outline how proposed activities in the grant would work with treatment and recovery communities in addition to first responders. Furthermore, the agreement provides $10,000,000 for the Strategic

Prevention Framework Rx program to increase awareness of opioid abuse and misuse in communities. SAMHSA shall collaborate with CDC to implement the most effective outreach strategy and to reduce duplication of activities. *[House Report, page 85]*

Action taken or to be taken

SAMHSA ensures that the Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths grantees develop a dissemination plan and a training course tailored to meet the needs of their community. The course uses SAMHSA's Opioid Overdose Prevention Toolkit as a guide, and includes a comprehensive prevention program, which focuses on prevention, treatment and recovery services to decrease the likelihood of drug overdose recurrence. Grantees are also equipping and training first responders with the use of devices that rapidly reverse the effects of opioids.

In addition, SAMHSA's Strategic Prevention Framework for Prescription Drugs (SPF-Rx) program assists grantees in developing capacity and expertise in the use of data from state run prescription drug monitoring programs (PDMP). Grantees are strategically planning and strengthening their current prescription drug misuse efforts through the use of PDMP data. The SPF Rx grant program is also intended to identify communities by geography and high-risk population (e.g., age group), as well as target those communities that are in need of primary and secondary prevention.

SAMHSA is continuing its collaboration with CDC to implement the most effective outreach strategies and reduce any duplication of activities. The two agencies are coordinating to ensure that the efforts are aligned with HHS's recently established policy and plan for prevention of Opioid-Related Overdoses and Deaths involving multiple Operating Divisions and offices.

Oral Fluid Drug Screening Guidelines.—The Committee is pleased with SAMHSA's recommendation of oral fluid as an alternative specimen for drug testing, and commends the agency for progress made to issue oral fluid guidelines for the Federal Drug-Free Workplace testing program. The Committee urges SAMHSA to implement the guidelines expeditiously in partnership with key stakeholders and other agencies. *[House Report, page 85]*

Action taken or to be taken

The Proposed Oral Fluid Mandatory Guidelines for the Federal Workplace Drug Testing Programs (OFMG) were published in the Federal Register in May 2015. SAMHSA has reviewed comments and is in the process of revising the OFMG in order to publish final OFMG in the near future.

Minority Fellowship Program.—The Committee understands there is a workforce shortage among children's mental health providers. The Committee is concerned that the National Minority Fellowship Program unnecessarily excludes related psychiatric subspecialists from programmatic eligibility. The Committee requests SAMHSA review internal eligibility criterion and provide an update in the fiscal year 2018 budget request. *[House Report, page 86]*

Action taken or to be taken

SAMHSA's Minority Fellowship Program (MFP) aims to reduce health disparities and improve health care outcomes for racially and ethnically diverse populations by increasing the number of culturally competent behavioral health providers available to underserved minority populations (e.g., Asian American, African American, American Indian/Alaska Native, Hispanic/Latino, and Native Hawaiian and other Pacific Islanders). SAMHSA supports efforts to include psychiatric subspecialties in the MFP, including efforts to alleviate the workforce shortage among children's mental health providers. SAMHSA regularly meets with the seven associated grantees for the Minority Fellowship Program and discusses and plans for the recruitment of fellows. The MFP was not previously authorized, but was recently codified in the 21st Century Cures Act. SAMHSA will continue to ensure the program meets the language specified in statute.