DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2017

Substance Abuse and Mental Health Services Administration

Justification of Estimates for Appropriations Committees

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Substance Abuse and Mental Health Services Administration
SAMHSA
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I am pleased to present the Substance Abuse and Mental Health Services Administration (SAMHSA) fiscal year 2017 Budget Request. SAMHSA is requesting a total of $4.3 billion. As the primary federal agency for 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, including serious mental illnesses, gain access to high quality services and that effective substance abuse prevention and mental health promotion strategies are implemented where they are needed most.

SAMHSA is committed to optimizing the impact of every dollar entrusted to our agency. This Budget Request maintains critical investments in FY 2016 and aligns with the Administration's priorities to address behavioral health for children, adults, families, and communities. Through its Block Grant programs, SAMHSA provides critical support of the behavioral health safety net, including substance abuse prevention, and support of vulnerable population such as those living with or at risk for HIV/AIDS, pregnant women, and individuals experiencing early serious mental illness

SAMHSA's FY 2017 budget request includes investments to:

- Expand access to care for opioid use disorders though a new two-year State Targeted Response Cooperative Agreements program financed with $920 million in new mandatory funds. In addition, the Budget invests in Medication-Assisted Treatment (MAT) and expansion of the types of practitioners able to prescribe buprenorphine. This funding is part of the Administration's $1 billion initiative to expand treatment for opioid use disorders.
- Help engage individuals with serious mental illness into care through a new $230 million two-year investment in early intervention services. This funding is part of the Administration's $500 million initiative to expand access to mental health services.
- Address the alarming rates of suicide across the nation for youth and adults, with increased focus on populations at highest risk - older adults and Native youth.
- Help communities address behavioral health crises by strengthening crisis system partnerships and ensuring availability of evidence-based strategies such as naloxone distribution and Assisted Outpatient Treatment.

SAMHSA provides strategic investments that foster innovation 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 2017, SAMHSA's initiatives 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. Whether in a crisis, such as an opioid overdose that gets reversed or a suicide that is averted, or by laying 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 Administrator

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

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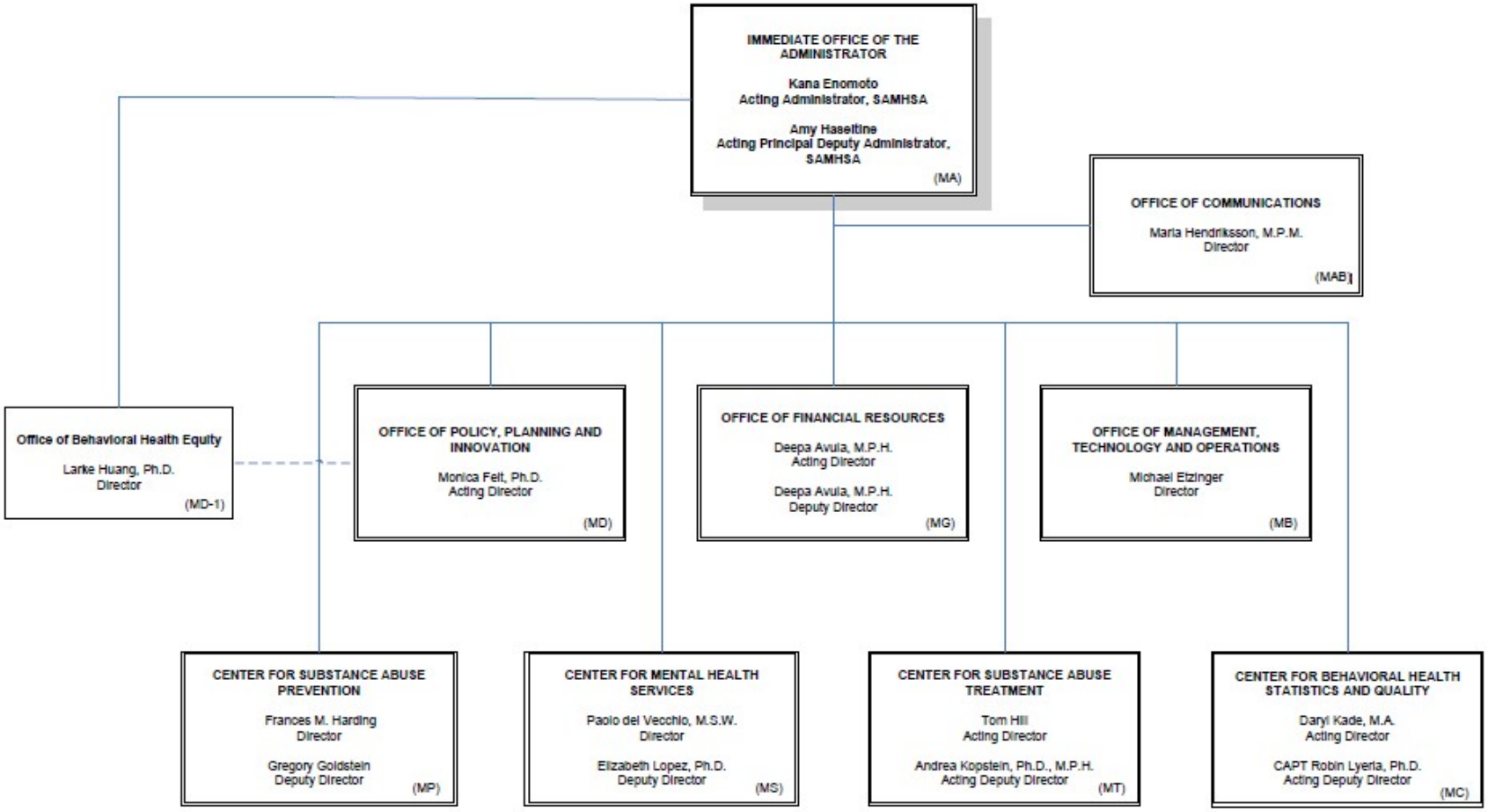
Organizational Structure:
Substance Abuse and Mental Health Services Administration (SAMHSA)



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Performance Budget Overview

Introduction

Now, more than ever, the need to face mental health and substance misuse is critical to the nation's future. Prevention, treatment, and support to help people recover from mental and/or substance use disorders 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, of the estimated 43.7 million adults with a mental illness[1] and 20.3 million adults with a substance use disorder in the past year,[1] many did not receive needed care. Only 41 percent of adults with diagnosable mental health problems received treatment.[1] Similarly, only 11 percent of people with a substance use disorder received treatment at a specialty substance abuse treatment facility.[1] The nation can do better. SAMHSA has a unique responsibility to focus on these preventable and treatable problems, which, if unaddressed, come with extraordinary 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 partnerships, policies, and programs that build resilience, improve access to quality treatment options, and facilitate recovery for people with, or at risk for, mental and/or substance use disorders.

[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

Behavioral health conditions take an exacting toll on individuals, communities, and society. They are primary drivers of disability,[2] impose a substantial economic burden on society,[3,4,5] inflict great costs on the healthcare system,[6] and lead to early death.[7] They demand a sustained and concerted approach.

This Budget Request seeks to advance SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities in several areas.
The Budget addresses the opioid (a class of drugs that includes prescription painkillers and heroin) overdose epidemic through a $920.0 million investment in new mandatory funding over the next two years to help individuals seek treatment, successfully complete treatment, and sustain recovery. States will receive funds based on the severity of the epidemic and on the strength of their strategy to respond to it. States can use these funds to expand treatment capacity and make services more affordable to those who cannot afford it. This funding is part of the Administration's $1.0 billion initiative to expand access to treatment for opioid use disorders by helping all Americans who want treatment to access it and get the help they need.

Additionally, the Budget advances the United States behavioral health system while addressing pressing behavioral health issues through investments in the development of crisis systems, strategies to utilize Assisted Outpatient Treatment, and early intervention for individuals with serious mental illness through a new $230.0 million investment of mandatory funds that is part of the Administration's $500.0 million two-year initiative to increase access to mental health services.

The Budget Request strategically and directly addresses the serious and preventable public health problem of suicide. In 2013, over 41,000 people died by suicide. Deaths by suicide exceeded deaths by homicide, HIV, opioid overdoses, or traffic incidents. Building on SAMHSA's current efforts to address this tragic reality, the Budget includes a new $26.0 million program that uses evidence-based strategies to reduce the number of suicides in America, with a particular focus on adults 45 to 64 years of age, the age group that has had the sharpest rate increase since 2000.

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[2] Murray, C. J., Abraham, J., Ali, M. K., Alvarado, M., Atkinson, C., Baddour, L. M. & Gutierrez, H. R. (2013). The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. *Jama*, *310*(6), 591-606.

[3] The Global Economic Burden of Non-Communicable Diseases, World Economic Forum, 2011, http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf. [4]

TR Insel, Assessing the Costs of Serious Mental Illness, Am J Psychiatry, 2008 June; 165(6): 663-665.

[5] Department of Justice National Drug Threat Assessment 2011, The Economic Impact of Illicit Drug Use on American Society, 2011, U.S. Department of Justice, http://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf.

[6] Goodell, S., Druss, B. G., Walker, E. R., & MAT, M. (2011). Mental disorders and medical comorbidity. *Robert Wood Johnson Foundation*, 2.

[7] E. Chesney et al., Risks of all-cause and suicide mortality in mental disorders: a meta-review, World Psychiatry; 2014: 13:1153-160.

Key Policy and Budget Priorities

SAMHSA's FY 2017 Budget Request seeks to accomplish two goals: 1) to support the systematic development of the behavioral healthcare system and 2) to address pressing behavioral health issues facing our nation.

SAMHSA will address the first goal by including funding in the Budget Request to support the priorities outlined in SAMHSA's strategic plan, *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018*. By building on the areas identified in *Leading Change 2.0*, SAMHSA will support the development of the United States behavioral health system in areas identified through planning and engagement with stakeholders. *Leading Change 2.0* focuses on six areas: Prevention of Substance Abuse and Mental Illness; Health Care and Health Systems Integration; Trauma and Justice; Recovery Support; Health Information Technology; and Workforce Development.

SAMHSA's Budget addresses the second goal through new investments that address critical public health needs, which demand immediate attention, including the opioid overdose epidemic, care for individuals with serious mental illness, rising suicides among older adults and Native youth, and the need for better-coordinated crisis systems to address behavioral health crises.

Summary of Budget Request and Themes

I. Advancing SAMHSA's Strategic Priorities

Prevention of Substance Abuse and Mental Illness – The Budget Request maintains a strong focus on prevention through existing programs that develop the capacity of states, communities, primary care providers, early childhood systems, and school systems to prevent the onset of substance use and promote mental health and wellness. These efforts continue to respond to public health priorities, including a focus on the prevention of suicide, opioid misuse, and the prevalence of underage drinking. This Budget supports national action and increased suicide prevention efforts as well as more resources for the prevention of prescription drug misuse. The Budget Request also includes funds to build awareness about behavioral health issues in schools and communities, including a special focus on communities, which have recently experienced civil unrest, through the Project Advancing Wellness and Resilience in Education (AWARE) program. The Budget Request also maintains the Mental Health Block Grant set-aside for evidence-based programs that address the treatment and support services needs of individuals with early serious mental illness, including psychotic disorders. It also includes funding to help people in the prodrome phase of psychosis. This funding would support and evaluate community programs for outreach and intervention with youth and young adults showing symptoms of being at risk for psychosis. Promising research shows that this early intervention can assist in preventing development of certain serious mental illnesses, such as schizophrenia or bipolar disorder.

Health Care and Health Systems Integration – The Budget Request supports a range of initiatives designed to help the behavioral health system adapt to broader system changes. It

invests in programs designed to integrate primary care and physical health services into mental health settings, provides coordinated and integrated care for people with mental and substance use disorders and HIV and/or viral hepatitis, and supports states and providers to adapt to a changing healthcare landscape. This Request includes $50.1 million for the Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT PDOA) program. Building upon the effort started in FY 2015, this expanded program will provide integrated care including MAT, psychosocial interventions, and HIV and Hepatitis C screening for individuals with opioid use disorders.

Trauma and Justice – The Budget Request maintains investments in systems designed to improve trauma-informed care for children and youth, and efforts to promote care that recognize and respond to trauma. These programs and other SAMHSA efforts build on SAMHSA's publication "Concept of Trauma and Guidance for a Trauma-Informed Approach" which introduces a concept of trauma and offers a framework for how an organization, system, or service sector can become trauma-informed. The Budget Request also supports a variety of programs to address the needs of people with mental and substance use disorders who are involved in, or are at risk of, involvement in the criminal justice system.

Recovery Support – The Budget Request maintains a variety of programs designed to meet the needs of people in recovery from mental and substance use disorders. These include efforts to provide help from peer providers and families with lived experience of recovery from mental and/or substance use disorders. Programs engage and respond to the self-identified needs and help find individual pathways to recovery. As part of state and community efforts to improve crisis response and follow-up to promote safety and stability, the Budget funds the Assisted Outpatient Treatment (AOT) program established in the Protecting Access to Medicare Act of 2014 and funded for the first time in FY 2016. This program will test the effectiveness and build best practices around AOT to inform the national conversation that is taking place on this important topic.

Health Information Technology – The Budget Request continues SAMHSA's focus on supporting the increased use of health information technology through its grant programs. SAMHSA will advance new approaches to manage and transfer behavioral health information while protecting privacy. This includes efforts to assist the field to use the latest technology and integrate services while complying with federal law governing the disclosure of information about substance use disorder treatment.

Workforce Development – Workforce development continues to be a key priority for SAMHSA. In this Budget Request, SAMHSA continues investments in training for behavioral health professionals, including programs to train peer providers and increase the number of culturally competent behavioral health professionals available to serve underserved populations. SAMHSA's Budget continues data development efforts to understand better the behavioral health workforce needs.

II. Meeting Pressing Public Health Challenges

In addition to strengthening the behavioral health field by addressing strategic priorities, SAMHSA is committed to meeting current behavioral health challenges facing the United States. As a result, this Budget Request proposes new efforts to address the opioid overdose epidemic, engage individuals with serious mental illness into care, prevent suicide, continues a strong focus on building better systems to help people, including those with a serious mental illness, having a behavioral health crisis, and expands the development of the healthcare workforce.

Opioid Overdose: Death from overdose of opioids, a class of drugs that includes prescription painkillers and heroin, have taken a heartbreaking toll on too many Americans. The Budget for SAMHSA supports the Administration's initiative to address alarming increase in opioid addiction and overdose deaths seen over the past decade. The Budget includes $920.0 million in new mandatory funding over the next two years to help individuals seek treatment, successfully complete treatment, and sustain recovery. States will receive funds based on the severity of the epidemic and on the strength of their strategy to respond to it. States can use these funds to expand treatment capacity and make services more affordable to those who cannot afford it. In addition to these mandatory funds, SAMHSA's Budget expands the Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT PDOA) program to serve a total of 46 States and funding for a new demonstration program related to expanding the types of providers permitted to prescribe buprenorphine. These programs directly align with the goal of expanding access to MAT, one of three primary goals the Department of Health and Human Services has articulated in its call to action to address the prescription drug and opioid crisis.

Serious Mental Illness: As part of the Administration's initiative to increases access to mental health services, the Budget invests $230.0 million in new mandatory resources over the next two years to engage individuals with serious mental illness into care. Research has found that individuals with psychosis often do not receive appropriate treatment for that condition for over a year. This delay in treatment worsens long-term outcomes for people experiencing these conditions affecting their behavioral health, physical health, and achievement of education and employment goals

Suicide: Between 1999 and 2013, the suicide rate in the United States rose from 10.46 to 13.02 per 100,000 people.[8] 41,149 Americans died by suicide in 2013, making suicide the 10th leading cause of death in the country above homicide, HIV, opioid overdoses, and traffic deaths.[9,10] Addressing this growing problem demands new resources and an approach that addresses populations at highest need. Currently, people aged 45 to 64 are at the highest risk for suicide followed by people ages 85 or older.[11] When compared to the general population, people between ages 45 and 59 have the highest numbers of suicide and those between ages 50 and 59

[8] CDC, Fatal Injury Reports, http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html
[9] CDC, Deaths, Final Data for 2013, Detailed Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf
[10] NHTSA Early Estimate of Motor Vehicle Traffic Fatalities for the First Half (Jan-Jun) of 2014, http://www-nrd.nhtsa.dot.gov/Pubs/812093.pdf
[11] CDC, Fatal Injury Reports, http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html

have the highest rates of suicide. However, many of the current suicide prevention resources focus on youth and young adults. In addition, systems that have the best chance of intervening to prevent suicide, such as primary care, are not often involved in suicide prevention efforts.

Recognizing the urgency of addressing this issue, SAMHSA proposes to target the problem proactively through the new $26.0 million Zero Suicide initiative. This new program will build on the National Strategy for Suicide Prevention's recommendation for a comprehensive, multi-setting approach to suicide prevention by incorporating both a strong community effort and a strong health systems effort. This proposal is based on a successful model that has prevented suicides by changing the culture and capacity of health systems by identifying those at risk and ensuring they are served with evidence-based approaches and follow-up care. This program can be a central part of the response to this growing concern. This effort will also include a $5.2 million set-aside to focus specifically on the issue of suicide as it relates to tribal populations.

Crisis Systems: In addition to focused efforts to address the suicide problem in the nation, SAMHSA, through the Increasing Crisis Access Response Efforts (ICARE) grant program, will address the need to build, fund, and sustain crisis systems capable of preventing and de-escalating behavioral health crises as well as connecting individuals and families with needed post-crisis services to prevent recurrence of the crisis situation.

III. Supporting HHS Tribal Health and Well-Being Coordination

American Indians and Alaska Natives (AI/ANs) bear a disproportionate burden of death, disease, disability, and injury compared to other racial and ethnic groups in the United States. For example, AI/ANs have a higher prevalence of obesity than their white counterparts do (33.9 percent versus 23.3 percent for men and 35.5 percent versus 21 percent for women), and are more than twice as likely to have diagnosed diabetes as non-Hispanic whites (16.1 percent to 7.1 percent). There has also been increasing concern over the persistently high rates of suicide, particularly among AI/AN youth. The most recently available death certificate data show the overall age-adjusted suicide rate for the AI/AN population was 18.3 per 100,000 in 2013, compared to 13.8 per 100,000 in the population overall. These and other health problems are driven by higher rates of poverty, unemployment, and low educational achievement, which in turn are linked to key risk behaviors, like alcohol and tobacco use.

For FY 2017, the Department of Health and Human Services (HHS) is articulating a department-wide Tribal Health and Well-Being Coordination Plan that calls on several HHS agencies - the Indian Health Service, Administration for Children and Families, SAMHSA, Health Resources and Services Administration, and the Centers for Disease Control and Prevention - to collaborate to improve health outcomes for AI/AN populations. SAMHSA's suicide prevention activities in support of this plan include the Garrett Lee Smith suicide prevention program, a set-aside for tribes in Zero Suicide, and the Tribal Behavioral Health Grant program.

The cross-cutting priorities for the initiative are:

- Building capacity and sustainable infrastructure in AI/AN communities.
- Improving access to and quality of health and human services in AI/AN communities.
- Strengthening connection to culture, language and life ways to build resilience and promote health and healthful behaviors, especially among AI/AN youth and young adults.

To ensure the greatest impact for these programs, available funding will target tribes with the highest need, either as direct awardees or as recipients of resources, support and technical assistance from funded tribal organizations and Tribal Epidemiology Centers (TECs). The agencies will define targeted outcomes and strive to streamline application and reporting requirements to ensure that increased burden is not placed on AI/AN communities.

Budget Request

SAMHSA's Budget Request for FY 2017 of $4.3 billion reflects a $590.2 million increase from the FY 2016 Enacted Level.

Program Increases:

State Targeted Response Cooperative Agreements (+$920.0 million, Mandatory)
The FY 2017 Budget Request includes a total of $920.0 million for the State Targeted Response Cooperative Agreements program ($460.0 million in FY 2017 and $460.0 million in FY 2018). This new effort would close the treatment gap in substance use disorder treatment by addressing commonly cited barriers to treatment through reducing the cost of treatment, expanding access to treatment, engaging patients in treatment, and addressing negative attitudes associated with accessing treatment. This funding is part of the Administration's $1.0 billion two-year initiative to expand access to treatment to reduce prescription drug abuse and heroin use.

Evidence-based Early Interventions (+$230.0 million, Mandatory)
The FY 2017 Budget Request includes a total of $230.0 million in mandatory funding for the Evidence-based Early Intervention Services ($115.0 million in FY 2017 and $115.0 million in FY 2018). Working in collaboration with set-aside funded activities, this new formula grant would provide additional funds to enable all states to establish supports and services for early intervention and enable states that already have programs to expand further their efforts. SAMHSA would administer this new formula grant program to support evidence-based early intervention. Plans include a minimum of $700,000 to each state and a tribal set-aside. This funding is part of the Administration's $500.0 million initiative to increase access to mental health care.

Suicide Prevention: National Strategy on Suicide Prevention (+$28.0 million)
The FY 2017 Budget Request is $30.0 million, an increase of $28.0 million from the FY 2016 Enacted Level. The proposed funding for this initiative will support the expansion of the National Strategy on Suicide Prevention program and create a new $26.0 million Zero Suicide program. This program includes a $5.2 million set-aside for tribes to address the high rates of

suicides among American Indian/Alaska Natives. While American Indian/Alaska Natives have the highest rates of youth suicide among any ethnic group, these rates remain highly elevated well into adulthood.

The program focuses on the critical need to address the risk of suicide for adults and older adults. It comprises two components. The first component, Zero Suicide in Behavioral Health Care, will provide nine grants to states to embed the Zero Suicide model throughout their behavioral healthcare systems including within Accountable Care Organizations. The foundational belief of Zero Suicide is that suicide deaths for adults under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge. The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, healthcare system. Specifically, this program will support implementation of post-discharge follow-up protocols for individuals at risk of suicide and provide suicide-specific treatment approaches. This component of the initiative would focus on statewide efforts to reduce suicide among those adults receiving care through the state's public behavioral health system.

The second component, Comprehensive State/Community Suicide Prevention, will provide seven grants to allow states to engage communities and organizations in a comprehensive effort to identify persons at risk for suicide and link them to needed services. Care systems that have adopted these approaches have been successful in reducing suicides. States with large (over 1,000) numbers of deaths by suicide, and states with high rates, but smaller numbers of suicides, will be eligible for these grants. Grant recipients will implement and evaluate evidence-based suicide prevention activities in the full spectrum of potential community and clinical suicide prevention settings including primary care, emergency rooms, schools/educational settings, the workplace, faith communities, and justice settings. A similar comprehensive approach fully implementing the Scottish National Strategy led to an 18 percent reduction in deaths by suicide in Scotland, including reductions among adult males who make up a significant majority of suicides in Scotland, as they do in the United States.

Crisis Systems (+$10.0 million)

The FY 2017 Budget Request is $10.0 million for Crisis Systems, an increase of $10.0 million from the FY 2016 Enacted Level. This includes $5.0 million in the Mental Health appropriation and $5.0 million in the Substance Abuse Treatment appropriation. The Increasing Crisis Access Response Efforts (ICARE) program helps communities build, fund, and sustain crisis systems capable of preventing and de-escalating behavioral health crises as well as connecting individuals, including those with serious mental illness, and families with needed post-crisis services.

Targeted Capacity Expansion: Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT PDOA) (+$25.1 million)

The FY 2017 Budget Requests $50.1 million, an increase of $25.1 million from the FY 2016 Enacted Level, to focus on medication-assisted treatment (MAT) expansion/enhancement efforts. The funding will enable SAMHSA to support 23 new MAT PDOA state grants at $1.0 million to expand/enhance MAT utilizing FDA-approved medications in combination with psychosocial services, recovery support services, and coordination/integration of HIV/hepatitis C direct

services. The program will target states that demonstrated a dramatic increase in treatment admissions for opioid use disorders and that experienced the highest rates of treatment admissions for opioid use disorders. Program outcomes include length of stay in treatment, first time treatment admissions, the number of people receiving MAT, the number of people receiving recovery support/relapse prevention services, and the number of MAT providers. SAMHSA will also track client-level outcomes such as abstinence from substance use, housing, employment and criminal justice status and social connectedness. Ultimately, individuals with opioid use disorders will have increased access to effective, comprehensive, coordinated care that will serve to foster recovery.

Cohort Monitoring and Evaluation of Medication-Assisted Treatment (+$30.0 million, mandatory)

The FY 2017 Budget Request includes a total of $30.0 million for the Cohort Monitoring and Evaluation of Medication-Assisted Treatment, ($15.0 million in FY 2017 and $15.0 million in FY 2018). This is an increase of $15.0 million from the FY 2016 Enacted Level. Public health and substance abuse treatment agencies will evaluate the short, medium, and long-term outcomes of substance abuse treatment programs in order to increase effectiveness reducing opioid use disorders, overdose, and death. Under this proposal, SAMHSA will work with other research agencies within the Department of Health and Human Services and will prospectively monitor the treatment outcomes of patients with opioid addiction entering medication-assisted treatment programs. This demonstration will provide valuable insight into the effectiveness of treatment programs employing medication-assisted treatment under real-world conditions and help identify opportunities to improve treatment for patients with opioid addiction. Systematic information on the outcomes of patients who undergo medication-assisted treatment is currently lacking. Cohort monitoring is commonly used to monitor treatment of patients with infectious diseases, such as tuberculosis treatment, and drives accountability for patient outcomes; a similar approach could be useful to improving addiction treatment. This funding is part of the Administration's $1.0 billion two-year initiative to increase access to treatment for prescription drug abuse and heroin use

Buprenorphine-Prescribing Authority Demonstration (+$10.0 million)

The FY 2017 Budget Request includes $10.0 million for a new program, Buprenorphine-Prescribing Authority Demonstration. SAMHSA intends to implement a services research demonstration project that will test the safety and effectiveness of allowing prescribing buprenorphine, a medication used to treat opioid use disorders, by non-physician advance practice providers in accordance with the providers' prescribing authority under state law. Currently only physicians are allowed to prescribe buprenorphine. Expanding prescribing authority to advance practice providers could increase the availability of MAT services. SAMHSA will collaborate with professional organizations that represent advance practice nurses, physician assistants, and other non-physician advance practice providers as well as addiction psychiatrists and primary care physicians to determine the appropriate training and supervision requirements for advance practice providers in order to assure patient safety and well-being while minimizing diversion of buprenorphine.

This demonstration project will target populations and geographic areas most affected by both high-need and limited access to DATA-waived physicians. SAMHSA will solicit Input from

stakeholders as needed to assure the project results in a feasible implementation strategy for increasing access to buprenorphine treatment in the targeted areas. SAMHSA will use a continuous quality improvement model to monitor the patient-level safety and effectiveness of the project. Impact of the project will be assessed using community-level measures such as overdose mortality, incidence of HIV and acute hepatitis C infections, and Drug Enforcement Agency reported drug seizures.

In FY 2017, SAMHSA plans to award seven new grants for up to three years and one evaluation and technical assistance contract for three years.

In addition, other efforts are underway to ensure access to buprenorphine. In 2015, the Secretary of the Department of Health and Human Services announced the development of an update to the regulation of buprenorphine. SAMHSA has led this rulemaking effort for the Department and is working in close partnership with the other HHS components and federal agencies.

Project Advancing Wellness and Resilience in Education (AWARE) (+$7.1 million)
The FY 2017 Budget Request is $72.0 million, an increase of $7.1 million from the FY 2016 Enacted Level. As part of the President's *Now is the Time* (*NITT*) initiative, this program seeks to raise awareness about mental health issues and connects young people who have behavioral health issues and their families with needed services. SAMHSA requests funding to support a new cohort of Project AWARE State Educational Agency awards, continuation grants to raise awareness and expand care in communities with civil unrest, 20 continuation Project AWARE SEA awards, 70 continuation Mental Health First Aid awards, *NITT* technical assistance, and evaluation contracts. This funding will serve over four million children. The increase represents a reallocation of funds from Youth Violence Prevention to Project AWARE. The reallocation of these funds will enable SAMHSA to avoid duplication among programs with like purposes.

Project AWARE also addresses the Administration's multi-agency Native Youth priority related to Improving Education Outcomes and Like Outcomes for Native Youth, in support of the HHS Tribal Health and Well-Being Coordination.

Agency-Wide Initiatives (+$10.0 million)
The FY 2017 Budget Request includes a total of $22.7 million for Agency-Wide Initiatives, an increase of $10.0 million from the FY 2016 Enacted Level. The $10.0 million increase in funding will support the development of a new Peer Professional Workforce Development program. The program aims to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Masters level addiction counselors working with young people ages 16 to 25. It will provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs. The funding will support up to 19 grants.

Program Decreases:

Youth Violence Prevention (-$23.1 million)

The FY 2017 Budget Request proposes eliminating the Youth Violence Prevention program in FY 2017. SAMHSA is requesting to reallocate funding from this program to *Now is the Time* Project Advancing Wellness and Resilience in Education (*NITT* Project AWARE). The reallocation of these funds to *NITT* Project AWARE will continue to bring to scale program activities, practices, and lessons learned in the youth violence prevention arena and address current and emerging issues. The reallocation of these funds will enable SAMHSA to avoid duplication among programs with like purposes.

Primary and Behavioral Health Care Integration (-$23.9 million)

The FY 2017 Budget Request is $26.0 million, a decrease of $23.9 million from the FY 2016 Enacted Level. This funding will continue to support the coordination and integration of primary care services into publicly funded community behavioral health settings. The decrease in funding will not result in the termination of any existing grants.

Screening, Brief Intervention and Referral to Treatment (SBIRT) (-$16.9 million)

The FY 2017 Budget Request is $30.0 million, a decrease of $16.9 million from the FY 2016 Enacted Level. The SBIRT program helps reduce the number of individuals who misuse drugs and alcohol and intervenes early to ensure individuals improve their health and overall quality of life. With the increasing adoption of SBIRT in healthcare settings, the Budget redirects resources to other priority treatment activities.

Treatment Systems for Homeless (-$4.9 million)

The FY 2017 Budget Request is $36.4 million, a decrease of $4.9 million from the FY 2016 Enacted Level. This decrease will not result in termination of any grant continuations nor will it significantly affect SAMHSA's ability to implement its homeless programs.

Criminal Justice Activities (-$16.1 million)

The FY 2017 Budget Request is $61.9 million ($50.0 million for Drug Courts and $11.9 million for Other Criminal Justice Activities), a decrease of $16.1 million from the FY 2016 Enacted Level. SAMHSA proposes to focus this portfolio more strategically to explore new approaches and a variety of models within the drug court umbrella.

Addiction Technology Transfer Centers (ATTC) (-$1.0 million)

The FY 2017 Budget Request is $8.1 million, a decrease of $1.0 million from the FY 2016 Enacted Level. In FY 2017, SAMHSA plans to fund a new cohort of 15 five-year ATTC grants. SAMHSA expects the ATTCs to sponsor over 1,000 events involving more than 30,000 unique participants in FY 2017. In addition to the number of participants, event topics and contact hours, other metrics to be collected include participant satisfaction measures such as self- assessed skill levels both pre and post training. Funding will allow the 15 ATTCs 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.

Program Support (-$2.0 million)

The FY 2017 Budget Request is $77.6 million, a decrease of $2.0 million from the FY 2016 Enacted Level. This level of funding will continue to cover overhead costs associated with

5600 Fishers Lane, including rent, the Federal Acquisition Service loan repayment program, and security charges.

In FY 2017, SAMHSA plans to support 665 FTEs with funding from the Mental Health, Substance Abuse Treatment, and Health Surveillance and Program Support appropriations.

Public Awareness and Support (-$2.1 million)

The FY 2017 Budget Request is $13.5 million, a decrease of $2.1 million from the FY 2016 Enacted Level. These funds will allow SAMHSA to maintain and update its web presence, develop innovative mobile apps, expand SAMHSA's presence on social media, and provide other critical resources to support the behavioral health field. 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. For example, through the National Outreach, Public Education and Engagement Initiative contract, SAMHSA will work with the Center for Disease Control and Prevention to disseminate information about prescriber guidelines on the dangers of prescription drug misuse.

$2.0 million of the reduced funding is because SAMHSA no longer needs the one-time funding for the effort "Science of Changing Social Norms." The lessons learned through the program in FY 2016 and SAMHSA's work with the National Academies' Board on Behavioral, Cognitive, and Sensory Sciences will inform SAMHSA's other communications efforts and programs in FY 2017 and beyond.

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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 from what works and does not work. 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.

One example of SAMHSA's contributions to an HHS Agency Priority Goal is its work to reduce tobacco use. SAMHSA's National Survey on Drug Use and Health (NSDUH) provides tobacco use prevalence data to help monitor tobacco rates and trends by various populations, including:

- In 2014, 3.8 percent of children and adolescents aged 12 to 17 years who had not previously smoked cigarettes in their lifetime, first smoked cigarettes in the past 12 months**.**
- These data represent a decline from 2009 to 2014; the percentage of past year initiates of cigarette use, ages 12-17, decreased from 6.2 percent to 3.8 percent.

NSDUH data also indicate that adults with mental or substance use disorders account for 40 percent of all cigarettes smoked. To address the high prevalence of tobacco use by this population, SAMHSA has been working with state behavioral health systems. In June 2014, SAMHSA conducted a *State Policy Academy for Tobacco Control in Behavioral Health,* which provided an opportunity for behavioral health leadership teams in participating states to build a collaborative action planning process to address the high rate of tobacco use by people with mental and/or substance use disorders.

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 provides data, analyses, and reports that help states and communities address the complex challenges associated with substance abuse and mental illness, such as disaster relief. SAMHSA responded to 15 different types of disasters during 2014 and 2015 including civil unrest, floods, suicide clusters, and fires. SAMHSA was in immediate contact with community and state behavioral health leaders, providing resources, subject matter experts, technical assistance, and counseling services via SAMHSA's Disaster Distress Helpline (DDH). The DDH is a national, toll-free, multilingual, and confidential crisis support service available to all residents in the United States and its territories.

SAMHSA also maintains its commitment to utilize performance data to manage and monitor its robust portfolio of grants. Due to technical difficulties with the existing Common Data Platform, SAMHSA is reconfiguring its approach to uniform data collection with the implementation of

SAMHSA's Performance Accountability and Reporting System (SPARS). This will provide a common data and reporting system for all SAMHSA discretionary grantees and allow 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 Activities	FY 2015[1,2] Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Now is the Time Presidential Initiative **Mental Health:**				
Project AWARE	$54,865	$64,865	$71,964	+$7,099
Project AWARE State Grants (non-add)	*39,902*	*49,902*	*57,001*	*+7,099*
Mental Health First Aid (non-add)	*14,963*	*14,963*	*14,963*	---
Healthy Transitions	19,951	19,951	19,951	---
Public Awareness and Support	---	2,000	---	-2,000
Science of Changing Social Norms	---	*2,000*	---	*-2,000*
Health Surveillance and Program Support:				
Behavioral Health Workforce	6,246	6,246	16,246	+10,000
Minority Fellowship Program - Youth/Addiction Counselors (non-add)	*5,246*	*5,246*	*5,246*	---
SAMHSA-HRSA BHWET Grant Program[1] (non-add)	---	---	---	---
Peer Professional Workforce Development (non-add)	---	---	*10,000*	*+10,000*
Behavioral Health Workforce Data and Development (non-add)	*1,000*	*1,000*	*1,000*	---
TOTAL[2] (information only -- amounts included below)	**81,062**	**93,062**	**108,161**	**+15,099**
Mental Health:				
Programs of Regional and National Significance	370,538	406,550	406,388	-162
Prevention and Public Health Fund (non-add)	*12,000*	*12,000*	*10,000*	*-2,000*
PHS Evaluation Funds (non-add)	---	---	*10,000*	*+10,000*
Children's Mental Health Services	117,026	119,026	119,026	---
Projects for Assistance in Transition from Homelessness	64,635	64,635	64,635	---
Protection and Advocacy for Individuals with Mental Illness	36,146	36,146	36,146	---
Evidence-based Early Interventions (Mandatory)	---	---	115,000	+115,000
Community Mental Health Services Block Grant	482,571	532,571	532,571	---
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*21,039*	---
Total, Mental Health	**1,070,916**	**1,158,928**	**1,273,766**	**+114,838**
Substance Abuse Prevention:				
Programs of Regional and National Significance	175,148	211,148	211,148	---
PHS Evaluation Funds (non-add)	---	---	*16,468*	*+16,468*
Total, Substance Abuse Prevention	**175,148**	**211,148**	**211,148**	---
Substance Abuse Treatment:				
Programs of Regional and National Significance	361,463	333,806	343,269	+9,463
Mandatory Funds (non-add)	---	---	*15,000*	*+15,000*
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*	*+28,000*
State Targeted Response Cooperative Agreements (Mandatory)	---	---	460,000	+460,000
Substance Abuse Prevention and Treatment Block Grant	1,819,856	1,858,079	1,858,079	---
PHS Evaluation Funds (non-add)	*79,200*	*79,200*	*79,200*	---
Total, Substance Abuse Treatment	**2,181,319**	**2,191,885**	**2,661,348**	**+469,463**

[1] Entries reflect 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.

All-Purpose Table
Substance Abuse and Mental Health Services Administration
(continued)

(Dollars in thousands)

Program Activities	FY 2015[1,2] Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Health Surveillance and Program Support:				
Health Surveillance and Program Support:	119,260	126,817	124,817	-2,000
Prevention and Public Health Fund (non-add)	---	---	*17,830*	*+17,830*
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*29,428*	*-1,000*
Public Awareness and Support	13,482	15,571	13,482	-2,089
PHS Evaluation Funds (non-add)	---	---	*13,482*	*+13,482*
Performance and Quality Information Systems	12,918	12,918	12,918	---
PHS Evaluation Funds (non-add)	---	---	*12,918*	*+12,918*
Agency-Wide Initiatives[1,2]	11,669	12,669	22,669	+10,000
PHS Evaluation Funds (non-add)	*1,000*	*1,000*	*1,000*	---
Data Request/Publications User Fees	1,500	1,500	1,500	---
Total, Health Surveillance and Program Support	**158,829**	**169,475**	**175,386**	**+5,911**
TOTAL, SAMHSA Program Level	**3,586,212**	**3,731,436**	**4,321,648**	**+590,212**
Less Cohort Monitoring and Evaluation of MAT Outcomes (Mandatory	---	---	*15,000*	*+15,000*
Less Evidence-based Early Interventions (Mandatory)	---	---	*115,000*	*+115,000*
Less State Targeted Response Cooperative Agreements (Mandatory)	---	---	*460,000*	*+460,000*
Less PHS Evaluation Funds	*133,667*	*133,667*	*213,535*	*+79,868*
Less Prevention and Public Health Funds	*12,000*	*12,000*	*27,830*	*+15,830*
Less Data Request and Publications User Fees	*1,500*	*1,500*	*1,500*	---
TOTAL, SAMHSA Budget Authority	**$3,439,045**	**$3,584,269**	**$3,488,783**	**-$95,486**
FTEs	**614**	**665**	**665**	---

[1] Entries reflect 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.

[2] The Minority Fellowship Program budgets from the Mental Health, Substance Abuse Prevention, and Substance Abuse Treatment appropriations have been comparably adjusted in this table to be in line with the FY 2017 Budget Request. These are reflected in the Health Surveillance and Program Support appropriation under the Agency-Wide Initiatives Workforce program.

NOW IS THE TIME

The Administration's plan to protect our children and our communities by reducing gun violence and increasing access to mental health services.

(Dollars in thousands)

Program Activities	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Now is the Time **Presidential Initiative**				
Mental Health:				
Project AWARE	$54,865	$64,865	$71,964	+$7,099
Project AWARE State Educational Agency Grants (non-add)	*39,902*	*49,902*	*57,001*	*+7,099*
Mental Health First Aid (non-add)	*14,963*	*14,963*	*14,963*	---
Healthy Transitions	19,951	19,951	19,951	---
Health Surveillance and Program Support:				
Public Awareness and Support	---	2,000	---	-2,000
Science of Changing Social Norms	---	*2,000*	---	*-2,000*
Behavioral Health Workforce	6,246	6,246	16,246	+10,000
Minority Fellowship Program-Youth/Addiction Counselors (non-add)	*5,246*	*5,246*	*5,246*	---
SAMHSA-HRSA BHWET Grant Program[1] (non-add)	---	---	---	---
Peer Professional Workforce Development (non-add)	---	---	*10,000*	*+10,000*
Behavioral Health Workforce Data and Development (non-add)	*1,000*	*1,000*	*1,000*	---
TOTAL [1]	**$81,062**	**$93,062**	**$108,161**	**+$15,099**

[1] Table 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.

Authorizing Legislation .....Sections 501, 505, 509, 516 and 520A the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....State and Local Education Agencies, Local Governmental Entities, Community Organizations and Provider Organizations

SAMHSA's *Now is the Time (NITT)* activities support the President's plan, in response to the tragedy at Sandy Hook Elementary School, to improve access to mental health services for young people. SAMHSA-supported activities under this initiative are helping teachers and other adults who interact with youth recognize signs of mental illness, improve referrals, and increase access to mental health services for young people aged 16 to 25. In addition, SAMHSA is funding the training of thousands of additional behavioral health professionals with a focus on serving students and young adults. Given that the majority of mental disorders begin before age 24, these efforts support early interventions that help get young people get treated early and therefore can help forestall the impact of untreated serious mental illness, such as disability.[12,13] The FY 2017 Budget Request includes $108.2 million for *Now is the Time*. This is a $15.1 million increase over the FY 2016 Enacted Level of $93.1 million. The FY 2017 Budget Request includes an increase from the FY 2016 Enacted Level for both the Project AWARE (Advancing Wellness and Resilience in Education) program and the Behavioral Health Workforce program and the elimination of the Science of Changing Social Norms initiative.

[12] Stafford, M.R., Jackson, H., Mayo-Wilson, E., Morrison, A.P. & Kendall, T. (2013). Early interventions to prevent psychosis; systematic review and meta-analysis. *BMJ.* 346(f185), 1-13.
[13] Goldstein, A.B., Heinssen, R.K. & Azrin, S.T, (2015). Accelerating science-to-practice for early psychosis. *Psychiatric Services.* 66(7), p.665.

Project AWARE

(Dollars in thousands)

Programs of Regional & National Significance	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
Project AWARE	$54,865	$64,865	$71,964	+$7,099
Project AWARE State Educational Agency Grants (non-add)	*39,902*	*49,902*	*57,001*	*+7,099*
Mental Health First Aid (non-add)	*14,963*	*14,963*	*14,963*	---

Authorizing Legislation..... Sections 501 and 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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

In FY 2014, in response to the tragedy at Sandy Hook Elementary School and as part of the President's *Now is the Time* initiative, SAMHSA provided $54.9 million to support Project AWARE (Advancing Wellness and Resilience in Education) to increase awareness of mental health issues and connect young people who have behavioral health issues and their families with needed services. SAMHSA collaborates with the Departments of Education and Justice in the development, implementation, and management of this initiative to maximize coordination and avoid duplication of efforts.

Project AWARE has multiple components. The first component, Project AWARE State Educational Agency (SEA) grants, is built on the highly successful Safe Schools/Healthy Students model, which is intended to create safe and supportive schools and communities. SAMHSA awarded these grants to 20 SEAs to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services.

The second component, 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 and/or substance use disorders in children and youth, including how to talk to adolescents and families experiencing these problems so that they are more willing to seek treatment. The target for the first year of the program was 750,000 individuals trained or served. In FY 2015, given a diverse grantee pool made up of both urban and rural school districts, the MHFA program trained or served nearly 4.5 million individuals. As a result, SAMHSA has increased the target for future years.

In FY 2014, SAMHSA funded 20 Project AWARE SEA awards and 100 MHFA Local Educational Agencies (LEAs) multi-year awards to grantees who applied for Department of Education School Climate Change awards. The project period for Project AWARE SEA awards

is five years and the project period for MHFA awards is two years. In FY 2015, SAMHSA provided continuation support for these Project AWARE SEA grants. In addition, SAMHSA awarded 70 new MHFA grants to community organizations to support the training of teachers and a broad array of actors who interact with youth through their programs at the community level, including parents, law enforcement, faith-based leaders, and other adults.

In FY 2016, SAMHSA is supporting the continuation of 90 grants (20 AWARE SEA grants and 70 MHFA Community grants) and related contracts. In addition, SAMHSA is awarding a new cohort of up to six grants to communities that have recently faced civil unrest. These grants will focus on high-risk youth and families in communities and surrounding areas that have experienced significant exposure to trauma. They will support evidence-based violence prevention and community youth engagement programs as well as linkages to trauma-informed behavioral health services. SAMHSA will prioritize funding grants from communities that have formed partnerships between key stakeholders including State and local governments (including multiple cities and counties if impacted); public or private universities and colleges; and non-profit community- and faith-based organizations. SAMHSA is coordinating extensively with the Department of Education in the administration of this grant program.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	$54,865,000
FY 2015	$54,865,000
FY 2016	$64,865,000
FY 2017	$71,964,000

Budget Request

The FY 2017 Budget Request is $72.0 million, an increase of $7.1 million from the FY 2016 Enacted Level. As part of the President's *Now is the Time* initiative, this program seeks to raise awareness about mental health issues and connects young people who have behavioral health issues and their families with needed services. SAMHSA requests funding to support a new cohort of Project AWARE State Educational Agency awards, continuation grants to raise awareness and expand care in communities with civil unrest, 20 continuation Project AWARE SEA awards, 70 continuation MHFA awards, *NITT* technical assistance, and evaluation contracts. SAMHSA has a target to serve over four million children. The increase represents a reallocation of funds from Youth Violence Prevention to Project AWARE. The reallocation of these funds will enable SAMHSA to avoid duplication among programs with like purposes.

Project AWARE is a program that also addresses the Administration's multi-agency Native Youth priority related to Improving Education Outcomes and Like Outcomes for Native Youth, in support of the HHS Tribal Health and Well-Being Coordination.

Healthy Transitions

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Healthy Transitions.....	$19,951	$19,951	$19,951	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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 and substance use disorders, 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 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,[14] be arrested,[15] drop out of school,[16] and be unemployed.[17] 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 support.

In FY 2014, SAMHSA provided $20.0 million for Healthy Transitions within the *Now is the Time* (*NITT*) 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 substance use disorder and are at high risk for suicide. Unfortunately, these youth are among the least likely to seek help.[18] Through this program, states are expanding services, developing

[14] 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.
[15] 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.
[16] Planty, M., Hussar, W., Snyder, T., Provasnik, S., Kena, G., Dinkes, R., Kemp, J. (2008). The condition of education 2008 (NCES 2008-031).
[17] 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.
[18] 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.

family and youth networks for information sharing and peer support, and disseminating best practices for services for these young individuals.

Grantees in their first year of the award have developed and built capacity within their states and local communities to deliver services. The *NITT* technical assistance and evaluation contracts have been providing training and technical assistance to grantees in order to meet grant requirements successfully.

In FY 2015, SAMHSA supported 17 *NITT* Healthy Transitions continuation grants and the *NITT* technical assistance and evaluation contracts. In FY 2016, SAMHSA will continue to support the continuation grants and the *NITT* technical assistance and evaluation contracts.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	$19,951,000
FY 2015	$19,951,000
FY 2016	$19,951,000
FY 2017	$19,951,000

Budget Request

The FY 2017 Budget Request is $20.0 million, the same as the FY 2016 Enacted Level. SAMHSA's request will support fourth-year continuation funding for the 17 *NITT* Healthy Transition grant recipients. In addition, this funding will support the *NITT* technical assistance and evaluation contracts. SAMHSA expects to refer up to 6,000 transition-aged youth with serious mental health conditions to related services through the Healthy Transitions program.

Healthy Transitions is a program that also addresses the Administration's multi-agency Native Youth priority related to Improving Education Outcomes and Like Outcomes for Native Youth, in support of the HHS Tribal Health and Well-Being Coordination.

Science of Changing Social Norms

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Science of Changing Social Norms.....	$---	$2,000	$---	-$2,000

Authorizing Legislation..... Sections 501 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method.....Contracts
Eligible Entities.....N/A

Program Description

The "Science of Changing Social Norms: Building the Evidence Base" laid fundamental groundwork upon which SAMHSA continues to build in FY 2016. In FY 2016, SAMHSA is beginning the next phase of the Science of Changing Social Norms program. Through this effort, SAMHSA will inform the development and testing of an array of messages designed to raise public awareness of the importance of behavioral health, promote health literacy to reduce the negative perceptions and attitudes about behavioral health issues, and help Americans make behavioral health a priority for public health action. Going forward, SAMHSA will use the insight gained through this effort to inform our communications about the importance of behavioral health.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$2,000,000
FY 2017	---

Budget Request

The FY 2017 Budget Request is $0.0 million, a decrease of $2.0 million from the FY 2016 Enacted Level. The reduction is because the one-time evaluation is no longer needed. The lessons learned through the program in FY 2016 and SAMHSA's work with the National Academies' Board on Behavioral, Cognitive, and Sensory Sciences will inform SAMHSA's other communications efforts and programs in FY 2017 and beyond.

Behavioral Health Workforce

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Behavioral Health Workforce.....	$6,246	$6,246	$16,246	+$10,000
Minority Fellowship Program-Youth/Addiction Counselors (non-add).....	*5,246*	*5,246*	*5,246*	---
SAMHSA-HRSA BHWET Grant Program[1] (non-add).....	---	---	---	---
Peer Professional Workforce Development (non-add).....	---	---	*10,000*	*+10,000*
Behavioral Health Workforce Data and Development (non-add).....	*1,000*	*1,000*	*1,000*	---

[1]The table reflects the transfer of funding associated with the Behavioral Health Workforce Expansion and Training (BHWET) program from SAMHSA to HRSA. HRSA and SAMHSA will continue to work together to implement this program.

Authorizing Legislation..... Section 501, 509, 516, and 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Community Colleges, Universities, States, National Organizations

Program Description and Accomplishments

SAMHSA's workforce activities help train additional behavioral health professionals to work with students and young adults with mental illnesses and other behavioral health problems. These activities include SAMHSA's Minority Fellowship Program-Youth/Addiction Counselors, a Peer Professional Workforce Development program, and the Behavioral Health Workforce Data and Development program.

Minority Fellowship Program Expansion-Youth (MFP-Y) and Addiction Counselors (MFP-AC)
In FY 2014, additional funding expanded the MFP to 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 populations.

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.

In addition, in FY 2014, funding expanded the MFP to support master's level addiction counselors (MFP-AC). 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.

The FY 2015 Budget provided $5.3 million in funding for MFP grants. The FY 2016 Enacted Level of $5.3 million sustains and strengthens the expansion program.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	$5,246,000
FY 2015	$5,246,000
FY 2016	$5,246,000
FY 2017	$5,246,000

Budget Request

The FY 2017 Budget Request includes $5.3 million, which is the same as the FY 2016 Enacted Level. This funding will provide continued support for five MFP-Y grants, two MFP-AC grants, and three technical assistance and evaluation support contracts.

Behavioral Health Workforce Data and Development

As of June 2014, there were more than 4,000 Mental Health Professional Shortage Areas in the United States, containing nearly a third of the American population, or 96 million people. Recent data indicate that almost 90 percent of persons with substance use disorders do not receive the services they need[19] and over half of those with any mental illness do not receive needed treatment.[20]

The President's *Now is the Time* initiative support new activities to expand the behavioral health workforce. In FY 2015, new workforce investments provided support for 2,116 new behavioral health professionals. To ensure the existing workforce investments would achieve desired outcomes, SAMHSA workforce activities in FY 2015 included $1.0 million to collaborate with

[19] 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.

[20] Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

HRSA on the Behavioral Health Minimum Data Set to develop consistent data collection methods to identify and track behavioral health workforce needs. In FY 2015 and in FY 2016, SAMHSA will continue to work with HRSA to develop a consistent and common data set and to develop clear goals and objectives to meet the national behavioral health workforce needs in America.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	$1,000,000
FY 2016	$1,000,000
FY 2017	$1,000,000

Budget Request

The FY 2017 Budget Request of $1.0 million is level with the FY 2016 Enacted Level. These funds will allow SAMHSA to continue collaborating with HRSA. These efforts will focus analytical and research projects in three behavioral health workforce focus areas: 1) expanded application of standardized minimum data set with state and professional organizations; 2) workforce modeling and projections to understand what behavioral health services are being provided, by whom and in what settings; and 3) development of certification/licensing/scope of practice framework for each state.

Peer Professional Workforce Development

The Peer Professional Workforce Development program will fund grants to provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs. The Peer Professional Workforce Development program's goal is to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-masters-level addiction counselors working with young people ages 16 to 25. Because they have lived with behavioral health conditions, the entry-level providers supported by this program will play a significant role in the delivery of prevention, outreach, engagement, and recovery support services. Studies show that individuals with a substance use disorder who regularly engage in peer-delivered interventions are more likely to abstain from substance misuse. Evidence also shows the effectiveness of those with mental disorders and their families in supporting their peers. The Behavioral Health Workforce Education and Training program, described below, focuses on supporting clinical internships, field placements, and certificate program completion across a range of professional and paraprofessional disciplines. In contrast, the Peer Professional Workforce Development program will focus on helping communities develop the infrastructure to train and certify peers, or people with lived experience with mental illness and/or substance use conditions, as behavioral health providers.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$10,000,000

Budget Request

The FY 2017 Budget Request of $10.0 million reflects an increase of $10.0 million from the FY 2016 Enacted Level. These funds will support the development of the new Peer Professional Workforce Development program. The program aims to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Masters level addiction counselors working with young people ages 16 to 25. It will provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs. The funding will support up to 19 grants.

SAMHSA-HRSA Behavioral Health Workforce Education and Training (BHWET) Grant Program

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. In FY 2014 through FY 2016, SAMHSA requested and Congress appropriated this funding to SAMHSA and HRSA carried out the program under a reimbursable agreement. In FY 2017, HHS is requesting that HRSA receive the funding for this program. SAMHSA has comparably adjusted impacted tables to avoid confusion. This is in line with HRSA's current authorities and will aid in streamlining efforts. SAMHSA and HRSA will continue to collaborate to sustain and strengthen the HRSA-SAMHSA partnership and the behavioral health workforce.

Outputs and Outcomes Table

Program: *Now is the Time*

NOTE: SAMHSA makes grant awards toward the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.2.18 Increase the number of children served. (Output)	FY 2015: 4,696,119 Target: 750,000 (Target exceeded)	4,696,119	4,696,119	Maintain
3.2.34 Increase the percentage of clients receiving services who report positive functioning at 6-month follow-up. (Outcome)	FY 2015: 66% Target: 64% (Target exceeded)	64%	64%	Maintain
3.2.36 Increase the percentage of clients receiving services who are currently employed at 6-month follow-up. (Outcome)	FY 2015: 56% Target: 56 % (Target met)	56%	56%	Maintain
4.4.20 Increase the Minority Fellowship awards. (Outcome)	FY 2016: Result Expected December 31, 2016 Target: 1,260 (Pending)	1,260	1,260	Maintain
4.4.21 Increase the Peer Professional Workforce Development. (Outcome)	FY 2016: Result Expected December 31, 2016 Target: 1,200 (Pending)	1,200	1,200	Maintain
4.4.22 Increase Behavioral Health Workforce Education and Training. (Outcome)	FY 2015: 2,116 Target: 3,700 (Target not met)	3,700	3,700	Maintain

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SAMHSA
Budget Exhibits
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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**]** *$1,117,727,000*: *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**]** *$31,039,000* 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 section 520E(b)(2) of the PHS Act shall not apply to funds appropriated in this Act for fiscal year **[**2016**]** *2017*: **[***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**]** *mental health prevention and treatment practices to* 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 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)*: 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*.

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**]** *$2,077,148,000*: *Provided*, That in addition to amounts provided herein, **[**the following amounts**]** *$109,200,000* 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*: Provided further, That notwithstanding section 508 of the PHS Act, up to 25 percent of the amounts made*

available to carry out such section may be used to carry out demonstration grants to provide intensive outpatient services and treatment as well as any of the services listed in section 508(d).

SUBSTANCE ABUSE PREVENTION

For carrying out titles III and V of the PHS Act with respect to substance abuse prevention, **[**$211,219,000**]** *$194,680,000: Provided, That in addition to amounts provided herein, $16,468,000 shall be available under section 241 of the PHS Act to supplement funds otherwise available for substance abuse prevention activities*.

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**]** *$99,228,000*: *Provided,* That in addition to amounts provided herein, **[**$31,428,000**]** *$56,828,000* 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) of the PHS Act shall remain available through September 30, **[**2017**]** *2018*: *Provided further,* That funds made available under this heading may be used to supplement program support funding provided under the headings

"Mental Health", "Substance Abuse Treatment", and "Substance Abuse Prevention"*: Provided further, That the Administrator may transfer 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. (Department of Health and Human Services Appropriations Act, 2016.)*

GENERAL PROVISIONS

SEC. 225. Notwithstanding subparagraph (B)(i) of section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)), the Secretary of Health and Human Services may, using amounts made available in this Act to carry out title V of the Public Health Service Act, establish and carry out a demonstration through fiscal year 2021 in which, for purposes of prescribing buprenorphine under such section 303(g)(2), the term "practitioner" shall be deemed to include non-physician providers authorized to prescribe buprenorphine by the jurisdiction in which the provider is licensed who meet such criteria as determined appropriate by the Secretary, in consultation with the Attorney General, for participation in the project. In implementing this demonstration project, the Secretary and Attorney General shall not be subject to the requirements of 5 U.S.C. 553. The Secretary may enter into grants, contracts, or cooperative agreements with one or more research institutions, and public and nonprofit entities to assist in carrying out such demonstration. In addition, amounts available for this fiscal year in other Acts to the Attorney General for carrying out section 303 of the Controlled Substances Act shall also be available to the Attorney General to facilitate and support the efficient operation of the demonstration under this section. Any authority for a provider to prescribe buprenorphine that

results from participating in this demonstration project shall end no later than the date such provider ceases to participate in this demonstration. (Department of Health and Human Services Appropriations Act, 2016.)

Language Analysis

Language Provision	Explanation
Provided further, That in addition to amounts provided herein, **[**$21,039,000**]** *$31,039,000* 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. This change would allow PHS Evaluation funds to be used to fund the Crisis Systems and Tribal Behavioral Health Grants programs in addition to activities supported in FY 2016. These evaluation efforts will enable the gathering and dissemination of best practices.
Provided further, That section 520E(b)(2) of the PHS Act shall not apply to funds appropriated in this Act for fiscal year **[**2016**]** *2017*:	Because all states will have received a grant under the Garrett Lee Smith Youth Suicide Prevention statewide program and the original purpose of the restriction in 520E (b) (2) has been served, this language would allow the program to continue by allowing states to receive a second grant.
[*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:**]**	It is not necessary to have specific statutory earmark for this activity, which is funded in the Budget at $46,887,000. This statutory earmark increases the administrative burden of the program.

Language Provision	Explanation
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**]** *mental health prevention and treatment practices to* address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset:	States must use at least 10 percent of their Community Mental Health Services Block Grant award to support evidence-based mental health promotion and treatment practices with respect to individuals with early serious mental illness.
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% of first time psychotic episodes) instead of only children (which represent less than 50% 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.
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,	Sets out the budget authority for the Substance Abuse Treatment appropriation.

Language Provision	Explanation
Provided, That in addition to amounts provided herein, **[**the following amounts**]** *$109,200,000* 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	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.
[; and (2) $2,000,000 to evaluate substance abuse treatment programs**]**:	The provision previously mentioned eliminates the need for this separate proviso as the amount is included in the $109,200,000.
Provided further, That notwithstanding section 508 of the PHS Act, up to 25 percent of the amounts made available to carry out such section may be used to carry out demonstration grants to provide intensive outpatient services and treatment as well as any of the services listed in section 508(d).	This provision would permit up to 25 percent of the Pregnant and Postpartum Women funding to be used for a subset of new grantees to pay directly for a wider range of required and optional family-centered services for pregnant and postpartum women and their minor children including intensive out-patient and out-patient treatment with housing components. In addition, certain grantees would be able to utilize funding to develop a collaborative infrastructure that is capable of building the region's long-term capacity to

Language Provision	Explanation
	meet the comprehensive substance abuse treatment needs of pregnant and post-partum women, as well as the needs of her infant, other children, and the family.
Provided, That in addition to amounts provided herein, $16,468,000 shall be available under section 241 of the PHS Act to supplement funds otherwise available for substance abuse prevention activities.	Sets the amount of Public Health Service Evaluation Fund dollars allocated to supplement the budget authority available for programs and activities authorized under titles III and V. This change would allow PHS Evaluation funds to be used to fund the Center for the Application of Prevention Technologies and Strategic Prevention Framework Rx programs. These evaluation efforts will enable the gathering and dissemination of best practices.
Provided further, That amounts made available in this Act for carrying out section 501(m) of the PHS Act shall remain available through September 30, **[**2017**]** *2018*:	SAMHSA's existing emergency authority allows it to tap certain programs up to one percent for emergency response grants. SAMHSA's ability to respond to disasters which occur at the end of the year, which is hurricane season, is hampered by low available balances. To ensure programs are only tapped to the extent necessary and to ensure that SAMHSA's emergency response is agile, this proviso allows funds tapped to be carried over one additional fiscal year, and only for the same purpose. This technical change updates the year.

Language Provision	Explanation
Provided further, That the Administrator 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.
SEC. 225. Notwithstanding subparagraph (B)(i) of section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)), the Secretary of Health and Human Services may, using amounts made available in this Act to carry out title V of the Public Health Service Act, establish and carry out a demonstration through fiscal year 2021 in which, for purposes of prescribing buprenorphine under such section 303(g)(2), the term "practitioner" shall be deemed to include non-physician providers authorized to prescribe buprenorphine by the jurisdiction in which the provider is licensed who meet such criteria as determined appropriate by the Secretary, in consultation with the Attorney General, for participation in the project. In implementing this demonstration project, the Secretary and Attorney General shall not be subject to the	This provision permits the Secretary to establish a buprenorphine demonstration project that permits non-physician providers to prescribe buprenorphine if such providers are allowed under State law. For purposes of carrying out this demonstration project, the Attorney General and Secretary are not subject to APA notice and comment rulemaking requirements. For non-physician providers who received authority to prescribe buprenorphine from the demonstration, that authority would end once their participation in the demonstration project ends.

requirements of 5 U.S.C. 553. The Secretary may enter into grants, contracts, or cooperative agreements with one or more research institutions, and public and nonprofit entities to assist in carrying out such demonstration. In addition, amounts available for this fiscal year in other Acts to the Attorney General for carrying out section 303 of the Controlled Substances Act shall also be available to the Attorney General to facilitate and support the efficient operation of the demonstration under this section. Any authority for a provider to prescribe buprenorphine that results from participating in this demonstration project shall end no later than the date such provider ceases to participate in this demonstration. (Department of Health and Human Services Appropriations Act, 2016.)	

Amounts Available for Obligation

(Whole dollars)

	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS, Ag, or, Interior)	$3,474,045,000	$3,634,269,000	$3,488,783,000
Across-the-board reductions (L/HHS, Ag, or Interior)	---	---	---
Subtotal, Appropriation (L/HHS, Ag, or Interior)	3,474,045,000	3,634,269,000	3,488,783,000
Comparable transfer to: Health Resources and Services Administration	(35,000,000)	(50,000,000)	---
Subtotal, adjusted general fund discr. appropriation	(35,000,000)	(50,000,000)	---
Total, Discretionary Appropriation	**3,439,045,000**	**3,584,269,000**	**3,488,783,000**
Mandatory Appropriation:			
Behavioral Health Initiative	---	---	115,000,000
Expanding Access to Treatment to Reduce Prescription Drug Abuse and Heroin Use	---	---	475,000,000
Transfer from the Prevention and Public Health Funds	12,000,000	12,000,000	27,830,000
Subtotal, adjusted mandatory appropriation	12,000,000	12,000,000	617,830,000
Offsetting collections from:			
Federal Source	133,667,000	133,667,000	213,535,000
Data Request and Publications User Fees	1,500,000	1,500,000	1,500,000
Unobligated balance, start of year	172,000	790,000	---
Unobligated balance, end of year	1,338,000	1,219,776	1,170,947
Unobligated balance, lapsing	---	---	---
Total obligations	**$3,586,212,000**	**$3,731,436,000**	**$4,321,648,000**

Summary of Changes

(Whole dollars)

2016	
Total estimated budget authority	$3,584,269,000
(Obligations)	3,584,269,000
2017	
Total estimated budget authority	3,488,783,000
(Obligations)	3,488,783,000
Net Change	**-$95,486,000**

Increases:	**FY2017 PB FTE**	**FY2017 PB BA**	**FY2017 +/- FY2016 FTE**	**FY2017 +/- FY2016 BA**
A. Built-in:				
1. Annualization of 2017 commissioned corps pay increase	---	$69,560	---	+$69,560
2. Annualization of 2017 civilian pay increase	---	821,408	---	+821,408
Subtotal, Built-in Increases	---	**890,968**	---	**+890,968**
A. Program:				
1. Agency-Wide Initiatives	---	22,669,000	---	+10,000,000
Subtotal, Program Increases	---	**22,669,000**	---	**+10,000,000**
Total Increases	---	---	---	**+10,890,968**
Decreases:				
A. Built-in:	---	---	---	---
1. Absorption of built-in increases	---	---	---	-890,968
Subtotal, Built-in Decreases	---	---	---	**-890,968**
A. Program:				
1. Mental Health PRNS	---	1,117,727,000	---	-8,162,000
2. Substance Abuse Prevention PRNS	---	194,680,000	---	-16,468,000
3. Substance Abuse Treatment PRNS	---	2,077,148,000	---	-33,537,000
4. Health Surveillance	---	---	---	-16,830,000
5. Program Support	---	77,559,000	---	-2,000,000
6. Public Awareness and Support	---	---	---	-15,571,000
7. Performance and Quality Information Systems	---	---	---	-12,918,000
Subtotal, Program Decreases	---	**3,467,114,000**	---	**-105,486,000**
Total Decreases	---	---	---	**-106,376,968**
Net Change	$---	$---	$---	**-$95,486,000**

Summary of Changes (Continued)

(Whole dollars)

2016	
Total estimated mandatory	$12,000,000
(Obligations)	12,000,000
2017	
Total estimated mandatory	617,830,000
(Obligations)	617,830,000
Net Change	**+$605,830,000**

Increases:	**FY2017 PB FTE**	**FY2017 PB Mandatory**	**FY2017 +/- FY2016 FTE**	**FY2017 +/- FY2016 Mandatory**
A. Program:				
1. Mental Health	---	---	---	---
2. Substance Abuse Treatment	---	---	---	---
3. Health Surveillance	---	17,830,000	---	+17,830,000
Subtotal, Program Increases	---	**590,000,000**	---	**+607,830,000**
Decreases:				
A. Program:				
1. Mental Health PRNS	---	10,000,000	---	-2,000,000
Subtotal, Program Decreases	---	**10,000,000**	---	**-2,000,000**
Net Change	---	**$600,000,000**	---	**+$605,830,000**

Authorizing Legislation

(Whole dollars)

Program Description/PHS Act:	FY 2016 Amount Authorized	FY 2016 Appropriations Act	FY 2017 Amount Authorized	FY 2017 President's Budget
Grants for the Benefit of Homeless Individuals Sec. 506……	Expired	$41,304,000	Expired	$36,386,000
Residential Treatment Programs for Pregnant and Postpartum Women Sec. 508……..……	Expired	$15,931,000	Expired	$15,931,000
Priority Substance Abuse Treatment Needs of Regional and National Significance Sec. 509*……	Expired	$244,966,000	Expired	$216,347,000
Substance Abuse Treatment Services for Children and Adolescents Sec. 514*……	Expired	$29,605,000	Expired	$29,605,000
Priority Substance Abuse Prevention Needs of Regional and National Significance Sec. 516*……	Expired	$204,148,000	Expired	$187,680,000
Programs to Reduce Underage Drinking Sec. 519B*……	Expired	$ 7,000,000	Expired	$ 7,000,000
Priority Mental Health Needs of Regional and National Significance Sec. 520A*……	Expired	$219,515,000	Expired	$256,325,000
Youth Interagency Research, Training, and Technical Assistance Centers Sec. 520C*……	Expired	$5,988,000	Expired	$5,988,000
Suicide Prevention for Children and Youth Sec. 520E*……	Expired	$23,427,000	Expired	$25,427,000
Sec. 520E2*……	Expired	$6,488,000	Expired	$6,488,000
Grants for Jail Diversion Programs Sec. 520G*……	Expired	$4,269,000	Expired	$4,269,000
Awards for Co-locating Primary and Specialty Care in Community-based Mental Health Settings Sec. 520K*……	Expired	$49,877,000	Expired	$26,004,000
PATH Grants to States Sec. 535(a)……	Expired	$64,635,000	Expired	$64,635,000
Community Mental Health Services for Children with Serious Emotional Disturbances Sec. 565 (f)……	Expired	$119,026,000	Expired	$119,026,000
Children and Violence Program Sec. 581*……	Expired	$23,099,000	Expired	0
Grants for Persons who Experience Violence Related Stress Sec. 582…..	Expired	$46,887,000	Expired	$46,887,000
Community Mental Health Services Block Grants Sec. 1920(a)……	Expired	$511,532,000	Expired	$511,532,000
Substance Abuse Prevention and Treatment Block Grants Sec. 1935(a)	Expired	$1,778,879,000	Expired	$1,778,879,000

Authorizing Legislation (Continued)

(Whole dollars)

Other Legislation/Program Description	FY 2016 Amount Authorized	FY 2016 Appropriations Act	FY 2017 Amount Authorized	FY 2017 President's Budget
Protecting Access to Medicare Act of 2014 P.L. 113-93, Sec. 224……	$15,000,000	$15,000,000	$15,000,000	$15,000,000
Protection and Advocacy for Individuals with Mental Illness Act P.L. 99-319, Sec. 117……	Expired	$36,146,000	Expired	$36,146,000
Health Surveillance and Program Support Program Management, Sec. 501……	Indefinite	$79,559,000	Indefinite	$77,559,000
Total, Program Management……	Indefinite	$79,559,000	Indefinite	$77,559,000
Heath Surveillance, Sec. 501, 505……	Indefinite	$16,830,000	Indefinite	0
Public Awareness and Support (FY12)……	Indefinite	$15,571,000	Indefinite	0
PQIS (FY12)…….……..	Indefinite	$12,918,000	Indefinite	0
Agency-Wide Initiatives……..…	Indefinite	$11,669,000	Indefinite	$21,669,000
TOTAL, SAMHSA Budget Authority…	$15,000,000	$3,584,269,000	$15,000,000	$3,488,783,000
Mandatory Legislation/Program Description	FY 2016 Amount Authorized	FY 2016 Appropriations Act	FY 2017 Amount Authorized	FY 2017 President's Budget
Prevention and Public Health Fund P.L. 111-148, Sec. 4002……	N/A	$12,000,000	N/A	$27,830,000
Mental Health Initiative……	N/A	0	N/A	$115,000,000
Expanding Access to Treatment to Reduce Prescription Drug Abuse and Heroin Use …	N/A	0	N/A	$475,000,000
TOTAL, SAMHSA Mandatory…	0	$12,000,000	0	$617,830,000

*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 2008 General Fund Appropriation: Base.....	$3,167,589,000	$3,393,841,000	$3,404,798,000	$3,291,543,000	
P.L. 110-161 Rescission (P.L. 110-161).....	---	---	---	-$57,503,000	1/
Subtotal.....	$3,167,589,000	$3,393,841,000	$3,404,798,000	$3,234,040,000	
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	2/
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	3/
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	4/
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	5/
S.R. 113-071 Subtotal.....	$3,347,951,097	---	$3,529,944,000	$3,434,935,000	

1/ Reflects a 1.7 percent across-the-board Rescission from the P.L. 110-161.

2/ Reflects a $508 thousand transfer to HHS.

3/ Reflects a 0.189 percent across-the-board Rescission from the P.L. 112-74, and $953,809 Ryan White transfer.

4/ Reflects the annualized level provided by the continuing resolution.

5/ Reflects the whole year appropriation.

Appropriations History (continued)

(Whole dollars)

	Budget Estimate to Congress	**House Allowance**	**Senate Allowanc**	**Appropriation**	
FY 2015 General Fund Appropriation: Base.....	$3,297,669,000	---	$3,431,878,000	$3,474,045,000	6/
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	
P.L. 114-113 Subtotal.....	$3,395,663,000	$3,642,710,000	$3,314,817,000	$3,634,269,000	7/
FY 2017 General Fund Appropriation: Base.....	$3,488,783,000	---	---	---	
Subtotal.....	$3,488,783,000	---	---	---	

6/ Reflects the whole year appropriation.

7/ Reflects the whole year appropriation.

Appropriations Not Authorized by Law

(Whole dollars)

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2016
Grants for the Benefit of Homeless Individuals Sec. 506.....	2003	$ 50,000,000	$ 16,700,000	$41,304,000
Residential Treatment Programs for Pregnant and Postpartum Women Sec. 508.....	2003	SSAN	$0	$15,931,000
Priority Substance Abuse Treatment Needs Sec. 509*.....	2003	$ 300,000,000	$ 322,994,000	$244,966,000
Substance Abuse Treatment Services for Children and Adolescents Sec. 514*.....	2003	$ 40,000,000	$ 20,000,000	$29,605,000
Priority Substance Abuse Prevention Needs of Regional and National Significance Sec. 516*.....	2003	$ 300,000,000	$ 138,399,000	$204,148,000
Priority Mental Health Needs of Regional and National Significance Sec. 520A*.....	2003	$ 300,000,000	$ 94,289,000	$219,515,000
Youth Interagency Research, Training, and Technical Assistance Centers Sec. 520C*.....	2007	$ 5,000,000	$ 3,960,000	$5,988,000
Suicide Prevention for Children and Youth Sec. 520E (GLS - State Grants).....	2007	$ 30,000,000	$ 17,829,000	$ 23,427,000
Sec. 520E2 (GLS-Campus Grants).....	2007	$ 5,000,000	$ 4,950,000	$6,488,000
Sec. 520G*.....	2003	$ 10,000,000	$ 6,043,000	$4,269,000
Awards for Co-locating Primary and Specialty Care in Community-based Mental Health Settings Sec. 520K*.....	2014	$ 50,000,000	$ 50,000,000	$ 49,877,000
PATH Grants to States Sec. 535(a).....	2003	$ 75,000,000	$ 46,855,000	$ 64,635,000
Community Mental Health Services for Children with Serious Emotional Disturbances Sec. 565 (f).....	2003	$ 100,000,000	$ 96,694,000	$119,026,000
Children and Violence Program Sec. 581*.....	2003	$ 100,000,000	$ 83,035,000	$ 23,099,000
Grants for Persons who Experience Violence Related Stress Sec. 582 *	2003	$ 50,000,000	$ 20,000,000	$ 46,887,000
Community Mental Health Services Block Grants Sec. 1920(a).....	2003	$ 450,000,000	$ 433,000,000	$511,532,000
Substance Abuse Prevention and Treatment Block Grants Sec. 1935(a).....	2003	$ 2,000,000,000	$ 1,785,000,000	$1,778,879,000
Other Legislation/Program Description				
Protection and Advocacy for Individuals with Mental Illness Act P.L. 99-319, Sec. 117.....	2003	$ 19,500,000	$ 32,500,000	$ 36,146,000
TOTAL, SAMHSA Budget Authority.....		$ 3,889,500,000	$ 3,174,664,000	$ 3,425,722,000
Mandatory Legislation/Program Description				
Prevention and Public Health Fund Suicide Prevention for Children and Youth Sec. 520E (GLS - State Grants).....	2007	$ 30,000,000	$ 17,829,000	$ 12,000,000
TOTAL, SAMHSA Mandatory.....		$ 30,000,000	$ 17,829,000	$ 12,000,000

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

**Congress authorized two provisions as section 514.

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Mental Health
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Mental Health Appropriation

(Dollars in thousands)

Program Activities	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Programs of Regional and National Significance	$370,538	$406,550	$406,388	-$162
Prevention and Public Health Fund (non-add)	*12,000*	*12,000*	*10,000*	*-2,000*
PHS Evaluation Funds (non-add)	---	---	*10,000*	*+10,000*
Children's Mental Health Services	117,026	119,026	119,026	---
Projects for Assistance in Transition From Homelessness	64,635	64,635	64,635	---
Protection and Advocacy For Individuals with Mental Illness	36,146	36,146	36,146	---
Evidence-based Early Interventions (Mandatory)	---	---	115,000	+115,000
Community Mental Health Services Block Grant	482,571	532,571	532,571	---
PHS Evaluation Funds (non-add)	*21,039*	*21,039*	*21,039*	---
Total, Mental Health[1]	**$1,070,916**	**$1,158,928**	**$1,273,766**	**+$114,838**

[1] 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.

The Mental Health FY 2017 Budget Request is $1.3 billion, an increase of $114.8 million from the FY 2016 Enacted Level. The request includes $1.2 billion in Budget Authority, of which $115.0 is mandatory funding, $31.0 million in PHS Evaluation Funds, and $10.0 million in Prevention and Public Health Funds.

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
CAPACITY				
Seclusion and Restraint	$1,147	$1,147	$1,147	$---
Youth Violence Prevention	23,099	23,099	---	-23,099
Project A W A R E	54,865	64,865	71,964	+7,099
Project AWARE State Grants (non-add)	*39,902*	*49,902*	*57,001*	*+7,099*
Mental Health First Aid (non-add)	*14,963*	*14,963*	*14,963*	---
Healthy Transitions	19,951	19,951	19,951	---
National Child Traumatic Stress Network	45,887	46,887	46,887	---
Children and Family Programs	6,458	6,458	6,458	---
Consumer and Family Network Grants	4,954	4,954	4,954	---
Project LAUNCH	34,555	34,555	34,555	---
Mental Health System Transformation and Health Reform	3,779	3,779	3,779	---
Primary and Behavioral Health Care Integration	49,877	49,877	26,004	-23,873
Suicide Prevention	60,032	60,032	88,032	+28,000
National Strategy for Suicide Prevention (non-add)	*2,000*	*2,000*	*30,000*	*+28,000*
Zero Suicide (non-add)	---	---	*26,000*	*+26,000*
AI/AN set-aside (non-add)	---	---	*5,200*	*+5,200*
Suicide Lifeline (non-add)	*7,198*	*7,198*	*7,198*	---
GLS - Youth Suicide Prevention - States (non-add)	*35,427*	*35,427*	*35,427*	---
Prevention & Public Health Fund (non-add)	*12,000*	*12,000*	*10,000*	*-2,000*
GLS - Youth Suicide Prevention - Campus (non-add)	*6,488*	*6,488*	*6,488*	---
GLS - Suicide Prevention Resource Center (non-add)	*5,988*	*5,988*	*5,988*	---
AI/AN Suicide Prevention Initiative (non-add)	*2,931*	*2,931*	*2,931*	---
Tribal Behavioral Health Grants	4,988	15,000	15,000	---
PHS Evaluation Funds (non-add)	---	---	*5,000*	*+5,000*
Homelessness Prevention Programs	30,696	30,696	30,696	---
Minority A I D S	9,224	9,224	15,935	+6,711
Crisis S y s t e m s	---	---	5,000	+5,000
PHS Evaluation Funds (non-add)	---	---	*5,000*	*+5,000*
Criminal and Juvenile Justice Programs	4,269	4,269	4,269	---
Assisted Outpatient Treatment for Individuals with Serious Mental Illness	---	15,000	15,000	---
Subtotal, Capacity	**353,781**	**389,793**	**389,631**	**-162**

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
SCIENCE AND SERVICE				
Practice Improvement and Training	7,828	7,828	7,828	---
Consumer and Consumer Supporter TA Centers	1,918	1,918	1,918	---
Primary and Behavioral Health Care Integration TTA	1,991	1,991	1,991	---
Disaster Response	1,953	1,953	1,953	---
Homelessness	2,296	2,296	2,296	---
HIV/AIDS Education	771	771	771	---
Subtotal, Science and Service	**16,757**	**16,757**	**16,757**	**---**
TOTAL, PRNS[1,2]	**$370,538**	**$406,550**	**$406,388**	**-$162**

[1] The Total PRNS in FY 2015 and FY 2016 includes $12.0 million in Prevention and Public Health Funds. The Total PRNS in FY 2017 includes $10.0 million in Prevention and Public Health Funds.

[2] 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.

Authorizing Legislation.....Sections 501, 520A, 520C, 520E, 520E-2, 520K, 581, and 582 of the Public Health Service Act and Sec. 224 of the Protecting Access to Medicare Act of 2014
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....States, Tribes, Provider Organizations, Community Organizations

Seclusion and Restraint

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Seclusion and Restraint.....	$1,147	$1,147	$1,147	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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 and/or substance use disorders. 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 and/or substance use disorders.

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,[21] key principles, and practice guidance for a trauma-informed approach,[22] 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

[21] 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.
[22] 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.

facilitates dissemination of trauma-informed practices across multiple service settings. In FY 2015, SAMHSA supported the continuation of this contract. In FY 2016, SAMHSA continues to support this contract.

Funding History

Fiscal Year	Amount
FY 2013	$2,121,167
FY 2014	$1,147,000
FY 2015	$1,147,000
FY 2016	$1,147,000
FY 2017	$1,147,000

Budget Request

The FY 2017 Budget Request is $1.1 million, the same level as the FY 2016 Enacted Level. 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.

Youth Violence Prevention

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Youth Violence Prevention	$23,099	$23,099	$---	-$23,099

Authorizing Legislation..... Section 501 and 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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.[23] The percent of high school students who have been in a physical fight decreased from 32.8 percent in 2011 to 24.7 percent in 2013.[24] 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 8 percent in 2013. However, other indicators of

[23] The *2013 Youth Risk Behavior Surveillance System – United States complete reference*
[24] The *2013 Youth Risk Behavior Surveillance System – United States complete reference*

violence have not significantly improved in recent years. Nationwide, in 2013, 17.9 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 2013, an estimated 20 percent of high school students reported being bullied on school property.

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.[25] 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:

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 2014, SAMHSA provided continuation funds for eight four-year grants through the SS/HS Planning, Local Education Agency and Local Community program grants (SS/HS State program). In FY 2015, SAMHSA provided continuation funds for the third year for these same grants and contracts. In FY 2016, SAMHSA is funding the final year of these grants and contracts.

[25] http://www.samhsa.gov/safe-schools-healthy-students

Funding History

Fiscal Year	Amount
FY 2013	$21,944,947
FY 2014	$23,099,000
FY 2015	$23,099,000
FY 2016	$23,099,000
FY 2017	---

Budget Request

The FY 2017 Budget Request is $0.0 million, a decrease of $23.1 million from the FY 2016 Enacted Level. SAMHSA is requesting to reallocate funding from this program to *Now is the Time* Project Advancing Wellness and Resilience in Education (*NITT* Project AWARE). The reallocation of funds to *NITT* Project AWARE will continue to bring to scale program activities, practices, and lessons learned in the youth violence prevention arena and address current and emerging issues. The reallocation of funds will also enable SAMHSA to avoid duplication among programs with like purposes.

Project AWARE

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Project AWARE	$54,865	$64,865	$71,964	+$7,099
Project AWARE State Educational Agency Grants (non-add).	*39,902*	*49,902*	*57,001*	*+7,099*
Mental Health First Aid (non-add)	*14,963*	*14,963*	*14,963*	---

Authorizing Legislation.....Sections 501 and 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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

With half of all mental health disorders showing first signs before a person turns 14 years old, and three quarters of mental health disorders beginning before age 24, to meaningfully affect the rates of mental disorders in our Nation, it is essential to begin screening, referring, and treating children and youth early. According to 2013 NSDUH data, one in 10 adolescents had a major depressive episode in the past year. Of those, only 38.1 percent received treatment or counseling. We know that overall, less than one in five children and adolescents with a diagnosable mental health problems receive the treatment they need.

Children and youth continue to face significant issues while at school and in the community. Youth Risk Behavior Survey data from 2013 show that many high school students engage in risky behaviors associated with the leading causes of death among youth and young adults, including 19.6 percent being bullied on school property, 8 percent attempting suicide, and over 7 percent not attending school because they felt unsafe at school or on their way there.

The AWARE grant programs provide critical funding to states and school districts to not only train adults to understand the signs and symptoms of youth experiencing a mental health crisis or at risk of developing mental disorders, but also to create and maintain essential infrastructures needed to support screening, early identification, referral, and receipt of care. These grants also provide funding to support the implementation of evidence-based programs to support the social-emotional development of children, and to create schools and communities where they feel safe and can thrive.

In FY 2014, in response to the tragedy at Sandy Hook Elementary School and as part of the President's *Now is the Time* initiative, SAMHSA provided $54.9 million to support Project AWARE (Advancing Wellness and Resilience in Education) to increase awareness of mental health issues and connect young people who have behavioral health issues and their families with needed services. SAMHSA collaborates with the Departments of Education and Justice in the development, implementation, and management of this initiative to maximize coordination and avoid duplication of efforts.

Project AWARE has multiple components. The first component, Project AWARE State Educational Agency (SEA) grants, is built on the highly successful Safe Schools/Healthy Students model. The Safe Schools/Healthy Students seeks to create safe and supportive schools and communities. SAMHSA awarded these grants to 20 SEAs to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services.

The second component, 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 and/or substance use disorders in children and youth, including how to talk to adolescents and families experiencing these problems so that they are more willing to seek treatment. The target for the first year of the program was 750,000 individuals trained or served. This original baseline target was an estimate of the population SAMHSA anticipated the grantees to reach. In FY 2015, given a diverse grantee pool made up of both urban and rural school districts, the 4.5 million individuals trained or served greatly exceed the anticipated target.

In FY 2014, SAMHSA funded 20 Project AWARE SEA awards and 100 MHFA Local Educational Agencies (LEAs) multi-year awards to grantees who applied for Department of Education School Climate Change awards. The project period for Project AWARE SEA awards is five years and the project period for MHFA awards is two years. In FY 2015, SAMHSA provided continuation support for these Project AWARE SEA grants. In addition, SAMHSA awarded 70 new MHFA grants to community organizations to support the training of teachers

and a broad array of actors who interact with youth through their programs at the community level, including parents, law enforcement, faith-based leaders, and other adults.

In FY 2016, SAMHSA is supporting the continuation of 90 grants (20 AWARE SEA grants and 70 MHFA Community grants) and related contracts. In addition, SAMHSA is awarding a new cohort of up to six grants to communities that have recently faced civil unrest. These grants will focus on high-risk youth and families in communities and surrounding areas that have experienced significant exposure to trauma. They will support evidence-based violence prevention and community youth engagement programs as well as linkages to trauma-informed behavioral health services. SAMHSA will prioritize funding grants from communities that have formed partnerships between key stakeholders including state and local governments (including multiple cities and counties if impacted); public or private universities and colleges; and non-profit community- and faith-based organizations. SAMHSA is coordinating extensively with the Department of Education in the administration of this grant program.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	$54,865,000
FY 2015	$54,865,000
FY 2016	$64,865,000
FY 2017	$71,964,000

Budget Request

The FY 2017 Budget Request is $72.0 million, an increase of $7.1 million from the FY 2016 Enacted Level. As part of the President's *Now is the Time* initiative, this program seeks to raise awareness about mental health issues and connects young people who have behavioral health issues and their families with needed services. SAMHSA requests funding to support a new cohort of Project AWARE State Educational Agency awards, continuation grants to raise awareness and expand care in communities with civil unrest, 20 continuation Project AWARE SEA awards, 70 continuation Mental Health First Aid awards, *NITT* technical assistance, and evaluation contracts. SAMHSA has a target to serve over four million children. The increase represents a reallocation of funds from Youth Violence Prevention to Project AWARE. The reallocation of these funds will enable SAMHSA to avoid duplication among programs with like purposes.

Project AWARE is a program that also addresses the Administration's multi-agency Native Youth priority related to Improving Education Outcomes and Like Outcomes for Native Youth, in support of the HHS Tribal Health and Well-Being Coordination.

Outputs and Outcomes Table

Program: Project AWARE

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.2.18 Increase the number of children served. (Output)	FY 2015: 4,696,119 Target: 750,000 (Target exceeded)	4,696,119	4,696,119	Maintain
3.2.19 Increase the number of children referred to mental health or related services. (Output)	FY 2015: 16,508 Target: Set baseline (Pending)	16,508	16,508	Maintain
3.2.39 Increase the number of individuals who have received training in prevention or mental health promotion. (Outcome)	FY 2015: 145,356 Target: Set baseline (Pending)	145,356	145,356	Maintain

Outputs and Outcomes Table

Program: Safe Schools Healthy Students State and Tribal [1]

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.2.45 Increase the number of organizations collaborating and sharing resources with other organizations as a result of the grant. (Output)	FY 2015: 76 Target: 73 (Target exceeded)	76	76	Maintain
3.2.46 Increase the number of individuals who receive training in prevention or mental health promotion. (Intermediate Outcome)	FY 2015: 4,787 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 2015: 2,070 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 2015: 12 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 2015: 52 Target: 52 (Target met)	52	52	Maintain
3.2.50 Reduce the percentage of middle and high school students who report current alcohol use in the past 30 days. (Intermediate Outcome)	FY 2015: 25.0% Target: 18.1% Target exceeded	25.0%	25.0%	Maintain

[1] This table reflects the outputs and outcomes of both Youth Violence Prevention and the Project Aware.

Healthy Transitions

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Healthy Transitions	$19,951	$19,951	$19,951	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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 and substance use disorders, 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 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,[26] be arrested,[27] drop out of school,[28] and be unemployed.[29] 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 Healthy Transitions within the *Now is the Time* (*NITT*) 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 substance use disorder and are at high risk for suicide. Unfortunately, these youth are among the least likely to seek help.[30] Through this program, states are expanding services, developing

[26] 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.
[27] 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.
[28] Planty, M., Hussar, W., Snyder, T., Provasnik, S., Kena, G., Dinkes, R., Kemp, J. (2008). The condition of education 2008 (NCES 2008-031).
[29] 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.
[30] 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.

family and youth networks for information sharing and peer support, and disseminating best practices for services for these young individuals.

Grantees in their first year of the award have developed and built capacity within their states and local communities to deliver services. The *NITT* technical assistance and evaluation contracts have been providing training and technical assistance to grantees in order to meet grant requirements successfully.

In FY 2015, SAMHSA supported 17 *NITT* Healthy Transitions continuation grants and the *NITT* technical assistance and evaluation contracts. In FY 2016, SAMHSA will continue to support the continuation grants and the *NITT* technical assistance and evaluation contracts.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	$19,951,000
FY 2015	$19,951,000
FY 2016	$19,951,000
FY 2017	$19,951,000

Budget Request

The FY 2017 Budget Request is $20.0 million, the same as the FY 2016 Enacted Level. SAMHSA's request will support fourth-year continuation funding for the 17 *NITT* Healthy Transition grant recipients. In addition, this funding will support the *NITT* technical assistance and evaluation contracts. SAMHSA expects to refer up to 6,000 transition aged youth with serious mental health conditions to related services through the Healthy Transitions program.

Healthy Transitions is a program that also addresses the Administration's multi-agency Native Youth priority related to Improving Education Outcomes and Like Outcomes for Native Youth, in support of the HHS Tribal Health and Well-Being Coordination.

Outputs and Outcomes Table

Program: Healthy Transitions

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result/ (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.2.34 Increase the percentage of clients receiving services who report positive functioning at 6-month follow-up. (Outcome)	FY 2015: 66.0% Target: 64.0% (Target exceeded)	64.0%	64.0%	Maintain
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 2015: 40.0% Target: 36.0% (Target exceeded)	36.0%	36.0%	Maintain
3.2.36 Increase the percentage of clients receiving services who are currently employed at 6-month follow-up. (Outcome)	FY 2015: 56.0% Target: 56.0% (Target met)	56.0%	56.0%	Maintain

National Child Traumatic Stress Network

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
National Child Traumatic Stress Network.....	$45,887	$46,887	$46,887	$---

Authorizing Legislation .....Section 582 of the Public Health Service Act
FY 2017 Authorization .....Expired
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.[31,32] 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.[33] While the effects of trauma and exposure to violence are found in all service sectors, it is particularly prominent among youth with mental and/or substance use disorders 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.[34]

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. The NCTSI 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 165 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

[31] 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.
[32] 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.
[33] Fairbank, J.A. (2008). The epidemiology of trauma, and trauma related disorders in children and youth. PTSD Research Quarterly, (19), 1050-1835.
[34] 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

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 resources and delivery of training and consultation to support the development of trauma-informed child-serving systems. The SAMHSA-funded National Center for Child Traumatic Stress (NCCTS) recipient, UCLA's Neuropsychiatric Institute, partners with Duke University Medical Center. Network members work together within and across diverse settings, including a wide variety of governmental and non-governmental organizations.

Data collected in FY 2014 demonstrate that the current NCTSN grantees have provided trauma-informed treatment to over 40,000 children, adolescents and family members. 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 2015, NCTSN grantee sites provided training to nearly 150,000 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 outlets (e.g., Facebook, Twitter, etc.) and by way of various platforms reached more than 1.5 million people nationwide. This campaign informed the public about the efforts and resources available through the NCTSI. Since the end of May 2015 through early August 2015, an audience of over 38 million has viewed the English and/or Spanish public service announcements (PSA) – "Notice" and "Bounce." The radio PSAs have aired over 21,000 times reaching an audience of over 70.0 million listeners.

In FY 2015, SAMHSA supported 78 NCTSI continuation grants and continued to build on the robust work of the NCTSN and improve and enhance the capacity of the NCTSI to deliver effective interventions and core trauma practices. Recipients of these grants include community providers and research organizations with expertise in child trauma. In FY 2016, SAMHSA is awarding up to 83 new five-year NCTSI grants for the program. SAMHSA will continue to encourage grantees to disseminate more broadly information regarding evidence-based interventions for the prevention and treatment of childhood trauma so more children can benefit from proven practices.

Funding History

Fiscal Year	Amount
FY 2013	$43,322,351
FY 2014	$45,887,000
FY 2015	$45,887,000
FY 2016	$46,887,000
FY 2017	$46,887,000

Budget Request

The FY 2017 Budget Request is $46.9 million, the same as the FY 2016 Enacted Level. SAMHSA requests funding to continue support 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 over 48,000 children and adolescents as well as train over 225,000 individuals.

The National Child Traumatic Stress Initiative is a program that addresses the Administration's multi-agency Native Youth priority providing Support for the Implementation of the Indian Child Welfare Act, in support of the HHS Tribal Health and Well-Being Coordination.

Outputs and Outcomes Table

Program: National Child Traumatic Stress Network

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2017 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 2015: 74.4% Target: 65.9% (Target exceeded)	77.0%	77.0%	Maintain
3.2.23 Increase the unduplicated count of the number of children and adolescents receiving trauma-informed services. (Outcome)	FY 2015: 29,579 Target: 2,309 (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 2015: 146,621 Target: 171,270 (Target not met)	225,710	225,710	Maintain

Children and Family Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Children and Family Programs	$6,458	$6,458	$6,458	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method..... Competitive Grants/Contracts/ Interagency Agreements
Eligible Entities..... Tribes

Program Description and Accomplishments

Youth of all ethnicities, races, and from all regions of the United States may be at risk for experiencing mental disorders.[35] 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 eliminate mental health disparities 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 reflect 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. 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 residing in Indian Health Service (IHS) service areas and the rate of death by suicide for this cohort is four times higher than the national average.[36] 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. In the last cohort of grantees, all four tribes that applied for a SAMHSA Systems of Care grant received funding, which supported those tribes in implementing the model they developed through Circles of Care. At the end of the three-year grant, Circles of Care grantees are able to position themselves to get funding to provide expanded services and support. The success of former grantees demonstrates that this program assists tribes to compete successfully for longer term federal funding to serve their youth with serious mental disorders and their families.

[35] Centers for Disease Control and Prevention (2013). Mental Health Surveillance Among Children – United States, 2005-2011. MMWR 2013; 62 (Suppl 2): 1-35.
[36] Department of Health and Human Services, Indian Health Service (2014). Trends in Indian Health 2014 Edition (Released March 2015). ISSN 1095 2896.

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. 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 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.[37]

In FY 2015, SAMHSA provided continuation support for the second year of 11 three-year Circles of Care grants to AI/AN communities and two RRTCs.

In FY 2016, SAMHSA is supporting 11 Circles of Care grants, as well as the two RRTCs.

Funding History

Fiscal Year	Amount
FY 2013	$6,460,794
FY 2014	$6,458,000
FY 2015	$6,458,000
FY 2016	$6,458,000
FY 2017	$6,458,000

Budget Request

The FY 2017 Budget Request is $6.5 million, the same as the FY 2016 Enacted Level. 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.

SAMHSA's Children and Family Programs address the Administration's multi-agency Native Youth priority related to Improving Education Outcomes and Like Outcomes for Native Youth, in support of the HHS Tribal Health and Well-Being Coordination.

[37] 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.

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 117.

Consumer and Family Network Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Consumer and Family Network Grants	$4,954	$4,954	$4,954	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Community Organizations

Program Description and Accomplishments

Consumers, including those living with serious mental illness, should have meaningful involvement in all aspects of their health care and treatment, including behavioral health care. There is growing recognition and evidence that consumer-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.

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 three grant activities: the Statewide Consumer Network Program, the Statewide Family Network Program, and the Statewide Peer Network Development Program for Recovery and Resiliency.

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.

The Statewide Peer Network Development Program for Recovery and Resiliency began in FY 2014 and builds the capacity of statewide consumer-run, family member-run, and addiction recovery community organizations to promote infrastructure development across the mental health and addiction recovery communities.

Funding for this program comes from SAMHSA's Mental Health appropriation and the Substance Abuse Treatment appropriation to allow for collaborative partnerships across the mental and substance use disorder fields. SAMHSA tracks any braided amounts spent or awarded under their distinct appropriations and ensures that funds are used for purposes consistent with legislative direction and intent of the appropriations. Eligible applicants for this program were those organizations that had an existing mental health or addiction statewide network award from SAMHSA.

In FY 2015, SAMHSA provided continuation funds for 12 Statewide Consumer Network grants, 26 Statewide Family Network grants, and a technical assistance contract. In addition, SAMHSA awarded a new cohort of Statewide Consumer Network, Statewide Family Network, and Statewide Peer Network Development grants. All grants were awarded to consumer-oriented community organizations. In FY 2016, SAMHSA plans to support nine Statewide Consumer Network continuation and eight new Statewide Consumer Network grants, five Statewide Family Network grant continuations, 21 new Statewide Family Network grants, and a technical assistance activity.

Funding History

Fiscal Year	Amount
FY 2013	$6,140,243
FY 2014	$4,954,000
FY 2015	$4,954,000
FY 2016	$4,954,000
FY 2017	$4,954,000

Budget Request

The FY 2017 Budget Request is $5.0 million, the same as the FY 2016 Enacted Level. SAMHSA requests funding to continue support for these grant programs 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.

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 117.

Project LAUNCH

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Project LAUNCH.....	$34,555	$34,555	$34,555	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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 age 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.[38] 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 as girls are. African American preschoolers are almost twice as likely to be expelled as Caucasian preschoolers are.[39] 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, secure, and cared for are all critical elements to ensure children start life with the tools and skills needed to succeed. Further, when children are struggling with social-emotional challenges, these issues need to be identified as early as possible and families must have access to resources and services that are appropriate and effective.

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.

[38] 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.
[39] Gilliam, W. (2005). Pre-kindergarteners left behind: Expulsion rates in state prekindergarten systems. Foundation for Child Development.

As of 2014, performance data for the program found:

- Approximately 145,000 children and parents were assessed on social and emotional functioning and screened for behavioral health issues in diverse settings (e.g., primary care, childcare, and home visiting);
- Project LAUNCH-supported home visiting and family strengthening programs have served nearly 2,300 families;
- Approximately 51,000 community providers have been trained on social-emotional and behavioral health for young children;
- Over 116,000 individuals received evidence-based mental health services; and
- Project LAUNCH data indicates that nearly 2,600 new organizations are collaborating, coordinating, and sharing resources to implement prevention/promotion strategies for young children.

The multi-site evaluation of Project LAUNCH is ongoing. Phase one of the evaluation used a meta-analytical approach to assess the implementation of Project LAUNCH. 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 better the impact of Project LAUNCH around the following: social and emotional development of children; externalizing and internalizing behaviors of children; family relationships and mental health status of parents; cognitive development of children; and physical health of children.

In FY 2015, SAMHSA supported 31 five-year continuation grants, five new four-year grants, and technical assistance and evaluation activities. 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 2016, SAMHSA is supporting 36 continuation grants and two continuation contracts.

Funding History

Fiscal Year	Amount
FY 2013	$32,828,505
FY 2014	$34,555,000
FY 2015	$34,555,000
FY 2016	$34,555,000
FY 2017	$34,555,000

Budget Request

The FY 2017 Budget Request is $34.6 million, the same as the FY 2016 Enacted Level. This funding will support 25 five-year continuation grants, 15 new grants, and contract activities that will improve health outcomes for young children. 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.

Project LAUNCH is a program that also addresses the Administration's multi-agency Native Youth priority related to Improving Education Outcomes and Like Outcomes for Native Youth, in support of the HHS Tribal Health and Well-Being Coordination.

Outputs and Outcomes Table

Program: Mental Health-Project LAUNCH

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
2.3.94 Increase the number of persons served. (Output)	FY 2015: 17,607 Target: 32,232 (Target not met)	38,594	38,594	Maintain
2.3.95 Increase the number of persons trained in mental illness prevention or mental health promotion. (Outcome)	FY 2015: 10,360 Target: 13,102 (Target not met but improved)	13,102	13,102	Maintain
2.4.00 Increase the number of 0 to 8 year old children screened for mental health or related interventions. (Outcome)	FY 2015: 21,914 Target: 44,775 (Target not met)	44,775	44,775	Maintain
2.4.01 Increase the number of 0 to 8 year old children referred to mental health or related interventions. (Outcome)	FY 2015: 3,783 Target: 9,114 (Target not met)	9,114	9,114	Maintain

Mental Health System Transformation and Health Reform

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Mental Health System Transformation and Health Reform.....	$3,779	$3,779	$3,779	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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.[40] 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.

In FY 2014, SAMHSA awarded seven five-year Transforming Lives through Supported Employment grants. In FY 2015, SAMHSA provided continuation funds for these grantees. In FY 2015, grantees developed strategic plans, participated in a learning community, received training on the Individual Placement and Support (IPS) supported employment model, completed hiring, and began service delivery in most of the sites. In FY 2016, SAMHSA is supporting the continuation of these grants and related technical assistance.

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

Funding History

Fiscal Year	Amount
FY 2013	$10,448,347
FY 2014	$10,556,000
FY 2015	$3,779,000
FY 2016	$3,779,000
FY 2017	$3,779,000

Budget Request

The FY 2017 Budget Request is $3.8 million, the same as the FY 2016 Enacted Level. 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 Grants

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure[1]	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 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 2014: 4,259 Target: 1,488 (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 2014: 57.1% Target: 52.1% (Target exceeded)	52.1%	52.1%	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 2014: 76.7% Target: 73.7% (Target exceeded)	73.7%	73.7%	Maintain
1.2.23 Increase the percentage of clients receiving services who are currently employed at 6-month follow-up. (Outcome)	FY 2014: 32.2% Target: 30.7% (Target exceeded)	30.7%	30.7%	Maintain

[1] These measures are being retired and replaced with new Supported Employment measures.

Primary and Behavioral Health Care Integration

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Primary and Behavioral Health Care Integration.....	$49,877	$49,877	$26,004	-$23,873

Authorizing Legislation .....Sections 520A and 520K of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method..... Competitive Grants/Cooperative Agreement/Contracts
Eligible Entities..... Qualified Community Mental Health Programs

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.[41] 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.[42]

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 health care 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 2015, SAMHSA has awarded 186 PBHCI grants. In FY 2015, the PBHCI grant program served more than 16,000 consumers. Functioning, social connectedness, and housing measures were consistently positive because of this intervention. An initial cross-site evaluation done in September 2013 examined the impact of the PBHCI grants on physical health outcomes. The results show increased receipt of integrated services and modest improvement in physical health outcomes. These physical health outcomes included improved blood pressure

[41] 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.
[42] E. Chesney et al., Risks of all-cause and suicide mortality in mental disorders: a meta-review, World Psychiatry; 2014: 13:1153-160.

measures by 19 percent, improved body mass index (BMI) levels by 43 percent, and improved cholesterol levels by 38 percent. The evaluation also identified decreases in hospitalization rates for individuals screened at intake from 6.2 percent to 2.7 percent after one year. An additional PBCHI evaluation project, funded by the HHS Office of the Assistant Secretary for Planning and Evaluation, is currently examining the impact of the program on consumers' use of medical services and their total healthcare costs as reflected in archival data from Medicaid/Medicare. The FY 2015 PBHCI grant application included programmatic enhancements because of these evaluation findings. In FY 2015, SAMHSA awarded a new PBHCI evaluation contract that builds on recommendations from the FY 2013 evaluation and seeks to use a more comprehensive approach to determine the impact of the PBHCI grants on the health of the clients served.

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 and substance use disorders 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 2015, SAMHSA supported 16 continuation grants, a new cohort of 60 PBHCI grants, and one technical assistance contract that is co-funded with HRSA. An evaluation contract in the Health Surveillance and Program Support appropriation supported the PBHCI evaluation. In FY 2016, SAMHSA is awarding a new cohort of grants to support the coordination and integration of primary care services into publicly funded community behavioral health settings.

Funding History

Fiscal Year	Amount
FY 2013	$30,633,567
FY 2014	$51,868,000
FY 2015	$51,868,000
FY 2016	$51,868,000
FY 2017	$26,004,000

Budget Request

The FY 2017 Budget Request is $26.0 million, a decrease of $23.9 million from the FY 2016 Enacted Level. This funding will continue to support the coordination and integration of primary care services into publicly funded community behavioral health settings. The decrease in funding will not result in the termination of any existing grants.

Outputs and Outcomes Table

Program: Primary & Behavioral Health Care Integration (PBHCI)

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.2.40 Increase the number of clients served. (Output)	FY 2015: 16,641 Target: 21,100 (Target not met)	56,552	30,528	-26,024
3.2.41 Increase the percentage of clients receiving services who report positive functioning at 6-month follow-up. (Outcome)	FY 2015: 57.0% Target: 49.9% (Target exceeded)	49.9%	49.9%	Maintain
3.2.42 Increase the percentage of clients receiving services who are currently employed at 6-month follow-up. (Outcome)	FY 2015: 20.1% Target: 22.1% (Target not met)	22.1%	22.1%	Maintain
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 2015: 73.4% Target: 65.7% (Target exceeded)	65.7%	65.7%	Maintain

Suicide Prevention Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Suicide Prevention	$60,032	$60,032	$88,032	+$28,000
National Strategy for Suicide Prevention (non-add)	*2,000*	*2,000*	*30,000*	*+28,000*
Zero Suicide (non-add)	---	---	*26,000*	*+26,000*
AI/AN set-aside (non-add)	---	---	*5,200*	*+5,200*
Suicide Lifeline (non-add)	*7,198*	*7,198*	*7,198*	---
GLS - Youth Suicide Prevention - States (non-add)	*35,427*	*35,427*	*35,427*	---
Prevention & Public Health Fund (non-add)	*12,000*	*12,000*	*10,000*	*-2,000*
GLS - Youth Suicide Prevention - Campus (non-add)	*6,488*	*6,488*	*6,488*	---
GLS - Suicide Prevention Resource Center (non-add)	*5,988*	*5,988*	*5,988*	---
AI/AN Suicide Prevention Initiative (non-add)	*2,931*	*2,931*	*2,931*	---

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. Through these programs, SAMHSA also supports HHS's Arc of *Keeping People Healthy and Safe*. 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 41,000 Americans die by suicide each year. One American dies by suicide every 12.8 minutes.[43] In 2008, suicide became the 10th leading cause of death in the United States and remained so through 2013, the most recent year for which there are available mortality data. For 2013, SAMHSA's National Survey on Drug Use and Health reported that approximately 13 million Americans age 18 and over attempted suicide, 9.3 million seriously considered suicide, and 2.7 million made a plan. While youth have the highest rates of suicide attempts, middle-aged adults have the highest number of deaths by suicide nationwide, and older adults 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.

[43] American Association of Suicidology. (2015). *USA Suicide 2013 Official Final Data*. Accessed May 8, 2015, from http://www.suicidology.org/portals/14/docs/resources/factsheets/2013datapgsv3.pdf.

National Strategy for Suicide Prevention

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
National Strategy for Suicide Prevention.....	$2,000	$2,000	$30,000	+$28,000

Authorizing Legislation .....Sections 520A and 520C of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... State Mental Health Authorities, States, Territories, Tribes, and the District of Columbia

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).[44] 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.[45] 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 (e.g. military families; lesbian, gay, bisexual, and transgender individuals; and Native American youth), 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, SAMHSA provided continuation funds for these four grants. In FY 2016, SAMHSA is supporting the continuation of these four grants.

[44] 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.
[45] ibid

Funding History

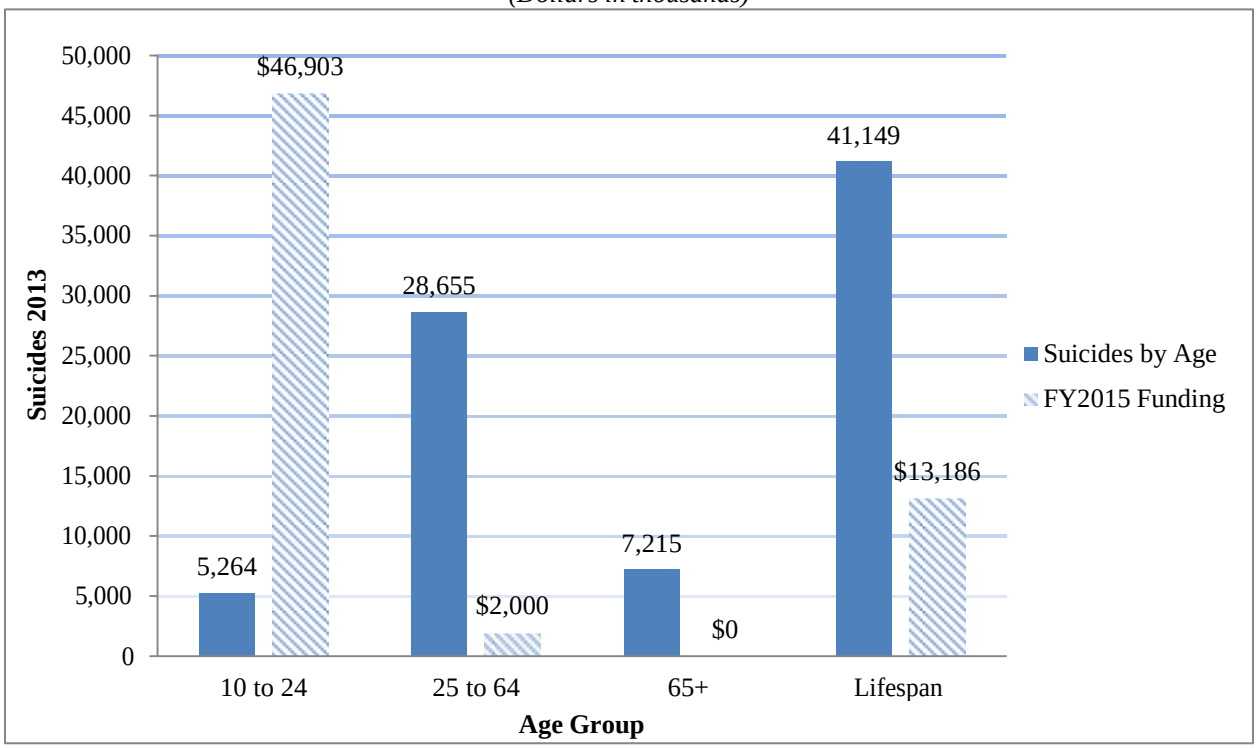
Fiscal Year	Amount
FY 2013	---
FY 2014	$2,000,000
FY 2015	$2,000,000
FY 2016	$2,000,000
FY 2017	$30,000,000

Budget Request

The FY 2017 Budget Request is $30.0 million, an increase of $28.0 million from the FY 2016 Enacted Level. The proposed increase in funding will support $2.0 million in NSSP grants and $26.0 million in Zero Suicide grants, including a $5.2 million set-aside for tribes. As shown in the graph below, the amount of funding available and the number of suicides by age groups have not corresponded in the past. Consistent with the National Strategy for Suicide Prevention's recommendation to focus on the lifespan, this funding will augment existing youth-focused funding. $1.2 million will support technical assistance and an evaluation contract.

Suicides by Age versus Suicide Funding

(Dollars in thousands)



To reduce the tragic number of deaths by suicide, the number of people at risk for suicide who receive effective behavioral health care needs to increase significantly. For this to occur, two overarching goals must be achieved. More Americans at risk must be able to access and be

engaged in mental and substance use disorder treatment, and the treatment they receive must be effective and based on the most recent science. The first requires a stronger and more systematic community approach. The second requires a stronger and more systematic health system response. For those at risk of suicide but who are not receiving mental health care, effective strategies for getting them into treatment are required. For those at risk of suicide who are receiving mental health care, that care must be more effective, more systematic, and more science-based. These two major requirements necessitate the two pronged approach described below and comprise the new Zero Suicide program.

The first component, Zero Suicide in Behavioral Health Care, will provide nine grants to states to embed the Zero Suicide model throughout their behavioral healthcare systems including within Accountable Care Organizations. Zero Suicide implementation has been successful in decreasing suicide rates. One example of a successful comprehensive approach was the Air Force Suicide Prevention Program that reduced suicide among pilots by 30 percent in the 1990's. The foundational belief of Zero Suicide is that suicide deaths for adults under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge. The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, healthcare system. A systematic approach to quality improvement in these settings is both available and necessary. Specifically, this program will support implementation of post-discharge follow-up protocols for individuals at risk of suicide and provide suicide-specific treatment approaches. This component of the initiative would focus on statewide efforts to reduce suicide among those adults receiving care through the state's public behavioral health system.

The second component, Comprehensive State/Community Suicide Prevention, will provide seven grants to allow states to engage communities and organizations in a comprehensive effort to identify persons at risk for suicide and link them to needed services. Care systems that have adopted these approaches have been successful in reducing suicides.[46,47,48,49,50,51] States with large (over 1,000) numbers of deaths by suicide, and states with high rates, but smaller numbers of suicides, will be eligible for these grants. Grant recipients will implement and evaluate these evidence-based suicide prevention activities in the full spectrum of potential community and clinical suicide prevention settings including primary care, emergency rooms, schools/educational settings, the workplace, faith communities, and justice settings. The initiative will be coordinated with Centers for Disease Control and Prevention's National Violent Death Reporting System and Injury Control Research Center for Suicide Prevention, National

[46] Knox, Litts, Talcott, Feig & Caine (2003), Risk of suicide and related adverse outcomes after exposure to suicide prevention program in the US Air Force: cohort study, BMJ 2003; 327 (7428):1376.
[47] Coffey CE Building a system of perfect depression care in behavioral health Jt Comm J Qual Patient Saf, 2007, : 33(4):193-199.
[48] While D, Bickley, H, Roscoe A et al; Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross sectional and before and after observational study, Lancet, 2012:379 (9820):1005-1012.
[49] May PA, Serna P, Hurt, L, Debruyn. LM Outcome evaluation of a public health approach to suicide prevention in an American Indian tribal nation AM J Public Health 2005; 95 (7) :1238-1244.
[50] Suicide Prevention Strategy 2013-2016.
[51] Scottish Government, Edinburgh 2013.

Institute of Mental Health, Health Resources and Services Administration (Federally Qualified Health Centers), Department of Veterans Affairs (outreach to veterans not receiving Veterans Health Administration healthcare), and Department of Defense. A similar comprehensive approach fully implementing the Scottish National Strategy led to an 18 percent reduction in deaths by suicide in Scotland, including reductions among adult males who make up a significant majority of suicides in Scotland, as they do in the United States.

Eligible entities for component one, focusing on health including behavioral healthcare systems, will include State Mental Health Authorities in states, territories, and the District of Columbia, tribes, and healthcare systems. Eligible entities for component two, addressing multi-sector approaches to suicide prevention will include State Mental Health Authorities in state, territories, and the District of Columbia, and tribes with identified high-risk communities.

The National Strategy for Suicide Prevention addresses the Administration's multi-agency Native Youth priority to Reduce Teen Suicide, in support of the HHS Tribal Health and Well-Being Coordination.

Suicide Lifeline

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Suicide Lifeline.....	$7,198	$7,198	$7,198	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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 2014, the National Suicide Prevention Lifeline answered calls from over 1.3 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 112,475 calls per month through November 2014, including a peak of 133,762 calls in August 2014. 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 to ensure that veterans calling the Lifeline have 24/7 access to a specialized veterans' suicide prevention hotline. In FY 2014, more than 35,500 callers per month that pressed "one" were seamlessly connected to the veterans' crisis line. The Lifeline also responds to calls from active duty military and their families. SAMHSA is in the process of developing a suicide hotline outcome measure to determine the number of people who contacted the Lifeline who believe the call prevented them from taking their lives.

The Lifeline Evaluation is a part of the National Suicide Prevention Evaluation (NSPE), which includes all of the programs in SAMHSA's suicide prevention portfolio. The NSPE is an evaluation that will assess the effect of SAMHSA's suicide prevention initiatives on reducing suicide attempts and mortality due to suicide. 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, emergency intervention, and follow-up protocols and have driven forward improvements in practice that are potentially 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 is awarding six new crisis center follow-up grants and the continuation of the Lifeline grant.

Funding History

Fiscal Year	Amount
FY 2013	$6,085,275
FY 2014	$7,198,000
FY 2015	$7,198,000
FY 2016	$7,198,000
FY 2017	$7,198,000

Budget Request

The FY 2017 Budget Request is $7.2 million, the same as the FY 2016 Enacted Level. SAMHSA is requesting funding 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 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.

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
GLS - Youth Suicide Prevention - States.....	$35,427	$35,427	$35,427	$---
Prevention & Public Health Fund (non-add).....	*12,000*	*12,000*	*10,000*	*-2,000*
GLS - Youth Suicide Prevention - Campus.....	6,488	6,488	6,488	---

Authorizing Legislation..... Sections 520E and 520E-2 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... States, Tribes, and Institutions of Higher Education

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.[52]

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 June 2014, 747,108 individuals participated in 25,608 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. About one third of trainees received training through campus-sponsored courses and educational seminars. More than 64 percent of trainees participated in state-sponsored training activities and 6.7 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 (but not the second) year following suicide prevention activities.

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

In FY 2015, SAMHSA provided continuation funds for 33 GLS State/Tribal grants and 33 GLS Campus grants and awarded new cohorts of 12 grants for GLS State/Tribal and 22 grants for GLS Campus programs. In FY 2016, SAMHSA is supporting 38 continuation and four new GLS State/Tribal grants and 37 continuation and 16 new GLS Campus grants as well as the National Suicide Prevention Evaluation.

Funding History

Fiscal Year	Amount
FY 2013	$41,323,126
FY 2014	$41,915,000
FY 2015	$41,915,000
FY 2016	$41,915,000
FY 2017	$41,915,000

Budget Request

The FY 2017 Budget Request is $41.9 million, the same as the FY 2016 Enacted Level. SAMHSA requests funding 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 Youth Suicide Prevention – State/Tribal and Campus addresses the Administration's multi-agency Native Youth priority to Reduce Teen Suicide, in support of the HHS Tribal Health and Well-Being Coordination.

Garrett Lee Smith Suicide Prevention Resource Center

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
GLS - Suicide Prevention Resource Center.....	$5,988	$5,988	$5,988	$---

Authorizing Legislation..... Section 520C of the Public Health Service Act
FY 2017 Authorization.....Expired
Allocation Method..... Competitive Grants
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 will support the continuation of this grant.

Funding History

Fiscal Year	Amount
FY 2013	$5,338,840
FY 2014	$5,988,000
FY 2015	$5,988,000
FY 2016	$5,988,000
FY 2017	$5,988,000

Budget Request

The FY 2017 Budget Request is $6.0 million, the same as the FY 2016 Enacted Level. Funding will 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.

American Indian/Alaska Native Suicide Prevention Initiative

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
AI/AN Suicide Prevention Initiative.....	$2,931	$2,931	$2,931	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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. As of 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.

In FY 2015, SAMHSA supported the continuation of this five-year contract. In FY 2016, SAMHSA will continue support for this activity through the existing contract.

Funding History

Fiscal Year	Amount
FY 2013	$2,784,738
FY 2014	$2,931,000
FY 2015	$2,931,000
FY 2016	$2,931,000
FY 2017	$2,931,000

Budget Request

The FY 2017 Budget Request is $2.9 million, the same level as the FY 2016 Enacted Level. 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 and substance use disorders, prevent suicide, and promote mental health through the contract continuation.

The American Indian/Alaska Native Suicide Prevention program addresses the Administration's multi-agency Native Youth priority to Improve Education Outcomes and Like Outcomes for Native Youth and Reduce Teen Suicide, in support of the HHS Tribal Health and Well-Being Coordination.

Outputs and Outcomes Table

Program: Suicide Prevention

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
2.3.59 Increase the total number of individuals trained in youth suicide prevention. (Outcome)	FY 2015: 131,909 Target: 161,000 (Target not met)	160,082	160,082	Maintain
2.3.60 Increase the total number of youth screened. (Output)	FY 2015: 7,100 Target: 73,996 (Target not met)	94,214	94,214	Maintain
2.3.61 Increase the number of calls answered by the suicide hotline. (Output)	FY 2015: 1,502,573 Target: 989,994 (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 2016: Result expected December 31, 2016 Target: Set baseline (Pending)	N/A	N/A	N/A
3.1.02 Increase the number of individuals referred to mental health or related services. (Intermediate Outcome)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)	N/A	N/A	N/A
3.1.03 Increase the number of organizations that establish management information/information technology system links across multiple agencies. (Intermediate Outcome)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)	N/A	N/A	N/A
3.1.04 Increase the number of organizations or communities that demonstrate improved readiness to change their systems. (Intermediate Outcome)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)	N/A	N/A	N/A
3.2.37 Increase the number of individuals referred to mental health or related services. (Output)	FY 2015: 5,588 Target: 5,911 (Target not met)	9,177	9,177	Maintain

Homelessness Prevention Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Homelessness Prevention Programs	$30,696	$30,696	$30,696	$---
Homelessness	2,296	2,296	2,296	---

Authorizing Legislation..... Sections 520A and 506 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Domestic Public and Community Organizations, Private Nonprofit Entities, 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 are considered "chronically homeless," and about nine percent (49,933) of homeless people are veterans.[53] Approximately 26 percent of individuals experiencing homelessness have a serious mental illness, 50 percent struggle with substance use disorders, and 66 percent of the chronically homeless population has a substance use disorder or other chronic health condition.[54,55]

The U.S. Interagency Council on Homelessness, in which HHS participates, has set aggressive goals to permanently house and address the needs of those who are chronically homeless and/or who are veterans and homeless. Two SAMHSA programs are helping to support the U.S. Interagency Council on Homelessness' strategic goal of ending homelessness: Services in Supportive Housing (SSH) and Cooperative Agreements to Benefit Homeless Individuals (CABHI).

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

[53] Snapshot of Homelessness. (n.d.). Retrieved August 21, 2015, from http://www.endhomelessness.org/pages/snapshot

[54] United State Interagency Council on Homelessness. Substance Abuse. Available at https://www.usich.gov/news/substance_abuse

[55] 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

and supportive services. This includes integration of treatment and other critical services for individuals with serious mental illness and substance use disorders. Target populations for this program include veterans and individuals with serious mental illness and/or substance use disorders. Through this program, SAMHSA supports HHS's Arc of *Keeping People Healthy and Safe*. 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 governments); the state Medicaid Office; and the state Mental Health and Substance Abuse Authorities. Data show that between intake and six-month follow up, abstinence from substance use increased by six percent, injection drug use decreased by 22 percent, and stability in housing increased by 49.8 percent. In FY 2015, SAMHSA supported 10 CABHI continuation grants to community-based public or non-profit entities.

In FY 2013, SAMHSA initiated the CABHI-States program, also 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 substance use disorders 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 mental and/or substance use disorder treatment and services for individuals with mental and/or substance use disorders experiencing homelessness. In FY 2015, SAMHSA supported a new cohort of nine grants for CABHI-States grantees. SAMHSA also made funds available to existing grantees to enhance and expand the services they were providing.

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 2016, SAMHSA will continue its CABHI efforts with up to 47 grants to states, local governments, and community-based organizations and corresponding TA and evaluation activities.

Funding History

Fiscal Year	Amount
FY 2013	$31,343,438
FY 2014	$32,992,000
FY 2015	$32,992,000
FY 2016	$32,992,000
FY 2017	$32,992,000

Budget Request

The FY 2017 Budget Request is $33.0 million, the same as the FY 2016 Enacted Level. This funding will 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 substance use disorders. 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 towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Minority AIDS	$9,224	$9,224	$15,935	+$6,711
HIV/AIDS Education	771	771	771	---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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.[56] African Americans accounted for 45 percent and Hispanics accounted for 23 percent of all HIV/AIDS cases diagnosed in 2013.[57] Psychiatric and psychosocial complications are frequently not diagnosed or 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 5,800 individuals received services in FY 2014.

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 and substance use disorders and HIV/AIDS. MAI CoC supports substance use disorder (SUD) 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,

[56] 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.
[57] 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.[58,59]

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 use disorder 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 2014, SAMHSA awarded 34 four-year HIV Continuum of Care grants and a technical assistance contract. 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, 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 2013	$9,571,658
FY 2014	$9,995,000
FY 2015	$9,995,000
FY 2016	$9,995,000
FY 2017	$16,706,000

Budget Request

The FY 2017 Budget Request is $16.7 million, an increase of $6.7 million from the FY 2016 Enacted Level. This represents a shift in funding from the Substance Abuse Treatment appropriation. This increase in funding will allow for the award of a new cohort of MAI Continuum of Care (CoC) grantees that will address the holistic behavioral health needs of those living with HIV. Three SAMHSA Centers, CMHS, CSAT, and CSAP, will jointly administer the program. This funding will continue to enhance and expand the provision of effective, culturally competent, HIV/AIDS-related mental health services in minority communities for

[58] Bhattacharya R, Shuhart MC. Hepatitis C and alcohol: interactions, outcomes, and implications. J Clin Gastroenterol. 2003;36(3):242-52.
[59] 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).

people living with HIV/AIDS. In addition, the funding will support continuation 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 117.

Criminal and Juvenile Justice Programs

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Criminal and Juvenile Justice Programs.....	$4,269	$4,269	$4,269	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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 psychiatric and substance use disorders than those of the general population.[60] Approximately 15 percent of people in the justice system with substance use disorders and 30 percent with mental illness receive treatment.[61] 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.[62,63] 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.

[60] 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.
[61] 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
[62] 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;
[63] Henrichson, C., & Delaney, R. (2012). The price of prisons: What incarceration costs taxpayers. New York: Vera Institute of Justice.

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 and/or substance use disorders 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 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 collaborative 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 and substance use disorders and with 54 percent reporting significant trauma exposure in their lives. BHTCCs provided an array of services, including clinical case management, mental and substance use disorder treatment services, trauma-specific treatment, peer support, and more. Based on Transformation Accountability System (TRAC) reporting data, 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.[64]

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, SAMHSA is continuing support for these grants and the evaluation.

[64] 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 2013	$5,876,801
FY 2014	$4,296,000
FY 2015	$4,296,000
FY 2016	$4,296,000
FY 2017	$4,296,000

Budget Request

The FY 2017 Budget Request is $4.3 million, the same as the FY 2016 Enacted Level. SAMHSA request will continue to provide comprehensive treatment and recovery support services for adolescents and adults with co-occurring mental and substance use disorders who come into contact with the criminal justice system, as well as offenders re-entering the community.

Behavioral Health Treatment Court Collaborative Grants program also addresses the Administration's multi-agency Native Youth priority to Increase Tribal Control of Criminal Justice, in support of the HHS Tribal Health and Well-Being Coordination.

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 117.

Practice Improvement and Training

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Practice Improvement and Training.....	$7,828	$7,828	$7,828	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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 and reform. 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 use disorder 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 is continuing this effort in FY 2015 and FY 2016.

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. 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.

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 what recovery-oriented care is and how to implement it, 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, 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, or at risk for, mental disorders, including those with the most serious mental illnesses and with co-occurring substance use

disorders. Research indicates alarming health disparities between people with serious mental and/or substance use disorders 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.[65] The project engages people with mental and/or substance use disorders, national organizations, communities, states, and tribes in the promotion of evidence-based tools for wellness. In FY 2016, SAMHSA plans to continue to fund this contract.

Funding History

Fiscal Year	Amount
FY 2013	$7,413,110
FY 2014	$7,828,000
FY 2015	$7,828,000
FY 2016	$7,828,000
FY 2017	$7,828,000

Budget Request

The FY 2017 Budget Request is $7.8 million, the same level as the FY 2016 Enacted Level. SAMHSA requests funding to address the need for disseminating key information, such as evidence-based mental health practices, to the mental health delivery system and engage in activities that support mental health system transformation and reform.

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 118.

Consumer and Consumer-Supporter TA Centers

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Consumer and Consumer Supporter Technical Assistance Centers..	$1,918	$1,918	$1,918	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method ..... Competitive Grants
Eligible Entities..... Community Organizations

[65] 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.

Program Description and Accomplishments

Consumer-centered services and supports 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, advocates, 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 the period of five years. These grants continue in FY 2016.

Funding History

Fiscal Year	Amount
FY 2013	$1,875,102
FY 2014	$1,918,000
FY 2015	$1,918,000
FY 2016	$1,918,000
FY 2017	$1,918,000

Budget Request

The FY 2017 Budget Request is $1.9 million, the same as the FY 2016 Enacted Level. SAMHSA's funding request will continue support of these 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 118.

Disaster Response

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Disaster Response	$1,953	$1,953	$1,953	$---

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Domestic Public or Private Nonprofit 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 the use of any 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 behaviorally oriented 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'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, the Disaster Distress Helpline received calls from 6,436 individuals and 7,848 text messages from 720 users.

Periodically, SAMHSA receives additional funding to help survivors of a particular emergency or disaster. In FY 2013, SAMHSA received a total of $7.5 million in supplemental funds to assist the survivors of Hurricane Sandy. Efforts focused on providing mental and substance use disorder treatment, restoring the capability of medication-assisted substance use disorder treatment services in the impacted areas, ensuring the operation of the Disaster Distress Helpline, and conducting resiliency training with educators.

In FY 2014, SAMHSA continued to support the Disaster Distress Helpline by the providing crisis counseling services across the nation. Funding continued to support the Disaster Technical Assistance Center in the provision of technical assistance, consultation, and information dissemination. These services assist SAMHSA in advancing state and local capacity to deliver effective behavioral health services that are well integrated with traditional public health and disaster recovery efforts. SAMHSA continued support for these activities in FY 2015. In addition, SAMHSA funded a new cooperative agreement, Networking, Certifying and Training Suicide Prevention Hotlines and a National and a National Disaster Distress Helpline. This jointly funded cooperative agreement will manage, enhance, and strengthen the National Suicide Prevention Lifeline and support Disaster Distress Helpline. SAMHSA is continuing support for these activities in FY 2016.

Funding History

Fiscal Year	Amount
FY 2013	$996,982
FY 2014	$1,953,000
FY 2015	$1,953,000
FY 2016	$1,953,000
FY 2017	$1,953,000

Budget Request

The FY 2017 Budget Request is $2.0 million, the same as the FY 2016 Enacted Level. SAMHSA is requesting funding to continue the support of a nationally available disaster distress crisis counseling telephone line through a connection to local crisis lines throughout the country and the Disaster Technical Assistance Center.

The output and outcome measures for Disaster Response are part of the Mental Health - Science and Service Activities outputs and outcomes table shown on page 118.

Tribal Behavioral Health Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Tribal Behavioral Health Grants	$4,988	$15,000	$15,000	$---
PHS Evaluation Funds (non-add)	---	---	*5,000*	*+5,000*

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
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.[66] Further, AI/AN high school students report higher rates of suicidal behaviors than the general population of U.S. high school students.[67] These behaviors include 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 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).[68]

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) AI/AN grantees and 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 use 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

[66] 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.
[67] 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.
[68] http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2011/AI-AN2011.pdf

SAMHSA to turn their assessments into action plans to be implemented in FY 2016. These action plans will report baseline data in FY 2017.

In FY 2016, as part of Generation Indigenous,[69] a White House-supported youth initiative focused on removing possible barriers to success for AI/AN youth, SAMHSA proposed an expansion of 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 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 103 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 and substance use disorders among AI/AN youth, and increase referral to treatment.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	$4,988,000
FY 2015	$4,988,000
FY 2016	$15,000,000
FY 2017	$15,000,000

Budget Request

The FY 2017 Budget Request is $30.0 million, the same as the FY 2016 Enacted Budget. This request includes $15.0 million in the Mental Health appropriation and $15.0 million in the Substance Abuse Prevention appropriation. This funding will continue support for programs that promote mental health and prevent substance use activities for high-risk AI/AN youth and their families.

[69] For additional information on this White House sponsored initiative see: http://genindigenous.com/

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.

The Tribal Behavioral Health Grants program addresses the Administration's multi-agency Native Youth priority to Reduce Teen Suicide, in support of the HHS Tribal Health and Well-Being Coordination.

Outputs and Outcomes Table

Program: Tribal Behavioral Health

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
2.4.10 Increase the number of grantees reporting a decrease in underage drinking in their community. (Output)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)			
2.4.11 Increase the number of participants receiving evidence-based mental health -related services as a result of the grant. (Output)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)			
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: Result expected December 31, 2016 Target: Set baseline (Pending)			
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: Result expected December 31, 2016 Target: Set baseline (Pending)			

Crisis Systems

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Crisis Systems	$---	$---	$5,000	+$5,000
PHS Evaluation Funds (non-add)	---	---	*5,000*	*+5,000*

Authorizing Legislation .....Section 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Communities

Program Description and Accomplishments

Behavioral health crises are critical times for intervention and treatment and key times to engage individuals in on-going treatment and recovery. Such crises often cause great disruption for individuals and those around them, including family members, teachers, law enforcement, and employers. Communities throughout America currently lack the capacity to provide needed services when children, young adults, and their family members experience behavioral health crises. For too many, the only resource available is hospital emergency departments that are not equipped to address their behavioral health needs and often where they experience long stays and unnecessary inpatient care. The number of patients with mental health and substance use conditions treated in emergency rooms (ER) has been on the rise for more than a decade.[70] In 2007, 12.0 million ER visits involved a diagnosis related to mental health and/or substance use conditions, which accounted for 12.5 percent of all ER visits in the United States, or one out of every eight ER visits. Mental health and substance use related ER visits were two and a half times more likely to result in hospital admissions than ER visits related to non- mental health and substance use related ER visits that resulted in hospitalization. Medicare was billed most frequently for mental health and substance use-related ER visits (30.1 percent), followed by private insurance (25.7 percent), uninsured (20.6 percent), and Medicaid (19.8 percent).[71]

Comprehensive crisis systems can be challenging to conceive and fund. These often require coordination among multiple systems, such as 911 lines and other facets of emergency response systems; first responders including police and EMT; emergency room and primary health care; court systems; multiple payers; social service providers; and behavioral healthcare providers. Comprehensive crisis systems also have to be designed, funded, and staffed to address and manage a range of ages, family situations, locations and crisis-situations, including various presenting conditions, such as serious mental illness (SMI). Well-managed crisis interventions can result in positive outcomes for the individual, family, and community, including increased understanding of mental and substance use disorders. Poorly managed crisis situations can result

[70] Larkin, G.L., Claassen, C.A., Edmond, J.A., Pelletier, A.J., and Camargo, C.A. Trends in U.S. Emergency Department Visits for Mental Health Conditions, 1992 to 2001. Psychiatric Services. 2005; 56:671-677
[71] Owens, P., Mutter, R., & Stocks, C. (n.d.). Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007. Retrieved August 21, 2015, from http://www.hcups.ahrq.gov/reports/statbriefs/sb92.pdf

in frustration, increased health and social services system costs, and negative outcomes for all involved, including potential harm to the individual experiencing the crisis or others.

While there are models of comprehensive crisis response systems that are operating successfully, these comprehensive systems are the exception. More commonly, law enforcement and emergency room personnel respond to public safety and health situations without the benefit of the range of services and support needed to prevent, manage, and follow up on behavioral health crises. Inadequate crisis response systems can result in harm to the individual in crisis, law enforcement, or others; unnecessary use of scarce and costly emergency room and inpatient settings; and inappropriate use of jails and criminal justice resources.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$5,000,000

Budget Request

The FY 2017 Budget Request includes a total of $10.0 million, an increase of $10.0 million for the FY 2016 Enacted Level. This includes $5.0 million in the Mental Health appropriation and $5.0 million in the Substance Abuse Treatment appropriation. This program will help communities build, fund, and sustain crisis systems capable of preventing and de-escalating behavioral health crises as well as connecting individuals, including those with serious mental illness, and families with needed post-crisis services.

In FY 2017, SAMHSA plans to provide Increasing Access Response Efforts (ICARE) grant opportunities to states and communities to develop and/or adopt sustainable, comprehensive, and coordinated community-based crisis response systems for children, youth and adults with mental health and/or addiction problems. Whether individuals receive services voluntarily or by court order, the ICARE initiative will help to reduce costly and unnecessary use of hospital emergency department and inpatient services. This initiative will also support the integration and expansion of services to fill gaps and enhance coordination within the comprehensive continuum of the crisis response services, while minimizing the risk for re-traumatization of individuals and families served. This activity will help communities build, fund, and sustain crisis systems. The crisis systems will be capable of preventing and de-escalating behavioral health crises. They will also help connect individuals including those with serious mental illness, and families with needed post-crisis services in order to prevent recurrence of the crisis situation. In many incidences, responses to these situations by emergency medical responders and behavioral healthcare providers are under-coordinated and un-sustained. These grants will help mitigate the demand for inpatient beds by people with serious mental illnesses and substance use disorders by coordinating effective crisis response with ongoing outpatient services and supports.

As a braided activity, SAMHSA will track separately any amounts spent or awarded under Crisis Systems through its distinct appropriation and ensure that funds are used for purposes consistent with legislative direction and intent of that appropriation.

Outputs and Outcomes Tables

Program: Crisis Systems: Increasing Access Response Efforts (ICARE)

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.1.05 Increase the number of organizations that entered into formal written inter/intra organizational agreements. (Outcome)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)			
3.1.06 Increase the percentage of clients receiving services who report positive functioning at 6-month follow-up. (Outcome)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)			
3.1.07 Increase the number of individuals referred to mental health or related services. (Outcome)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)			

Assisted Outpatient Treatment for Individuals with Serious Mental Illness

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Assisted Outpatient Treatment for Individuals with Serious Mental Illness	$---	$15,000	$15,000	$---

Authorizing Legislation ..... Section 224 of the Protecting Access to Medicare Act of 2014
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Communities

Program Description and Accomplishments

Recent data show that one in five American adults experience a mental health issue and one in 25 Americans live with a serious mental illness, 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 serious mental illness, 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 serious mental illness. 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 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 is implementing an AOT grant program through awarding approximately 20 cooperative agreements for up to $1,000,000 each to support the implementation of Section 224 of PAMA, the Assisted Outpatient Treatment Grant Programs for Individuals with Serious Mental Illness pilot program. The goal of the pilot is to improve the health and social outcomes for the individuals served in the program, such as increasing healthcare utilization, improving behavioral health and other health outcomes, and reducing rates of homelessness and incarceration. The AOT grant program will prepare and execute evidence-based, recovery oriented, and person-centered treatment plans with consumer input, provide case management and evidence-based services that support the individual and the treatment plan, ensure individuals are made aware of criteria for AOT completion, and ensure appropriate referrals to medical and social services providers based on the individual's needs.

Grants will be awarded 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. Grants will only be awarded to applicants that have not previously implemented an AOT program.

Grantees will be required to participate in a cross site evaluation which will assess the effectiveness and impact of the AOT grant programs. Additional program outcomes that will be evaluated will include, but are not be limited to, health and social outcomes such as the rates of incarceration, employment, health care utilization, mortality, suicide, substance use, hospitalization, homelessness, and use of services.

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

Annual reports will be made to Congress at the end of each fiscal year beginning in 2016 and ending in 2018. These reports will include any cost savings and public health outcomes; rates of incarceration; rates of homelessness; and individual and family satisfaction with program participation.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$15,000,000
FY 2017	$15,000,000

Budget Request

The FY 2017 Budget Request includes $15.0 million, the same as the FY 2016 Enacted Level. SAMHSA plans to award twelve grants at approximately $1.0 million each. The remaining funds will be used to support technical assistance and evaluation of the grant program. This funding will continue 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 towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
1.2.05 Increase the percentage of clients receiving services who report positive functioning at 6-month follow-up. (Outcome)	FY 2015: 59.0% 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 2015: 62.5% Target: 70.5% (Target not met but improved)	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 2015: 47.5% Target: 22.2% (Target exceeded)	47.5%	47.5%	Maintain
1.2.88 Increase the number of individuals screened for mental health or related interventions. (Outcome)	FY 2015: 29,745 Target: 20,341 (Target exceeded)	29,813	24,709	-5,104

[1]Includes the following: Law Enforcement and Behavioral Health Partnerships for Early Diversion, Jail Diversion and Trauma Recovery Program-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 towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
1.4.06 Increase the number of people trained by CMHS Science and Service Programs. (Output)	FY 2015: 27,297 Target: 18,827 (Target exceeded)	16,271	16,271	Maintain
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program. (Output)	FY 2015: 38,941[1] Target: 110,000 (Target not met)	40,947[2]	40,947	Maintain
1.4.14 Increase the number of calls answered by the Disaster Distress Hotline. (Output)	FY 2015: 3,260 Target: 6,436 (Target not met)	3,228	3,228	Maintain
1.4.15 Increase the number of text messages answered by the Disaster Distress Hotline. (Output)	FY 2015: 15,044 Target: 4,131 (Target exceeded)	4,131	4,131	Maintain

[1]Results are preliminary and will be updated when additional data is available.

[2]Target aggregates CSAT and CMHS Science and Service individuals trained and CSAP CAPT individuals trained.

SAMHSA/Mental Health
PRNS Mechanism Table Summary

(Dollars in thousands)

Program Activity	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Programs of Regional & National Significance						
Grants/Cooperative Agreements						
Continuations	390	$211,629	411	$219,913	594	$275,319
New/Competing	221	98,484	269	119,949	99	62,948
Subtotal	611	310,112	680	339,862	693	338,268
Contracts						
Continuations	22	55,778	24	54,619	29	63,364
New/Competing	7	4,648	7	12,068	4	4,756
Subtotal	29	60,426	31	66,688	33	68,120
Total, Mental Health PRNS[1]	**640**	**$370,538**	**711**	**$406,550**	**726**	**$406,388**

[1] The Total PRNS in FY 2015 and FY 2016 includes $12.0 million in Prevention and Public Health Funds. The Total PRNS in FY 2017 includes $10.0 million in Prevention and Public Health Funds.

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

(Dollars in thousands)

Programs of Regional & National Significance	FY2015 Final		FY2016 Enacted		FY2017 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
CAPACITY:						
Seclusion and Restraint						
Grants						
Continuations	---	$---	---	$---	---	$---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	1,147	1	1,147	1	1,147
New/Competing	---	---	---	---	---	---
Subtotal	1	1,147	1	1,147	1	1,147
Total, Seclusion and Restraint	**1**	**1,147**	**1**	**1,147**	**1**	**1,147**
Youth Violence Prevention						
Grants						
Continuations	8	19,795	8	20,087	---	---
New/Competing	---	---	---	---	---	---
Subtotal	8	19,795	8	20,087	---	---
Contracts						
Continuations	2	3,091	2	3,012	---	---
New/Competing	1	213	---	---	---	---
Subtotal	3	3,304	2	3,012	---	---
Total, Youth Violence Prevention	**11**	**23,099**	**10**	**23,099**	**---**	**---**
Project AWARE						
Grants						
Continuations	20	40,304	90	44,839	95	58,481
New/Competing	70	8,545	6	11,781	2	4,720
Subtotal	90	48,849	96	56,619	97	63,201
Contracts						
Continuations	2	5,477	2	6,546	3	8,763
New/Competing	1	539	1	1,700	---	---
Subtotal	3	6,016	3	8,246	3	8,763
Total, Project AWARE	**93**	**54,865**	**99**	**64,865**	**100**	**71,964**
National Child Traumatic Stress Network						
Grants						
Continuations	78	42,705	---	---	83	43,726
New/Competing	---	---	83	43,784	---	---
Subtotal	78	42,705	83	43,784	83	43,726
Contracts						
Continuations	---	3,182	---	3,103	---	3,161
New/Competing	---	---	---	---	---	---
Subtotal	---	3,182	---	3,103	---	3,161
Total ,National Child Traumatic Stress Network	**78**	**45,887**	**83**	**46,887**	**83**	**46,887**

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final No.	FY 2015 Final Amount	FY 2016 Enacted No.	FY 2016 Enacted Amount	FY 2017 President's Budget No.	FY 2017 President's Budget Amount
Children and Family Programs						
Grants						
Continuations	11	4,375	11	4,383	---	---
New/Competing	---	---	---	---	11	4,560
Subtotal	11	4,375	11	4,383	11	4,560
Contracts						
Continuations	2	2,083	2	2,075	2	1,898
New/Competing	---	---	---	---	---	---
Subtotal	2	2,083	2	2,075	2	1,898
Total, Children and Family Programs	**13**	**6,458**	**13**	**6,458**	**13**	**6,458**
Healthy Transitions						
Grants						
Continuations	17	17,567	17	16,932	17	16,929
New/Competing	---	---	---	---	---	---
Subtotal	17	17,567	17	16,932	17	16,929
Contracts						
Continuations	---	2,384	---	2,194	---	3,022
New/Competing	---	---	---	825	---	---
Subtotal	---	2,384	---	3,019	---	3,022
Total, Healthy Transitions	**17**	**19,951**	**17**	**19,951**	**17**	**19,951**
Consumer and Family Network Grants						
Grants						
Continuations	38	2,621	14	1,330	43	4,092
New/Competing	22	1,719	37	3,162	2	200
Subtotal	60	4,340	51	4,492	45	4,292
Contracts						
Continuations	---	520	---	311	---	462
New/Competing	---	94	---	150	2	200
Subtotal	---	614	---	462	2	662
Total, Consumer and Family Network Grants	**60**	**4,954**	**51**	**4,954**	**47**	**4,954**
Project LAUNCH						
Grants/Cooperative Agreements						
Continuations	31	25,744	36	29,492	25	18,448
New/Competing	5	3,387	---	---	15	10,950
Subtotal	36	29,131	36	29,492	40	29,399
Contracts						
Continuations	1	4,251	2	5,063	1	5,156
New/Competing	1	1,173	---	---	---	---
Subtotal	2	5,424	2	5,063	1	5,156
Total, Project LAUNCH	**38**	**34,555**	**38**	**34,555**	**41**	**34,555**
Mental Health System Transformation and Health Reform						
Grants						
Continuations	7	2,637	7	2,633	7	2,643
New/Competing	---	---	---	---	---	---
Subtotal	7	2,637	7	2,633	7	2,643
Contracts						
Continuations	---	997	---	235	1	1,136
New/Competing	1	145	---	911	---	---
Subtotal	1	1,142	---	1,146	1	1,136
Total, Mental Health System Transformation and Health Reform	**8**	**3,779**	**7**	**3,779**	**8**	**3,779**

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final No.	FY 2015 Final Amount	FY 2016 Enacted No.	FY 2016 Enacted Amount	FY 2017 President's Budget No.	FY 2017 President's Budget Amount
Primary and Behavioral Health Care Integration						
Grants						
Continuations	16	6,179	53	21,019	60	24,186
New/Competing	60	40,668	27	25,754	---	---
Subtotal	76	46,847	80	46,773	60	24,186
Contracts						
Continuations	---	3,030	---	3,104	---	1,818
New/Competing	---	---	---	---	---	---
Subtotal	---	3,030	---	3,104	---	1,818
Total, PBHCI	**76**	**49,877**	**80**	**49,877**	**60**	**26,004**
National Strategy for Suicide Prevention						
Grants						
Continuations	4	1,879	4	1,880	---	---
New/Competing	---	---	---	---	16	26,000
Subtotal	4	1,879	4	1,880	16	26,000
Contracts						
Continuations	---	121	---	120	---	---
New/Competing	---	---	---	---	2	4,000
Subtotal	---	121	---	120	2	4,000
Total, National Strategy for Suicide Prevention	**4**	**2,000**	**4**	**2,000**	**18**	**30,000**
Suicide Lifeline						
Grants						
Continuations	12	690	1	5,288	7	5,978
New/Competing	1	5,288	6	690	---	---
Subtotal	13	5,978	7	5,978	7	5,978
Contracts						
Continuations	---	1,220	---	1,220	---	1,220
New/Competing	---	---	---	---	---	---
Subtotal	---	1,220	---	1,220	---	1,220
Total, Suicide Lifeline	**13**	**7,198**	**7**	**7,198**	**7**	**7,198**
GLS - Youth Suicide Prevention - States						
Grants						
Continuations	33	22,110	38	27,765	42	30,664
New/Competing	12	8,705	4	2,891	---	---
Subtotal	45	30,814	42	30,656	42	30,664
Contracts						
Continuations	1	4,613	1	4,771	1	4,763
New/Competing	---	---	---	---	---	---
Subtotal	1	4,613	1	4,771	1	4,763
Total, GLS - States	**46**	**35,427**	**43**	**35,427**	**43**	**35,427**
GLS - Youth Suicide Prevention - Campus						
Grants						
Continuations	33	3,184	37	3,513	39	3,830
New/Competing	22	2,085	17	1,759	14	1,481
Subtotal	55	5,270	54	5,272	53	5,311
Contracts						
Continuations	---	1,218	---	1,216	---	1,177
New/Competing	---	---	---	---	---	---
Subtotal	---	1,218	---	1,216	---	1,177
Total, GLS - Campus	**55**	**6,488**	**54**	**6,488**	**53**	**6,488**

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final No.	FY 2015 Final Amount	FY 2016 Enacted No.	FY 2016 Enacted Amount	FY 2017 President's Budget No.	FY 2017 President's Budget Amount
GLS - Suicide Prevention Resource Center						
Grants						
Continuations	---	---	1	5,634	1	5,634
New/Competing	1	5,634	---	---	---	---
Subtotal	1	5,634	1	5,634	1	5,634
Contracts						
Continuations	---	---	---	354	---	354
New/Competing	---	354	---	---	---	---
Subtotal	---	354	---	354	---	354
Total, GLS - Suicide Prevention Resource Center	**1**	**5,988**	**1**	**5,988**	**1**	**5,988**
AI/AN Suicide Prevention Initiative						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	2,788	1	2,931	1	2,931
New/Competing	1	143	---	---	---	---
Subtotal	2	2,931	1	2,931	1	2,931
Total, AI/AN	**2**	**2,931**	**1**	**2,931**	**1**	**2,931**
Homelessness Prevention Programs						
Grants						
Continuations	10	4,217	17	14,758	39	20,010
New/Competing	23	19,730	30	9,800	6	4,523
Subtotal	33	23,946	47	24,558	45	24,533
Contracts						
Continuations	3	6,687	2	4,507	3	6,163
New/Competing	---	63	1	1,631	---	---
Subtotal	3	6,750	3	6,138	3	6,163
Total, Homelessness Prevention Programs	**36**	**30,696**	**50**	**30,696**	**48**	**30,696**
Minority AIDS						
Grants						
Continuations	34	7,752	34	7,751	34	7,753
New/Competing	---	---	---	---	30	6,187
Subtotal	34	7,752	34	7,751	64	13,940
Contracts						
Continuations	---	962	1	1,473	1	1,995
New/Competing	---	510	---	---	---	---
Subtotal	---	1,472	1	1,473	1	1,995
Total, Minority AIDS	**34**	**9,224**	**35**	**9,224**	**65**	**15,935**
Crisis Systems						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	3	4,328
Subtotal	---	---	---	---	3	4,328
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	672
Subtotal	---	---	---	---	---	672
Total, Crisis Systems	**---**	**---**	**---**	**---**	**3**	**5,000**

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final No.	FY 2015 Final Amount	FY 2016 Enacted No.	FY 2016 Enacted Amount	FY 2017 President's Budget No.	FY 2017 President's Budget Amount
Criminal and Juvenile Justice Programs						
Grants						
Continuations	17	2,907	17	2,912	17	2,921
New/Competing	---	---	---	---	---	---
Subtotal	17	2,907	17	2,912	17	2,921
Contracts						
Continuations	1	975	1	777	2	1,348
New/Competing	1	387	1	579	---	---
Subtotal	2	1,362	2	1,357	2	1,348
Total, Criminal and Juvenile Justice Programs	**19**	**4,269**	**19**	**4,269**	**19**	**4,269**
Tribal Behavioral Health Grants						
Grants						
Continuations	20	3,811	20	3,818	67	11,580
New/Competing	---	---	47	7,762	---	---
Subtotal	20	3,811	67	11,580	67	11,580
Contracts						
Continuations	---	1,177	---	1,756	---	3,420
New/Competing	---	---	---	1,664	---	---
Subtotal	---	1,177	---	3,420	---	3,420
Total, Tribal Behavioral Health Grants	**20**	**4,988**	**67**	**15,000**	**67**	**15,000**
Assisted Outpatient Treatment for Individuals with Serious Mental Illness						
Grants						
Continuations	---	---	---	---	12	12,567
New/Competing	---	---	12	12,567	---	---
Subtotal	---	---	12	12,567	12	12,567
Contracts						
Continuations	---	---	---	---	2	2,433
New/Competing	---	---	2	2,433	---	---
Subtotal	---	---	2	2,433	2	2,433
Total, Assisted Outpatient Treatment for Individuals with Serious Mental Illness	**---**	**---**	**14**	**15,000**	**14**	**15,000**
Subtotal, CAPACITY	**625**	**$353,781**	**694**	**$389,793**	**709**	**$389,631**
SCIENCE AND SERVICE:						
Practice Improvement Training						
Grants						
Continuations	1	3,151	1	3,156	1	3,157
New/Competing	---	---	---	---	---	---
Subtotal	1	3,151	1	3,156	1	3,157
Contracts						
Continuations	4	4,309	6	3,952	7	4,671
New/Competing	1	368	1	720	---	---
Subtotal	5	4,677	7	4,672	7	4,671
Total, Practice Improvement Training	**6**	**7,828**	**8**	**7,828**	**8**	**7,828**
Consumer and Consumer Supporter TA Centers						
Grants						
Continuations	---	---	5	1,799	5	1,796
New/Competing	5	1,800	---	---	---	---
Subtotal	5	1,800	5	1,799	5	1,796
Contracts						
Continuations	---	---	---	119	---	122
New/Competing	---	118	---	---	---	---
Subtotal	---	118	---	119	---	122
Total, CCSTAC	**5**	**1,918**	**5**	**1,918**	**5**	**1,918**

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final No.	FY 2015 Final Amount	FY 2016 Enacted No.	FY 2016 Enacted Amount	FY 2017 President's Budget No.	FY 2017 President's Budget Amount
Primary and Behavioral Health Care Integration TA						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	1,929	1	1,991	1	1,991
New/Competing	---	62	---	---	---	---
Subtotal	1	1,991	1	1,991	1	1,991
Total, PBHCI TA	**1**	**1,991**	**1**	**1,991**	**1**	**1,991**
Disaster Response						
Grants						
Continuations	---	---	---	923	---	923
New/Competing	---	923	---	---	---	---
Subtotal	---	923	---	923	---	923
Contracts						
Continuations	1	1,030	1	1,030	1	1,030
New/Competing	---	---	---	---	---	---
Subtotal	1	1,030	1	1,030	1	1,030
Total, Disaster Response	**1**	**1,953**	**1**	**1,953**	**1**	**1,953**
Homelessness						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	1,817	---	745	1	2,296
New/Competing	---	479	1	1,551	---	---
Subtotal	1	2,296	1	2,296	1	2,296
Total, Homelessness	**1**	**2,296**	**1**	**2,296**	**1**	**2,296**
HIV/AIDS Education						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	1	771	1	867	1	887
New/Competing	---	---	---	-96	---	-116
Subtotal	1	771	1	771	1	771
Total, HIV/AIDS	**1**	**771**	**1**	**771**	**1**	**771**
Subtotal, SCIENCE AND SERVICE	**15**	**16,757**	**17**	**16,757**	**17**	**16,757**
TOTAL, MH PRNS[1]	**640**	**$370,538**	**711**	**$406,550**	**726**	**$406,388**

[1] 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.

Grant Awards Table

(Whole dollars)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	611	680	693
Average Awards	$507,549	$499,798	$488,296
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)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Budget Authority	$117,026	$119,026	$119,026	$---
10% set-aside for youth in prodrome phase of psychosis (non-add)	---	---	*11,903*	*+11,903*

Authorizing Legislation ..... Sections 561 to 565 of the Public Health Service Act
FY 2017 Authorization .....Expired
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 50 percent of those in need of mental health services actually receive treatment.[72] Authorized 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. Approximately nine percent to 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 support to meet the needs of children and youth with SED.

CMHI supports the development and implementation of comprehensive, community-based services that use the SOC approach. The SOC approach 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 appropriately, effectively, and with a 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 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.

[72] 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 use, and outcomes.

In FY 2011, SAMHSA first awarded SOC Expansion Planning grants to bring systems of care to scale from community to statewide focus, where the grantee develops a comprehensive strategic plan for improving and expanding services and supports broadly throughout a state or political subdivision of a state, tribe, or territory. In FY 2012, SAMHSA first funded SOC Expansion Implementation grants to assist states, tribes and larger geographic areas in implementing their strategic plans to expand the SOC approach to improve outcomes for children and youth with serious mental disorders and their families.

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), and support coordinated planning and funding efforts.

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 youths' mental health. The evaluation includes a 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) whether children and families stay in services longer in communities that achieve higher service and SOC ratings.

With the growth of the program, the evaluation process continues to gather data from children and families involved in SOCs and documents the ways in which different cohorts of grantees have changed over the years. In addition to infrastructure and service evaluation, a sector and comparison study is evaluating differences in outcomes between SOC eligible youth involved in education, juvenile justice, and child welfare systems and similar youth not enrolled in SOC services. The evaluation continues to monitor the outcomes of children, youth and families through various data profile reports, and continuous quality improvement reports. The evaluation has added activities to assess the associated costs and cost savings of the SOC approach, and provides technical assistance to grantees to promote family engagement in the evaluation. Evaluation activities also help determine the grantees ability to sustain the program at the end of federal funding.

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 (nine six-year grants and 45 four-year grants). Also, SAMHSA 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 plans to support 47 continuation grants, 53 new grants, and five contracts.

Funding History

Fiscal Year	Amount
FY 2013	$111,430,194
FY 2014	$117,026,000
FY 2015	$117,026,000
FY 2016	$119,026,000
FY 2017	$119,026,000

Budget Request

The FY 2017 Budget Request is $119.0 million, the same as the FY 2016 Enacted Level. 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 on Mental Health. During the prodrome phase, a disease process has begun but is not yet diagnosable or inevitable. Intervention during this phase is critical and may prevent the further development of serious emotional disturbances and ultimately serious mental illness. It is important to take action during this stage to mitigate or delay the progression of mental illness, reduce disability, and 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. 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.

SAMHSA is requesting funding to support 86 continuation grants, 14 new grants and five continuation contracts. This funding will provide training to 5,101 people in the mental health and related workforce and serve 6,610 children with serious emotional disturbances.

SAMHSA/Mental Health
Mechanism Table

(Dollars in thousands)

Program Activity	FY 2015 Final No.	FY 2015 Final Amount	FY 2016 Enacted No.	FY 2016 Enacted Amount	FY 2017 President's Budget No.	FY 2017 President's Budget Amount
Children's Mental Health Services						
Grants/Cooperative Agreements						
Continuations	54	$49,115	47	$44,915	86	$84,144
New/Competing	24	47,669	53	52,805	14	13,500
Subtotal	78	96,784	100	97,720	100	97,644
Contracts						
Continuations	2	9,599	2	12,276	2	12,359
New/Competing	1	1,626	---	---	---	---
Subtotal	3	11,224	2	12,276	2	12,359
Technical Assistance	3	9,018	3	9,030	3	9,023
Total, Children's Mental Health Services	**84**	**$117,026**	**105**	**$119,026**	**105**	**$119,026**

* Totals may not add due to rounding.

Outputs and Outcomes Table

Program: Children's Mental Health Services

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 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 2015: 13,595 Target: 6,610 (Target exceeded)	13,595	13,595	Maintain
3.2.25 Increase the percentage of children receiving services who report positive social support at 6 month follow-up. (Outcome)	FY 2015: 87.4% 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 2015: 64.5% Target: 62.7% (Target exceeded)	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 2015: 4,800 Target: 5,101 (Target not met)	5,101	5,101	Maintain

Grant Awards Table

(Whole dollars)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	78	100	100
Average Awards	$1,240,818	$977,202	$976,440
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	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
Budget Authority	$64,635	$64,635	$64,635	$---

Authorizing Legislation .....Section 521 of the Public Health Service Act
FY 2017 Authorization .....Expired
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.[73] 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) has a serious mental illness.[74,75,76] 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.[77]

The United States Interagency Council on Homelessness estimates that the national public cost of chronic homelessness is $3.7 to $4.7 billion per year,[78] and the human costs are untold. Data show that funding the Projects for Assistance in Transition from Homelessness (PATH) program, which includes identifying and connecting a person experiencing chronic homelessness to primary medical and behavioral health treatment and services, *and* housing them, is two to

[73] 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

[74] 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

[75] National Alliance on Mental Illness. Mental Health by the Numbers. Available at: https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

[76] 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

[77] National Alliance on Mental Illness (2004). Homelessness. Available at: http://www2.nami.org/Template.cfm?Section=security&template=/ContentManagement/ContentDisplay.cfm&ContentID=47556

[78] United States Interagency Council on Homelessness (2014). The True Cost of Doing Nothing. Available at: http://usich.gov/blog/the-true-cost-of-doing-nothing

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 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 and substance use disorder treatment services, case management, assistance with accessing housing, and other supportive services. 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 2014, the PATH program outreached to 185,524 individuals experiencing homelessness and enrolled 63 percent of individuals with a SMI into the PATH program (80,411 individuals). Additionally, 52 percent of enrolled individuals were experiencing a co-occurring substance use disorder. Of those enrolled in PATH, 62,632 individuals received community mental health services. 12,446 individuals received substance use treatment through PATH, while 17,318 individuals were referred by PATH to substance use treatment services in the community. In addition, PATH assisted 17,474 individuals with addressing complex housing needs and referred 27,881 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.

Funding History

Fiscal Year	Amount
FY 2013	$61,405,176
FY 2014	$64,635,000
FY 2015	$64,635,000
FY 2016	$64,635,000
FY 2017	$64,635,000

Budget Request

The FY 2017 Budget Request is $64.6 million, level from the FY 2016 Enacted Level. 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 suffering from SMI or those suffering from SMI and from substance use disorders 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 towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 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 2014: 64.0% Target: 47.0% (Target exceeded)	66.0%	66.0%	Maintain
3.4.16 Increase the number of homeless persons contacted. (Outcome)	FY 2014: 185,524 Target: 182,000 (Target exceeded)	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 2014: 58.0% Target: 55.0% (Target exceeded)	58.0%	58.0%	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 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 (+/-) FY 2016
Alabama	$613,000	$609,000	$609,000	$---
Alaska	300,000	300,000	300,000	---
Arizona	1,349,000	1,341,000	1,341,000	---
Arkansas	304,000	302,000	302,000	---
California	8,809,000	8,760,000	8,760,000	---
Colorado	1,019,000	1,013,000	1,013,000	---
Connecticut	799,000	795,000	795,000	---
Delaware	300,000	300,000	300,000	---
District of Columbia	300,000	300,000	300,000	---
Florida	4,332,000	4,308,000	4,308,000	---
Georgia	1,669,000	1,660,000	1,660,000	---
Hawaii	300,000	300,000	300,000	---
Idaho	300,000	300,000	300,000	---
Illinois	2,704,000	2,689,000	2,689,000	---
Indiana	1,011,000	1,005,000	1,005,000	---
Iowa	334,000	333,000	333,000	---
Kansas	377,000	375,000	375,000	---
Kentucky	469,000	466,000	466,000	---
Louisiana	733,000	729,000	729,000	---
Maine	300,000	300,000	300,000	---
Maryland	1,271,000	1,264,000	1,264,000	---
Massachusetts	1,558,000	1,550,000	1,550,000	---
Michigan	1,729,000	1,719,000	1,719,000	---
Minnesota	811,000	806,000	806,000	---
Mississippi	300,000	300,000	300,000	---
Missouri	893,000	888,000	888,000	---
Montana	300,000	300,000	300,000	---
Nebraska	300,000	300,000	300,000	---
Nevada	616,000	612,000	612,000	---
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 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 (+/-) FY 2016
New Jersey	$2,137,000	$2,125,000	$2,125,000	$---
New Mexico	300,000	300,000	300,000	---
New York	4,221,000	4,198,000	4,198,000	---
North Carolina	1,379,000	1,371,000	1,371,000	---
North Dakota	300,000	300,000	300,000	---
Ohio	1,986,000	1,975,000	1,975,000	---
Oklahoma	453,000	450,000	450,000	---
Oregon	631,000	627,000	627,000	---
Pennsylvania	2,366,000	2,353,000	2,353,000	---
Rhode Island	300,000	300,000	300,000	---
South Carolina	680,000	676,000	676,000	---
South Dakota	300,000	300,000	300,000	---
Tennessee	909,000	904,000	904,000	---
Texas	4,993,000	4,966,000	4,966,000	---
Utah	591,000	588,000	588,000	---
Vermont	300,000	300,000	300,000	---
Virginia	1,471,000	1,463,000	1,463,000	---
Washington	1,329,000	1,321,000	1,321,000	---
West Virginia	300,000	300,000	300,000	---
Wisconsin	836,000	832,000	832,000	---
Wyoming	300,000	300,000	300,000	---
American Samoa	50,000	50,000	50,000	---
Guam	50,000	50,000	50,000	---
Northern Marianas	50,000	50,000	50,000	---
Puerto Rico	891,000	886,000	886,000	---
Virgin 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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Budget Authority	$36,146	$36,146	$36,146	$---

Authorizing Legislation ..... The PAIMI Act, 42 U.S.C. 10801 et seq.
FY 2017 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 2014, the most recent data available, the PAIMI program met its target by successfully resolving complaints of alleged abuse, neglect, and rights violations 86.1 percent of the time.

In FY 2014, the 57 state PAIMI Programs:

- Served 13,936 PAIMI-eligible individuals/clients: 2,889 children and youth (ages 0 to 18) and 10,284 adults (ages 19 to 64), and 763 older adults (age 65 and older). These individuals filed 11,454 complaints alleging abuse, neglect, and/or rights violations.
- Of the closed 11,454 complaints: 3,290 of the allegations were not substantiated, lacked legal merit, or were withdrawn by the client; 8,304 were substantiated, including 1,632

for abuse, 1,449 for neglect, and 5,223 for rights violation allegations.

- Resolved 89 percent of abuse, 81 percent of neglect allegations, and 89 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 health treatment; safer, cleaner facility environment; discharge into an appropriate community-based setting; and discharge from a nursing facility.

In FY 2014, SAMHSA continued to fund 57 annual grants to states and territories as well as continued technical assistance activities and support for grantees. This funding is level in FY 2015 and FY 2016.

Funding History

Fiscal Year	Amount
FY 2013	$34,342,895
FY 2014	$36,146,000
FY 2015	$36,146,000
FY 2016	$36,146,000
FY 2017	$36,146,000

Budget Request

The FY 2017 Budget Request is $36.1 million. This is the same as the FY 2016 Enacted Level. 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. These grantees protect and advocate 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. As in years past, PAIMI will also train and educate individuals on key topics such as seclusion and restraint or Olmstead implementation, or reach through contact with individuals who may be homeless or in state psychiatric hospitals approximately 140,000 individuals through the program.

Outputs and Outcomes Table

Program: Protection & Advocacy

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.4.12 Increase the number of people served by the PAIMI program. (Outcome)	FY 2014: 13,936 Target: 16,499 (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 2014: 82,246 Target: 92,953 (Target not met)	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 2014: 72.6% Target: 87.0% (Target not met)	88.0%	88.0%	Maintain

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State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 (+/-) FY 2016
Alabama	$456,090	$456,202	$453,927	-$2,275
Alaska	428,000	428,000	428,000	---
Arizona	616,908	620,810	626,647	+5,837
Arkansas	428,000	428,000	428,000	---
California	3,156,787	3,133,536	3,140,455	+6,919
Colorado	433,624	437,326	438,135	+809
Connecticut	428,000	428,000	428,000	---
Delaware	428,000	428,000	428,000	---
District of Columbia	428,000	428,000	428,000	---
Florida	1,704,717	1,724,396	1,738,618	+14,222
Georgia	917,657	924,616	925,855	+1,239
Hawaii	428,000	428,000	428,000	---
Idaho	428,000	428,000	428,000	---
Illinois	1,075,584	1,068,437	1,066,611	-1,826
Indiana	599,111	601,509	600,014	-1,495
Iowa	428,000	428,000	428,000	---
Kansas	428,000	428,000	428,000	---
Kentucky	428,000	428,000	428,000	---
Louisiana	428,000	428,000	428,000	---
Maine	428,000	428,000	428,000	---
Maryland	456,617	461,758	466,079	+4,321
Massachusetts	506,963	507,383	507,635	+252
Michigan	903,618	900,554	887,745	-12,809
Minnesota	444,348	447,204	445,862	-1,342
Mississippi	428,000	428,000	428,000	---
Missouri	544,367	538,623	537,067	-1,556
Montana	428,000	428,000	428,000	---
Nebraska	428,000	428,000	428,000	---
Nevada	428,000	428,000	428,000	---
New Hampshire	428,000	428,000	428,000	---

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State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 (+/-) FY 2016
New Jersey	$681,414	$684,418	$678,274	-$6,144
New Mexico	428,000	428,000	428,000	---
New York	1,525,779	1,522,543	1,522,025	-518
North Carolina	896,314	900,754	909,421	+8,667
North Dakota	428,000	428,000	428,000	---
Ohio	1,031,064	1,026,130	1,019,427	-6,703
Oklahoma	428,000	428,000	428,000	---
Oregon	428,000	428,000	428,000	---
Pennsylvania	1,074,746	1,068,002	1,058,493	-9,509
Rhode Island	428,000	428,000	428,000	---
South Carolina	452,783	455,079	457,932	+2,853
South Dakota	428,000	428,000	428,000	---
Tennessee	586,600	587,219	588,845	+1,626
Texas	2,255,157	2,268,331	2,278,827	+10,496
Utah	428,000	428,000	428,000	---
Vermont	428,000	428,000	428,000	---
Virginia	666,587	672,622	671,615	-1,007
Washington	574,891	573,924	573,555	-369
West Virginia	428,000	428,000	428,000	---
Wisconsin	498,588	496,018	494,780	-1,238
Wyoming	428,000	428,000	428,000	---
American Samoa	229,300	229,300	229,300	---
Guam	229,300	229,300	229,300	---
Northern Marianas	229,300	229,300	229,300	---
Puerto Rico	551,889	538,623	528,173	-10,450
Virgin Islands	229,300	229,300	229,300	---
American Indian Con	229,300	229,300	229,300	---

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Community Mental Health Services Block Grant (MHBG)

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Community Mental Health Services Block Grant.....	$482,571	$532,571	$532,571	$---
PHS Evaluation Funds (non-add).....	*21,039*	*21,039*	*21,039*	---

Authorizing Legislation .....Section 1911 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Formula Grant
Eligible Entities.....States, Territories, Freely Associated States, District of Columbia

Program Description and Accomplishments

Behavioral health problems are more common in the United States than is generally realized. According to the 2014 Behavioral Health Barometer: United States, approximately 4.2 percent of U.S. adults (an estimated 10.0 million individuals) reported having serious mental illness (SMI) within the year prior to being surveyed.[79,80] Nearly a third of these individuals did not receive any services in the year before being surveyed.[81]

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.[82] Recipients of MHBG funds must develop comprehensive community mental health service plans and support Mental Health Planning Councils that include consumers of mental health services and family members. The MHBG distributes funds for a variety of services and for planning, administration, and educational activities. 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

[79] Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[80] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: United States, 2014. HHS Publication No. SMA–15–4895. Rockville, MD: Substance Abuse and Mental Health Services Administration
[81] Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[82] 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

families, and veterans). Through the administration of the MHBG, SAMHSA supports implementation of practices demonstrated and 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 critical 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. For example, planning, coordination, needs assessment, quality assurance, program development, training, and evaluation are all important activities that are necessary to develop and maintain an effective public health system for mental health services but not generally supported by Medicaid or other programs. The MHBG statute requires a five percent set-aside of the MHBG allocation 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 and use of health information technology and integration of physical and behavioral health services.

SAMHSA encourages states to use block grant resources to support and not supplant services that commercial and public insurer plans cover. SAMHSA's MHBG and Substance Abuse Prevention and Treatment Block Grant (SABG) applications aligns with changes in federal/state environments, including the impacts of the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Tribal Law and Order Act (TLOA). The new design 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.[83,84] Permitting MHBG recipients to submit the application/plan biennially reduces the burden on states.

States received the FY 2016 to FY 2017 Block Grant Application on July 1, 2015 to further efforts to have states use and report the opportunities offered under various federal initiatives. The FY 2016 and FY 2017 Block Grant Application continues to allow states to submit one application for both the mental health and substance abuse block grants as well as a biennial plan for the state mental and substance use disorder treatment systems. This application also reflects the Affordable Care Act's strong emphasis on coordinated and integrated care along with the

[83] 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).
[84] State Plan (Sec. 1932 (b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x-32(b)).

need to improve services for persons facing behavioral health crises. Under the application, SAMHSA Block Grant funds have four purposes:

1) To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
2) 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;
3) For the Substance Abuse Prevention and Treatment Block Grant: to fund primary prevention-universal, selective, and indicated prevention activities and services for individuals not identified as needing treatment; and
4) To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.

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 has been working with states and state representative organizations to identify and implement a core set of measures, which include approved quality measures, to assess outcomes and quality in programming. This effort has sought to both guide and align the measurement requirements of other major service purchasers, such as Medicaid and Medicare, and thus facilitate efficiencies in state reporting of behavioral health quality measures to federal entities. It is anticipated that once implemented, states will develop an implementation plan – both general to all states and unique to their particular state – regarding the specifics and realities of how these measures are being collected and reported, as well as how this effort is being coordinated with required reporting activities from Medicaid, Medicare, and other public payers.

There are many individuals, both adolescent and adult, with co-occurring mental illness and substance use disorders. 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 Child 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 2014 show that:

- For the 57 states and territories that reported data in the Employment Domain, 17.9 percent of the mental health consumers were in competitive employment;
- For the 58 states and territories that reported data in the Housing Domain, 78.8 percent of the mental health consumers were living in private residences;

- For the 59 states and territories that reported data in the Access/Capacity Domain, state mental health agencies provided mental health services for approximately 22 people per 1,000 population;
- For the 51 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 50 states and territories that reported data in the Perception of Care Domain, 70.9 percent of adult mental health consumers improved functioning as a direct result of the mental health services they received.

An independent evaluation of the MHBG demonstrated that funds allow states to explore new innovations and strategies; target emerging needs with special programs; pay for recovery-focused and consumer-centered services not covered by commercial insurance, Medicaid, or Medicare; and create the administrative, organizational, or service delivery linkages that foster a community-based, transformed system of mental health services. The program study is complete and the final report is available on the SAMHSA website (http://store.samhsa.gov/shin/content//SMA10-4610/SMA10-4610.pdf).

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."[85] 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 promising 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. The additional funds provided to the MHBG program fully offset the increase in the set aside.

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

Funding History

Fiscal Year	Amount
FY 2013	$436,808,709
FY 2014	$482,571,000
FY 2015	$482,571,000
FY 2016	$532,571,000
FY 2017	$532,571,000

Budget Request

The FY 2017 Budget Request is $532.6 million, the same as the FY 2016 Enacted Level. SAMHSA proposes to support the continuation of the Community Mental Health Services Block Grant and plans to serve 7,620,000 adults with serious mental illness and children with serious emotional disturbances through the public mental health system. In FY 2017, SAMHSA proposes to maintain the 10 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.

Outputs and Outcomes Table

Program: Mental Health Block Grant

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
2.3.11 Increase the number of evidence-based practices (EBPs) implemented. (Output)	FY 2014: 4.3 per State Target: 4.2 per State (Target exceeded)	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 2014: 7,296,842 Target: 6,340,320 (Target exceeded)	7,620,000	7,620,000	Maintain
2.3.15 Increase the rate of consumers (adults) reporting positively about outcomes. (Outcome)	FY 2014: 71.3% Target: 72.0% (Target not m but improved)	71.8%	71.8%	Maintain
2.3.16 Increase the rate of family members (children/adolescents) reporting positively about outcomes. (Outcome)	FY 2014: 67.3% Target: 67.0% (Target exceeded)	66.1%	66.1%	Maintain
2.3.81 Increase the percentage of service population receiving any evidence-based practice. (Outcome)	FY 2014: 10.8% Target: 7.2% (Target exceeded)	10.8%	10.8%	Maintain

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Community Mental Health Services Block Grant Program
CFDA #93.958

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 (+/-) FY 2016
Alabama	$6,646,898	$7,351,221	$7,352,060	+$839
Alaska	793,287	972,230	1,070,196	+97,966
Arizona	10,737,941	11,639,880	12,226,159	+586,279
Arkansas	4,227,658	4,483,965	4,557,692	+73,727
California	63,093,869	69,180,482	70,226,872	+1,046,390
Colorado	6,900,325	8,482,852	8,373,549	-109,303
Connecticut	4,785,704	5,237,154	5,299,684	+62,530
Delaware	1,042,835	1,417,398	1,524,264	+106,866
District of Columbia	927,814	1,057,109	1,158,138	+101,029
Florida	31,701,900	33,793,628	34,752,383	+958,755
Georgia	14,325,637	17,179,928	16,682,768	-497,160
Hawaii	2,368,691	2,636,917	2,823,874	+186,957
Idaho	2,561,105	2,378,674	2,436,321	+57,647
Illinois	17,158,047	19,839,321	19,434,267	-405,054
Indiana	8,381,873	9,110,702	9,024,235	-86,467
Iowa	3,686,277	4,067,863	4,051,196	-16,667
Kansas	3,454,659	3,771,945	3,811,757	+39,812
Kentucky	6,357,925	6,628,893	6,589,016	-39,877
Louisiana	5,513,361	6,183,159	6,182,022	-1,137
Maine	1,802,317	2,009,425	2,028,145	+18,720
Maryland	9,032,488	8,532,072	8,643,115	+111,043
Massachusetts	9,971,207	10,493,458	10,070,209	-423,249
Michigan	14,515,920	16,018,438	15,626,940	-391,498
Minnesota	7,089,713	7,862,764	7,551,467	-311,297
Mississippi	4,187,582	4,674,359	4,623,816	-50,543
Missouri	7,793,723	8,562,000	8,473,492	-88,508
Montana	1,359,717	1,497,654	1,545,887	+48,233
Nebraska	2,103,021	2,325,306	2,337,539	+12,233
Nevada	4,651,021	5,075,524	5,395,342	+319,818
New Hampshire	1,841,227	1,808,281	1,813,702	+5,421

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State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 (+/-) FY 2016
New Jersey	$12,975,405	$14,331,474	$13,992,766	-$338,708
New Mexico	2,791,090	2,995,653	3,080,291	+84,638
New York	28,236,385	32,425,192	31,373,445	-1,051,747
North Carolina	12,834,233	14,308,507	14,347,012	+38,505
North Dakota	816,996	879,581	889,532	+9,951
Ohio	15,076,166	16,292,879	15,897,769	-395,110
Oklahoma	4,978,056	5,434,052	5,483,485	+49,433
Oregon	5,983,509	6,726,815	6,885,888	+159,073
Pennsylvania	16,252,021	17,997,348	17,761,900	-235,448
Rhode Island	1,749,226	1,862,535	1,856,552	-5,983
South Carolina	6,656,055	7,435,778	7,495,762	+59,984
South Dakota	947,022	1,051,067	1,083,411	+32,344
Tennessee	8,802,254	10,325,846	10,311,592	-14,254
Texas	36,712,474	40,925,451	41,153,437	+227,986
Utah	3,490,243	3,858,877	3,972,584	+113,707
Vermont	821,044	896,094	905,085	+8,991
Virginia	11,372,201	11,578,454	11,244,868	-333,586
Washington	10,443,964	11,606,420	11,908,638	+302,218
West Virginia	2,646,507	2,906,084	2,889,218	-16,866
Wisconsin	7,274,287	8,440,552	8,267,157	-173,395
Wyoming	535,764	543,194	607,956	+64,762
American Samoa	88,293	98,148	98,343	+195
Guam	256,962	287,665	290,429	+2,764
Marshall Islands	110,039	125,103	128,046	+2,943
Micronesia	171,112	190,316	190,638	+322
Northern Marianas	82,585	91,782	92,870	+1,088
Palau	50,000	50,000	50,000	---
Puerto Rico	5,930,860	6,539,088	6,531,728	-7,360
Virgin Islands	169,164	187,864	187,912	+48

Evidence-based Early Interventions

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Evidence-based Early Interventions (Mandatory)	---	---	$115,000	+$115,000

Authorizing Legislation .....New Authorization
FY 2017 Authorization .....New Authorization
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... States, Tribes, Communities, Territories

Program Description and Accomplishments

Less than half of children and adults with diagnosable mental health problems receive the treatment they need. As part of the Administration's $500.0 million initiative to increase access to mental health services, this effort would help engage individuals with serious mental illness in care.

This proposal will fund a new formula grant for states to support evidence-based early intervention programs for individuals with serious mental illnesses (SMI). Significant delays in the identification and treatment of SMI are common; for example, research has repeatedly found that individuals with psychosis often do not receive appropriate treatment for that condition for over a year. This delay in treatment worsens long-term outcomes for people experiencing these conditions affecting their behavioral health, physical health, and achievement of education and employment goals. The five percent set-aside in the Community Mental Health Services Block Grant for early intervention programs required by Congress through the FY 2014 and FY 2015 appropriations laws has been very effective in increasing the availability of programs to engage people with SMI in care earlier than has generally been the case. The FY 2016 appropriations law increases the set-aside to 10 percent. As of 2016, 32 states have established early intervention programs, compared to two states that had such programs in 2008. Many of these new programs build on recent research funded by NIMH, namely the Recovery After an Initial Schizophrenia Episode (RAISE) project. Participants in this study showed improvements in both symptoms and quality of life and were more likely to be working or going to school. However, in a significant number of states, even with the increase of the set-aside to 10 percent, the amount of funding provided will be insufficient to establish and operate even one early intervention program, which generally requires about $700,000 a year. Working in collaboration with set-aside funded activities, this new formula grant would provide additional funds to enable all states to establish supports and services for early intervention and enable states that already have programs to expand their efforts. SAMHSA would administer this new formula grant program to support evidence-based early intervention services. SAMHSA plans to award a minimum of $700,000 to each state and a tribal set-aside.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$115,000,000

Budget Request

The FY 2017 Budget Request is $230.0 million in new mandatory funding, as part of the Administration's $500.0 million initiative to increase access to mental health care. This includes $115.0 million in FY 2017 and FY 2018. Working in collaboration with set-aside funded activities, this new formula grant would provide additional funds to enable all states to establish supports and services for early intervention and enable states that already have programs to further expand their efforts. SAMHSA would administer this new formula grant program to support evidence-based early intervention services. Plans include a minimum of $700,000 to each state and a tribal set-aside. This request is part of the Administration's $500.0 million two-year initiative to improve mental health services and to engage individuals with serious mental illness into care.

SAMHSA
Substance Abuse Prevention
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Substance Abuse Prevention Appropriation

(Dollars in thousands)

Program Activities	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Programs of Regional and National Significance....	$175,148	$211,148	$211,148	$---
PHS Evaluation Funds (non-add).....	---	---	*16,468*	*+16,468*
Total, Substance Abuse Prevention[1].....	**$175,148**	**$211,148**	**$211,148**	**$---**

[1] 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.

The Substance Abuse Prevention appropriation FY 2017 Budget Request of $211.1 million is level with the FY 2016 Enacted level. The request includes $194.6 million in Budget Authority and $16.5 million in PHS Evaluation Funds.

Programs of Regional and National Significance (PRNS)
Substance Abuse Prevention Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
CAPACITY				
Strategic Prevention Framework	$109,484	$119,484	$119,484	$---
Strategic Prevention Framework Rx (non-add)	---	*10,000*	*10,000*	---
PHS Evaluation Funds (non-add)	---	---	*10,000*	*+10,000*
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths	---	12,000	12,000	---
Federal Drug-Free Workplace	4,894	4,894	4,894	---
Minority AIDS	41,205	41,205	41,205	---
Sober Truth on Preventing Underage Drinking Act (Stop Act)	7,000	7,000	7,000	---
Tribal Behavioral Health Grants	---	15,000	15,000	---
Subtotal, Capacity	**162,583**	**199,583**	**199,583**	**---**
SCIENCE AND SERVICE				
Fetal Alcohol Spectrum Disorder	1,000	---	---	---
Center for the Application of Prevention Technologies	7,493	7,493	7,493	---
PHS Evaluations Funds (non-add)	---	---	*6,468*	*+6,468*
Science and Service Program Coordination	4,072	4,072	4,072	---
Subtotal, Science and Service	**12,565**	**11,565**	**11,565**	**---**
TOTAL, PRNS [1]	**$175,148**	**$211,148**	**$211,148**	**$---**

[1] 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.

Authorizing Legislation ..... Sections 516, 519B, 519D of the PHS Act
FY 2017 Authorization ..... Expired
Allocation Method ..... Competitive Grants/Cooperative Agreements/Contracts
Eligible Entities..... States, Tribes, Communities, and Private Non-Profit Organizations

Strategic Prevention Framework

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Strategic Prevention Framework.....	$109,484	$119,484	$119,484	$---
Strategic Prevention Framework Rx (non-add).....	---	*10,000*	*10,000*	---
PHS Evaluations Funds (non-add).....	---	---	*10,000*	*+10,000*

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2017 Authorization .....Expired
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 substance use disorder, 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 FY 2014, 27.0 million people ages 12 or older used an illicit drug in the past 30 days, which corresponds to about 1 in 10 Americans (10.2 percent). In the same year, an estimated 4.3 million people ages 12 or older reported current nonmedical use of prescription pain relievers.[86] The Strategic Prevention Framework – State Incentive Grant (SPF-SIG) program is a prevention and intervention tool, which provides a foundation for the success of the Strategic Prevention Framework - Partnerships for Success (SPF-PFS) program. Initiated in FY 2009, the SPF-SIG program was an infrastructure and service delivery grant program that supported 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 two of the nation's top substance use prevention priorities: underage drinking among youth and young adults age 12 to 20 and prescription drug misuse among individuals ages 12 to 25. Additionally, this program allows states to address other substance use issues such as heroin, marijuana, and inhalants.

Data show that states and communities receiving Partnerships For Success funding have made improvements in reducing the impact of substance use. The 2014 National Survey on Drug U s e

[86] 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.

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 2014, 22.8 percent of underage people reported current use of alcohol, 13.8 percent reported binge drinking, and 3.4 percent reported heavy alcohol use. The binge-drinking rate declined from 19.3 percent to 14.2 percent, and the rate of heavy drinking declined from 6.2 percent to 3.7 percent.[87]

In addition, the overall rate of non-medical use of prescription drugs such as pain relievers, tranquilizers, stimulants, and sedatives, has remained nearly constant over the last two years. In 2014, the percent of people aged 12 or older who reported current nonmedical use of pain relievers (1.6 percent) was lower than the percentages in most years from 2002 to 2012, but was similar to the percentage in 2013.[88] Prescription drug and opioid misuse continues to be a concern, as overdose deaths increase. These data highlight the continued need for targeted strategies geared toward educating families about the dangers of prescription drug and opioid interactions, educating consumers and prescribers about the dangers of high-risk prescribing, ensuring proper training of first responders, and implementing drug take back programs.

Trends in substance use often coincide with trends in perceived risk. If individuals believe using a particular substance is risky, they will be less likely to use it, and vice versa. Given the influence of perceived risk on use, perceived risk is an important factor to monitor.

Over the past five years, the perceived risk related to marijuana use has decreased. Between 2007 and 2013, the percentage of youth aged 12 to 17 who believe there is a great risk in smoking marijuana once a month decreased from 34.4 percent to 24.2 percent. During the same time period, the number of youth who perceived great risk in smoking marijuana once or twice a week also decreased from 54.6 percent to 39.5 percent. As the perceived risk has decreased, the percentage of youth that used marijuana in the past month has increased from 6.7 percent to 7.1 percent.[89]

This correlation between perceived risk and substance use informed the design and implementation of SAMHSA's FY 2015 Partnerships For Success program. As in 2014, the program continued to address underage drinking and prescription drug misuse among youth and young adults. However, in FY 2015, grantees were also encouraged to address issues related to marijuana and heroin use.

Preliminary findings from the cross-site evaluation for the Partnership For Success program will be available in September 2016. The evaluation is addressing the following questions:

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[87] 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.

[88] 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.

[89] http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

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 2015, SAMHSA funded 38 new Strategic Prevention Framework grants and 34 grant continuations. In FY 2016, SAMHSA is supporting 63 Strategic Prevention Framework grant continuations.

Strategic Prevention Framework for Prescription Drugs (SPF Rx)

Drug overdose death rates have increased five-fold since 1980.[90] Since 2000, the drug overdose death rates have continued to increase and have more than doubled.[91] 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 recent increase in drug-poisoning deaths.[92] Opioid painkillers were involved in 30 percent of drug overdose deaths where a drug was specified in 1999, compared to nearly 70 percent in

In 2011, opioid analgesics were involved in 41 percent of drug poisoning deaths (16,917 deaths). In 2013, opioid analgesics-related deaths decreased to 37 percent (16,235 deaths). Historically, CDC has programmatically characterized all opioid pain reliever deaths (natural and semisynthetic opioids, methadone, and other synthetic opioids) as "prescription" opioid overdoses.[94] Between 2013 and 2014, the age-adjusted rate of death involving methadone remained unchanged; however, the age-adjusted rate of death involving natural and semisynthetic opioid pain relievers, heroin, and synthetic opioids, other than

[90] 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.
[91] 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.
[92] Paulozzi LJ. Prescription drug overdoses: A review. J. Safety Res 43(4):283–9. 2012.
[93] 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.
[94] Paulozzi LJ, Jones C, Mack K, Rudd R. Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. MMWR Morb Mortal Wkly Rep 2011; 60:1487–92.

methadone (e.g., fentanyl) increased 9 percent, 26 percent, and 80 percent, respectively.[95] Prescription opioid-related overdose deaths now outnumber overdose deaths involving all illicit drugs combined.[96] Due to these alarming trends, SAMHSA is prioritizing efforts to address prescription drug misuse and overdose deaths.

According to the 2014 NSDUH survey, 2.5 percent or 6.5 million individuals in the U.S. who are 12 or older used prescription drugs non-medically in the past month, including (1.6 percent) use of pain relievers, (0.7 percent) use of tranquilizers, (0.6 percent) use of stimulants, and (0.1 percent) use of sedatives. Rates of non-medical use of prescription drugs in the past month are highest (4.8 percent) among individuals who are 18 to 25 years old. According to the Treatment Episode Data Set, in 2012, nearly 10 percent of individuals who entered substance use disorder treatment facilities reported pain relievers (non-heroin opioids/synthetics) as the primary substance of abuse.[97]

Funding for SAMHSA and the Centers for Disease Control and Prevention (CDC) in FY 2015 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 coordinated 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 – Partnership For Success program.

In FY 2016, SAMHSA is implementing 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 will also focus on raising community awareness and bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients. SAMHSA will also track 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. SMAHSA plans to award up to 29 grants.

[95] Rose A. Rudd, MSPH; Noah Aleshire, JD; Jon E. Zibbell, PhD; R. Matthew Gladden, PhD ; Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014, Morbidity and Mortality Weekly. Report. 2016; 64(50):1378- 1382.

[96] Centers for Disease Control and Prevention. Vitalsigns [database]. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2015. Available at http://www.cdc.gov/drugoverdose/data/overdose.html

[97] http://www.samhsa.gov/data/sites/default/files/2002_2012_TEDS_National/2002_2012_Treatment_Episode_Data_Set_National_Tables.htm

Funding History

Fiscal Year	Amount
FY 2013	$107,901,699
FY 2014	$109,484,000
FY 2015	$109,484,000
FY 2016	$119,484,000
FY 2017	$119,484,000

Budget Request

The FY 2017 Budget Request is $119.5 million with $109.5 million from Budget Authority and $10.0 million from Public Health Service Evaluation Funds. This is the same as the FY 2016 Enacted Level. Funding will support up to 29 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 2017, SAMHSA will also support the continuation of 70 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 Tables

Program: Partnerships for Success

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
2.3.78 Increase the number of communities who report an increase in prevention activities that are supported by collaboration and leveraging of funding streams. (Output)	FY 2014: 89[1] Target: 50 (Target not met)	200	200	Maintain
2.3.79 Increase the number of EBPs implemented by sub-recipient communities. (Output)	FY 2014: 58[2] Target: 950 (Target not met)	1,400	1,400	Maintain
2.3.80 Increase the number of sub-recipient communities that improved on one or more targeted NOMs indicators. (Outcome)	FY 2013: 45 Target: 50 (Target not met but improved)	200	200	Maintain

[1] Preliminary estimate.

[2] Estimate, data available in March, 2016.

Outputs and Outcomes Tables

Program: Strategic Prevention Framework Rx

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 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: 100.0% (Pending)	100.0%	100.0%	Maintain
3.3.12 Increase the percent of funded states reporting reductions in opioid overdoses. (Outcome)	FY 2016: Result expected August 31, 2017 Target: 55.0% (Pending)	55.0%	55.0%	Maintain

Federal Drug-Free Workplace

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Federal Drug-Free Workplace	$4,894	$4,894	$4,894	$---

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2017 Authorization .....Expired
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 is widespread and has 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, 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.

SAMHSA funded the Drug-Free Workplace drug testing activities in FY 2014 and FY 2015. These activities will continue in FY 2016 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 SAMHSA Administrator 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). 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.

In FY 2015 and FY 2016, continued funding for the Federal Drug-Free Workplace Programs ensured the testing of federal employees in national security, public health, and public safety positions for the use of illegal, the misuse of prescription drugs, and the inspection certification of HHS-certified laboratories.

Funding History

Fiscal Year	Amount
FY 2013	$5,251,583
FY 2014	$4,894,000
FY 2015	$4,894,000
FY 2016	$4,894,000
FY 2017	$4,894,000

Budget Request

The FY 2017 Budget Request of $4.9 million is the same as the FY 2016 Enacted Level. In FY 2017, 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, perform random testing of those designed testing positions of national security, public health, and public safety, and perform 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's 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;
- Implementation of the final Oral Fluid Specimen Mandatory Guidelines;
- Development of a Marijuana Toolkit for public use;
- 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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Minority AIDS	$41,205	$41,205	$41,205	$---

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2017 Authorization .....Expired
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.[98] 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, meaning that more Americans are living with HIV than ever before. In addition, because HIV and viral hepatitis share common modes of transmission, one third of HIV infected individuals are also infected with hepatitis C.[99] This suggests that the U.S. is facing an era of rising infections, greater challenges in serving people who are living with HIV, and higher healthcare costs.

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

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

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.

SAMHSA helps to prevent HIV and hepatitis infection acquired through substance misuse 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 Ready-To-Respond Initiative provides funding to expand knowledge and experience about blended substance misuse and HIV prevention practices for at-risk minority populations. The Capacity-Building Initiative supports grantees in building a solid foundation for delivering evidence-based substance abuse 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 2014, the preliminary results of a cross-site evaluation of SAMHSA's Minority AIDS programs show that participants who received individual-based services had significant improvement from baseline to exit in several areas. The changes from baseline to exit are as follows:

1) HIV/AIDS knowledge (Cohort 9: 18.1 percent; Cohort 10: 9.5 percent);
2) Sexual Self-Efficacy (Cohort 9: 10.8 percent; Cohort 10: 6.5 percent);
3) Perceived risk of harm from unprotected vaginal sex (Cohort 9: 7.7 percent; Cohort 10: 5.6 percent);
4) Perceived risk of harm from unprotected anal sex (Cohort 9: 6.1 percent; Cohort 10: 6.1 percent); and
5) Perceived risk of harm from unprotected oral sex (Cohort 9: 12.8 percent; Cohort 10: 11.6 percent).

The cross-site evaluation examined program inputs, outputs, outcomes, and the relationships among them. The evaluation found that participants who received Protocol-Based Counseling (PBC) through these programs were more likely to show decreases in past 30-day use of illicit drugs (excluding marijuana), increases in protected oral and vaginal sex, and increases in sexual self-efficacy when compared to participants who did not receive PBC. The evaluation also found that participants who received Comprehensive Risk Counseling Services through C S A P ' s

Minority AIDS programs were more likely to increase their perception of risk of harm from using marijuana when compared to participants who did not receive this intervention.

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/substance use disorder screening, primary prevention, and treatment for racial/ethnic minority populations with or at high risk for mental and substance use disorders and HIV/AIDS. Minority AIDS Continuum of Care grants support substance use disorder 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. 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.[100,101]

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 use disorder 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 Minority AIDS Continuum of Care grants, a technical assistance contract, and awarded a new evaluation contract. SAMHSA also provided funding for 34 new grants under the MSI CBO program and 54 new grants under the HIV Capacity-Building Initiative program. These funds supported 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 FY 2016, SAMHSA plans to support 131 grant continuations and 31 Minority AIDS Continuum of Care new grants. Funding will also support a technical assistance and evaluation efforts.

[100] Bhattacharya R, Shuhart MC. Hepatitis C and alcohol: interactions, outcomes, and implications. J Clin Gastroenterol. 2003;36(3):242-52.
[101] 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).

Funding History

Fiscal Year	Amount
FY 2013	$40,995,653
FY 2014	$41,205,000
FY 2015	$41,205,000
FY 2016	$41,205,000
FY 2017	$41,205,000

Budget Request

The FY 2017 Budget Request of $41.2 million is the same as the FY 2016 Enacted Level. SAMHSA will support up to 148 grant continuations and 70 new grants 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.

Outputs and Outcomes Table

Program: Minority AIDS

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
2.3.56 Increase the number of program participants exposed to substance abuse prevention education services. (Output)	FY 2014: 3,507[1] Target: 3,891 (Target not met)	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 2014: 88.7% Target: 91.2% (Target not met)	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 2014: 20,386 Target: 32,975 (Target not met)	21,137	21,137	Maintain

[1]The 2014 actuals reflect the closeout of HIV Cohort 7.

Sober Truth on Preventing Underage Drinking Act (Stop Act)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Sober Truth on Preventing Underage Drinking (STOP Act).....	$7,000	$7,000	$7,000	$---

Authorizing Legislation .....Section 519B of the PHS Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities..... Current 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.[102] Those who report getting drunk 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.[103] 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.[104]

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.[105] Indeed, rates of current, binge, and heavy alcohol use among 12 to 20 year-olds have declined from 2002 to 2013.[106] Findings from the 2013 National Survey on Drug Use and Health (NSDUH) indicate that the rate of current alcohol use among 12 to 20 year-olds decreased from 28.8 percent in 2002 to 22.7 percent in 2013. The binge-drinking

[102] Chaloupka, Grossman, & Saffer, 2002; O'Brien et al., 2013; A. White & Hingson, 2013
[103] A. White & Hingson, 2013
[104] A. White & Hingson, 2013
[105] e.g., Calear & Christensen, 2010; Lemstra et al., 2010; Ttofi & Farrington, 2011
[106] *SAMHSA, 2014*

rate in that age group declined from 19.3 percent to 14.2 percent and the rate of heavy drinking declined from 6.2 percent to 3.7 percent.

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 will award 97 grant continuations in FY 2016. Data on outcomes will be available in FY 2016.

Funding History

Fiscal Year	Amount
FY 2013	$6,993,928
FY 2014	$6,983,000
FY 2015	$7,000,000
FY 2016	$7,000,000
FY 2017	$7,000,000

Budget Request

The FY 2017 Budget Request of $7.0 million is level with the FY 2016 Enacted Level. In 2017, SAMHSA will support 79 new STOP Act grants. This funding will continue and deepen SAMHSA's commitment to reduce and prevent underage drinking.

Outputs and Outcomes Table

Program: Sober Truth on Preventing Underage Drinking (Stop Act)[1]

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.3.01 Percentage of coalitions that report at least 5 percent improvement in the past 30-day use of alcohol in at least two grades. (Outcome)	FY 2014: 43.8% Target: 40.0% (Target exceeded)	45.0%	45.0%	Maintain
3.3.02 Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades. (Outcome)	FY 2014: 30.0% Target: 60.9% (Target not met)	45.0%	45.0%	Maintain
3.3.03 Percentage of coalitions that report improvement in youth perception of parental disapproval on the use of alcohol in at least two grades. (Outcome)	FY 2014: 33.3% Target: 54.5% (Target not met)	45.0%	45.0%	Maintain

[1] FY 2015 data available in August 2016.

Fetal Alcohol Spectrum Disorders (FASD)

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Fetal Alcohol Spectrum Disorder.....	$1,000	$---	$---	$---

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2017 Authorization .....Expired
Allocation Method .....Contracts
Eligible Entities..... Domestic and Public Entities

Program Description and Accomplishments

Fetal alcohol spectrum disorders (FASD) are a group of conditions that can occur in an individual whose mother consumed alcohol during pregnancy. These effects can include a mix of physical problems and problems with behavior and learning. The prevalence of the full spectrum of FASD in the general U.S. population is estimated at 9.1 per 1,000 live births,[107] although this estimate is based on passive surveillance. A recent study based on active surveillance of in-school reviews suggest that the national rate could potentially be closer to 50 per 1,000.[108] In addition, studies among foster and adoptive youth[109] indicate that misdiagnosis of individuals with FASD may further disguise the true prevalence.

SAMHSA's FASD Center for Excellence (CFE) focuses on preventing FASD among women of childbearing age and improving the quality of life for individuals and families affected by these disorders. The FASD CFE uses a comprehensive approach across the lifespan to work toward reducing the number of infants exposed to alcohol prenatally, increasing the functioning of individuals who have a FASD, and addressing the challenges of individuals and families affected by FASD.

As part of these efforts, the FASD CFE established a website that provides the public with information and resources on the prevention of FASD. Products can be downloaded and used by primary care, behavioral health care, and other providers to educate women of child-bearing age, individuals, and their families about the dangers of drinking while pregnant to prevent new and recurring alcohol-exposed pregnancies. The website has resources like the FASD Treatment Improvement Protocol 58 (TIP 58) that reviews alcohol screening tools and interventions for use with pregnant women and women of childbearing age to prevent FASD and accomplish

[107] May, P. A., Gossage, J. P., Kalberg, W. O., Robinson, L. K., Buckley, D., Manning, M., & Hoyme, H. E. (2009). Prevalence and epidemiologic characteristics of FASD from various research methods with an emphasis on recent in-school studies. *Developmental Disabilities Research Reviews, 15*(3), 176-192.
[108] May, P. A., Baete, A., Russo, J., Elliott, A. J., Blankenship, J., Kalberg, W. O., Buckley, D., Brooks, M., Hasken, J., Abdul-Rahman, O., Adam, M. P., Robinson, L. K., Manning, M., Hoyme, E. (2014). Prevalence and characteristics of Fetal Alcohol Spectrum Disorders. *Pediatrics, 134*(5), 854-866.
[109] Chasnoff, I. J., Wells, A. M., & King, L. (2015). Misdiagnosis and missed diagnoses in foster and adoptive children with prenatal alcohol exposure. *Pediatrics, 135*(2), 264-270.

outcomes that achieve a better quality of life for individuals with FASD. TIP 58 also outlines methods for identifying individuals with a FASD and modifying treatment accordingly to guide professionals in how to screen an individual for a FASD so that appropriate referrals are made for an intervention or diagnosis to achieve successful outcomes and better quality of life. The Tools for Success curriculum educates Juvenile Justice system professionals on understanding the challenges facing individuals with a FASD so individuals receive appropriate care and support within justice systems to limit undue suffering. "FASD: The Basics" is an educational presentation created to provide the latest and most accurate FASD information. It covers the history of FASD discovery, examines cause and effects of FASD, and discusses the methods and resources for diagnosis, treatment and FASD prevention. The presentation is used by families and others who support individuals with a FASD to better understand the mental and physical challenges of such individuals and their families, so that appropriate care is given at home, in academic institutions, and in communities.

FASD CFE also convenes an expert panel that provides guidance and recommendations about best practices for healthcare providers and social service organizations. The FASD CFE has organized a Self-Advocates with FASD Network (comprising young adults with FASD) and a Birth Mothers Network that advocates for services, provides mutual support, and works to improve the quality of life for people with FASD. In addition, the FASD CFE collaborated with the National Institute on Alcohol Abuse and Alcoholism's Interagency Coordinating Committee on FASD to advance new research and best practices on FASD. The FASD CFE also coordinated and collaborated with organizations such as the National Organization on Fetal Alcohol Syndrome to develop curricula for juvenile justice systems and certified addictions counselors, and provided ongoing support to the National Association of FASD State Coordinators to integrate FASD services into existing healthcare systems. The FASD CFE convened 10 "Building FASD State Systems" conferences to facilitate the development of comprehensive systems of care for people affected by FASD. Finally, the FASD CFE also established a Native Communities Initiative to address FASD in American Indian/Alaska Native (AI/AN)/Native Hawaiian populations.

In FY 2014 and FY 2015, the CFE provided technical assistance and training to other federal and national partners to assist them in developing evidence-based prevention, intervention, and treatment approaches. The FASD CFE focuses on women of child-bearing age, individuals and families affected by FASD, states, local communities, AI/AN communities, military families, and health, social service, and faith-based providers who study and/or provide services for individuals affected by FASD. In FY 2016, this program is eliminated but strategies to ensure women are educated on the risks of FASD will continue through other efforts.

Funding History

Fiscal Year	Amount
FY 2013	$1,103,511
FY 2014	$998,000
FY 2015	$1,000,000
FY 2016	---
FY 2017	---

Budget Request

The FY 2017 Budget Request of $0.0 million is the same as the 2016 Enacted Budget and represents the elimination of funding for the program. SAMHSA will continue to focus on the prevention of alcohol misuse through other existing substance abuse prevention programs and work with CDC and other federal partners on issues related to FASD.

Center for the Application of Prevention Technologies

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Center for the Application of Prevention Technologies (CAPT).....	$7,493	$7,493	$7,493	$---
PHS Evaluations Funds (non-add).....	---	---	*6,468*	*+6,468*

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2017 Authorization .....Expired
Allocation Method .....Contracts
Eligible Entities..... Domestic and Public Entities

Program Description and Accomplishments

Generating high quality performance data on the effectiveness of prevention programming from states and communities is an ongoing challenge. As grantees (states and communities) move toward greater accountability for achieving and documenting results, greater reliance on data to inform and guide program management and decision-making and enhanced capacity to meet higher expectations for documented performance from SAMHSA and other federally funded programs are required.

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. The CAPT continues to develop behavioral health indicators, related 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. In FY 2013, 88 percent of those served (approximately 7,700 individuals) reported that the training increased their capacity to do prevention work and 100 percent reported that it increased their organizational capacity. In FY 2014, the CAPT delivered its foundational SAPST "Training of Trainers" to 296 participants who delivered the SAPST 31 times to 1,153 participants in 28 states. Also in FY 2014, 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 for prescription drug misuse and opioid abuse and overdose, binge drinking in college populations and underage drinking.

In FY 2016, funding will continue to support the delivery of technical assistance and workforce development to the prevention field.

Funding History

Fiscal Year	Amount
FY 2013	$8,097,521
FY 2014	$7,493,000
FY 2015	$7,493,000
FY 2016	$7,493,000
FY 2017	$7,493,000

Budget Request

The FY 2017 Budget Request of $7.5 million is the same as the FY 2016 Enacted Level. The program will provide technical assistance and training to over 7,500 individuals in the prevention field.

Outputs and Outcomes Table

Program: Center for the Application of Prevention Technologies (CAPT)

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY2017 Target
1.4.09 Increase the number of individuals trained by SAMHSA's Science and Services Program. (Output)	FY 2015: 38,941[1] Target: 110,000 (Target not met)	40,947[2]	40,947	Maintain
1.4.11 Prevention: increase the number of individuals trained by the CAPT. (Output)	FY 2014: 9,146 Target: 5,216 (Target exceeded)	5,216	5,216	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 2014: 91.0% Target: 90.0% (Target exceeded)	90.0%	90.0%	Maintain
1.4.13 Increase the percent of participants that agree or strongly agree that the training or TA provided increased their organization's capacity to do substance abuse prevention work. (Outcome)	FY 2014: 100.0% Target: 92.0% (Target exceeded)	95.0%	95.0%	Maintain

[1] Results are preliminary.

[2] Target aggregates CSAT and CMHS Science and Service individuals trained and CSAP CAPT individuals trained.

Science and Service Program Coordination

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Science and Service Program Coordination.....	$4,072	$4,072	$4,072	$---

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2017 Authorization .....Expired
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 reports 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. There are 8.7 million adolescent and transition age youth that drink. 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 addition, since the Town Hall Meetings under the Underage Drinking Prevention Education Initiatives occur biennially, numbers served increase in the years the meetings occur and decrease in alternate years.

In FY 2014, community-based organizations registered to host 1,345 events. These events were held in all 50 states, the District of Columbia, and five territories. Approximately 1,160 individuals attended live online training webinars and SAMHSA responded to 1,301 requests for technical assistance in planning, promoting, hosting, and evaluating events. Science and Service performance data for FY 2013 show that 16,177 people were trained and almost 9,000 received technical assistance. In FY 2015, SAMHSA continued funding of four contracts. In FY 2016, SAMHSA will fund three contracts to support these activities.

Funding History

Fiscal Year	Amount
FY 2013	$5,168,406
FY 2014	$4,072,000
FY 2015	$4,072,000
FY 2016	$4,072,000
FY 2017	$4,072,000

Budget Request

The FY 2017 Budget Request of $4.1 million is the same as the FY 2016 Enacted Level. These funds will support SAMHSA's top strategic initiative, prevention of substance abuse and mental illness, which includes a focus on preventing underage drinking and on American Indians/Alaska Natives through the provision of technical assistance.

The Science and Service Program Coordination addresses the Administration's multi-agency Native Youth priority related to Improving Education Outcomes and Like Outcomes for Native Youth, in support of the HHS Tribal Health and Well-Being Coordination.

Tribal Behavioral Health Grants

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Tribal Behavioral Health Grants	$---	$15,000	$15,000	$---

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2017 Authorization .....Expired
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.[110] Further, AI/AN high school students report higher rates of suicidal behaviors than the general population of U.S. high school students.[111] These behaviors include 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 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).[112]

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 and 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 turn their assessments into action plans to be implemented in FY 2016. These action plans will report baseline data in FY 2017.

In FY 2016, as part of Generation Indigenous,[113] a White House-supported youth initiative focused on removing possible barriers to success for AI/AN youth, 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

[110] 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.
[111] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Available at http://www.cdc.gov/healthyyouth/yrbs/index.htm.
[112] http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2011/AI-AN2011.pdf
[113] For additional information on this White House sponsored initiative see: http://genindigenous.com/

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 expands these activities to approximately 103 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 and substance use disorders among AI/AN youth, and increase referral to treatment.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$15,000,000
FY 2017	$15,000,000

Budget Request

The FY 2017 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 2016 Enacted Level. 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.

Tribal Behavioral Health Grants is a program that addresses the Administration's multi-agency Native Youth priority to Reduce Teen Suicide, in support of the HHS Tribal Health and Well-Being Coordination.

Outputs and Outcomes Table

Program: Tribal Behavioral Health

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
2.4.10 Increase the number of grantees reporting a decrease in underage drinking in their community. (Output)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)			
2.4.11 Increase the number of participants receiving evidence-based mental health -related services as a result of the grant. (Output)	FY 2016: Result expected December 31, 2016 Target: Set baseline (Pending)			
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: Result expected December 31, 2016 Target: Set baseline (Pending)			
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: Result expected December 31, 2016 Target: Set baseline (Pending)			

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths....	$---	$12,000	$12,000	$---

Authorizing Legislation ..... Section 516 of the PHS Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants, Contracts
Eligible Entities..... States

Program Description and Accomplishments

Opioid overdose is a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids. Overdose from prescription opioids accounted for 71 percent of all deaths related to pharmaceutical overdose in 2013.[114] In 2014, 29,467 Americans died because of an overdose involving prescription opioids or heroin, nearly five times the number of opioid overdose-related deaths in 2000.[115] During this same period (from 2000 to 2013) the number of opioid prescriptions in the Unites States rose from 126 million to 207 million, almost doubling.[116]

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 the Association of State and Territorial Health Officials, the National Association of State Alcohol and Drug Abuse Directors, the American Association for the Treatment of Opioid Dependence and SAMHSA, 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 naloxone in preventing death from an overdose. Naloxone is an opioid antagonist that

[114] Centers for Disease Control and Prevention (CDC). Prescription Drug Overdose in the United States: Fact Sheet. (2015) Available from URL: http://www.cdc.gov/homeandrecreationalsafety/overdose/facts.html.
[115] National Institute on Drug Use (NIDA). Overdose Death Rates. (2015) Available from URL: http://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.
[116] 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

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.

The Toolkit is one of the most downloaded SAMHSA publications with approximately 10,500 downloads per month. The toolkit provides evidence-based guidance for using safe prescribing practices, identifying patients at risk for overdose, engaging patients in prevention and risk-reduction efforts, and accessing addiction treatment. It gives communities and local governments the material to develop policies and practices in order to prevent and respond appropriately to opioid-related overdose.

As the rates of prescription drug misuse, heroin use, overdoses, and opioid-related overdose deaths increase, communities are searching for ways to reduce the death rate from opioid-related overdoses. In FY 2016, SAMHSA is providing $12.0 million for Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths. These grants will help states identify communities of high need and to provide education, training, and resources necessary to tailor the overdose kits to meet their specific needs. The grant funds could be used for purchasing naloxone, equipping first responders with naloxone, and providing training on other overdose death prevention strategies, supporting education on these strategies, and providing materials to assemble and disseminate overdose kits. This grant program aligns with the Department of Health and Human Services Secretary's 2015 Opioid Initiative, which includes the expanded use of naloxone to treat opioid overdoses as well as opioid prescribing practices and the expanded use of medication-assisted treatment to reduce opioid use disorders and overdose.

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. The Centers for Disease Control and Prevention (CDC) will evaluate this grant program for its efficacy in reducing overdose deaths from opioids.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$12,000,000
FY 2017	$12,000,000

Budget Request

The FY 2017 Budget Request is $12.0 million, the same as the FY 2016 Enacted Level. This funding will provide continuation grants to 10 states to reduce the number of opioid overdose-related deaths. Funding will help states purchase naloxone, equip first responders in high-risk communities, support education on the use of naloxone and other overdose death prevention

strategies, provide the necessary materials to assemble overdose kits, and cover expenses incurred from dissemination efforts.

The FY 2017 Budget Request includes funding for a naloxone-related program within both SAMHSA and HRSA. HRSA and SAMHSA request funding ($10.0 million and $12.0 million, respectively) to implement opioid related activities, and will continue to coordinate efforts to ensure that duplication is avoided.

SAMHSA/Center for Substance Abuse Prevention
PRNS Mechanism Table Summary

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Grants						
Continuations	198	$70,108	291	$129,255	367	$159,291
New/Competing	121	64,492	160	39,730	149	9,850
Supplements	---	---	---	---	---	---
Subtotal	319	134,600	451	168,985	516	169,141
Contracts						
Continuations	24	29,850	21	37,227	24	37,376
New	5	10,697	5	4,936	1	4,631
Subtotal	29	40,548	26	42,163	25	42,007
Total, Substance Abuse Prevention PRNS [1]	**348**	**$175,148**	**477**	**$211,148**	**541**	**$211,148**

[1] 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.

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final No.	FY 2015 Final Amount	FY 2016 Enacted No.	FY 2016 Enacted Amount	FY 2017 President's Budget No.	FY 2017 President's Budget Amount
CAPACITY:						
Strategic Prevention Framework						
Grants						
Continuations	34	$53,564	63	$93,527	131	$102,937
New/Competing	38	39,127	59	9,520	---	---
Supplements	---	---	---	---	---	---
Subtotal	72	92,691	122	103,047	131	102,937
Contracts						
Continuations	11	14,469	6	13,785	9	15,819
New	1	2,324	4	2,653	---	728
Subtotal	12	16,793	10	16,437	9	16,547
Total, Strategic Prevention Framework	**84**	**109,484**	**132**	**119,484**	**140**	**119,484**
Grants to Prevent Prescription Drug/Opioid						
Overdose Related Deaths						
Grants						
Continuations	---	---	---	---	10	11,239
New	---	---	10	11,253	---	---
Subtotal	---	---	10	11,253	10	11,239
Contracts						
Continuations	---	---	---	---	---	761
New	---	---	---	747	---	---
Subtotal	---	---	---	747	---	761
Total, Grants to Prevent Prescription Drug/ Opioid Overdose Related Deaths	**---**	**---**	**10**	**12,000**	**10**	**12,000**
Federal Drug-Free Workplace						
Contracts						
Continuations	4	4,751	4	4,291	6	4,421
New	1	143	1	603	---	473
Subtotal	5	4,894	5	4,894	6	4,894
Total, Federal Drug-Free Workplace	**5**	**4,894**	**5**	**4,894**	**6**	**4,894**

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

(Dollars in thousands)

Programs of Regional & National Significance	FY2015 Final No.	FY2015 Final Amount	FY2016 Enacted No.	FY2016 Enacted Amount	FY2017 President's Budget No.	FY2017 President's Budget Amount
Minority AIDS						
Grants						
Continuations	67	11,968	131	31,078	148	30,215
New/Competing	88	25,307	31	4,890	70	6,123
Subtotal	155	37,276	162	35,968	218	36,339
Contracts						
Continuations	3	3,783	4	5,237	4	4,866
New	1	146	---	---	---	---
Subtotal	4	3,929	4	5,237	4	4,866
Total, Minority AIDS	**159**	**41,205**	**166**	**41,205**	**222**	**41,205**
Sober Truth on Preventing Underage Drinking						
Act						
Grants						
Continuations	97	4,576	97	4,651	18	853
New/Competing	---	58	---	---	79	3,727
Subtotal	97	4,633	97	4,651	97	4,579
Contracts						
Continuations	1	1,367	2	2,349	2	2,421
New	1	1,000	---	---	---	---
Subtotal	2	2,367	2	2,349	2	2,421
Total, Sober Truth on Preventing Underage						
Drinking Act	**99**	**7,000**	**99**	**7,000**	**99**	**7,000**
Tribal Behavioral Health Grants						
Grants						
Continuations	---	---	---	---	60	14,048
New/Competing	---	---	60	14,067	---	---
Subtotal	---	---	60	14,067	60	14,048
Contracts						
Continuations	---	---	---	---	---	951,863
New/Competing	---	---	---	933	---	---
Subtotal	---	---	---	933	---	952
Total, Tribal Behavioral Health Grants	**---**	**---**	**60**	**15,000**	**60**	**15,000**
Subtotal, CAPACITY	**347**	**$162,583**	**472**	**$199,583**	**537**	**$199,583**

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

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final No.	FY 2015 Final Amount	FY 2016 Enacted No.	FY 2016 Enacted Amount	FY 2017 President's Budget No.	FY 2017 President's Budget Amount
SCIENCE AND SERVICE:						
Fetal Alcohol Spectrum Disorder						
Contracts						
Continuations	1	$966	---	---	---	---
New	---	34	---	---	---	---
Subtotal	1	1,000	---	---	---	---
Total, Fetal Alcohol Spectrum Disorder	**1**	**1,000**	**---**	**---**	**---**	**---**
Center for the Application of Prevention						
Technologies						
Contracts						
Continuations	---	443	1	7,493	1	7,493
New	1	7,050	---	---	---	---
Subtotal	1	7,493	1	7,493	1	7,493
Total, Center for the Application of Prevention Technologies	**1**	**7,493**	**1**	**7,493**	**1**	**7,493**
Science & Service Program Coordination						
Contracts						
Continuations	4	4,072	4	4,072	2	643
New	---	---	---	---	1	3,429
Subtotal	4	4,072	4	4,072	3	4,072
Total, Science & Service Program Coordination	**4**	**4,072**	**4**	**4,072**	**3**	**4,072**
Subtotal, SCIENCE AND SERVICE	**6**	**12,565**	**5**	**11,565**	**4**	**11,565**
TOTAL, CSAP[1]	**353**	**$175,148**	**477**	**$211,148**	**541**	**$211,148**

[1] 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.

Grant Awards Table

(Whole dollars)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	324	451	516
Average Awards	$415,433	$374,690	$327,793
Range of Awards	$50,000 - $2,300,000	$50,000 - $2,300,000	$50,000 - $2,300,000

SAMHSA
Substance Abuse Treatment
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Substance Abuse Treatment Appropriation

(Dollars in thousands)

Program Activities	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Programs of Regional and National Significance.....	$361,463	$333,806	$343,269	+$9,463
Mandatory Funds (non-add).....	---	---	*15,000*	*+15,000*
PHS Evaluation Funds (non-add).....	*2,000*	*2,000*	*30,000*	*+28,000*
State Targeted Response Cooperative Agreements				
(Mandatory).....	---	---	460,000	+460,000
Substance Abuse Prevention and Treatment Block Grant...	1,819,856	1,858,079	1,858,079	---
PHS Evaluation Funds (non-add).....	*79,200*	*79,200*	*79,200*	---
**Total, Substance Abuse Treatment[1]..... **	**$2,181,319**	**$2,191,885**	**$2,661,348**	**+$469,463**

[1] 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.

The Substance Abuse Treatment FY 2017 Budget Request is $2.7 billion. This is an increase of $469.5 million from the FY 2016 Enacted Level. The request includes $2.6 billion in Budget Authority, of which $475.0 million is mandatory funding, and $109.2 million in Public Health Service (PHS) Evaluation funds.

Programs of Regional and National Significance (PRNS)
Substance Abuse Treatment Appropriation

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
CAPACITY:				
Opioid Treatment Programs/Regulatory Activities	$8,724	$8,724	$8,724	$---
Screening, Brief Intervention and Referral to Treatment	46,889	46,889	30,000	-16,889
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*	*+28,000*
Targeted Capacty Expansion	23,223	36,303	61,303	+25,000
Medication-Assisted Treatment for Prescription Drug				
and Opioid Addiction (non-add)	*12,000*	*25,000*	*50,080*	*+25,080*
Cohort Monitoring and Evaluation of Medication-Assisted				
Treatment Outcomes (Mandatory)	---	---	15,000	+15,000
Buprenorphine-Prescribing Authority Demonstration	---	---	10,000	+10,000
Pregnant and Postpartum Women	15,931	15,931	15,931	---
Strengthening Treatment Access and Retention	1,000	---	---	---
Recovery Community Services Program	2,434	2,434	2,434	---
Access To Recovery	38,223	---	---	---
Children and Families	29,605	29,605	29,605	---
Treatment Systems for Homeless	41,386	41,304	36,386	-4,918
Minority AIDS	65,570	65,570	58,859	-6,711
Criminal Justice Activities	78,000	78,000	61,946	-16,054
Crisis Systems	---	---	5,000	+5,000
Subtotal, Capacity	**350,985**	**324,760**	**335,188**	**10,428**
SCIENCE AND SERVICE:				
Addiction Technology Transfer Centers	9,046	9,046	8,081	-965
Special Initiatives/ Outreach	1,432	---	---	---
Subtotal, Science and Service	**10,478**	**9,046**	**8,081**	**-965**
TOTAL, PRNS[1]	**$361,463**	**$333,806**	**$343,269**	**+$9,463**

[1]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.

Opioid Treatment Programs/Regulatory Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Opioid Treatment Programs/Regulatory Activities.....	$8,724	$8,724	$8,724	$---

Authorizing Legislation .....Section 509 of the Public Health Service Act
Authorization .....Expired
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 and States

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.[117] Communities across the nation also face the risk that individuals who inject opioids will contract and spread HIV and hepatitis C.[118] The underlying cause of these problems is increasing rates of opioid use disorders.[119,120] With increasing incidence of opioid use disorders, there is a corresponding increase in admissions for treatment of opioid use disorders[121] medication-assisted treatment (MAT) 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 use disorders, including opioid use disorders. 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 use disorder.[122] A search of SAMHSA's behavioral health treatment locator reveals only 20.0 percent of surveyed facilities offer MAT for individuals with opioid use disorders. The majority of the 1,400 opioid treatment programs (OTPs) which provide supervised dosing of

[117] U.S. Department of Health and Human Services. Addressing prescription drug abuse in the United States: current activities and future opportunities. 2013. Available at: http://www.cdc.gov/homeandrecreationalsafety/overdose/hhs_rx_abuse.html
[118] Substance Abuse and Mental Health Services Administration. Associations of nonmedical pain reliever use and initiation of heroin use in the United States. 2013. Available at: http://samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.htm
[119] 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.
[120] 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.
[121] 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
[122] 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.

methadone - and 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-based 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, but some physicians who attempt to meet the unmet need for treatment by serving more individuals are prevented from doing so due to the patient limit on prescribing buprenorphine.

SAMHSA is responsible for regulating OTPs and processing waivers for physicians who wish to treat opioid use disorders with buprenorphine. SAMHSA reviews new and renewal applications for OTPs and oversees their accreditation. Opioid Treatment Programs 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 20 to 24 site visits to recently-accredited programs each year. SAMHSA conducts unannounced OTP site visits to investigate complaints. In addition to regulating OTPs, SAMHSA provides training and technical support through a contract entitled, Medical Education and Support Services for Opioid Treatment Programs. 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 Opioid Treatment Program Standards, a document published in early 2015, was developed with support from this contract and these activities continue for FY 2016. The contract will be re-competed for FY 2017.

SAMHSA also implements DATA 2000 in coordination with Drug Enforcement Agency. This includes approving waivers for qualified practitioners to provide medication-assisted treatment in office-based settings. More than 30,000 practitioners have been granted waivers since 2001. Approximately a third of these practitioners can treat up to 100 patients each. Waiver processing is conducted under a contract entitled DATA Waiver Processing and Support Project. In FY 2016, SAMHSA will publish a review and update regarding oral use of buprenorphine and begin developing a similar technical advisory for potential new formulations.

SAMHSA has two cooperative agreements with the American Academy of Addiction Psychiatry that provide education, training, and mentors to providers. One program focuses on the safe and appropriate use of opioids for pain. In FY 2015, this effort offered 10 new live webinars and 10 live follow-up question and answer sessions. A total of 2,621 people were trained in these and other activities.

The second program focuses on medication-assisted treatment for opioid use disorders. In FY 2015, this effort provided 17 live webinars and 12 new on-line modules and involved 22,399 physicians and other health professionals. The cooperative agreement for these activities is being re-competed for a one-year extension in FY 2016. In addition, SAMHSA is supporting 14 contacts in FY 2016.

SAMHSA has supported the education of addiction treatment program staff on the subject of hepatitis by funding a three-year supplement to the Addiction Technology Transfer Center Network. FY 2016 is the last year of funding for this activity, which will continue training medical and behavioral healthcare staff with a focus on federally qualified health centers. Through the Behavioral Health Information Technology and Standards contract, SAMHSA funded a competition that resulted in three new mobile applications for overdose prevention, 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, SAMHSA is building on the success of these activities by conducting a demonstration project using health information technology for care coordination with OTPs to include new programs and software vendors.

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 have been offered in conjunction with annual meetings of various national organizations including, in 2015, the Association of American Indian Physicians and the National Rural Institute on Alcohol and Drug Abuse. 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 will be produced in a "pocket" version in FY 2016. This contract is also being 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. A report is forthcoming, and in 2016, this report will be converted into a patient-centered, multi-disciplinary clinical guide. Additional activities for FY 2016 under this contract include CME training in Indiana, Virginia, Minnesota, Vermont, California, Missouri, and Alabama. SAMHSA funded seven contracts supporting technical assistance and logistics in FY 2016.

Funding History

Fiscal Year	Amount
FY 2013	$12,421,373
FY 2014	$8,724,000
FY 2015	$8,724,000
FY 2016	$8,724,000
FY 2017	$8,724,000

Budget Request

The FY 2017 Budget Request is $8.7 million, the same as the FY 2016 Enacted Level. In FY 2017, SAMHSA proposes funding pilot regional MAT Centers of Excellence in two HHS regions. The Centers of Excellence will provide community-specific training and technical assistance to support the delivery of quality services in areas of MAT expansion and facilitate program development through stakeholder collaboration. SAMHSA plans to continue PCSS MAT to support professional development and expansion of a well-trained workforce,

capable of delivering high quality MAT for all FDA approved medications, in a manner that complements the efforts of the MAT Centers of Excellence. In addition, SAMHSA intends to support technical assistance contracts including the Data Waiver Processing and Support contract.

Screening, Brief Intervention and Referral to Treatment

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Screening, Brief Intervention and Referral to Treatment.....	$46,889	$46,889	$30,000	-$16,889
PHS Evaluation Funds (non-add).....	*2,000*	*2,000*	*30,000*	*+28,000*

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Single State Authority and Health Departments in States, Territories and the District of Columbia, Federally Recognized American Indian/Alaska Native Tribe or Tribal Organizations, Domestic Public and Private Non-Profit Entities, 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, 24.6 million (9.6 percent) use illicit drugs, 60.1 million (22.9 percent) binge drink, and 16.5 million (6.3 percent) drink heavily.[123] This increases the cost to society by compromising individual health and potentially causing injury to others. The National Institute on Drug Abuse found that misuse of illicit drugs and alcohol costs society $417.0 billion each year.[124] Of the individuals who need treatment for substance use disorders, only 10 percent receive help.[125] The vast majority of those meeting criteria for having a substance use disorder (SUD) do not believe they need treatment.

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

[123] 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.
[124] National Institute on Drug Abuse (2015), *Trends and Statistics*, http://www.drugabuse.gov/related-topics/trends-statistics.
[125] 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.

and reduce the rate of substance misuse. Studies have shown that this approach is effective in helping reduce harmful alcohol consumption.[126,127,128]

The SBIRT program seeks to increase its use 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 demonstrate the utility of the SBIRT approach and encourage wider adoption of SBIRT by healthcare providers. SAMHSA also supports the SBIRT Medical Residents and Health Professionals Training grant programs.

The SBIRT program requires state grant recipients to implement the model in all primary care settings, including hospitals, trauma centers, federally qualified health centers, and other relevant settings. Recipients may use funds to screen for substance use and co-occurring mental and substance use disorders. 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 implementing SBIRT with their patients.[129] The SBIRT Medical Residents and Health Professionals Training grant programs support SBIRT training efforts for psychologists, pharmacists, dentists, and physician assistants. These efforts aim to develop further the primary healthcare workforce in SUD treatment and services.

SAMHSA has demonstrated the effectiveness of SBIRT and continues to disseminate SBIRT practices. As of 2015, SAMHSA data show roughly 2.0 million individuals have received screening and/or intervention through this initiative.[130] Of those screened, roughly 15 percent were determined to be at risk, another 2.5 percent were referred for brief treatment, and an additional 2.5 percent are referred to specialty treatment.[131] As of 2015, about 600 medical residents and 14,500 nonresidents (e.g. physician assistants, psychologists, and social workers) have been trained in SBIRT practices.[132]

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[126] 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.
[127] Kahan, M., Wilson, L., & Becker, L. (1995). *Effectiveness of physician-based interventions with problem drinkers: A review*. Canadian Medical Association Journal, *152*, 851–859.
[128] 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.
[129] RTI International (2009). *RTI International to Evaluate Comprehensive Substance Abuse Intervention Programs for SAMHSA.* http://www.rti.org/newsroom/news.cfm?obj=070E322D-5056-B172-B8E8D0FB9C898DB7
[130] *Services Accountability Improvement System*, (2015)
[131] *Services Accountability Improvement System*, (2015)
[132] *Services Accountability Improvement System*, (2015)

In FY 2015, SAMHSA funded 63 SBIRT Student Training grants to institutions of higher learning to develop a workforce of residents, physician assistants, social workers, nurses, dentists, psychologists, and pharmacists. SAMHSA also funded 24 continuation grants including nine state SBIRT continuation grants, 13 SBIRT Medical Professional Training continuation grants, and two SBIRT Medical Professional Training continuation grants. SAMHSA also supported funding of six contracts.

In FY 2016, SAMHSA is supporting 61 grant continuations (three state SBIRT, two SBIRT Medical Professional Training grants, and 56 Student Training grants), eight new State SBIRT grants, 12 new SBIRT Student Training grants, and one contract to continue integrating SBIRT into general medical and primary care settings.

Funding History

Fiscal Year	Amount
FY 2013	$47,463,653
FY 2014	$46,889,000
FY 2015	$46,889,000
FY 2016	$46,889,000
FY 2017	$30,000,000

Budget Request

The FY 2017 Budget Request is $30.0 million, a decrease of $16.9 million from the FY 2016 Enacted Level. As health care providers increasingly adopt the SBIRT model, the Budget prioritizes other substance use disorder treatment activities. SAMHSA plans to fund continuations grants for three state SBIRT, nine SBIRT Student Training grants, and 56 SBIRT Medical Professional Training grants. These grantees provide alcohol and drug screening. Many grantees also provide depression screening; grantees will be able to explore the addition of trauma screening in their programs. Lessons learned from these efforts will be used to develop an implementation package for SBIRT to encourage its development and sustainability across healthcare settings. SAMHSA will support the efforts to screen approximately 145,000 individuals per year and refer approximately 20 percent of these individuals for treatment using the SBIRT approach.

Outputs and Outcomes Table

Program: Screening, Brief Intervention and Referral to Treatment

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
1.2.40 Increase the number of clients served. (Output)	FY 2015: 331,111 Target: 52,510 (Target exceeded)	143,783	143,783	Maintain
1.2.41 Increase the percentage of clients receiving services who had no past month substance use. (Outcome)	FY 2015: 29.6% Target: 36.0% (Target not met but improved)	36.0%	36.0%	Maintain

Targeted Capacity Expansion

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Targeted Capacity Expansion.....	$23,223	$36,303	$61,303	+$25,000
Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (non-add).....	*12,000*	*25,000*	*50,080*	*+25,080*

Authorizing Legislation ..... Sections 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
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, and Federally Qualified Health Centers, SAMHSA Certified Opioid Treatment Programs, Licensed Outpatient Substance Abuse Treatment Programs

Program Description and Accomplishments

Urgent, unmet, and emerging substance use disorder (SUD) treatment and recovery support service capacity needs remain a critical issue for the nation. These needs not being addressed lead to a host of individual, societal, and community consequences. In an effort to assist communities in overcoming these barriers, the Targeted Capacity Expansion (TCE) program was initiated. The program provides rapid, strategic, comprehensive, and integrated community-based responses to gaps in and capacity of SUD treatment and recovery support services. Examples of such needs include limited or no access to medication-assisted treatment (MAT) for opioid use disorders; lack of resources needed to adopt and implement health information technologies (HITs) in SUD 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/naloxone, methadone, and injectable extended release naltrexone) in combination with evidence-based behavioral therapies for opioid use disorders. MAT is a safe and effective strategy for decreasing the frequency and quantity of opioid use and reducing the risk of overdose and death.

In 2010, drug overdoses overtook traffic accidents, guns, and falls, as a cause of death, totaling more than 38,329 overall deaths, 30,006 of which were unintentional.[133] On average, 105 people die every day as a result of a drug overdose; 52 from overdose of prescription painkillers.[134,135]

[133] CDC. (2010). Compressed Mortality File Underlying Cause-of-Death Wide-ranging OnLine Data for Epidemiologic Research (WONDER) on Mortality. Retrieved from http://wonder.cdc.gov/mortsql.html.
[134] CDC. (2015*). National vital statistics system mortality data*. Retrieved from http://www.cdc.gov/nchs/deaths.htm
[135] http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving_OA_Heroin_US_2000-2014.pdf

Heroin overdose deaths have also increased with 8,200 people dying in 2013.[136] Overdose deaths involving opioid pain relievers quadrupled from 1999 to 2013. From 2002 to 2013, heroin overdose deaths have nearly quadrupled with 8,200 people dying in 2013.[137] Heroin overdose death rates increased by 26% from 2013 to 2014 and have more than tripled since 2010, from 1.0 per 100,000 in 2010 to 3.4 per 100,000 in 2014.[138] Despite these troubling statistics, significant gaps persist between treatment need and capacity. In 2012, 48 states and the District of Columbia reported levels of opioid use disorder 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.[139]

MAT PDOA addresses treatment needs of individuals who have an opioid use disorder by expanding/enhancing treatment system capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based MAT and recovery support services.

The program aim of expanding and enhancing MAT and recovery support services aligns well with the goals of the U.S. Department of Health and Human Services comprehensive strategy to address the opioid public health crisis across. Targeting states with the highest rates and dramatic increases in primary treatment admissions of opioid use disorders, the FY 2015 program supported 11 state grants at $1.0 million annually for three years. The funds enabled the 11 states to expand access to MAT and recovery support services in approximately 22 communities with the greatest need. The program outcomes include increasing length of stay in treatment, first time treatment admissions, the number of people receiving MAT, the number of people receiving recovery support/relapse prevention services, and the number of MAT providers. SAMHSA also used $1.0 million to support a contract that provides training and technical assistance to grantees.

In FY 2016, SAMHSA will use $11.5 million for 11 new state grants to expand MAT and recovery support services and coordinate and integrate direct services for HIV and hepatitis C; these grants will prioritize treatment regimens that are less susceptible to diversion for illicit purposes. SAMHSA will use a total of $2.5 million to provide training and technical assistance to new and continuing grantees. SAMHSA will also support continued funding for 11 state grants.

Targeted Capacity Expansion

The TCE program supports numerous efforts including the provision of peer-to-peer addiction recovery services, the use of technology-assisted care, and the delivery of Medication Assisted Treatment.

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[136] CDC. (2015). Vital Signs: Today's Heroin Epidemic. Retrieved from http://wonder.cdc.gov/wonder/help/mcd.html

[137] CDC. (2015). Vital Signs: Today's Heroin Epidemic. Retrieved from http://wonder.cdc.gov/wonder/help/mcd.html

[138] Rose A. Rudd, MSPH1; Noah Aleshire, JD1; Jon E. Zibbell, PhD1; R. Matthew Gladden, PhD1, Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014, Morbidity and Mortality Weekly Report. January 1, 2016 / 64(50); 1378-82.

[139] 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.

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

Access to treatment still remains inadequate for underserved populations living with substance use disorders and/or co-occurring mental and substance use disorders, such as those living in rural and extremely rural areas. A key component of this access challenge relates to a lack of dependable transportation but many organizations experience significant financial constraints in serving these populations. SAMHSA believes providers who use health information technologies can help patients improve their access to necessary care and prevention services. For example, telehealth and telepsychiatry can bring addiction medicine providers to clients in areas without local specialists and web-based tools can improve communication and help deliver much-needed support and education. Health information technologies can also enable providers to document and coordinate better care 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, and web-based technologies and applications, telemedicine, and telepsychiatry. 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 track and manage their health to ensure treatment and prevention services are available when and where needed.

TCE-TAC and its predecessor program (Targeted Capacity Expansion-Health Information Technology) have affected 48 behavioral healthcare organizations across 23 states. Grantees have deployed all of the above mentioned technologies to provide substance use disorder treatment services directly or via remote service delivery (i.e., telemedicine). In FY 2014, the TCE-TAC and TCE- HIT programs served roughly 3,500 individuals.

In FY 2015, SAMHSA funded 13 TCE-TAC continuation awards. In FY 2016, SAMHSA is funding 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.

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

Peer support is built on the premise that individuals in recovery from substance use disorders 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 use disorders. Peer support and peer recovery support services have been shown to reduce healthcare costs.[140] 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 growing demand and diverse settings in which peer providers are employed. Since 2002, SAMHSA has awarded over 75 grants to community-based organizations to provide peer recovery support services to individuals in or seeking recovery from substance use disorders and their families. The primary objective of these services is to

[140] OPTUM. (2013). Innovations in Consumer-Centered, Recovery-Oriented Care.

help individuals and families 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 5,600 individuals and their families. Significant strides have been made in increasing abstinence, work and educational opportunities, social connections, housing stability, housing support, and decreasing criminal justice involvement. In FY 2013, the percentage of people who were employed or currently attending school increased from 16.4 percent at intake to 34.2 percent at six-month follow-up and abstinence in the past 30 days from alcohol and drug use improved from 71.2 percent at intake to 86.8 percent at six-month follow-up. In addition, the percentage of individuals reporting stability in housing improved from 46.5 percent at intake to 56.5 percent at six-month follow-up.

In FY 2015, SAMHSA funded 16 continuation grants and in FY 2016, SAMHSA is supporting 15 new TCE peer-to-peer grants. Additionally, SAMHSA supported two contracts in FY 2015 and FY 2016.

Funding History

Fiscal Year	Amount
FY 2013	$26,516,495
FY 2014	$13,223,000
FY 2015	$23,223,000
FY 2016	$36,303,000
FY 2017	$61,303,000

Budget Request

The FY 2017 Budget Request includes a total of $61.3 million, an increase of $25.0 million from the FY 2016 Enacted Level. SAMHSA plans to fund 51 continuation grants. This includes 22 MAT PDOA, 13 TCE-TAC, and 16 TCE-PTP grants.

The FY 2017 Budget Request for the MAT PDOA grant program is $50.1 million, an increase of $25.1 million from the FY 2016 Enacted Level. The $25.1 million increase will focus specifically on MAT expansion/enhancement efforts. The funding will enable SAMHSA to support 23 new MAT PDOA state grants at $1.0 million to expand/enhance MAT utilizing FDA-approved medications in combination with psychosocial services, recovery support services, and coordination/integration of HIV/hepatitis-C direct services. This funding will increase the number of States receiving MAT PDOA grants from 22 to 45. The program will target states that demonstrated a dramatic increase in treatment admissions for opioid use disorders and that experienced the highest rates of treatment admissions for opioid use disorders. Program outcomes include length of stay in treatment, first time treatment admissions, the number of people receiving MAT, the number of people receiving recovery support/relapse prevention services, and the number of MAT providers. SAMHSA will also track client-level outcomes such as abstinence from substance use, housing, employment and criminal justice status and

social connectedness.Ultimately, individuals with opioid use disorders will have increased access to effective, comprehensive, coordinated care that will serve to foster recovery.

Outputs and Outcomes Table

Program: Medication-Assisted Treatment for Prescription Drug and Opioid Addiction

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
1.3.01 Increase the number of admissions for Medication Assisted Treatment. (Output)	FY 2016: Result expected Dec 31, 2016 Target: Set baseline (Pending)			
1.3.02 Increase number of clients receiving integrated care. (Output)	FY 2016: Result expected Dec 31, 2016 Target: Set baseline (Pending)			
1.3.03 Decrease illicit drug use at 6-month follow-up. (Outcome)	FY 2016: Result expected Dec 31, 2016 Target: Set baseline (Pending)			

Cohort Monitoring and Evaluation of Medication-Assisted Treatment Outcomes

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Cohort Monitoring and Evaluation of Medication-Assisted Treatment Outcomes (Mandatory).....	$---	$---	$15,000	+$15,000

Authorizing Legislation .....New Authorization
FY 2017 Authorization .....New Authorization
Allocation Method ..... Contracts/Cooperative Agreements
Eligible Entities.....Public and Private nonprofit institutions

Program Description and Accomplishments

As part of the Administration's two-year initiative to expand access to treatment for prescription drug abuse and heroin use, the Budget proposes the Cohort Monitoring and Evaluation of Medication-Assisted Treatment Outcomes. Public and substance abuse treatment agencies will evaluate the short, medium, and long-term outcomes of substance abuse treatment programs in order to increase effectiveness reducing opioid use disorders, overdose, and death. Under this proposal, SAMHSA will work with other research agencies within the Department of Health and Human Services and will prospectively monitor the treatment outcomes of patients with opioid addiction entering medication-assisted treatment programs. This demonstration will provide valuable insight into the effectiveness of treatment programs employing medication-assisted treatment under real-world conditions and help identify opportunities to improve treatment for patients with opioid addiction. Systematic information on the outcomes of patients who undergo medication-assisted treatment is currently lacking. Cohort monitoring is commonly used to monitor treatment of patients with infectious diseases, such as tuberculosis treatment, and drives accountability for patient outcomes; a similar approach could be useful to improving addiction treatment.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$15,000,000

Budget Request

The FY 2017 Budget Request includes $30.0 million in mandatory funding ($15.0 million in FY 2017 and $15.0 million in FY 2018) for the new program, Cohort Monitoring and Evaluation of MAT Outcomes. These funds would evaluate the outcomes of substance abuse treatment programs. This effort intends to increase MAT effectiveness by reducing opioid use disorders,

overdose, and death. This funding is part of the Administration's $1.0 billion initiative to increase access to treatment for prescription drug abuse and heroin use.

Buprenorphine-Prescribing Authority Demonstration

(Dollars in thousands)

Programs of Regional & National Significance	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
Buprenorphine-Prescribing Authority Demonstration.....	$---	$---	$10,000	+$10,000

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities.....Public and Private nonprofit institutions

Program Description and Accomplishments

Access to medication assisted treatment is widely considered to be inadequate to meet the current need for the treatment of opioid use disorder.[141] Buprenorphine, in various formulations, is a Schedule III prescription drug approved by the Food and Drug Administration (FDA) for the treatment of opioid use disorder. Its effectiveness in treating addiction and reducing mortality is well established. The Drug Addiction Treatment Act of 2000 (DATA 2000) excludes the prescription of buprenorphine by advance practice nurses, physician assistants, and other non-physician advance practice providers, even if they are authorized to prescribe controlled Schedule III substances by the jurisdiction in which they are licensed.[142] To improve the public health response to the national crisis of opioid use disorder and overdose deaths, the Budget explores alternative approaches to improving access to treatment through a services research demonstration program to determine the safety and effectiveness of prescribing buprenorphine by non-physician advance practice providers in accordance with the provider's prescribing authority under state law. In all cases, training will be provided to minimize risk of diversion.

[141] 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.
[142] Health Resources and Services Administration (2015), Health of the Workforce. http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/chartbook

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$10,000,000

Budget Request

The FY 2017 Budget Request is $10.0 million, an increase of $10.0 million from the FY 2016 Enacted Level for Buprenorphine-Prescribing Authority Demonstration, a new program. SAMHSA intends to implement a services research demonstration project that will test the safety and effectiveness of allowing prescribing buprenorphine by non-physician advance practice providers in accordance with the providers' prescribing authority under state law. SAMHSA will collaborate with professional organizations that represent advance practice nurses, physician assistants, and other non-physician advance practice providers as well as addiction psychiatrists and primary care physicians to determine the appropriate training and supervision requirements for advance practice providers in order to assure patient safety and well-being while minimizing diversion of buprenorphine.

This demonstration project will target populations and geographic areas most affected by both high-need and limited access to physicians with buprenorphine prescribing authority. Input from stakeholders will be solicited as needed to assure the project results in a feasible implementation strategy for increasing access to buprenorphine treatment in the targeted areas. In coordination with the Drug Enforcement Agency (DEA), the impact of the project will be assessed using community-level measures such as overdose mortality, incidence of HIV and acute hepatitis C infections, and DEA reported drug seizures. For the purposes of this demonstration, SAMHSA has proposed changes to the general provision to allow inclusion of non-physician providers in the demonstration.

In FY 2017, SAMHSA plans to award seven new grants for up to three years and one evaluation and technical assistance contract for three years.

Pregnant and Postpartum Women

(Dollars in thousands)

Programs of Regional & National Significance	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
Pregnant and Postpartum Women.....	$15,931	$15,931	$15,931	$---

Authorizing Legislation .....Section 508 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

Two percent of mothers living with children under the age of 18 reported symptoms that meet the clinical criteria for misuse of or dependence on illicit drugs or prescription drugs.[143] Since many traditional substance use disorder 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.[144] Since 2003, SAMHSA has supported comprehensive residential substance use disorder 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 interventions; home management and life skills training and education; testing; 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.

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[143] National Institute on Drug Abuse. (2010). *Substance Abuse Evaluated Among Women With Children*. Retrieved from NIDANotes: http://www.drugabuse.gov/news-events/nida-notes/2010/12/substance-abuse-evaluated-among-women-children

[144] Women and Treatment, Office of National Drug Control Policy, http://www.whitehouse.gov/ondcp/women-treatment

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 use disorder treatment.

In FY 2015, SAMHSA supported six new three-year PPW program grant awards totaling $3.0 million and the continuation of 19 PPW grants totaling $9.5 million. In addition, SAMHSA supported one new two-year Addiction Technology Transfer Center (ATTC) supplemental grant, which develops curriculum materials and disseminates the PPW program family-centered model to organizations and providers outside the grant program. SAMHSA funded seven contracts to continue support of comprehensive substance use disorder prevention, treatment, and recovery support services for women. A new five-year SAMHSA-funded evaluation of the PPW program started in FY 2015, assessing the effectiveness of the PPW program, documenting best practices and lessons learned, disseminating lessons learned that could be applied in other programs, and guiding programmatic and policy changes. The cross-site evaluation includes a process and outcome evaluation based on data from biannual and quarterly progress reports, local evaluations, Government Performance and Results Act of 2010 data, and other qualitative or quantitative data. In FY 2015, SAMHSA also 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. SAMHSA is studying sustained models of care, developing training curricula, and planning for a state policy academy in order to support this effort.

In FY 2016, SAMHSA is supporting 26 three-year residential treatment grant continuations, one ATTC supplement grant continuation to continue support for comprehensive substance use disorder prevention, treatment, and recovery support services for women, their minor children, and family members. SAMHSA expects that these funds will support services for additional individuals, including 950 women, 1,900 children, and 1,000 other family members.

Funding History

Fiscal Year	Amount
FY 2013	$15,634,445
FY 2014	$15,931,000
FY 2015	$15,931,000
FY 2016	$15,931,000
FY 2017	$15,931,000

Budget Request

The FY 2017 Budget Request is $15.9 million and is the same as the FY 2016 Enacted Level. In FY 2017, SAMHSA anticipates funding innovation grants, which will test different models for family-centered treatment programs, including outpatient treatment programs, which can be evaluated, replicated, and taken to scale by various organizations. These grants will help reduce the effects of substance use disorders; co-occurring depression, anxiety, and other mental health

issues; and trauma on pregnant and postpartum women, their minor children, and other family members. SAMHSA anticipates funding for two to five grants to reflect a range of local community-based organizations as well as grants to states, territories, and tribes.

The innovation grants will provide grantees with the flexibility to select different configurations of required and optional family-centered services for pregnant and postpartum women and their minor children, including, as today, residential treatment and intensive out-patient treatment. Grantees will be allowed to develop a comprehensive package of services tailored to their local needs. Innovation grantees will be required to partner with one or more agencies involved with pregnant and postpartum women and infants who need substance use disorder treatment services, including primary health care agencies, child welfare, housing, and criminal justice to establish mutually-beneficial and sustainable partnerships. The Budget includes new appropriations language to allow the program to deliver outpatient treatment services.

In FY 2017, SAMHSA will also support six three-year residential treatment grant continuations and five contracts to increase access and availability to comprehensive, coordinated, and integrated treatment, and recovery support services for women, their minor children, and family members.

Strengthening Treatment Access and Retention

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Strengthening Treatment Access and Retention.....	$1,000	$---	$---	$---

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Contracts
Eligible Entities.....Domestic Public and Private Entities

Program Description and Accomplishments

Millions of previously uninsured people with mental and substance use disorders have gained health insurance coverage to treat these disorders because of the insurance expansions under the Affordable Care Act.[145] There is an urgent need for behavioral healthcare providers to develop the business operations capacity needed to function efficiently in this redesigned healthcare services environment. Historically, substance use disorder treatment providers have served as the primary source of treatment to the nation's low income and vulnerable populations.

[145] Substance Abuse and Mental Health Services Administration. *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020*. HHS Publication No. SMA-14-4883. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

SAMHSA's Strengthening Treatment Access and Retention (STAR) program supports behavioral healthcare providers in their efforts to upgrade their business operations capacity in a changing health care marketplace. Treatment providers receive intensive training and support through coach-facilitated peer learning networks. Since 2012, SAMHSA has provided training to more than 1,500 provider organizations through 100 learning networks. In FY 2014, SAMHSA supported two State-level learning networks and converted the learning network curriculum modules to an online self-paced learning program, providing Continuing Education Units (CEUs) to participants. Roughly 450 individuals registered for courses in the first two months following the announcement of the new offering. Over 85 percent of learning network participants reported that they are better prepared to make changes to business practices in their organizations because of this training.

In FY 2015, SAMHSA supported one contract under the STAR program for the continuation of the provider business operations learning network contract. Due to the program's elimination in FY 2016, SAMHSA will incorporate these learning networks into other financing efforts rather than support these networks as stand-alone efforts.

Funding History

Fiscal Year	Amount
FY 2013	$1,584,387
FY 2014	$1,664,000
FY 2015	$1,000,000
FY 2016	---
FY 2017	---

Budget Request

The FY 2017 Budget Request of $0.0 is the same as the 2016 Enacted Level, representing the elimination of funding for the program. Much of the technical assistance provided to behavioral health industry treatment providers for business operations will be incorporated into other contracts with more focus on not only the opportunities under the Affordable Care Act but also through partnerships and shared business practices.

Recovery Community Services Program

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Recovery Community Services Program.....	$2,434	$2,434	$2,434	$---

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
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.[146] Since 1998, SAMHSA has recognized the value of individuals in recovery in addressing substance use disorders. People in recovery can assist others by providing peer social support to persons in or seeking recovery from substance use disorders. The delivery of recovery support services by people in recovery is known as peer recovery support services (PRSS). PRSS can be a strong component in helping individuals and families address substance use disorders in the context of chronic disease management. PRSS programs are often provided by recovery community organizations (RCOs) that are led by people in recovery and have missions to assist others in recovery. SAMHSA initiated the Recovery Community Services Program (RCSP) to help build an infrastructure for PRSS programs and RCOs to support the development and expansion of peer recovery services. Since the inception of the RCSP, over 74 RCOs and other organizations have received funding to expand PRSS locally and lay the groundwork for a national network of PRSS programs.

Though the RCSP was a services program, 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 through the RCSP Statewide Network grant program.

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

Recovery Community Services Program Statewide Network (RCSP-SN)

The FY 2014 RCSP-SN grant program utilized prior evaluation data to support a new statewide approach to enhance the presence of people with lived experience in recovery from substance use disorders as key partners in state systems. Key activities include collaborating on local and state workforce-development activities, 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 will help states to design peer services and PRSS programs that are authentic to the recovery experience, complimentary to clinical practice, demonstrate strong recovery outcomes, and are sustainable over time. Additionally, the statewide networks can 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 2015, SAMHSA funded the continuation of the 10 grants and plans to continue the funding for those grants in FY 2016. In addition, SAMHSA has funded supporting technical assistance contracts for all three cohorts of grantees.

Statewide Peer Networks for Recovery and Resiliency (SPN-RR)

To ensure collaboration across the mental and substance use disorder programs, SAMHSAs Centers for Mental Health Services (CMHS) and Substance Abuse Treatment (CSAT) funded nine braided SPN-RR grants ($0.4 million in CMHS and $0.4 million in CSAT). Through this grant program, it is expected that the increased involvement of individuals in recovery from mental and substance use disorders will improve access to and increase the quality of behavioral health systems, services, treatment, and recovery supports statewide. This program addresses the need for people in recovery from mental and/or substance use disorders to be an integral part of the treatment system and to build the capacity of statewide consumer-run, family member-run, and addiction recovery community services organizations to promote a combined infrastructure development across the mental health and addiction recovery communities. SAMHSA tracks any braided amounts spent or awarded under their distinct appropriations and ensures that funds are used for purposes consistent with legislative direction and intent of the appropriations. Eligible applicants for this program were those organizations that had an existing mental health or addiction statewide network award from SAMHSA.

In FY 2015, SAMHSA funded eight new one-year SPN-RR grants. Funding also supported a technical assistance integrated contract. In FY 2016, SAMHSA is supporting eight new one-year grants.

Funding History

Fiscal Year	Amount
FY 2013	$2,445,461
FY 2014	$2,434,000
FY 2015	$2,434,000
FY 2016	$2,434,000
FY 2017	$2,434,000

Budget Request

The FY 2017 Budget Request is $2.4 million, the same as the FY 2016 Enacted Level. SAMHSA plans to support a new cohort of 10 State Network grants and technical assistance to continue the efforts of building addiction recovery networks throughout the nation and the collaboration among peer-run organizations working toward mental and substance use disorders service integration.

Access to Recovery

(Dollars in thousands)

Programs of Regional & National Significance	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
Access to Recovery.....	$38,223	$ ---	$ ---	$---

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... States, Territories, District of Columbia, Federally Recognized American Indian/Alaska Native Tribes and Tribal Organizations

Program Description and Accomplishments

Access to Recovery (ATR) is a grant program that promotes person-centered care and choice of services and providers and supports states/tribes in developing expanded provider networks, including faith-based and secular providers, to provide comprehensive substance use disorder treatment and recovery support services. Since 2004, the ATR program has served over 650,000 clients through 75 grantees. From 2010 to 2014, ATR data showed increases in the number of clients employed post treatment, improved numbers of clients with stable housing post treatment, and a dramatic increase in abstinence from alcohol and/or illegal drugs.[147]

[147] Substance Abuse and Mental Health Services Administration. (2014). *Accomplishment and Lessons from the ATR Program FY 2010 -2014*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Through ATR, providers work with clients to link them to coverage for treatment services, where appropriate. Under ATR, states and tribal organizations are required to establish provider networks and develop a voucher-based mechanism to ensure client choice of treatment providers. ATR grant funds also support linkages between clients and treatment providers through state health information exchanges that ensure coordination and non-duplication of services and include traditional and non-traditional providers, such as faith-based and peer providers.

Performance data show increased functioning of clients receiving services through ATR. In FY 2013, ATR clients who were employed or currently attending school improved from 30.3 percent at intake to 49.6 percent at six-month follow-up; abstinence from alcohol and drug use for the past 30 days improved from 68 percent at intake to 83.5 percent at six-month follow-up; and those who reported stability in housing improved from 34.9 percent at intake to 45.6 percent at six-month follow-up.

Beginning in FY 2014, the ATR program encouraged grantees to seek reimbursement from third-party payers for services covered by other sources, such as Medicaid, employer-based health coverage and Marketplace plans. Grantees were encouraged to focus on services that are likely not covered by insurance such as supportive services and direct services for those who are ineligible for insurance or unable to acquire such health coverage.

In FY 2014, SAMHSA awarded six fully funded three-year grants. These grants were funded with Prevention and Public Health Funds. In addition, funds supported one contract. In FY 2015, SAMHSA fully funded five additional grants. This support helps to increase the adoption and implementation of integrated, peer-driven, recovery support, services, and systems for people with substance use disorders and mental health problems.

The FY 2016 Enacted Level eliminates funding for ATR. Many of the clinical services provided under ATR are now covered by public and private insurance. In addition, some states are now assisting in sustaining recovery support services and client choice with Substance Abuse Prevention and Treatment Block Grant funding. SAMHSA has identified successful substance use disorder treatment and recovery oriented systems of care models and will continue to offer technical assistance to states and tribes/tribal entities that want to maintain and develop further this activity. Multi-year funding continued for six ATR grants funded in FY 2014 and five ATR grants funded in FY 2015. The 11 ATR grant recipients will serve a minimum of 50,000 individuals.

Funding History

Fiscal Year	Amount
FY 2013	$93,127,920
FY 2014	$50,000,000
FY 2015	$38,223,000
FY 2016	---
FY 2017	---

Budget Request

The FY 2017 Budget Request of $0.0 is level with the 2016 Enacted Level, representing the elimination of funding for the ATR program. Many of the clinical services provided under ATR are now covered by public and private insurance. In addition, states are able to assist in sustaining recovery support services and client choice with Substance Abuse Prevention and Treatment Block Grant funding. However, multi-year funding for five ATR grants awarded in FY 2015 will continue to provide services through FY 2017.

Outputs and Outcomes Table

Program: Access to Recovery

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target[1]	FY 2018 Target[2]	FY 2018 Target +/- FY 2017 Target
1.2.32 Increase the number of clients gaining access to treatment. (Output)	FY 2015: 25,645 Target: 11,150 (Target exceeded)	8,000		
1.2.33 Increase the percentage of adults receiving services who had no past month substance use. (Outcome)	FY 2015: 84.1% Target: 80.0% (Target exceeded)	80.0%		
1.2.35 Increase the percentage of adults receiving services who had no/reduced involvement with the criminal justice system. (Outcome)	FY 2015: 97.0% Target: 93.0% (Target exceeded)	93.0%		
1.2.36 Increase the percentage of adults receiving services who had improved social support. (Outcome)	FY 2015: 91.7% Target: 88.0% (Target exceeded)	88.0%		

[1]The target change is based on resources and previous performance.
[2]The program ends in FY 2017.

Children and Families

(Dollars in thousands)

Programs of Regional & National Significance	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
Children and Families	$29,605	$29,605	$29,605	$---

Authorizing Legislation .....Section 514 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Single State Agencies in States, Territories, and District of Columbia, Federally Recognized American Indian/Alaska Native Tribes and Tribal Organizations

Program Description and Accomplishments

Substance use plays a significant role in the lives of children and youth (ages 12 to 25) throughout the nation. In 2013, 8.8 percent of youth between the ages of 12 and 17 and 21.5 percent of youth between the ages of 18 and 25 reported currently using illicit drugs.[148] On average, 31 percent of children are removed from home care due to parental alcohol and/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 use and/or co-occurring substance use and mental disorders on America's communities.

Treatment for Youth with Substance Use Disorders (SUDs)

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 are not receiving treatment.[149] Adolescents constitute 7.4 percent of total admissions to the public substance use disorder (SUD) treatment system.[150] Youth have psychological, developmental, and emotional strengths and needs, which are distinct from the adults who make up the majority of the SUD treatment and recovery population. The neurological and developmental differences between youth and adults require tailored treatment and recovery approaches for youth with SUDs.

SAMHSA's programs to treat youth with SUDs and/or co-occurring substance use 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.

[148] 2013 National Survey on Drug Use and Health (NSDUH)
[149] 2013 National Survey on Drug Use and Health (NSDUH)
[150] 2012 TEDS Report, CBHSQ

The initiative helps to further the use of, and access to, effective evidence-based family-centered treatment approaches for youth with SUDs and/or co-occurring substance use and mental disorders. 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, which increase the availability of appropriate treatment for youth with SUDs.

From FY 2012 to FY 2014, these programs served approximately 2,500 individuals with approximately 56 percent of clients reporting being abstinent from substance use and 80 percent employed or engaged in productive activities. Since FY 2012, the initiative has assisted in developing or strengthening the infrastructures in 24 states, territories, and tribes, which resulted in the development of policies to increase access to treatment for youth with SUDs, an expanded trained workforce, the dissemination of evidence-based family centered practices, and the implementation of financial mechanisms to fund treatment for youth with SUDs.

In FY 2015, SAMHSA began a new five-year evaluation to assess the effectiveness of the initiative, document best practices, and 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 supports states, territories, and tribes in strengthening their existing infrastructure through the development a comprehensive strategic plan to improve treatment for adolescents and/or transitional aged youth with SUD and/or co-occurring substance use and mental disorders. The implementation grant is infrastructure and direct services. It further strengthens the existing state, territory, and tribal infrastructure system and provides direct treatment services for adolescents and/or transitional aged youth and their families/care givers with SUDs and/or co-occurring substance use and mental disorders.

Addressing Child Abuse and Neglect

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 use. From September 2014 through March 2015, NCSACW disseminated over 3,200 informational materials, which includes reports, guidance documents, presentations from conferences and webinars, research articles, tools kits, and grantee site-specific tools. NCSACW facilitated 30 events, attended by an estimated 1,881 participants, with an average of 62 attendees per event. NCSACW monitored and provided support to trainees on web-based tutorials. Since 2007, 26,639 users have completed the NCSACW's tutorials. NCSACW's activities have assisted professionals throughout the nation in improving cross system collaboration and being better prepared to meet child welfare mandates for timely child permanency decisions. NCSACW continues to provide support and technical assistance and training to state agencies developing collaborative approaches to the treatment of pregnant women with opioid use disorders. Online tutorials and website content are being updated. NCSACW will conduct an evaluation of SAMHSA's FY 2015 Family Drug Treatment Court grant program.

In FY 2015, SAMHSA funded the continuation of 11 youth treatment grants, four contracts, 13 new two-year youth treatment planning grants, and 11 new three-year youth treatment implementation grants.

In FY 2016, SAMHSA is maintaining FY 2015 activities by supporting 32 grant continuations (11 for youth treatment grants, 10 for youth treatment planning grants, and 11 for youth treatment implementation) and three contracts. SAMHSA also intends to fund two new youth treatment implementation grants and one new contract to support treatment for youth with SUD.

Funding History

Fiscal Year	Amount
FY 2013	$29,018,408
FY 2014	$29,605,000
FY 2015	$29,605,000
FY 2016	$29,605,000
FY 2017	$29,605,000

Budget Request

The FY 2017 Budget Request is $29.6 million, the same as the FY 2016 Enacted Level. SAMHSA plans to support 14 grant continuations (13 for youth treatment implementation grants and one youth treatment grant) and three contracts. In FY 2017, SAMHSA also intends to fund 10 new youth treatment planning grants and 10 new youth treatment implementation grants. These funds will continue to address the gaps in substance use disorder treatment by providing services for youth, their families, and caregivers.

Treatment Systems for Homeless

(Dollars in thousands)

Programs of Regional & National Significance	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
Treatment Systems for Homeless.....	$41,386	$41,304	$36,386	-$4,918

Authorizing Legislation ..... Section 506 and 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Community-Based Public and Private Non-Profit Entities and State Mental Health Authorities and Single State Authorities for Substance Abuse in Partnership

Program Description and Accomplishments

SAMHSA's Treatment Systems for Homeless portfolio supports services for those with substance use disorders or co-occurring mental and substance use disorders. These activities

target those who experience 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 30 percent.[151] 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 2014, 578,242 individuals were experiencing homelessness. Of these individuals, 99,434 were experiencing chronic homelessness, 117,084 had severe mental illness, 116,770 were affected by chronic substance misuse, and 49,933 were veterans.[152]

Many factors contribute to the problem of homelessness, including lack of affordable housing, foreclosures, rising housing costs, job loss, underemployment, mental illness, and 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 by 2015; preventing and ending chronic homelessness by 2017; preventing and ending homelessness for families, youth, and children by 2020; 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 use disorders and their families. SAMHSA manages five Treatment Systems for Homelessness grant programs:

Grants for the Benefit of Homeless Individuals - Services in Supportive Housing (GBHI-SSH)
In FY 2008, SAMHSA initiated the GBHI-SSH to provide treatment services within a permanent supportive housing approach for those who experience chronic homelessness. In addition to strengthening substance use disorder treatment and co-occurring mental and substance use disorder treatment, this program requires placement in permanent housing for enrolled individuals. In FY 2014, SAMHSA expanded the focus to include veterans who experience homelessness.

[151] 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
[152] U.S. Department of Housing and Urban Development (HUD) 2014 Continuum of Care (CoC) Homeless Assistance Programs-Homeless Populations and Subpopulations Report. Available at: https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2014.pdf

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 substance use disorders. Target populations for this program include veterans and individuals with serious mental illness and/or substance use disorders. Through this program, SAMHSA supports HHS's Arc of *Keeping People Healthy and Safe*. 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 governments); 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 substance use disorders 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 behavioral health treatment and services for individuals with mental and/or substance use disorders experiencing homelessness. This program was further enhanced in FY 2015 with the implementation of CABHI State Enhancement grants, which enabled CABHI-State grantees to build upon their programs.

Based on FY 2014 data for CSAT funded programs, 65.1 percent of clients in Treatment Systems for Homeless-supported programs report abstinence from substance use at a six-month follow up, while approximately 31 percent of clients report being employed or engaged in productive activities and 45.8 percent of clients report having a permanent place to live in the community.[153]

In FY 2015, SAMHSA supported 31 new grants (nine CABHI-States, 14 CABHI-States Enhancements, and eight for GBHI-SSH). SAMHSA also supported 36 continuation grants (10 CABHI-States and 26 GBHI-SSH). Additional funds supported three contracts for national evaluation and technical assistance.

[153] Services Accountability Improvement System (SAIS); www.samhsa-gpra.samhsa.gov ; 2014.

In FY 2016, SAMHSA supports 30 new CABHI grants to states, local governments, and community based organizations and 51 continuation grants (32 GBHI-SSH, seven CABHI-States Enhancements, and 12 CABHI-States). Additional funds support cross-center contracts for national evaluation and technical assistance.

Funding History

Fiscal Year	Amount
FY 2013	$39,396,853
FY 2014	$41,386,000
FY 2015	$41,386,000
FY 2016	$41,304,000
FY 2017	$36,386,000

Budget Request

The FY 2017 Budget Request is $36.4 million, a decrease of $4.9 million from the FY 2016 Enacted Level. This decrease will not result in the termination of any grant continuations. In FY 2017, the Grants for the Benefit of Homeless Individuals-Services in Supportive Housing ends. SAMHSA plans to offset this cohort with a new CABHI-State cohort. Therefore, it will not significantly affect SAMHSA's ability to implement its Homelessness programs. 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 plans to award 38 continuation grants; 23 for CABHI-State, seven for CABHI-States Enhancement and eight for GBHI-SSH. SAMHSA also plans to award 15 new CABHI grants. Additional funds will support the continuation of cross-center contracts for national evaluation and technical assistance.

Outputs and Outcomes Table

Program: Treatment Systems for Homeless

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.4.22 Increase the percentage of clients receiving services who had no past month substance use. (Outcome)	FY 2015: 65.2% Target: 66.4% (Target not met but improved)	63.7%	63.7%	Maintain
3.4.23 Increase the number of clients served. (Output)	FY 2015: 4360 Target: 5800 (Target not met but improved)	5100	5100	Maintain
3.4.24 Increase the percentage of homeless clients receiving services who were currently employed or engaged in productive activities. (Outcome)	FY 2015: 30.2% Target: 31.7% (Target not met)	30.0%	30.0%	Maintain
3.4.25 Increase the percentage of clients receiving services who had a permanent place to live in the community. (Outcome)	FY 2015: 46.1% Target: 33.0% (Target exceeded)	33.0%	33.0%	Maintain

Minority AIDS

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Minority AIDS	$65,570	$65,570	$58,859	-$6,711

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Domestic Public and Private Non-Profit Entities

Program Description and Accomplishments

At the end of 2011, 23 percent of all people living with HIV/AIDS in the United States were women; a disproportionate percent of the women living with HIV are Black/African American and Hispanic/Latina women.[154] According to recent data, young men who have sex with men are also particularly affected by HIV, representing 25 percent of all new HIV infections.[155] In addition, the Department of Health and Human Services' Hepatitis Action Plan notes that people with HIV also are disproportionately affected by viral hepatitis and related adverse health conditions.[156]

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 use disorder (SUD) and co-occurring substance use and mental disorders 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 270 per 100,000).

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[154] Center for Disease Control and prevention. (2015). *HIV Among Women*. Retrieved from CDC.gov: http://www.cdc.gov/hiv/group/gender/women/indez/html

[155] Center for Disease Control and prevention. (2011). *New multiyear data show annual HIV infections in U.S. relatively stable*. Retrieved from CDC.gov:
http://www.cdc.gov/nchhstp/newsroom/2011/HIVIncidencePressRelease.html

[156] Health and Human Services. (2015). *Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care and Treatment of Viral Hepatitis*. Retrieved from HHS.gov:
http://www.hhs.gov/ash/initiatives/hepatitis/
www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf. (n.d.). Retrieved from Whitehouse.gov:
www.whitehouse.gov/sites/default/files/uploads/NHAS.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 disorders treatment and 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 the first half of FY 2014, grantees served nearly 4,000 new clients. Client demographics reported included 58.8 percent Black/African American, 55.4 percent Hispanic/Latino, 3.11 percent American Indian, and less than 2 percent Asian/Pacific Islanders. More than 1,600 clients have been tested for hepatitis B virus and HCV. Those who tested positive were referred for confirmatory testing and treatment services. About 70 percent of clients reported reductions in unprotected sexual contact with an individual who is or was HIV positive or has AIDS.[157]

In FY 2015, SAMHSA funded 74 TCE-HIV: High Risk continuation grants, 26 new grant awards, and supported three contracts. In FY 2016, SAMHSA supported 78 grant continuations, 23 new grants, 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.

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.

By August, 2014, grantees had enrolled approximately 3,000 clients in SUD treatment. Nearly 2,400 clients self-reported traumatic experiences and 66.3 percent of them were referred to trauma-support services. Program effectiveness was demonstrated by client reports of reduced unprotected sexual contact with an individual intoxicated on some substance (25.9 percent) and quality of life improvements in such categories as employment and education (30 percent).[158]

[157] Services Accountability Improvement System (SAIS), 2014
[158] Services Accountability Improvement System (SAIS), 2014

In FY 2015, SAMHSA supported five grant continuations and supporting contracts. SAMHSA will continue to support five grant continuations and supporting contracts in FY 2016.

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 (MAI CoC Pilot: Integration of HIV Medical Care into BH Programs or "MAI-CoC")

In FY 2014, 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 disorder (SUD) 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 for racial/ethnic minority populations. This program also provides primary prevention services for SUD 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 and 36 percent of those who misuse alcohol are infected with hepatitis C virus.[159,160]

SAMHSA currently supports an ongoing 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 use disorder 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, including the programs described in this section.

In FY 2015 SAMHSA funded the continuation of 34 HIV MAI CoC grants and supported technical assistance efforts. SAMHSA continues to support these 34 programs in FY 2016.

Funding History

Fiscal Year	Amount
FY 2013	$61,918,238
FY 2014	$65,570,000
FY 2015	$65,570,000
FY 2016	$65,570,000
FY 2017	$58,859,000

[159]Bhattacharya R, Shuhart MC. Hepatitis C and alcohol: interactions, outcomes, and implications. JClin Gastroenterol. 2003;36(3):242-52.

[160] 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).

Budget Request

The FY 2017 Budget Request is $58.9 million, a decrease of $6.7 million from the FY 2016 Enacted Level. This represents a shift in funding to the Mental Health appropriation. In FY 2017, this shift in funding will allow for the award of a new cohort of MAI Continuum of Care (COC) grantees that will address the holistic behavioral health needs of those living with HIV. Three SAMHSA Centers will jointly administer the program. This funding will 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. SAMHSA also plans to fund 86 grant continuations and support three contracts for evaluation and technical assistance. SAMHSA will also award 57 new TCE-HIV grants. SAMHSA also plans to award five new TCE-HIV: Minority Women grants. With these efforts, SAMHSA expects to serve 4,500 clients through the TCE-HIV: High Risk Population program and 3,000 clients in the TCE-HIV Minority Women program.

Criminal Justice Activities

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Criminal Justice Activities.....	$78,000	$78,000	$61,946	-$16,054

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
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 and Government with Direct Involvement with Adult Criminal Courts, Tribal Organizations and Individual Adult Tribal Healing to Wellness Courts, 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 substance use disorders and/or co-occurring substance use and mental disorders.

Drug Courts

Many individuals who come in contact with law enforcement and the criminal or juvenile justice systems have a mental and/or substance use disorder. For example, more than 80 percent of state prisoners, 72 percent of federal prisoners, and 82 percent of jail inmates meet the criteria for having either a mental health or substance use issue. Studies have found that for youth in the juvenile justice system, 50 percent to 70 percent met the criteria for a mental disorder and 60 percent met the criteria for a substance use disorder. Of those youth with co-occurring mental

and substance use issues, almost 30 percent experienced severe disorders that impaired their ability to function.[161] The criminal justice system was the major source of referrals to substance use treatment, with probation or parole treatment admissions representing the largest proportion of criminal justice system referrals.[162] Of the probation or parole admissions, most were males between the ages of 18 and 44.[163] The most common substances reported by these referrals were alcohol, marijuana, and methamphetamine. Similarly, in SAMHSA's adolescent substance use disorder 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 abuse/neglect or criminal behavior, mental illness, and veterans' issues. Drug courts represent the coordinated efforts of the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities to actively 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 use disorders, and develop the capacity and skills to become fully-functioning parents, employees, and citizens.

Of the almost 2,900 drug courts for adults, juveniles and those in the family dependency in existence in 2015, many lack sufficient funding for substance use disorder treatment and recovery services.[164] 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 substance use disorders 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 clinical needs of clients and ensure clients are treated 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 at risk, wraparound/recovery support services designed to improve access and retention, drug testing for illicit substances required for supervision, treatment compliance, and therapeutic intervention, education support, relapse prevention and long-term management, medication-assisted treatment (MAT), 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

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[161] SAMHSA. (2015). *Criminal and Juvenile Justice*. Retrieved from Topics: http://www.samhsa.gov/criminal-juvenile-justice

[162] 2012 Client Level Data/TEDS CBHSQ. http://www.samhsa.gov/data/client-level-data-teds

[163] SAMHSA. (2015). *Criminal and Juvenile Justice*. Retrieved from Topics: http://www.samhsa.gov/criminal-juvenile-justice

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

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 2014, 7,064 clients received services through the Drug Court Programs. Of these, 59.8 percent of adult clients were either employed or engaged in productive activities. Of the adult clients who received services, 42.2 percent had a permanent place to live in the community, 85.6 percent had no past month substance use, and 91.2 percent had no involvement with the criminal justice system thirty days prior to intake.

In FY 2015, SAMHSA supported the continuation of 103 drug court grants, 10 new adult and family drug court grants, and 49 new Treatment Drug Courts. Additionally, SAMHSA conducted a performance evaluation of 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, 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 MAT to drug court clients. Drug court judges, however, retained judicial discretion in cases where specified conditions for MAT provision were not met.

In FY 2016, SAMHSA is funding 123 drug court grant continuations, one contract, and 61 new Drug Court grants, with enhancements such as the inclusion of peer navigators, including new BJA jointly funded drug court grants.

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 8.3 percent of individuals involved with the criminal justice system who are in need of substance use disorder treatment receive it as part of their justice system supervision. Approximately one-half of the institutional treatment provided is educational programming.[165] Over the past decade, awareness of the need for a continuum of care of

[165] 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.

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 offenders 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, referrals related to substance use disorder treatment for clients, alcohol and drug treatment, wraparound services drug testing, and relapse prevention and long-term management support.

In FY 2014, 2,232 clients received services through the Offender Reentry Program with 79 percent of clients reporting no substance use in the past month. Nearly 94 percent of clients receiving services had no involvement with the criminal justice system at the time of the evaluation.

In FY 2015, SAMHSA supported 13 ORP grant continuations, four contracts, and eighteen new ORP grants that will implement the Risk-Needs- Responsivity Simulation Tool to implement best practices and opioid overdose prevention programs.[166]

In FY 2016, SAMHSA is funding 10 ORP grant continuations, 12 new ORP grants, and two contracts.

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 and/or substance use disorders 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 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 collaborative 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

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

BHTCC, with two-thirds of them identified as having co-occurring mental and substance use disorder treatment services, trauma-specific treatment, peer support, and more. Based on Transformation Accountability System (TRAC) reporting data, 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. 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.[167]

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, SAMHSA continues support for these grants and the evaluation.

Funding History

Fiscal Year	Amount
FY 2013	$63,558,000
FY 2014	$74,816,000
FY 2015	$78,000,000
FY 2016	$78,000,000
FY 2017	$61,946,000

Budget Request

The FY 2017 Budget Request is $61.9 million ($50.0 million for Drug Courts and $11.9 million for Other Criminal Justice Activities), a $16.1 million decrease from the FY 2016 Enacted Level.

SAMHSA plans to support 91 Drug Court continuations grants, five contracts, and 63 Drug Court new grants. These programs will continue to provide comprehensive treatment and recovery support services for adolescents and adults with substance use disorders who come into contact with the criminal justice system, as well as offenders re-entering the community. SAMHSA proposes to use this program to explore promising new approaches and identify potential models for replication. Through the Criminal Justice Drug Court grant program over 4,000 clients will be served in FY 2017, equal to the number served by the FY 2016 cohort.

SAMHSA plans to support 27 Offender Reentry Program (ORP) continuation grants and one contract. Through the Other Criminal Justice/ORP grant program, 2,000 clients will be served in FY 2017. SAMHSA will not continue funding for 13 ORP grants that awarded in FY 2016.

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

The Criminal Justice Activities under the Drug Courts, Offender Re-Entry, and Behavioral Health Treatment Court Collaborative programs address the Administration's multi-agency Native Youth priority to Increase Tribal Control of Criminal Justice, in support of the HHS Tribal Health and Well-Being Coordination.

Outputs and Outcomes Table

Program: Criminal Justice - Drug Courts

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
1.2.72 Increase the percentage of adult clients receiving services who were currently employed or engaged in productive activities. (Outcome)	FY 2015: 58.9% Target: 55.0% (Target exceeded)	55.0%	55.0%	Maintain
1.2.73 Increase the percentage of adult clients receiving services who had a permanent place to live in the community. (Outcome)	FY 2015: 43.8% Target: 41.0% (Target exceeded)	41.0%	41.0%	Maintain
1.2.74 Increase the percentage of adult clients receiving services who had no involvement with the criminal justice system. (Outcome)	FY 2015: 91.8% Target: 91.0% (Target exceeded)	91.0%	91.0%	Maintain
1.2.76 Increase the percentage of adult clients receiving services who had no past month substance use. (Outcome)	FY 2015: 85.1% Target: 71.0% (Target exceeded)	71.0%	71.0%	Maintain
1.2.79 Increase the number of adult clients served. (Output)	FY 2015: 5,497 Target: 4,413 (Target exceeded)	4,369	4,369	Maintain

Outputs and Outcomes Tables

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

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
1.2.80 Increase the number of clients served. (Outcome)	FY 2015: 1,366 Target: 2,500 (Target not met)	2,000[1]	2,000	Maintain
1.2.81 Increase the percentage of clients who had no past month substance use. (Outcome)	FY 2015: 75.2% Target: 80.0% (Target not met)	73.0 %[2]	73.0 %	Maintain
1.2.84 Increase the percentage of clients receiving services who had no involvement with the criminal justice system. (Outcome)	FY 2015: 94.8% Target: 94.9% (Target not met but improved)	94.0 %	94.0 %	Maintain

[1,2] Decrease in target from prior year level reflects a decrease in funding and changes in data trends.

Program: Criminal Justice - Teen Courts [1]

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
1.2.89 Number of teen court clients served. (Output)	FY 2014: 852 Target: 852 (Baseline)	600	300	-300
1.2.90 Increase the percentage of teen court clients receiving services who had no involvement with the criminal justice system. (Outcome)	FY 2014: 99.4% Target: 99.4% (Target met)	90.0%	90.0%	Maintain
1.2.91 Increase the percentage of teen court clients receiving services who had no past month substance use. (Outcome)	FY 2014: 70.1% Target: 70.1% (Target met)	88.0%	60.0%	-28.0%

[1] These measures are retired.

Crisis Systems

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Crisis Systems	$---	$---	$5,000	+$5,000

Authorizing Legislation ..... Sections 520A and 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts
Eligible Entities.....States and Communities

Program Description and Accomplishments

The times in which individuals experience crises from mental and substance use disorders are prime for intervention and treatment and key to engagement in ongoing treatment and recovery. Such crises often cause great disruption for individuals and those around them, including family members, teachers, law enforcement, and employers. Many communities currently lack the capacity to provide needed services when children, young adults, and their family members experience behavioral health crises. For too many, the only resources available are hospital emergency departments, which are ill-equipped to provide appropriate and affordable behavioral health care. The number of patients with mental health and substance abuse conditions treated in emergency rooms (ER) has been on the rise for more than a decade.[168] In 2007, 12.0 million ER visits involved a diagnosis related to mental health and/or substance use conditions, which accounted for 12.5 percent of all ER visits in the United States, or one out of every eight ER visits. Behavioral health related ER visits were two and a half times more likely to result in hospital admissions than ER visits related to non-behavioral health related ER visits that resulted in hospitalization. Medicare was billed most frequently for behavioral health-related ER visits (30.1 percent), followed by private insurance (25.7 percent), uninsured (20.6 percent), and Medicaid (19.8 percent).[169]

Comprehensive crisis systems can be challenging to conceive and fund. These often require coordination among multiple systems, such as 911 lines and other facets of emergency response systems; first responders including police and emergency medical technicians, emergency room and primary health care; court systems; multiple payers; social service providers; and behavioral healthcare providers. Comprehensive crisis systems also have to be designed, funded, and staffed to address and manage a range of crisis-situations, including various presenting conditions including serious mental illness (SMI), ages, family situations, and locations. Well- managed crisis interventions can result in positive outcomes for the individual, family, and community, including increased understanding of mental and substance use disorders. In contrast, poorly managed crisis situations can result in frustration, increased health and social

[168] Larkin, G.L., Claassen, C.A., Edmond, J.A., Pelletier, A.J., and Camargo, C.A. Trends in U.S. Emergency Department Visits for Mental Health Conditions, 1992 to 2001. Psychiatric Services. 2005; 56:671-677
[169] Owens, P., Mutter, R., & Stocks, C. (n.d.). Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007. Retrieved August 21, 2015, from http://www.hcups.ahrq.gov/reports/statbriefs/sb92.pdf

services system costs, and negative outcomes for all involved, including potential harm to the individual experiencing the crisis or others.

While there are models of comprehensive crisis response systems that are operating successfully, these comprehensive systems are the exception. More commonly, law enforcement and emergency room personnel respond to public safety and health situations without the benefit of the range of services and support needed to prevent, manage, and follow up on behavioral health crises. Inadequate crisis response systems can result in harm to the individual in crisis, law enforcement, or others; unnecessary use of scarce and costly emergency room and inpatient settings; and inappropriate use of jails and criminal justice resources.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$5,000,000

Budget Request

The FY 2017 Budget Request is $10.0 million, an increase of $10.0 million from the FY 2016 Enacted Level. This includes $5.0 million from the Substance Abuse Treatment appropriation and $5.0 million from the Mental Health appropriation.

In FY 2017, SAMHSA plans to award three grants to states and communities to develop and/or adopt sustainable, comprehensive, and coordinated community-based crisis response systems for children, youth, and adults with mental health and/or addiction problems including those with SMI. The Increasing Crisis Access Response Efforts initiative will help reduce costly and unnecessary use of hospital emergency department and inpatient services. This effort will support the integration and expansion of services to fill gaps and enhance coordination within the comprehensive continuum of the crisis response services, while minimizing the risk for re-traumatization of individuals and families served.

This activity will help communities build, fund, and sustain crisis systems. The crisis systems will be capable of preventing and de-escalating behavioral health crises. They will also help connect individuals and families with needed post-crisis services in order to prevent recurrence of the crisis situation. In many incidences, responses to these situations by emergency medical responders and behavioral healthcare providers are under-coordinated and un-sustained. These grants are expected to help mitigate the demand for inpatient beds by people with serious mental illnesses and substance use disorders by coordinating effective crisis response with ongoing outpatient services and support.

As a braided activity, SAMHSA will track separately any amounts spent or awarded under Crisis Systems through the distinct appropriations and ensure that funds are used for purposes consistent with legislative direction and intent of each appropriation.

Outputs and Outcomes Tables

Program: Crisis Systems

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
3.1.05 Increase the number of organizations that entered into formal written inter/intra organizational agreements. (Outcome)	FY 2016: Result expected Dec 31, 2016 Target: Set baseline (Pending)			
3.1.06 Increase the percentage of clients receiving services who report positive functioning at 6 month follow-up. (Outcome)	FY 2016: Result expected Dec 31, 2016 Target: Set baseline (Pending)			
3.1.07 Increase the number of individuals referred to mental health or related services. (Outcome)	FY 2016: Result expected Dec 31, 2016 Target: Set baseline (Pending)			

Addiction Technology Transfer Centers

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Addiction Technology Transfer Centers	$9,046	$9,046	$8,081	-$965

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
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 $700.0 billion a year in increased healthcare costs, crime, and lost productivity.[170, 171]

Addiction is a treatable disease and research in the science of addiction and the treatment of substance use disorders has led to development of evidence-based practices that help people achieve recovery and resume productive lives. One critical need, however, is to help recruit, train, and support treatment providers. SAMHSA supports training to help foster use of evidence-based practices and prepare providers to work in an increasingly challenging, integrated care environment.

SAMHSA supports the Addiction Technology Transfer Center Network (ATTC Network) to develop and provide low or no cost training opportunities, including online training, to behavioral health professionals. The ATTC Network currently includes 10 Regional Centers, four National Focus Area Centers, and a Network Coordinating Office.

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, young professionals from a variety of backgrounds.[172]

Treating persons with substance use disorders 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 use disorder clinical directors face significant challenges filling open positions.[173] Common hurdles for many

[170] National Institute for Drugs and Alcohol. (2015). *Trends and Statistics*. Retrieved from NIH/NIDA: http://www.drugabuse.gov/related-topics/trends-statistics
[171] ibid
[172] 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 inresidence at the University of Missouri-Kansas City. Available at: http://www.attcnetwork.org/documents/VitalSignsReport.pdf
[173] ibid

substance use disorder treatment facilities include difficulty retaining and recruiting qualified individuals, the need for a young, diverse racial/ethnic workforce capable of working in integrated settings, and the perception that substance use disorders are not a valid health issue (i.e., that addiction is a 'choice').[174]

To address the gaps in workforce, the ATTC Network supports national and regional activities focused on training substance use disorder and other healthcare professionals. The ATTC Network decreases the gap in time between the release of new scientific findings and evidence-based practices to the implementation of these interventions by front-line substance use disorder clinicians. The ATTCs disseminate evidence-based and promising practices to addiction treatment/recovery professionals, public health/mental health personnel, institutional and community corrections professionals, and other related disciplines. The ATTC Network dissemination models include technical assistance, training events, a growing catalog of educational and training materials, and an extensive array of web-based resources created to translate the latest science for adoption into practice by the substance use disorder workforce.

In FY 2014, SAMHSA funded 10 ATTC grants to support programs in each of the 10 HHS regions to provide technical assistance, workforce training, and support collaboration with the Health Resources and Services Administration (HRSA), the Centers for Medicare & Medicaid Services (CMS), the Administration for Children and Families (ACF), and the SAMHSA Regional Administrators as well as other partners. Five awards support one national and four focus area ATTCs, which also provide technical assistance and workforce training. FY 2014 data show that the ATTCs trained approximately 38,600 providers and held a total of 1,216 events, including training sessions, meetings, and technical assistance. Overall, approximately 90 percent of participants report implementing improvements in treatment methods on the basis of information and training provided by the ATTC Network.[175]

In FY 2015, SAMHSA supported the 15 three-year continuation ATTC grant awards. In FY 2016, SAMHSA will support these 15 continuation ATTC grant awards. The recipients are expected to conduct over one thousand events (training sessions, meetings and technical assistance), with more than 30,000 unique participants. SAMHSA will evaluate the program and plans to collect metrics including number of participants, event topics, contact hours, and participant self-assessed skill levels both pre and post training.

[174] ibid
[175] Services Accountability Improvement System. (2014); www.samhsa-gpra.samhsa.gov

Funding History

Fiscal Year	Amount
FY 2013	$9,008,366
FY 2014	$9,024,000
FY 2015	$9,046,000
FY 2016	$9,046,000
FY 2017	$8,081,000

Budget Request

The FY 2017 Budget Request is $8.1 million, a decrease of $1.0 million from the FY 2016 Enacted Level. In FY 2017, SAMHSA plans to fund a new cohort of 15 five-year ATTC grants. SAMHSA expects the ATTC grantees to sponsor over 1,000 events involving more than 30,000 unique participants in FY 2017. In addition to the number of participants, event topics and contact hours, other metrics to be collected include participant satisfaction measures such as self-assessed skill levels both pre and post training. Funding will allow the 15 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.

Special Initiatives/Outreach

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Special Initiatives/Outreach.....	$1,432	$---	$---	$---

Authorizing Legislation .....Section 509 of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... 105 Nationally Recognized Historically Black Colleges and Universities

Program Description and Accomplishments

Although there are ongoing efforts to promote diversity and culturally competent care, the behavioral health system is not meeting the needs of many minorities seeking behavioral health care.[176] The current workforce needs additional training to adequately address the situation.[177]

[176] NAMI. (n.d.), *Multicultural Action Center.* http://www2.nami.org/Find-Support/Diverse-Communities

[177] Mental Health America, http://www.mentalhealthamerica.net/positions/cultural-competence, African-Americans, NAMI, https://www.nami.org/Find-Support/Diverse-Communities/African-Americans.

According to the Surgeon General's report titled "Mental Health, United States 2010", African Americans represent 19.2 percent of all psychiatrists, 5.1 percent of all psychologists, and 17.5 percent of social workers in the U.S. of the individuals clinically-trained as mental health professionals.

Communities of color often struggle with how to discuss and address issues related to mental and substance use disorders. The Historically Black Colleges and Universities-Center for Excellence (HBCU-CFE) recognizes there are service gaps related to mental and substance use disorders. In addition, many factors affect access to behavioral health care and workforce development. For those HBCUs located in rural areas, barriers include affordability, availability, and geographic location, lack of transportation, lack of insurance, and lack of culturally-appropriate services within the community. In recent years, there has been a growing awareness of the importance of promoting behavioral health on college campuses. Students report depression and anxiety among top impediments to academic performance.[178] However, students may not be aware of available resources or how to access critical services. Therefore, it is important to develop innovative strategies to engage students in behavioral health awareness and health promotion.

SAMHSA, through its Special Initiatives/Outreach, supports the HBCU-CFE at Morehouse School of Medicine (http://hbcucfe.net/). This innovative national resource center is dedicated to continuing the effort to network the 105 HBCUs throughout the United States. The Center promotes workforce development by cultivating leaders and disseminating of best practices in order to increase the participation of African-Americans in the behavioral health professions. The HBCU-CFE also supports a policy academy that focuses on workforce and leadership development, cross-systems collaboration, cultural competence, and eliminating disparities. The HBCU-CFE collaborates with other HHS agencies, including the Office of Minority Health. The HBCU-CFE has increased services to an underserved population, African-American college students and faculty, while also heightening interest in behavioral health services and careers.

In FY 2014, SAMHSA awarded one contract for Project LIFT (Leadership Initiatives for Tomorrow), which supports emerging leaders in underserved communities, and one grant for the HBCU-CFE. In addition, SAMHSA made 30 behavioral health capacity expansion sub-awards to support and promote opportunities for HBCUs to foster careers in behavioral health through internships; expansion of culturally appropriate, evidence-based, emerging best and practices; screening and referral services for students at risk of behavioral health issues; and behavioral health promotion and prevention activities.

According to the March 2015 HBCU-CFE Quarterly Report to SAMHSA, data revealed that 74 percent of the HBCU-CFE internships were completed in local and community-based organizations providing substance use disorder treatment services. In addition, 64 percent of HBCU grantees reported an increase in involvement in mental health initiatives on campus. Because of their program, Xavier University of Louisiana received SAMHSA's *2013 Recovery Month Annual Event Award*.[179]

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[178] American College Health Association-National Health Assessment II: Reference Group Data Report Spring, 2012. Retrieved from ACHA NCHA: http://www.acha-ncha.org/reports_acha-nchaii.html

[179] Services Accountability Improvement System. (2014); www.samhsa-gpra.samhsa.gov

In FY 2015, SAMHSA awarded the continuation of one Project LIFT contract and one HBCU-CFE grant award. In addition, SAMHSA funded 34 behavioral health capacity expansion awards to HBCUs. This funding helps to promote behavioral health literacy on the HBCU campuses. Recipients also participate in one of the four "Check Yourself" initiatives that support Mental Health First Aid, Kognito, eCHECKUP TO GO, and myStudent Body online assessments. FY 2015 programs will also provide 28 paid student internships and one Human Service Student internship. These undergraduate and graduate students participate in on-campus prevention initiatives and complete 3000 internship hours.

Other funding to the HBCU-CFE will support five peer educator interns to assist with the Question, Persuade, Refer Gatekeeper Suicide Prevention Training. This program targets freshmen and sophomores in order to increase awareness and expose students to evidence-based practices. The training provides tools to help students recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to get help. In FY 2016, these activities will be phased out but SAMHSA will ensure that workforce development activities for communities of color remain a priority through other funded initiatives.

Funding History

Fiscal Year	Amount
FY 2013	$1,991,589
FY 2014	$1,432,000
FY 2015	$1,432,000
FY 2016	---
FY 2017	---

Budget Request

The FY 2017 Budget Request is $0.0 and is the same as the FY 2016 Enacted Level. This represents the elimination of the program. SAMHSA recognizes the importance of expanding the workforce to support community behavioral health needs, especially for communities of color and has ensured that workforce development is included in all relevant grants.

Outputs and Outcomes Table

Program: Treatment - Other Capacity[1]

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
1.2.25 Increase the percentage of adults receiving services who had no past month substance use. (Outcome)	FY 2015: 64.9% Target: 60.0% (Target exceeded)	60.0%	60.0%	Maintain
1.2.26 Increase the number of clients served. (Output)	FY 2015: 16,725 Target: 30,849 (Target not met)	31,000	31,000	Maintain
1.2.27 Increase the percentage of adults receiving services who were currently employed or engaged in productive activities. (Outcome)	FY 2015: 43.8% Target: 45.0% (Target not met)	43.0%	43.0%	Maintain
1.2.28 Increase the percentage of adults receiving services who had a permanent place to live in the community. (Outcome)	FY 2015: 50.1% Target: 47.0% (Target exceeded)	47.0%	47.0%	Maintain
1.2.29 Increase the percentage of adults receiving services who had no involvement with the criminal justice system. (Outcome)	FY 2015: 96.9% Target: 93.0% (Target exceeded)	93.0%	93.0%	Maintain

[1]These measures include data from HIV/AIDS Outreach, Pregnant & Postpartum Women, Recovery Community Services Program - Services, Recovery-Oriented Systems of Care, SAT-ED, TCE/HIV, Targeted Capacity Expansion, Targeted Capacity Expansion- Health Information Technology, Targeted Capacity Expansion- Peer to Peer, Targeted Capacity Expansion- Technology Assisted Care, and Crisis Support programs.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table Summary

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Grants/Cooperative Agreements:						
Continuations	395	157,849	476	196,748	390	155,444
New/Competing	253	147,179	195	84,081	235	120,068
Subtotal	648	305,028	671	280,829	625	275,512
Contracts:						
Continuations	17	42,712	13	35,896	15	46,719
New/Competing	14	13,723	8	17,081	3	21,038
Subtotal	31	56,435	21	52,977	18	67,757
Total, Substance Abuse Treatment [1]	**679**	**$361,463**	**692**	**$333,806**	**643**	**$343,269**

[1] 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.

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
CAPACITY:						
Opioid Treatment Programs/Regulatory Activities						
Grants						
Continuations	3	$2,400	2	$1,397	1	$1,000
New/Competing	---	---	1	1,000	2	1,400
Subtotal	3	2,400	3	2,397	3	2,400
Contracts						
Continuations	3	5,135	2	1,711	5	5,154
New/Competing	4	1,190	5	4,615	---	1,170
Subtotal	7	6,324	7	6,327	5	6,324
Total, Opioid Treatment Programs/Regulatory Activities	**10**	**8,724**	**10**	**8,724**	**8**	**8,724**
Screening, Brief Intervention and Referral to Treatment						
Grants						
Continuations	24	18,236	61	23,233	68	25,348
New/Competing	64	21,320	20	16,747	---	---
Subtotal	88	39,556	81	39,980	68	25,348
Contracts						
Continuations	2	7,097	1	5,853	1	4,438
New/Competing	4	236	---	1,056	1	214
Subtotal	6	7,333	1	6,909	2	4,652
Total, Screening, Brief Intervention and Referral to Treatment	**94**	**46,889**	**82**	**46,889**	**70**	**30,000**
Targeted Capacity Expansion - General						
Grants						
Continuations	30	7,672	12	10,715	51	29,204
New/Competing	11	10,706	39	18,409	23	23,865
Subtotal	41	18,377	51	29,124	74	53,069
Contracts						
Continuations	1	2,710	2	4,485	1	7,418
New/Competing	1	2,136	---	2,694	---	816
Subtotal	2	4,846	2	7,179	1	8,234
Total, Targeted Capacity Expansion - General	**43**	**23,223**	**53**	**36,303**	**75**	**61,303**
Cohort Monitoring and Evaluation of Medication-Assisted						
Treatment Outcomes						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	1	15,000
Subtotal	---	---	---	---	1	15,000
Total, Cohort Monitoring and Evaluation of Medication-Assisted						
Treatment Outcomes	---	---	---	---	**1**	**15,000**
Buprenorphine-Prescribing Authority Demonstration						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	7	7,865
Subtotal	---	---	---	---	7	7,865
Contracts						
Continuations	---	---	---	---	---	635
New/Competing	---	---	---	---	1	1,500
Subtotal	---	---	---	---	1	2,135
Total, Buprenorphine-Prescribing Authority Demonstration	---	---	---	---	**8**	**10,000**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final No.	FY 2015 Final Amount	FY 2016 Enacted No.	FY 2016 Enacted Amount	FY 2017 President's Budget No.	FY 2017 President's Budget Amount
Pregnant & Postpartum Women						
Grants						
Continuations	19	9,482	26	12,793	6	3,048
New/Competing	7	3,393	---	---	20	9,750
Subtotal	26	12,875	26	12,793	26	12,798
Contracts						
Continuations	---	1,218	---	2,674	---	3,133
New/Competing	---	1,838	---	464	---	---
Subtotal	---	3,056	---	3,138	---	3,133
Total, Pregnant & Postpartum Women	**26**	**$15,931**	**26**	**$15,931**	**26**	**$15,931**
Strengthening Treatment Access and Retention						
Contracts						
Continuations	1	990	---	---	---	---
New/Competing	---	10	---	---	---	---
Subtotal	1	1,000	---	---	---	---
Total, Strengthening Treatment Access and Retention	**1**	**1,000**	**---**	**---**	**---**	**---**
Recovery Community Services Program						
Grants						
Continuations	10	1,000	10	1,000	8	400
New/Competing	8	398	8	400	10	1,000
Subtotal	18	1,398	18	1,400	18	1,400
Contracts						
Continuations	---	986	---	1,017	---	273
New/Competing	---	50	---	17	---	761
Subtotal	---	1,036	---	1,034	---	1,034
Total, Recovery Community Services Program	**18**	**2,434**	**18**	**2,434**	**18**	**2,434**
Access to Recovery						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	5	35,424	---	---	---	---
Subtotal	5	35,424	---	---	---	---
Contracts						
Continuations	---	2,261	---	---	---	---
New/Competing	---	538	---	---	---	---
Subtotal	---	2,799	---	---	---	---
Total, Access to Recovery	**5**	**38,223**	**---**	**---**	**---**	**---**
Children and Families						
Grants						
Continuations	11	$9,407	32	$20,673	14	$11,174
New/Competing	24	12,432	2	1,600	20	11,092
Subtotal	35	21,839	34	22,273	34	22,266
Contracts						
Continuations	2	4,607	3	4,891	3	5,943
New/Competing	2	3,158	1	2,441	---	1,396
Subtotal	4	7,766	4	7,332	3	7,339
Total, Children and Families	**39**	**29,605**	**38**	**29,605**	**37**	**29,605**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Treatment Systems for Homeless						
Grants						
Continuations	36	15,487	51	27,108	38	26,053
New/Competing	31	21,141	30	9,776	15	6,038
Subtotal	67	36,628	81	36,884	53	32,091
Contracts						
Continuations	3	4,720	---	2,623	1	4,295
New/Competing	---	37	---	1,797	---	---
Subtotal	3	4,758	---	4,420	1	4,295
Total, Treatment Systems for Homeless	**70**	**41,386**	**81**	**41,304**	**54**	**36,386**
Minority AIDS						
Grants						
Continuations	113	46,038	117	47,609	86	23,822
New/Competing	26	13,358	22	11,698	57	28,683
Subtotal	139	59,397	139	59,306	143	52,505
Contracts						
Continuations	2	4,578	3	5,570	3	6,280
New/Competing	1	1,595	---	694	---	73
Subtotal	3	6,173	3	6,264	3	6,354
Total, Minority AIDS	**142**	**65,570**	**142**	**65,570**	**146**	**58,859**
Criminal Justice Activities						
Grants						
Continuations	133	39,230	150	43,775	118	35,395
New/Competing	77	29,006	73	24,450	63	18,294
Subtotal	210	68,236	223	68,225	181	53,689
Contracts						
Continuations	2	6,945	2	6,508	1	8,148
New/Competing	2	2,819	2	3,268	---	109
Subtotal	4	9,764	4	9,775	1	8,257
Total, Criminal Justice Activities	**214**	**78,000**	**227**	**78,000**	**182**	**61,946**
Crisis Systems						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	3	4,512
Subtotal	---	---	---	---	3	4,512
Contracts						
Continuations	---	---	---	---	---	488
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	488
Total, Crisis Systems	**---**	**---**	**---**	**---**	**3**	**5,000**
Subtotal, CAPACITY	**662**	**$350,985**	**677**	**$324,760**	**628**	**$335,188**

SAMHSA/Substance Abuse Treatment
PRNS Mechanism Table by Program, Project, and Activity

(Dollars in thousands)

Programs of Regional & National Significance	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
SCIENCE AND SERVICE:						
Addiction Technology Transfer Centers						
Grants						
Continuations	15	8,598	15	8,447	---	---
New/Competing	---	---	---	---	15	7,568
Subtotal	15	8,598	15	8,447	15	7,568
Contracts						
Continuations	---	398	---	563	---	513
New/Competing	---	50	---	36	---	---
Subtotal	---	448	---	599	---	513
Total, Addiction Technology Transfer Centers	**15**	**9,046**	**15**	**9,046**	**15**	**8,081**
Special Initiatives/Outreach						
Grants						
Continuations	1	300	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	1	300	---	---	---	---
Contracts						
Continuations	1	1,067	---	---	---	---
New/Competing	---	65	---	---	---	---
Subtotal	1	1,132	---	---	---	---
Total, Special Initiatives/Outreach	**2**	**1,432**	**---**	**---**	**---**	**---**
Subtotal, SCIENCE AND SERVICE	**17**	**10,478**	**15**	**9,046**	**15**	**8,081**
Total, CSAT PRNS [1]	**679**	**$361,463**	**692**	**$333,806**	**643**	**$343,269**

[1]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.

Grant Awards Table

(Whole dollars)

	FY2015 Final	FY2016 Enacted	FY 2017 President's Budget
Number of Awards	648	671	625
Average Award	$470,722	$418,523	$440,819
Range of Awards	$300,000-$7,575,000	$300,000-$600,000	$300,000-$600,000

State Targeted Response Cooperative Agreements

(Dollars in thousands)

Program Activity	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
State Targeted Response Cooperative Agreements (Mandatory)	$---	$---	$460,000	+$460,000

Authorizing Legislation ..... New Legislation
FY 2017 Authorization ..... New Legislation
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

Death from overdose of opioids, a class of drugs that includes prescription pain relievers and heroin, has taken a heartbreaking toll on too many Americans. In 2014, 28,647 deaths were related to overdose of opioids. Americans are abusing opioids and too few are getting treatment. Individuals who want to but do not undergo treatment often report cost and lack of access as reasons why they do not get treatment.

The State Targeted Response Cooperative Agreements program is a new two-year program to address commonly cited barriers to receiving treatment. This funding is part of the Administration's $1.0 billion Expanding Access to Treatment Initiative to address opioid misuse epidemic by helping all Americans who want treatment to access it and get the help they need. These cooperative agreements will be awarded to states based on need and the strength of their strategies proposed to close the opioid use disorder treatment gap. Proposed strategies must be evidence-based and focused on the main factors preventing individuals from seeking and successfully completing treatment, and achieving recovery. States would be required to track and regularly report progress toward closing the opioid use disorder treatment gap and reducing opioid-related overdose deaths based upon measures developed in collaboration with HHS. Eligible activities would include but not be limited to:

- Addressing commonly cited barriers to receiving treatment by reducing the cost of treatment, expanding access to treatment, engaging patients in treatment, and addressing stigmas associated with accessing treatment;
- Training and certifying opioid use disorder treatment providers like physicians, nurses, counselors, social workers, care coordinators and case managers;
- Supporting innovative delivery of Medication Assisted Treatment;
- Eliminating or reducing treatment costs for under- and uninsured patients;
- Providing treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings;
- Enhancing prevention using evidence-based methods proven to reduce the number of persons with opioid use disorders;
- Supporting innovative telehealth in rural and underserved areas to increase the capacity of communities to support behavioral health; and

- Integrating health IT programs, including enhancing clinical decision tools, to support identification of patients with opioid use disorder and engage them in treatment.

A portion of the funds would be used to support an evaluation.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$460,000,000

Budget Request

The FY 2017 Budget Request is $920.0 million ($460.0 million in FY 2017 and $460.0 million in FY 2018). This new effort will address commonly cited barriers to receiving treatment. This funding is part of the Administration's $1.0 billion initiative to increase access to treatment for prescription drug abuse and heroin use. This funding will help all those who seek treatment, access it and get the help they need.

Substance Abuse Prevention and Treatment Block Grant

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Substance Abuse Prevention and Treatment Block Grant.....	$1,819,856	$1,858,079	$1,858,079	$ ---
PHS Evaluation Funds (non-add).....	*$79,200*	*$79,200*	*$79,200*	*$ ---*

Authorizing Legislation .....Sections 1921-1935 of the Title XIX, Part B, Subpart II and Section 1941-1956 of Title XIX, Part B, Subpart III of the Public Health Service Act
FY 2017 Authorization .....Expired
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

Roughly 24 million Americans who are 12 and over, including 2.2 million adolescents (aged 12 to 17) reported illicit drug use in 2013. Roughly 60 million Americans age 12 and over reported past month binge drinking in 2013, including 1.6 million adolescents. While 22.7 million Americans met the criteria for needing treatment due to a substance use disorder, only 2.5 million received treatment at a specialized facility.[180]

The Substance Abuse Prevention and Treatment Block Grant (SABG) program distributes funds to 60 eligible states, territories and freely associated states[181], 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 use disorder prevention, treatment, and recovery support services for individuals, families, and communities impacted by substance misuse and substance use disorders. The SABG's overall goal is to support and expand substance use disorder 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

[180] Substance use and mental health estimates from the 2013 National Survey on Drug Use and Health, Sept. 4, 2014, http://www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.htm. -

[181] 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

public health funding.[182] 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 substance use disorders, improved business practices such as facilitating enrollment in appropriate health coverage and use of health information technology and integration of physical and behavioral health.[183] 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:

1) To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
2) 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;
3) 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 substance use disorder, and indicated prevention interventions that serve people who exhibit some symptoms of a substance use disorder, but do not yet meet criteria for a diagnosis); and
4) To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, 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:

1) Allow recovery to be pursued through personal choice and many pathways;
2) Encourage providers to assess performance based on outcomes that demonstrate client successes; and
3) Expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services.

<u>Funding Allocations and Requirements</u>

SABG funds are distributed[184] 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 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

[182] SABG State Agency Reported Expenditures by Target Activity Within Source of Funds, State/Jurisdiction Selection: All States/Jurisdictions (2015)

[183] 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.

[184] Block Grants and Formula Grants: A Guide for Allocation Calculations; 2007 Department of Health and Human Services, SAMHSA.

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. In FY 2017, SAMHSA proposes to work with Congress, states, and other stakeholders to explore how technical changes to maintenance of effort (MOE) authorities could improve its effectiveness. Potential improvements that could be considered include: the year in which a final decision is made on non-compliance; whether the MOE should be calculated based on statewide spending; and whether more flexibility to set alternative penalties would improve State compliance.

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.[185] 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.

Application Process

States prepare and submit to SAMHSA for approval an application, which includes a behavioral health assessment and plan that describes how the grantees and their respective SABG sub-recipients intend to expend SABG funds. SAMHSA block grant application aligns with changes in federal/state environments, including the impacts of the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Tribal Law and Order Act (TLOA). States have the opportunity to complete a combined application for mental health and substance use disorder services, submit a biennial versus an annual plan,[186,187] and provide information

[185] Substance Abuse and Mental Health Services Administration. (2015). *Block Grant Laws and Regulations.* Retrieved from SAMHSA: http://www.samhsa.gov/grants/block-grants/laws-regulations.

[186] 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 Act (42 USC § 300x-2)).

regarding their efforts to respond to various changes in federal and state law. Submitting the application/plan biennially reduces the burden on states to prepare and submit an application/plan every year.

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."[188]

Performance and Evaluation

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. 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 use disorder data systems), ensures consistency in the use of measures, and provides a more complete perspective of the delivery of mental and substance use disorder 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.[189] SAMHSA data shows that the SABG has been successful in expanding treatment capacity by supporting approximately two million[190] 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 2012, at discharge, clients demonstrated high abstinence rates from both illegal drug (73.4 percent) and alcohol (81.6 percent) use. State substance abuse authorities reported the following outcomes for services provided during FY 2012, the most recent year for which data is available:

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[187] State Plan (Sec. 1932 (b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x-32(b)).

[188] Centers for Medicare & Medicaid. (n.d.). *Federal Policy Guidance.* Retrieved from Medicaid.gov: http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html

[189] http://tie.samhsa.gov/SAPT2010.html#Evaluation.

[190] Substance Abuse and Mental Health Services Administration (2015). *Clients Level Data / TEDS.* Retrieved from SAMHSA.gov: http://www.samhsa.gov/data/client-level-data-teds

- For the 50 states[191] and the District of Columbia that reported data concerning abstinence from alcohol use, 50 of 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, 49 of 50 identified improvements in client employment;
- For the 50 states and D.C. that reported criminal justice data, 45 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, 44 of 50 identified improvements in stable housing for clients based on data reported to TEDS.

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.[192] 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 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.*[193] 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.[194] 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

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[191] Source: West Virginia numbers have been included in the text, but they appear lower than expected.

[192] Substance Abuse and Mental Health Services Administration (2015). *Substance Abuse Prevention and Treatment Block Grant.* Retrieved from SAMHSA.gov: http://www.samhsa.gov/grants/block-grants/sabg

[193] "Front Matter." *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington, DC: The National Academies Press, 2009. http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx.

[194] Substance Abuse and Mental Health Services Administration (2015). *Synar Program.* Retrieved from SAMHSA.gov: http://www.samhsa.gov/synar

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.

Funding History

Fiscal Year	Amount
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	$1,858,079,000

Budget Request

The FY 2017 Budget Request is $1.9 billion and is level with the FY 2016 Enacted Level. Despite the wide scale opportunity to obtain insurance coverage created by the Affordable Care Act, significant gaps in coverage, as well as the subsequent reliance on the public behavioral health safety net remain. The SABG helps address this gap. SABG funds will also continue to support certain services (e.g., recovery support efforts) 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.

Outputs and Outcomes Table

Program: Treatment Activities[1]

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
1.2.43 Increase the number of admissions to substance abuse treatment programs receiving public funding. (Output)	FY 2014: 1,879,641 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 2015: 72.3% Target: 74.0% (Target not met)	74.0%	74.0%	Maintain
1.2.49 Increase the percentage of clients reporting no alcohol use in the past month at discharge. (Outcome)	FY 2015: 83.6% Target: 78.0% (Target exceeded)	78.0%	78.0%	Maintain
1.2.50 Increase the percentage of clients reporting being employed/in school at discharge. (Outcome)	FY 2014: 36.6% Target: 43.0% (Target not met)	40.0%	40.0%	Maintain
1.2.51 Increase the percentage of clients reporting no involvement with the Criminal Justice System. (Outcome)	FY 2014: 94.6% Target: 92.0% (Target exceeded)	92.0%	92.0%	Maintain
1.2.85 Increase the percentage of clients receiving services who had a permanent place to live in the community. (Outcome)	FY 2014: 91.6% Target: 92.0% (Target not met)	92.0%	92.0%	Maintain

[1]Targets revised based on data trends.

Outputs and Outcomes Table

Program: Synar Amendment

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
2.3.49 Increase the number of States and Territories (including Puerto Rico) whose retail sales violation rate is at or below 20%. (Outcome)	FY 2014: 49 Target: 52 (Target not 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 2014: 30 Target: 34 (Target not met but improved)	33	33	Maintain

Outputs and Outcomes Table

Program: Prevention Set-Aside

NOTE: SAMHSA makes grant awards towards the end of the year. Therefore, the FY 2017 targets are based on the FY 2016 Enacted Level and the FY 2018 targets are based on the FY 2017 President's Budget.

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/ FY 2017 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 to 17). (Outcome)	FY 2014: 35.3%[1] (Historical actual)	22.0%	22.0%	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 to 20). (Outcome)	FY 2014: 71.0% Target: 57.0% (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 to 17). (Outcome)	FY 2014: 49.0% Target: 59.0% (Target not met)	63.0%	63.0%	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: 24.0% Target: 37.3% (Target not met)	43.0%	43.0%	Maintain

[1]Virginia and West Virginia estimates were suppressed due to low precision.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARTY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 (+/-) FY 2016
Alabama	$22,940,958	$23,089,486	$23,089,486	$---
Alaska	5,539,999	5,889,074	$5,889,074	---
Arizona	39,546,174	40,187,732	$40,187,732	---
Arkansas	13,437,498	13,524,497	$13,524,497	---
California	250,323,608	254,414,759	$254,414,759	---
Colorado	25,300,234	28,777,345	$28,777,345	---
Connecticut	17,596,359	18,212,225	$18,212,225	---
Delaware	6,824,460	6,967,796	$6,967,796	---
District Of Columbia	6,824,460	6,967,796	$6,967,796	---
Florida	110,662,825	111,379,297	$111,379,297	---
Georgia	51,162,012	57,152,217	$57,152,217	---
Hawaii	8,212,595	8,469,866	$8,469,866	---
Idaho	8,480,929	8,535,838	$8,535,838	---
Illinois	67,210,630	67,645,777	$67,645,777	---
Indiana	32,038,656	32,246,086	$32,246,086	---
Iowa	13,009,122	13,093,348	$13,093,348	---
Kansas	11,823,116	11,899,663	$11,899,663	---
Kentucky	20,247,285	20,378,373	$20,378,373	---
Louisiana	24,865,443	25,026,431	$25,026,431	---
Maine	6,824,460	6,967,796	$6,967,796	---
Maryland	33,860,758	34,079,985	$34,079,985	---
Massachusetts	39,588,772	39,845,084	$39,845,084	---
Michigan	55,692,281	56,052,853	$56,052,853	---
Minnesota	23,946,997	24,102,039	$24,102,039	---
Mississippi	13,714,768	13,803,562	$13,803,562	---
Missouri	26,363,508	26,548,475	$26,548,475	---
Montana	6,824,460	6,967,796	$6,967,796	---
Nebraska	7,592,087	7,641,241	$7,641,241	---
Nevada	16,698,170	16,890,047	$16,890,047	---
New Hampshire	6,824,460	6,967,796	$6,967,796	---

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
FY 2017 DISCRETIONARTY STATE/FORMULA GRANTS
Substance Abuse Prevention and Treatment Block Grant (SABG)
CFDA #93.959

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 (+/-) FY 2016
New Jersey	$46,379,126	$48,064,193	$48,064,193	$---
New Mexico	9,503,584	9,565,114	$9,565,114	---
New York	111,110,689	111,830,061	$111,830,061	---
North Carolina	43,374,576	44,991,909	$44,991,909	---
North Dakota	6,146,271	6,533,547	$6,533,547	---
Ohio	64,120,596	64,535,736	$64,535,736	---
Oklahoma	17,039,024	17,149,341	$17,149,341	---
Oregon	20,024,554	20,578,346	$20,578,346	---
Pennsylvania	58,720,026	59,100,201	$59,100,201	---
Rhode Island	7,549,597	7,598,476	$7,598,476	---
South Carolina	23,164,181	23,717,773	$23,717,773	---
South Dakota	5,683,588	6,041,710	$6,041,710	---
Tennessee	29,359,704	31,978,247	$31,978,247	---
Texas	139,837,820	144,708,674	$144,708,674	---
Utah	16,481,871	16,588,581	$16,588,581	---
Vermont	6,076,965	6,459,874	$6,459,874	---
Virginia	41,709,858	41,979,903	$41,979,903	---
Washington	37,296,200	37,784,663	$37,784,663	---
West Virginia	8,378,435	8,432,680	$8,432,680	---
Wisconsin	27,023,026	27,197,983	$27,197,983	---
Wyoming	3,948,749	4,197,559	$4,197,559	---
Red Lake Indians	590,206	594,027	$594,027	---
American Samoa	333,546	342,788	$343,454	+666
Guam	970,730	1,004,691	$1,014,297	+9,606
Northern Marianas	311,984	320,555	$324,340	+3,785
Puerto Rico	22,405,098	22,838,224	$22,811,437	-26,787
Palau	127,671	132,231	$133,471	+1,240
Marshall Islands	415,696	436,931	$447,189	+10,258
Micronesia	646,411	664,690	$665,784	+1,094
Virgin Islands	639,053	656,127	$656,265	+138

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SAMHSA
Health Surveillance and Program Support
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Health Surveillance

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Health Surveillance	$47,258	$47,258	$47,258	$---
PHS Evaluation Funds (non-add)	*30,428*	*30,428*	*29,428*	*-1,000*
Prevention and Public Health Fund (non-add)	---	---	*17,830*	*+17,830*
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 2017 Authorization .....Expired
Allocation Method ..... Federal/Intramural, Contracts, Other
Eligible Entities..... Not Applicable

Program Description and Accomplishments

Federal, state, and local authorities and other healthcare stakeholders use data and reports drawn from SAMHSA's national surveys to inform behavioral health policy. Information on behavioral health at the community level serves to identify current and emerging problems and highlight opportunities for progress that may vary from larger geographical areas. When communities have access to surveillance data over time, they can then direct targeted prevention efforts to the most vulnerable populations.

The Health Surveillance budget supports many of the critical behavioral health data systems, national surveys, and surveillance activities for the Department of Health and Human Services (HHS) undertaken by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ), the government's lead agency for behavioral health statistics. Key activities are highlighted below. For a complete description on CBHSQ activities and funding from across SAMHSA's appropriations, see the Performance Quality and Information Systems tab.

- The National Survey on Drug Use and Health (NSDUH)[195] serves as the nation's primary source for information on the prevalence of substance use and mental health and related health conditions. In FY 2013, SAMHSA awarded a new NSDUH contract to finance annual surveys through FY 2017. SAMHSA supported the NSDUH surveys at $52.7 million in FY 2015, and is funding the FY 2016 NSDUH surveys at the same level. Of this amount, $13.8 million is from Health Surveillance, with the remaining amount supported by the Substance Abuse Treatment appropriation. The Mental Health Appropriation provides an additional $1.0 million each year for evaluation of mental health elements.

- The Community Behavioral Health Data Initiative (CDI) coordinates three separate existing data efforts and creates new opportunities for cross-agency and public-private

[195] NSDUH data are collected under SAMHSA's legislative mandate; see 42 U.S.C. 290aa-4.

partnerships to address critical public health questions. These data efforts include the Community Early Warning and Monitoring System (C-EMS), SAMHSA's Emergency Department Surveillance System (SEDSS) (formerly the Drug Abuse Warning Network (DAWN)), and the Program Studies on Treatment and Recovery (PSTAR). Data from other agencies such as the Center for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) can augment this coordinated initiative and then be reported by regional and community type. Moreover, the longitudinal nature of these data will allow those evaluating the effectiveness of services and policies in a community to measure the impact and outcomes of those interventions.

- Emergency Department (ED) data remain an important component of public health because ED data provides a picture of the most urgent behavioral and other health issues in the community. ED data are an excellent tool for monitoring trends in mental health and substance use and related conditions across the nation. ED data also provide important surveillance for targeting emerging behavioral health issues. SAMHSA's Emergency Department Surveillance System collects data from hospitals in a variety of communities and provides a summary of visits by patients with mental health conditions and substance use problems. By collaborating with the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS), SAMHSA has an opportunity to understand more comprehensively the nature and course of behavioral health presentations to emergency departments, including those related to both mental health and substance use.

- The Behavioral Health Services Information System (BHSIS)[196] is the primary source of data on substance use and mental disorder treatment facilities and treatment admissions. BHSIS also provides information for people who need help finding mental and/or substance use disorder treatment through the BHSIS Behavioral Health Treatment Services Locator. Every year individuals, families, community groups, and organizations use the Treatment Services Locator more than two million times to identify appropriate treatment services. SAMHSA's Treatment Services Locator (https://findtreatment.samhsa.gov/) provides accurate, timely, and regularly updated information on mental and substance use treatment facilities across the country. The base cost of BHSIS is $21.0 million for FY 2015, FY 2016 and FY 2017. Of this, $17.0 million is from Health Surveillance appropriation and $4.0 million is from Substance Abuse Treatment Block Grant appropriation. SAMHSA will fund basic BHSIS operations in FY 2017 at the same levels as FY 2015 and FY 2016. In addition, the Mental Health Appropriation provides $7.5 million for a behavioral health services facility survey. This funding ensures a holistic approach to data collection related to behavioral health and allows for the inclusion of mental health services facility data in the BHSIS survey.

- The Analytic Support Center (ASC) that undertakes a number of analytic and scientific research on practice-related topics in response to requests from SAMHSA centers, HHS

[196] BHSIS data are collected under SAMHSA's legislative mandate; see 42 U.S.C. 290aa-4.

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agencies, the Office of National Drug Control Policy, and the Department of Justice. ASC's funding includes a total of $2.5 million for FY 2015 and $3.0 million for FY 2016 with $2.0 million supported from Health Surveillance appropriation.

Funding History

Fiscal Year	Amount
FY 2013	$45,421,000
FY 2014	$47,258,000
FY 2015	$47,258,000
FY 2016	$47,258,000
FY 2017	$47,258,000

Budget Request

The FY 2017 Budget Request is $47.3 million. This is the same as the FY 2016 Enacted Level. This includes $29.4 million from PHS Evaluation Funds and $17.8 million from Prevention and Public Health Funds. This funding will support the continuation of the NSDUH, NREPP, BHSIS, C-EMS, and the Analytic Support Center contracts.

Health Surveillance funding in FY 2017 includes $2.3 million for Operations and $7.2 million to support the administrative costs of CBHSQ personnel, programs, and interagency agreements.

Mechanism Table for Health Surveillance

(Dollars in thousands)

Program Activity	FY2015 Final No.	FY2015 Final Amount	FY2016 Enacted No.	FY2016 Enacted Amount	FY2017 President's Budget No.	FY2017 President's Budget Amount
Health Surveillance						
Contracts						
Continuations	4	$41,100	3	$36,194	3	$33,463
New/Competing	4	6,158	1	11,064	---	13,795
Subtotal	8	47,258	4	47,258	3	47,258
Total, Health Surveillance	**8**	**$47,258**	**4**	**$47,258**	**3**	**$47,258**

Program Support

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Program Support	$72,002	$79,559	$77,559	-$2,000

Authorizing Legislation .....Section 501 of the Public Health Service Act
FY 2017 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 614 Full Time Equivalents (FTEs) in FY 2015 and projects that the number of FTE will grow to 665 in FY 2016. The Program Support appropriation supported 491 of these FTEs. Staff positions that are not covered through the Health Surveillance and Program Support appropriation are funded with Substance Abuse Prevention and Treatment Block Grant set-aside for activities associated with technical assistance, data collection and evaluation, and from other program lines for activities directly relating to the administration of those particular programs.

SAMHSA applies an estimated internal administrative charge for overhead expenses to all programs, projects, and activities.

Funding History

Fiscal Year	Amount
FY 2013	$77,997,779
FY 2014	$72,002,000
FY 2015	$72,002,000
FY 2016	$79,559,000
FY 2017	$77,559,000

Budget Request

The FY 2017 Budget Request is $77.6 million, a decrease of $2.0 million from the FY 2016 Enacted Level. This level of funding will continue to cover overhead costs associated with 5600 Fishers Lane, including rent, the Federal Acquisition Service loan repayment program, and security charges.

In FY 2017, SAMHSA plans to support 665 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)

Program Activity	FY2015 Final		FY2016 Enacted		FY2017 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Program Support						
Contracts						
Continuations	---	$72,002	---	$79,559	---	$77,559
New/Competing	---	---	---	---	---	---
Subtotal	---	72,002	---	79,559	---	77,559
Total, Program Support	**---**	**$72,002**	**---**	**$79,559**	**---**	**$77,559**

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Public Awareness and Support

(Dollars in thousands)

Program Activity	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
Program Level	$13,482	$15,571	$13,482	-$2,089
PHS Evaluation Funds (non-add)	---	---	*13,482*	*+13,482*

Authorizing Legislation ..... Sections 501, 509, 516, and 520A of the Public Health Service Act
FY 2017 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[197] estimated that at some point in their lives, almost half of all Americans will experience symptoms of a mental and/or substance use disorder. In addition, half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.[198] For these reasons, it is important to identify issues early and help individuals get the treatment they need as soon as possible. Fortunately, because of the Affordable Care Act and the implementation of the Mental Health Parity and Addiction Equity Act, more people than ever before have access to mental health care and substance use disorder treatment. Communities are increasingly engaging in prevention strategies and approaches 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 and substance use disorders, serve as an expert on behavioral health issues, and lead public health efforts to advance the behavioral health of the nation.

Collaborating Across Agencies

SAMHSA collaborates with other agencies to promote awareness of behavioral health. For example, SAMHSA coordinates with the Centers for Disease Control and Prevention (CDC) to promote the Million Hearts Campaign and prescriber guidelines for opioids under the Materials Development and Marketing Support (MDMS) contract. SAMHSA also supports the National Outreach, Public Education, and Engagement Initiative (NOPEEI) contract, which provides communications support for national outreach and public education initiatives across a variety of behavioral health topics, including a national effort to support recovery from mental and substance use disorders.

[197] 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.
[198] Ibid.

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), which manages SAMHSA's print and online information resources. The Public Engagement Platform provides a customer-oriented fulfillment system, including an online store, call-in contact center, warehouse, email updates, exhibit program, and strategic collaborations to fulfill the educational and training needs of the public and health service providers. The various channels of communication managed by SAMHSA generated more than 34 million customer interactions in FY 2015, disseminated over 26 million copies of SAMHSA publications, and referred over 565,000 people to treatment.

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. For example, in response to severe storms and flooding in Texas, SAMHSA disseminated an e-blast on June 8, 2015, less than 24 hours after the disaster occurred, to over 100,000 recipients. The e-blast featured SAMHSA's Disaster Distress Helpline and a link to download SAMHSA's mobile app for behavioral health first responders.

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. For example, to further support behavioral health first responders, SAMHSA developed and launched the behavioral health disaster response mobile app (http://www.store.samhsa.gov/apps/disaster/) that allows behavioral health first responders to zero in on the exact location to respond to a disaster and easily access and share behavioral health resources, updated in real-time, with those most in need at the site of a disaster. Since its launch, there have been more than 12,600 downloads of the behavioral health disaster response app, and more than 18,600 down loads of "Know Bullying," a mobile app released in FY 2014 (http://store.samhsa.gov/apps/bullying/) that gives parents and caregivers the tools they need to talk to their children about bullying. This app has been downloaded over times. In February of 2015, SAMHSA launched the "Suicide Safe" app (http://store.samhsa.gov/apps/suicidesafe/) 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 over 28,900 times since its launch. In the future, SAMHSA will continue to innovate in these new platforms by launching additional mobile apps to address other important behavioral health topics.

SAMHSA will continue to provide critical information resources in a timely fashion, and access to emergency response networks, for the public and the behavioral health workforce.

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. The increasingly effective reach of these online channels is

demonstrated by the fact that the number of people following SAMHSA on Twitter has increased more than 680 percent (from 7,000 to over 55,000) since 2013, and "likes" of SAMHSA's Facebook page have increased from 20,000 to over 57,000 during the same time period.

In the course of prioritizing the internet as a strategic business initiative and communications asset, SAMHSA consolidated and modernized SAMHSA's web presence. Through an ongoing focused effort (Project Evolve), almost 90 disparate websites created for various SAMHSA-sponsored campaigns and programs are being consolidated under SAMHSA.gov, and will be completed in FY 2016. SAMHSA's focused efforts ensure that the agency speaks to the nation with a unified voice. Project Evolve will also help eliminate multiple web development and maintenance efforts, resulting in lower overall operating costs, greater efficiency, increased effectiveness, and improved service for visitors to SAMHSA's website.

SAMHSA's Role as a Leader in 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 problems at the national level, by geographic region, and for each of the 50 states and the District of Columbia. SAMHSA has also completed an agency-wide Strategic Communications Plan to increase the utility and reach of its data reports and other public education materials.

As part of the President's *Now is the Time* effort, SAMHSA charged the National Academies' 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, which SAMHSA continues to build in FY 2016. In FY 2016, SAMHSA is beginning the next phase of the "Science of Changing Social Norms" program. Through this effort, SAMHSA will inform the development and testing of an array of messages designed to raise public awareness of the importance of behavioral health, promote health literacy to reduce the negative perceptions and attitudes about behavioral health issues, and help Americans make behavioral health a priority for public health action. Going forward, SAMHSA will use the insight gained through this effort to inform our communications about the importance of behavioral health.

Funding History

Fiscal Year	Amount
FY 2013	$13,545,351
FY 2014	$13,482,000
FY 2015	$13,482,000
FY 2016	$15,571,000
FY 2017	$13,482,000

Budget Request

The FY 2017 Budget Request is $13.5 million, a reduction of $2.1 million from the FY 2016 Enacted Level. The $2.0 million reduction is because the one-time finding for the effort "Science of Changing Social Norms" is no longer needed. The lessons learned through the program in FY 2016 and SAMHSA's work with the National Academies' Board on Behavioral, Cognitive, and Sensory Sciences will inform SAMHSA's other communications efforts and programs in FY 2017 and beyond. Funds for Public Awareness and Support will allow SAMHSA to maintain and update 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. 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. For example, through the National Outreach, Public Education and Engagement Initiative contract, SAMHSA will work with the CDC to disseminate information about prescriber guidelines on the dangers of prescription drug misuse.

Mechanism Table for Public Awareness and Support

(Dollars in thousands)

Program Activity	FY2015 Final No.	FY2015 Final Amount	FY2016 Enacted No.	FY2016 Enacted Amount	FY2017 President's Budget No.	FY2017 President's Budget Amount
Public Awareness and Support						
Grants						
Continuations	---	$---	---	$---	---	$---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	5	11,020	5	12,093	5	5,794
New/Competing	1	2,462	2	3,478	1	7,688
Subtotal	6	13,482	7	15,571	6	13,482
Total, Public Awareness and Support	**6**	**$13,482**	**7**	**$15,571**	**6**	**$13,482**

Outputs and Outcomes Table

Program: Public Awareness and Support

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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)	400,000	400,000	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)	33,000,000	34,300,00	+1,300,000

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Performance and Quality Information Systems

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Program Level	$12,918	$12,918	$12,918	$---
PHS Evaluation Funds (non-add)	---	---	*12,918*	*+12,918*

Authorizing Legislation ..... Sections 501, 509, 516, and 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Contracts
Eligible Entities..... Not Applicable

Program Description and Accomplishments

Performance and Quality Information Systems (PQIS) provide continuous support for the performance measurement efforts including quality improvement activities. This program promotes greater efficiencies in the collection, analysis, and reporting of data and other information. The program will facilitate accountability, clarity in outcomes measures, and improvements in the quality and accessibility of data and other information for use by program staff, grantees, and the public.

In FY 2015 and FY 2016, funding will continue to support the National Registry of Evidence-based Programs and Practices (NREPP). NREPP (http://www.samhsa.gov/nrepp) is a searchable online system that provides states, tribes, local governments, and communities with tools for identifying and implementing evidence-based mental health promotion, substance abuse prevention, and mental and substance use disorder treatment interventions. SAMHSA is implementing changes to NREPP to address enhanced rigor and highlight promising practices that are of a particular importance to vulnerable populations. These changes to the review process will bring NREPP into alignment with other government registries of evidence-based programs and practices.

SAMHSA requests continued funding for Performance and Quality Information Systems to address the need for a uniform data collection and reporting system for SAMHSA management and staff. In FY 2015, funding to phase in the implementation of SAMHSA's common data platform (CDP) was $5.0 million. In FY 2016 and FY 2017, SAMHSA will combine this funding with Grantee Data Technical Assistance funding for a total of $10.9 million. This approach will allow for the funding of a single common data platform, including programmatic training and technical assistance, known as SAMHSA's Performance Accountability and Reporting System (SPARS). SPARS will provide a common data and reporting system for all SAMHSA discretionary grantees and allow for programmatic technical assistance on the use of data to enhance grantee performance monitoring and improve the quality of service delivery. These funds will provide SAMHSA's management and staff with the ability to analyze program data at multiple levels (state, program, community, etc.), provide tailored, real-time information about the progress and activity of each grantee, and provide data to grantees to support them in the efficient and effective implementation of projects.

PQIS funding also supports operations ($2.6 million in FY 2015 and $1.5 million in FY 2016). The operations budget funds the administrative and support costs for CBHSQ programs, and interagency agreements.

Funding History

Fiscal Year	Amount
FY 2013	$8,803,289
FY 2014	$12,918,000
FY 2015	$12,918,000
FY 2016	$12,918,000
FY 2017	$12,918,000

Budget Request

The FY 2017 Budget Request is $12.9 million, the same as the FY 2016 Enacted Level. SAMHSA will use these funds to continue support for operations at $1.5 million, NREPP at $1.5 million, and SPARS at $10.9 million. This funding will support system development, training, and technical assistance.

Mechanism Table for Performance and Quality Information Systems

(Dollars in thousands)

Program Activity	FY2015 Final No.	FY2015 Final Amount	FY2016 Enacted No.	FY2016 Enacted Amount	FY2017 President's Budget No.	FY2017 President's Budget Amount
Performance and Quality Information Systems						
Grants						
Continuations	---	$---	---	$---	---	$---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	3	12,918	3	12,918	3	12,918
New/Competing	---	---	---	---	---	---
Subtotal	3	12,918	3	12,918	3	12,918
Total, Performance and Quality Information Systems	**3**	**$12,918**	**3**	**$12,918**	**3**	**$12,918**

Outputs and Outcomes Table

Program: Performance and Quality Information Systems

Measure	Year and Most Recent Result Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 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 2014: 1,745,133[1] Target: 1,882,149 (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 2015: 45 Target: 55 (Target not met)	55	55	Maintain

[1] FY 2015 data was not collected because of technical and programmatic changes associated with the website.

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Agency-Wide Initiatives

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Agency-wide Initiatives[1]	$11,669	$12,669	$22,669	+$10,000
Behavioral Health Workforce (non-add)	*11,669*	*12,669*	*22,669*	*+10,000*
Minority Fellowship Program (non-add)	*10,669*	*11,669*	*11,669*	---
Minority Fellowship Program-Base (non-add)	*5,423*	*6,423*	*6,423*	---
Counselors (non-add)	*5,246*	*5,246*	*5,246*	---
Peer Professional Workforce Development (non-add)	---	---	*10,000*	*+10,000*
Behavioral Health Workforce Data and Development (non-add)	*1,000*	*1,000*	*1,000*	---
PHS Evaluation Funds (non-add)	*1,000*	*1,000*	*1,000*	---

[1] Totals in FY 2015 (-$35.0 million) and FY 2016 (-$50.0 million) are comparably adjusted to reflect the transfer of the Behavioral Health Workforce Expansion and Training program from SAMHSA to HRSA in FY 2017.

Authorizing Legislation ..... Sections 501, 509, 516, and 520A of the Public Health Service Act
FY 2017 Authorization .....Expired
Allocation Method .....Competitive Grants/Contracts/Cooperative Agreements
Eligible Entities..... Community Colleges, Universities, States, National Organizations

Program Description and Accomplishments

Behavioral Health Workforce

As SAMHSA implements the *Leading Change 2.0* Strategic Initiatives for 2015-2018, the Strategic Initiative on Workforce Development provides the opportunity for a concerted focus on developing and expanding the behavioral health workforce.

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 and substance use disorders 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 health or substance use disorder services for minority populations that are underserved. This will result in improved quality of mental and substance use disorder 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 and substance use disorder

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, SAMHSA funded six continuation grants and plans to fund these again in FY2016.

In previous years, program activities were spread through three of SAMHSA's centers. To improve the administration of these workforce programs, SAMHSA has realigned the programs within a unified approach under Agency-Wide Initiatives. The focus on building the components of the mental health, substance use prevention and substance use disorder treatment workforce will be maintained through enhanced collaborative efforts between SAMHSA's centers.

Minority Fellowship Program Expansion-Youth (MFP-Y) and Addiction Counselors (MFP-AC)
Begun FY 2014, MFP-Y this effort 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.

The FY 2015 Budget provided $10.7 million in funding for MFP grants. The FY 2016 Enacted Level of $11.7 million sustains and strengthens the expansion program.

Funding History

Fiscal Year	Amount
FY 2013	$5,436,000
FY 2014	$10,669,000
FY 2015	$10,669,000
FY 2016	$11,669,000
FY 2017	$11,669,000

Budget Request

The FY 2017 Budget Request is $11.7 million, which is level with the FY 2016 Enacted Level. 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.

Peer Professional Workforce Development

The Peer Professional Workforce Development program will fund grants to provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs. The Peer Professional Workforce Development program's goal is to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-masters-level addiction counselors working with young people ages 16 to 25. Because they have lived with behavioral health conditions, the entry-level providers supported by this program will play a significant role in the delivery of prevention, outreach, engagement, and recovery support services. Evidence has found that individuals with a substance use disorder who regularly engage in peer-delivered interventions are more likely to abstain from substance misuse. Similar evidence has shown the effectiveness of those with mental disorders and their families in supporting their peers. While the Behavioral Health Workforce Education and Training program (described below) focuses on supporting clinical internships, field placements, and certificate program completion across a range of professional and paraprofessional disciplines (some of whom may be peers), the Peer Professional Workforce Development program will focus on helping communities develop the infrastructure to train and certify peers, or people with lived experience with mental illness and/or substance use conditions, as behavioral health providers.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	$10,000,000

Budget Request

The FY 2017 Budget Request of $10.0 million reflects an increase of $10.0 million from the FY 2016 Enacted Level. These funds will support the development of the new Peer Professional Workforce Development program. The program aims to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Masters level addiction counselors working with young people ages 16 to 25. It will provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs. The funding will support up to 19 grants.

SAMHSA-HRSA Behavioral Health Workforce Education and Training (BHWET) Grant Program

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. In FY 2014, FY 2015 and FY 2016, SAMHSA requested and Congress appropriated this funding to SAMHSA. During this time, HRSA carried out the program under a reimbursable agreement. In FY 2017, HHS is requesting that HRSA receive the funding for this program. This is in line with HRSA's current authorities and will aid in streamlining efforts. SAMHSA and HRSA will continue to collaborate to sustain and strengthen the HRSA-SAMHSA partnership and the behavioral health workforce. SAMHSA has comparably adjusted impacted tables.

Behavioral Health Workforce Data and Development

As of June 2014, there were more than 4,000 Mental Health Professional Shortage Areas (HPSAs) in the United States, containing nearly a third of the American population, or 96 million people. Recent data indicate that almost 90 percent of persons with substance use disorders do not receive the services they need[199] and over half of those with mental illness do not receive needed treatment.[200]

The President's *Now is the Time* initiative supports new activities to expand the behavioral health workforce. In FY 2015, new workforce investments provided support for 2,116 new behavioral health professionals. To ensure the existing workforce investments would achieve desired outcomes, SAMHSA workforce activities in FY 2015 included $1.0 million to collaborate with HRSA on the Behavioral Health Minimum Data Set to develop consistent data collection methods to identify and track behavioral health workforce needs. In FY 2016, SAMHSA

[199] 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.

[200] Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

continues to work with HRSA to develop a consistent and common data set and to develop clear goals and objectives to meet the national behavioral health workforce needs in America.

Funding History

Fiscal Year	Amount
FY 2013	---
FY 2014	---
FY 2015	$1,000,000
FY 2016	$1,000,000
FY 2017	$1,000,000

Budget Request

The FY 2017 Budget Request of $1.0 million is level with the FY 2016 Enacted Level. These funds will allow SAMHSA to continue collaborating with HRSA. These efforts will focus analytical and research projects in three behavioral health workforce focus areas: 1) expanded application of standardized minimum data set with state and professional organizations; 2) workforce modeling and projections to understand what behavioral health services are being provided, by whom and in what settings; and 3) development of certification/licensing/scope of practice framework for each state.

Mechanism Table for Agency-Wide Initiatives

(Dollars in thousand)

Program Activity Agency-Wide Initiatives	FY2015 Final		FY2016 Enacted		FY2017 President's Budget	
	No.	Amount	No.	Amount	No.	Amount
Behavioral Health Workforce:						
Minority Fellowship Program-Base[1]						
Grants						
Continuations	6	$4,796	6	$4,770	6	$4,755
New/Competing	---	---	2	1,000	2	1,000
Subtotal	6	4,796	8	5,770	8	5,755
Contracts						
Continuations	1	627	1	653	1	668
New/Competing	---	---	---	---	---	---
Subtotal	1	627	1	653	1	668
Total, MFP-Base	**7**	**5,423**	**9**	**6,423**	**9**	**6,423**
Minority Fellowship Program-Youth/Addiction Counselors						
Grants						
Continuations	7	4,261	7	4,261	7	4,261
New/Competing	---	---	---	---	---	---
Subtotal	7	4,261	7	4,261	7	4,261
Contracts						
Continuations	2	985	2	985	2	985
New/Competing	---	---	---	---	---	---
Subtotal	2	985	2	985	2	985
Total, MFP-Youth/Addiction Counselors	**9**	**5,246**	**9**	**5,246**	**9**	**5,246**
Peer Professional Workforce Development						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	19	9,343
Subtotal	---	---	---	---	19	9,343
Contracts						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	657
Subtotal	---	---	---	---	---	657
Total, PPWD	**---**	**$---**	**---**	**$---**	**19**	**$10,000**
Behavioral Health Workforce Data and Development						
Grants						
Continuations	---	---	---	---	---	---
New/Competing	---	---	---	---	---	---
Subtotal	---	---	---	---	---	---
Contracts						
Continuations	---	---	1	1,000	1	1,000
New/Competing	1	1,000	---	---	---	---
Subtotal	1	1,000	1	1,000	1	1,000
Total, Behavioral Health Workforce Data and Development	**1**	**1,000**	**1**	**1,000**	**1**	**1,000**
Subtotal, Behavioral Health Workforce	**17**	**11,669**	**19**	**12,669**	**38**	**22,669**
Total, Agency-Wide[2]	**17**	**$11,669**	**19**	**$12,669**	**38**	**$22,669**

1 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.

[2] 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.

SAMHSA
Center for Behavioral Health Statistics and Quality (CBHSQ)
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SAMHSA
Center for Behavioral Health Statistics and Quality

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Substance Abuse Treatment Appropriation				
Substance Abuse Block Grant Set Aside				
Budget Authority				
National Survey on Drug Use and Health	$1,626	$698	$698	---
Total Budget Authority	**1,626**	**698**	**698**	**---**
PHS Evaluation Funds	43,689	38,233	38,233	---
Analytic Support Center	562	1,000	1,000	---
Behavioral Health Services Information System	4,413	3,972	3,972	---
Substance Abuse and Mental Health Data Archive	2,035	1,291	1,291	---
Community Behavioral Health Data Initiative	1,500	5,750	5,750	---
SAMHSA's Emergency Department Surveillance System (non-add	*1,500*	*4,500*	*4,500*	---
Program Studies on Treatment and Recovery (non-add)	---	*1,250*	*1,250*	---
Data Collection and Evaluation Activities	296	---	---	---
Operations	187	305	305	---
Payroll	4,987	7,122	7,122	---
Total PHS Evaluation Funds	**57,670**	**57,674**	**57,674**	**---**
Total Substance Abuse Block Grant Set Aside	**59,296**	**58,372**	**58,372**	**---**
Health Surveillance and Program Support Appropriation				
Health Surveillance				
Budget Authority				
National Survey on Drug Use and Health	2,405	13,795	---	-13,795
Community Behavioral Health Data Initiative	2,000	1,778	---	-1,778
Community Early Warning and Monitoring System (non-add)	*2,000*	*1,778*	*---*	*-1,778*
Common Data Platform	1,800	---	---	---
Data Collection and Evaluation Activities	6,374	---	---	---
Innovation and Logistical Services Support	1,334	---	---	---
Content Management	1,230	---	---	---
Operations	1,687	1,257	---	-1,257
Total Budget Authority	**16,830**	**16,830**	**---**	**-16,830**
PHS Evaluation Funds				
National Registry for Evidence Based Programs and Practices	2,212	2,043	1,103	-940
Behavioral Health Services Information System	16,668	17,028	17,028	---
Analytic Support Center	2,000	2,020	1,012	-1,008
Community Behavioral Health Data Initiative	1,000	1,222	2,011	+789
Community Early Warning and Monitoring System (non-add)	*1,000*	*1,222*	*2,011*	*+789*
Innovation and Logistical Services Support	846	---	---	---
Content Management	973	---	---	---
Operations	1,497	1,118	1,162	+44
Payroll	5,232	6,998	7,112	+114
Total PHS Evaluation Funds	**30,428**	**30,428**	**29,428**	**-1,000**
Prevention and Public Health Fund				
Analytic Support Center	---	---	1,008	+1,008
National Survey on Drug Use and Health	---	---	13,795	+13,795
National Registry for Evidence Based Programs and Practices	---	---	904	+904
Community Behavioral Health Data Initiative	---	---	989	+989
Community Early Warning and Monitoring System (non-add)	---	---	*989*	*+989*
Operations	---	---	1,134	+1,134
Total Prevention and Public Health Fund	**---**	**---**	**17,830**	**+17,830**
Total Health Surveillance	**47,258**	**47,258**	**47,258**	**---**

SAMHSA/Center for Behavioral Health Statistics and Quality (CBHSQ)

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Performance and Quality Information Systems				
Budget Authority				
National Registry for Evidence Based Programs and Practices	330	1,463	---	-1,463
Common Data Platform	3,590	10,000	---	-10,000
Grantee Data Technical Assistance	3,185	---	---	---
Data Collection and Evaluation Activities	2,005	---	---	---
Innovation and Logistical Services Support	376	---	---	---
Content Management	881	---	---	---
Operations	2,551	1,455	---	-1,455
Total Budget Authority	**12,918**	**12,918**	**---**	**-12,918**
PHS Evaluation Funds				
National Registry for Evidence Based Programs and Practices	---	---	1,498	+1,498
Common Data Platform	---	---	10,000	+10,000
Operations	---	---	1,420	+1,420
Total PHS Evaluation Funds	**---**	**---**	**12,918**	**+12,918**
Total Performance and Quality Information Systems	**12,918**	**12,918**	**12,918**	**---**
Agency-Wide Initiatives				
PHS Evaluation Funds				
Behavioral Health Workforce Data and Development	940	967	966	-1
Operations	60	33	34	+1
Total Agency-Wide Initiatives	**1,000**	**1,000**	**1,000**	**---**
Total Health Surveillance and Program Support	**61,176**	**61,176**	**61,176**	**---**
Total Substance Abuse Block Grant Set Aside and Health Surveillance and Program Support	**$120,472**	**$119,548**	**$119,548**	**$---**

Resources by Activity

(Dollars in thousands)

Program Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
National Survey on Drug Use and Health	$47,721	$52,727	$52,727	$---
Behavioral Health Services Information System	21,081	21,000	21,000	---
CBHSQ Logistics and Analytic Support Center	2,562	3,020	3,020	---
Substance Abuse and Mental Health Data Archive	2,035	1,291	1,291	---
Common Data Platform	5,390	10,000	10,000	---
Grantee Data Development Technical Assistance	3,185	---	---	---
National Registry for Evidence Based Programs and Practices	2,542	3,505	3,505	---
Community Behavioral Health Data Initiative	4,500	8,750	8,750	---
Community Early Warning and Monitoring System (non-add)	*3,000*	*3,000*	*3,000*	---
SAMHSA's Emergency Department Surveillance System (non-add)	*1,500*	*4,500*	*4,500*	---
Program Studies on Treatment and Recovery (non-add)	---	*1,250*	*1,250*	---
Behavioral Health Workforce Data and Development	940	967	966	-1
Data Collection and Evaluation Activities	8,676	---	---	---
Innovation and Logistical Services Support	2,555	---	---	---
Content Management	3,084	---	---	---
Operations	5,982	4,169	4,056	-113
Payroll	10,219	14,120	14,234	+114
Total Program Activities	**$120,472**	**$119,548**	**$119,548**	**$---**

Authorizing Legislation .....Sections 501, 505, 1911, 1921 of the PHS Act
FY 2017 Authorization .....Expired
Allocation Method .....Contracts
Eligible Entities..... Not Applicable

Overview

This section provides a detail breakout of SAMHSA's surveillance efforts. It is not additive to the Health Surveillance and Program Support appropriation. However, this chapter helps highlight the important data collection, analysis and management activities that SAMHSA undertakes for the Department of Health and Human Services (HHS).

Program Description and Accomplishments

Collecting, analyzing and reporting health data are activities necessary for tracking and evaluating trends in all aspects of health, including behavioral health.[201] Data from large national surveys allow researchers, practitioners and leaders to assess the status and identify long-term trends in behavioral health. These data are also critical for evaluating the impact of federally funded programs.

The Center for Behavioral Health Statistics and Quality (CBHSQ) is the government's lead agency for behavioral health statistics. CBHSQ performs a variety of activities including surveillance and data collection; evaluation; statistical and analytic support; service systems research; and performance and quality information systems. In addition, CBHSQ is responsible

[201] Thacker, S.; Berkelman, R. Public health surveillance in the United States. Epidemiologic Reviews. 1988; 10:164-90.

for establishing baselines, tracking trends over time, and evaluating the impact of SAMHSA's behavioral health programs. By creating an integrated data strategy and a national framework for quality improvement in behavioral healthcare data, CBHSQ helps inform policy, measure program impacts, and lead efforts to improve quality of services and outcomes for individuals, families, communities, and tribal communities. CBHSQ's efforts improve accountability and transparency in the development and dissemination of information to support the behavioral healthcare delivery system.

Surveillance and Data Collection

SAMHSA manages a number of critical behavioral health data systems for the Department of Health and Human Services (HHS) that provide high quality data on the incidence and prevalence of mental and substance use disorders, the use of emergency and specialty care, and more recently, local indicators of behavioral health status of communities.

National Surveillance and Data Collection

The National Survey on Drug Use and Health (NSDUH) collects information under SAMHSA's legislative mandate[202] on the prevalence of substance use and mental disorders and related health conditions for the nation. The current NSDUH contract which will support annual surveys through FY 2017, and will be re-competed in FY 2017. CBHSQ is working to expand the scope of behavioral health data collection by developing definitions that take into account new mental disorder criteria specified in the Diagnostic and Statistical Manual, – Fifth Edition (DSM-5). Also, CBHSQ partnered with the Office of the Assistant Secretary for Planning and Evaluation and the Institute of Medicine for guidance on collection of data about other behavioral health issues (including trauma, recovery, serious emotional disturbance among children and adult disorders with impairment) through extramural data collection initiatives or possibly through NSDUH. In response to Congressional recommendations, CBHSQ is exploring the feasibility of conducting a NSDUH-like survey in Puerto Rico, the U.S. Virgin Islands, and other U.S. territories.

In future years, NSDUH will undergo a redesign to address the latest topics. Potential topics include but are not limited to electronic cigarettes, synthetic marijuana, alignment of treatment questions for substance use and mental health, revision of questions to align with DSM-5, adult disorders with functional impairment, serious emotional disturbance in children, trauma, and recovery.

In FY 2015, funding for NSDUH and NSDUH-related activities was $47.7 million. An additional $1.0 million from the Mental Health appropriation funded evaluation of mental health services. SAMHSA intends to continue $52.7 million in funding for the current FY 2016 NSDUH contract and a new contract in FY 2017.

Behavioral Health Services Information System (BHSIS)

Each year millions of Americans receive treatment for mental and substance use disorders. In order to improve the care provided to these clients and to broaden the availability of treatment

[202] See 42 U.S.C. 290aa-4.

options, SAMHSA and state and local governments need information about the nature and extent of the services being provided. BHSIS is the primary source of data on substance use and mental disorder treatment facilities and treatment admissions. In addition, people requiring mental and/or substance use disorder treatment need assistance finding resources to aid them in getting appropriate care. The BHSIS program includes the Behavioral Health Treatment Services Locator. The Services Locator is accessed more than two million times a year by individuals, families, community groups, and organizations to identify appropriate treatment services.

In FY 2015, CBHSQ continued to explore the potential for integrating buprenorphine providers and National Health Service Corps Facilities into the Treatment Services Locator. In addition, SAMHSA implemented a new coordinated strategy for conducting the substance use and mental health facility surveys in FY 2014. The base cost of BHSIS is $21.0 million in FY 2015, FY 2016 and FY 2017. Of this, $17.0 million is from Health Surveillance appropriation and $4.0 million is from Substance Abuse Treatment Block Grant appropriation. SAMHSA will fund basic BHSIS operations in FY 2017 at the same levels as FY 2015 and FY 2016. In addition, the Mental Health appropriation provides $7.5 million for a behavioral health services facility survey. This funding ensures a holistic approach to data collection related to behavioral health and allows for the inclusion of mental health services facility data in the BHSIS survey.

Community Behavioral Health Data Initiative (CDI)

SAMHSA uses data collected from local communities to design and deliver programs and services. These data are an important component of a strong public health infrastructure. Information on behavioral and physical health at the community level serves to identify current and emerging problems and highlight opportunities for progress that may vary from larger geographical areas. Importantly, when communities have access to surveillance data over time, communities can then direct targeted prevention efforts at the most vulnerable populations.

Under the Community Behavioral Health Data Initiative (CDI) structure, SAMHSA more closely coordinates three separate existing data efforts to create new opportunities for cross-agency and public-private partnerships to address critical public health questions and use more effectively existing or decreasing resources. The three separate existing data efforts are the Community Early Warning and Monitoring System (C-EMS), SAMHSA's Emergency Department Surveillance System (SEDSS), and the Program Studies on Treatment and Recovery (PSTAR). Data from this coordinated initiative can be augmented with data from other agencies, such as the Center for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), and then be reported by region and community type. Moreover, the longitudinal nature of these data will allow those evaluating the effectiveness of services and policies in a community to measure the impact and outcomes of those interventions.

In FY 2016, CBHSQ plans to initiate the next phase of this activity through an agreement with the Council of State and Territorial Epidemiologists (CSTE). CSTE is responsible for establishing national case definitions for most infectious diseases and is also working on mental health and substance use indicators with the intent of establishing a national surveillance system similar to the National Notifiable Diseases Surveillance System used by CDC. Working with CSTE on this activity enhances the probability of a successful launch of a community level surveillance system for mental health and substance use indicators.

In FY 2015, CDI's funding of $4.5 million supported the development and integration of the C-EMS and SEDSS data collection programs. In FY 2016 and FY 2017, funding for CDI is level at $8.8 million. This includes $3.0 million to support C-EMS, $4.5 million for SEDSS, which will support its development and hospital recruitment, and $1.3 million for PSTAR

Community Early Warning and Monitoring System (C-EMS)

The foundation of SAMHSA's community-based work, C-EMS, provided the basis for community data development in FY 2015. In collaboration with AHRQ, CBHSQ will further develop these data system of community-level data collection related to emergency departments. This expanded collaboration will engage additional federal partners including the Centers for Disease Control and Prevention /Office of State, Tribal, Local and Territorial Support, and bring in a new external partner, the CSTE, to apply data from resources at the local, state, and national levels to populate a database available to communities to develop data tables and reports for use in surveillance of local behavioral health status.

SAMHSA will consider developing data toolkits with survey measures and instructions in the use of these measures, as well as technical assistance in sampling and survey deployment, to assist communities interested in conducting local behavioral/public health surveillance. These data may be uploaded to a community behavioral health database that SAMHSA and contributing communities may use to understand community behavioral health needs and changes over time. SAMHSA provided $3.0 million in FY 2015 and plans to provide level funding through FY 2017 to expand the current efforts by including other community data resources to develop and collect community-level data.

SAMHSA's Emergency Department Surveillance System (SEDSS)

Emergency Department (ED) data remain an important component of public health data because they provide a picture of the most urgent behavioral and other health issues in the community. ED data are an excellent tool for monitoring trends in mental and substance use disorders and related conditions. When examined across the nation, they provide important surveillance for targeting emerging behavioral health issues. SAMHSA has authority to collect emergency department data.[203] SAMHSAs Emergency Department Surveillance System collects data from hospitals in a variety of communities and provides a summary of visits by patients with mental health conditions and substance use problems. This data is vital for understanding the nature and number of visits made to emergency departments in the United States for substance use and mental disorders.[204] By collaborating with the Centers for Disease Control's National Center for Health Statistics, SAMHSA has an opportunity to understand more comprehensively the nature and course of behavioral health presentations to emergency departments. To implement fully data collection efforts, SAMHSA provided $1.5 million in FY 2015, and intends to provide $4.5 million in FY 2016 and FY 2017. As SEDSS continues, SAMHSA will also consider other recruitment protocols to increase hospital participation.

[203] See 42 U.S.C. 290aa-4.

[204] Lucas A. Johnson, Rebecca L. Johnson, Ray-Bernard Portier, *Current "Legal Highs"*, The Journal of Emergency Medicine, Volume 44, Issue 6, June 2013, Pages 1108-1115, http://dx.doi.org/10.1016/j.jemermed.2012.09.147.

Program Studies on Treatment and Recovery (PSTAR)

The Affordable Care Act is changing how behavioral health services are financed and is increasing treatment for certain populations with mental and substance use disorders that had not previously been treated in primary care and behavioral health specialty programs (e.g., youth involved in the criminal justice system, and individuals with co-occurring mental health, substance use, and physical health conditions).

To analyze newly emerging trends and to understand the full impact of these changes in service delivery, CBHSQ is implementing the Program Studies on Treatment and Recovery (PSTAR). PSTAR will collect data on: 1) the organization and structure of care delivery; 2) the accessibility, availability, and continuity of care; 3) the quality and effectiveness of treatment; and 4) the financing and cost of behavioral health services.

In FY 2015, SAMHSA awarded a new contract, the Analytic Support Center, which includes support for a feasibility study to assess the best and most cost-effective ways to implement the PSTAR program. Of special interest is furthering an understanding of how local variations may affect special populations of interest (e.g., veterans, minorities, and individuals with co-occurring conditions).

It is expected that PSTAR will become a public health resource that works in concert with the other data initiatives under the CDI, other facility data systems, and ongoing analytic projects within CBHSQ to respond to critical questions related to health insurance coverage, parity, program effectiveness, financing, and access.

The results of a FY 2014 feasibility study of options for implementing the PSTAR survey indicated that the initiation of the project will be more incremental than originally envisioned. In FY 2016 and FY 2017, PSTAR funding is $1.3 million per year.

Evaluation

Consistent with the Administration's increased emphasis on the use of rigorous and independent program evaluation to determine if programs achieve intended outcomes at a reasonable cost, SAMHSA's evaluation efforts continue to support the systematic collection of data to assess its investments in discretionary and block grant programs. CBHSQ continues to conduct a review of all of SAMHSA's evaluation activities. This process helps SAMHSA identify evaluations that could benefit from in-house evaluation expertise. Since the implementation of SAMHSA's evaluation policy, for all new SAMHSA program evaluations, CBHSQ meets with program staff and the SAMHSA Evaluation Team to gather information about planned evaluation activities, program objectives, and budget estimates for evaluation. During this period, CBHSQ reviews the planned grant or contract language to ensure there is sufficient description of evaluation and data collection plans. CBHSQ's role in the evaluation activities varies and may include:
1) conducting an evaluation; 2) co-directing an evaluation using a contractor to gather data and assist with report writing; or 3) serving as a consultant as needed on evaluations that are directed by an originating center within SAMHSA. With these activities, CBHSQ is actively engaged in evaluation, design, and implementation.

During FY 2015, CBHSQ provided additional recommendations to implement fully the evaluation policy, develop its evaluation staff, and expand availability of information developed through evaluations for program use and public awareness of the impact of SAMHSA's program efforts.

In FY 2016 and FY 2017, CBHSQ will continue implementation of the evaluation guidance and begin to provide training in evaluation design to relevant SAMHSA staff, continue to convene the SET, and look for ways to collaborate within SAMHSA to establish more rigorous evaluation activity at the agency.

Statistical and Analytic Support

CBHSQ Analytic Support Center (ASC) conducts analytic and scientific research on behavioral health policy and practices.

The ongoing Substance Abuse and Mental Health Data Archive (SAMHDA) serves as SAMHSA's primary repository for public access data files. Funding for the new SAMHDA contract for FY 2016 and FY 2017 is $1.3 million per year. SAMHDA provides free access and on-line analytic tools to the public. Resources are also used to sustain a program for providing limited public access to files restricted for privacy or other reasons, serving to expand the use and application of data collected under SAMHSA's other surveys.

Funding also supports positions focused on analyzing and reporting on data collected within CBHSQ, the rest of SAMHSA, and HHS, as well as identifying and analyzing information from other data sets that may help inform the work of SAMHSA. SAMHSA employees also respond to requests for data and explanations of existing data points; prepare internal reports; support SAMHSA staff in the development of materials that require statistical information; and prepare short reports, data spotlights, and manuscripts for publication. These staff support data needs by serving on workgroups that require data analysis as part of their function and prepare data requests for departmental activities. Particularly important is the inclusion of the Health Economics and Financing Team that focuses on studies related to cost and financing trends as health care delivery models change. Some of these positions have been created by in-sourcing tasks that are most appropriately done by federal staff, are less expensive than contract staff, and/or are mission critical and thus improve SAMHSA's capacity to respond to data and information needs relevant to SAMHSA's mission.

The budget also includes authority for an estimated $1.5 million in user fees for extraordinary data and publication requests.

Services Systems Research

SAMHSA's practice-based service systems research program complements efforts in its sister agencies of the National Institutes of Health, the Agency for Healthcare Research and Quality, and Center for Disease Control and Prevention. This provides pilot data for full-scale research proposals to the National Institutes of Health or other practice settings in which to test models developed through these agencies' research efforts. The program focuses thematically on critical

gaps in knowledge about prevention, wellness, treatment, and recovery services for individuals, families, and communities at risk for or experiencing mental illnesses, substance use disorders, and related chronic conditions. Of particular interest to SAMHSA are issues of quality, cost, access to, and outcomes of behavioral health services both in the primary and specialty care service sectors. SAMHSA focuses significant attention on developing analyses that enhance understanding of the economic and cost implications of changes in health insurance access for behavioral health care within the larger SAMHSA analytic agenda coordinated through CBHSQ. A team of health economists and health services researchers focus on cost and finance studies related to behavioral health.

Performance and Quality Information Systems

SAMHSA requests continued funding for Performance and Quality Information Systems to address the need for uniform data collection and reporting system for SAMHSA management and staff. In FY 2015, funding to phase in the implementation of SAMHSA's Common Data Platform (CDP) was $5.0 million. In FY 2016 and FY 2017, SAMHSA will combine this funding with Grantee Data technical assistance (TA) funding for a total of $10.9 million. Funding will be used for this single common data platform, which will also include programmatic training and technical assistance, SAMHSA's Performance Accountability and Reporting System (SPARS), will provide a common data and reporting system for all SAMHSA discretionary grantees and allow for programmatic TA on use of the data to enhance grantee performance monitoring and improve quality of service delivery. These funds will provide a uniform data collection and reporting system for SAMHSA management and staff.

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online system that provides states, tribes, local governments, and communities with tools for identifying and implementing evidence-based mental health promotion, substance abuse prevention, and mental and substance use disorder treatment interventions. SAMHSA is implementing changes to NREPP to address enhanced rigor and highlight promising practices that are of a particular importance to vulnerable populations. These changes to the review process will bring NREPP into alignment with other government registries of evidence-based programs and practices.

Agency-Wide Initiatives

Behavioral Health Workforce Data and Development

As of June 2014, there were more than 4,000 Mental Health Professional Shortage Areas in the United States, which include nearly a third of the American population, or 96 million people. Recent data indicate that almost 90 percent of persons with substance use disorders do not

receive the services they need[205] and over half of those with any mental illness do not receive needed treatment.[206]

The President's *Now is the Time* initiative supports new activities to expand the behavioral health workforce. In FY 2015, new workforce investments provided support for approximately 3,500 new behavioral health professionals. To ensure the existing workforce investments would achieve desired outcomes, SAMHSA workforce activities in FY 2015 included $1.0 million to collaborate with HRSA on the Behavioral Health Minimum Data Set to develop consistent data collection methods to identify and track behavioral health workforce needs. In FY 2015, SAMHSA has worked with HRSA to develop a consistent and common data set and to develop clear goals and objectives to meet the national behavioral health workforce needs in America. SAMHSA intends to continue funding in FY 2016 and FY 2017 at the same level as FY 2015.

The FY 2017 Budget Request of $1.0 million for Behavioral Health Workforce Data and Development is level with the FY 2016 Enacted Budget. These funds will allow SAMHSA to continue collaborating with HRSA in order to focus analytical and research projects in three behavioral health workforce focus areas: 1) expanded application of standardized minimum data set with state and professional organizations; 2) workforce modeling and projections to understand what behavioral health services are being provided, by whom, and in what settings; and 3) development of certification/licensing/scope of practice framework for each state.

[205] 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.
[206] Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

(Dollars in millions)

Resource Summary	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Drug Resources by Decision Unit and Function			
Programs of Regional and National Significance			
Substance Abuse Prevention	$175.148	$211.148	$211.148
Substance Abuse Treatment	361.463	333.806	343.269
Total Programs of Regional and National Significance	536.611	544.954	554.417
State Targeted Response Cooperative Agreements (Mandatory)	---	---	460.000
Substance Abuse Prevention and Treatment Block Grant[1]			
Prevention	363.971	371.616	371.616
Treatment	1,455.885	1,486.463	1,486.463
Total, Substance Abuse Prevention and Treatment Block	1,819.856	1,858.079	1,858.079
Health Surveillance and Program Support[2,3]			
Prevention	20.841	21.828	22.849
Treatment	83.163	87.112	91.398
Total, Health Surveillance and Program Support	104.003	108.940	114.247
Total Funding	**$2,460.470**	**$2,511.973**	**$2,986.743**
Drug Resources Personnel Summary			
Total FTEs	421	448	460
Drug Resources as a Percent of Budget			
Total Agency Budget	$3,586.212	$3,731.436	$4,321.648
Drug Resources Percentage	68.6%	67.3%	69.1%

[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

[3] Totals are comparably adjusted in FY 2015 (-$35.0 million) and FY 2016 (-$50.0 million) to reflect the transfer of the Behavioral Health Workforce Expansion and Training program from SAMHSA to HRSA in FY 2017.

Drug Budget Split between Prevention and Treatment

(Dollars in thousands)

Substance Abuse Prevention	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Programs of Regional and National Significance (PRNS)			
Strategic Prevention Framework	$109,484	$119,484	$119,484
Strategic Prevention Framework Rx (non-add)	---	*10,000*	*10,000*
Budget Authority (non-add)	*109,484*	*119,484*	*109,484*
PHS Evaluation Funds (non-add)	---	---	*10,000*
Federal Drug-Free Workplace	4,894	4,894	4,894
Minority AIDS	41,205	41,205	41,205
Sober Truth on Preventing Underage Drinking	7,000	7,000	7,000
Fetal Alcohol Syndrome Disorder	1,000	---	---
Center for the Application of Prevention Technologies	7,493	7,493	7,493
Budget Authority (non-add)	*7,493*	*7,493*	*1,025*
PHS Evaluation Funds (non-add)	---	---	*6,468*
Science and Service Program Coordination	4,072	4,072	4,072
Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths	---	12,000	12,000
Tribal Behavioral Health Grants	---	15,000	15,000
Total, Substance Abuse Prevention PRNS	**175,148**	**211,148**	**211,148**
Substance Abuse Prevention and Treatment Block Grant[1]	363,971	371,616	371,616
PHS Evaluation Funds (non-add)	*15,840*	*15,840*	*15,840*
Total, Substance Abuse Prevention and Treatment Block Grant	**363,971**	**371,616**	**371,616**
Health Surveillance and Program Support[2,3,4]			
Health Surveillance	6,498	6,376	6,548
Prevention and Public Health Fund (non-add)	---	---	*2,470*
Budget Authority (non-add)	*2,314*	*2,271*	---
PHS Evaluation Funds (non-add)	*4,184*	*4,106*	*4,077*
Program Support	9,901	10,735	10,746
Public Awareness and Support	1,348	1,557	1,348
PHS Evaluation Funds (non-add)	---	---	*1,348*
Performance and Quality Information Systems	1,776	1,743	1,790
PHS Evaluation Funds (non-add)	---	---	*1,790*
Agency Wide Initiatives	1,167	1,267	2,267
PHS Evaluation Funds (non-add)	*100*	*100*	*100*
Data Request/Publication User Fees	150	150	150
Total, Health Surveillance and Program Support	**20,841**	**21,828**	**22,849**
Total, Substance Abuse Prevention	**$559,960**	**$604,592**	**$605,613**

[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%).

[3] The FY 2015 Final and FY 2016 Enacted levels for Agency-Wide Initiatives are comparably adjusted to the FY 2017 President's Budget. They show the Minority Fellowship Program (MFP) in the HSPS appropriation.

[4] Totals for Agency-Wide Initiatives in FY 2015 (-$35.0 million) and FY 2016 (-$50.0 million) are comparably adjusted to reflect the transfer of the Behavioral Health Workforce Expansion and Training program from SAMHSA to HRSA in FY 2017.

Drug Budget Split between Prevention and Treatment (Continued)

(Dollars in thousands)

Substance Abuse Treatment	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Programs of Regional and National Significance (PRNS)			
Opioid Treatment Programs/Regulatory Activities	$8,724	$8,724	$8,724
Prescription Drug and Opioid Medication-Assisted Treatment			
Screening, Brief Intervention and Referral to Treatment	46,889	46,889	30,000
Budget Authority (non-add)	*44,889*	*44,889*	---
PHS Evaluation Funds (non-add)	*2,000*	*2,000*	*30,000*
Target Capacity Expansion	23,223	36,303	61,303
Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (non-add)	*12,000*	*25,000*	*50,080*
Cohort Monitoring and Evaluation of Medication-Assisted Treatment Outcomes (Mandatory)	---	---	15,000
Buprenorphine-Prescribing Authority Demonstration	---	---	10,000
Pregnant & Postpartum Women	15,931	15,931	15,931
Strengthening Treatment Access and Retention	1,000		---
Recovery Community Services Program	2,434	2,434	2,434
Access to Recovery	38,223	---	---
Children and Family Programs	29,605	29,605	29,605
Treatment Systems for Homeless	41,386	41,304	36,386
Minority AIDS	65,570	65,570	58,859
Criminal Justice Activities	78,000	78,000	61,946
Addiction Technology Transfer Centers	9,046	9,046	8,081
Minority Fellowship Program	---	---	---
Crisis Systems	---	---	5,000
Special Initiatives/Outreach	1,432	---	---
Total, Substance Abuse Treatment PRNS	**361,463**	**333,806**	**343,269**
State Targeted Response Cooperative Agreements (Mandatory)	**---**	**---**	**460,000**
Substance Abuse Prevention and Treatment Block Grant[1]	1,455,885	1,486,463	1,486,463
PHS Evaluation Funds (non-add)	*63,360*	*63,360*	*63,360*
Total, Substance Abuse Prevention and Treatment Block Grant	**1,455,885**	**1,486,463**	**1,486,463**
Health Surveillance and Program Support[2,3,4]			
Health Surveillance	25,993	25,506	26,192
Prevention and Public Health Fund (non-add)	---	---	*9,882*
Budget Authority (non-add)	*13,464*	*13,464*	---
PHS Evaluation Funds (non-add)	*16,736*	*16,422*	*16,310*
Program Support	39,603	42,939	42,986
Public Awareness and Support	5,393	6,228	5,393
PHS Evaluation Funds (non-add)	---	---	*5,393*
Performance and Quality Information Systems	7,105	6,972	7,160
PHS Evaluation Funds (non-add)	---	---	*7,160*
Agency Wide Initiatives	4,668	5,068	9,068
PHS Evaluation Funds (non-add)	*400*	*400*	*400*
Data Request/Publication User Fees	600	600	600
Total, Health Surveillance and Program Support	**83,163**	**87,112**	**91,398**
Total, Substance Abuse Treatment	**$1,900,510**	**$1,907,382**	**$2,381,130**

[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%).

[3] The FY 2015 Final and FY 2016 Enacted levels for Agency-Wide Initiatives are comparably adjusted to the FY 2017 President's Budget. They show the Minority Fellowship Program (MFP) in the HSPS appropriation.

[4] Totals for Agency-Wide Initiatives in FY 2015 (-$35.0 million) and FY 2016 (-$50.0 million) are comparably adjusted to reflect the transfer of the Behavioral Health Workforce Expansion and Training program from SAMHSA to HRSA in FY 2017.

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 2017 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 Cooperative Agreements (Mandatory) funding.

Budget Summary
In FY 2017, SAMHSA requests a total of $3.0 billion for drug control activities, an increase of $472.0 million from the FY 2016 Enacted Level. The budget directs resources to activities that have demonstrated improved health outcomes and that increase service capacity. SAMHSA has three major drug-related decision units: Substance Abuse Prevention, Substance Abuse

Treatment, and Health Surveillance and Program Support. Each decision unit is discussed below:

Substance Abuse Prevention

Substance Abuse Prevention Programs of Regional and National Significance
Total FY 2017 Request: $211.1 million
(Reflects level funding from the FY 2016 Enacted Level)
The Substance Abuse Prevention Programs of Regional and National Significance (PRNS) support states and communities in carrying out an array of activities to improve the quality and availability of prevention services. The FY 2017 Budget Request for SAMHSA's Substance Abuse Prevention PRNS includes $211.1 million, which covers the eight programmatic activities described below.

Strategic Prevention Framework (PRNS non-add)
Total FY 2017 Request: $119.5 million
(Reflects level funding from the FY 2016 Enacted Level)
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 program goals include: reducing substance abuse-related problems; preventing the onset and reducing the progression of substance use disorders; strengthening prevention capacity and infrastructure at the state and community levels in support of prevention; and leveraging, redirecting, and realigning statewide funding streams for substance abuse prevention. Through the SPF program, SAMHSA will continue to address the nation's top emerging substance abuse priorities, such as prescription drugs, other opioids, underage drinking, marijuana, heroin, and intoxicative inhalants.

See page 159 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's Strategic Prevention Framework for Prescription Drugs (SPF Rx) will raise awareness about the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program will also focus on raising community awareness and bringing prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and their patients.

See page 161 in the CSAP chapter for the start of the full description of these efforts.

Budget Request
The FY 2017 Budget Request is $119.5 million with $109.5 million from Budget Authority and $10.0 million from Public Health Service (PHS) Evaluation Funds. This is level with the FY 2016 Enacted Level. Funding will support up to 20 grant continuations and nine state SPF Rx 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 2017, SAMHSA will also support the continuation of 70 Strategic Prevention Framework Partnership 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)
Total FY 2017 Request: $4.9 million
(Reflects level funding from the FY 2016 Enacted Level)
SAMHSA's activities related to the Federal Drug-Free Workplace support to 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 regulated industry; and 2) oversight of the National Laboratory Certification Program, which certifies laboratories to conduct forensic drug testing for federal agencies, federally regulated industries and the private sector.

See page 165 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request of $4.9 million is the same as the FY 2016 Enacted Level. In FY 2017, SAMHSA will continue oversight of the Executive Branch Agencies' Federal Drug-Free Workplace activities and the National Laboratory Certification Program.

Minority AIDS (PRNS non-add)
Total FY 2017 Request: $41.2 million
(Reflects level funding from the FY 2016 Enacted Level)
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 167 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request of $41.2 million is the same as the FY 2016 Enacted Level. SAMHSA will support up to 148 grant continuations and 70 new grants 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.

Sober Truth on Preventing Underage Drinking (PRNS non-add)
Total FY 2017 Request: $7.0 million
(Reflects level funding from the FY 2016 Enacted Level)
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 171 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request of $7.0 million is level with the FY 2016 Enacted Level. In 2017, SAMHSA will support 79 new STOP Act grants. This funding effort will continue and deepen SAMHSA's commitment to reduce and prevent underage drinking.

Centers for the Application of Prevention Technologies (PRNS non-add)
Total FY 2017 Request: $7.5 million
(Reflects level funding from the FY 2016 Enacted Level)
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. CAPT 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 176 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request of $7.5 million is the same as the FY 2016 Enacted Level. The program will provide technical assistance and training to over 7,500 individuals in the prevention field.

Science and Service Program Coordination (PRNS non-add)
Total FY 2017 Request: $4.1 million
(Reflects level funding from the FY 2016 Enacted Level)
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. These contracts support the Tribal Training and Technical Assistance (TTA) Center and the Underage Drinking Prevention Education Initiatives (UADPEI). The TTA Center provides comprehensive, broad, focused, and/or intensive training to communities seeking to address and prevent mental and substance use disorders, suicide, and promote mental health.

See pages 180 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request of $4.1 million is level with the FY 2016 Enacted Level. These funds will support SAMHSA's top strategic initiative, prevention of substance abuse and mental illness, which includes a focus on preventing underage drinking and on American Indians/Alaska Natives through the provision of technical assistance.

Tribal Behavioral Health Grants (PRNS non-add)
Total FY 2017 Request: $15.0 million
(Reflects level funding from the FY 2016 Enacted Level)
SAMHSA's Tribal Behavioral Health Grants focus on mental and substance use disorders and suicides among Native youth.

See page 181 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2017 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 2016 Enacted Level. 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.

Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths (PRNS non-add)
Total FY 2017 Request: $12.0 million
(Reflects level funding from the FY 2016 Enacted Level)
Opioid-related overdose is a significant contributor to accidental deaths among those who use, misuse, or abuse illicit and prescription opioids. 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 naloxone, 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 185 in the CSAP chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $12.0 million, the same as the FY 2016 Enacted Level. This funding will provide continuation grants to 10 states to reduce the number of opioid overdose-related deaths.

Substance Abuse Treatment

Substance Abuse Treatment Programs of Regional and National Significance
Total FY 2017 Request: $343.3 million
(Reflects $9.5 million increase from the FY 2016 Enacted Level)

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 2017 Budget Request for SAMHSA's Substance Abuse Treatment PRNS includes $343.3 million, which covers 17 programmatic activities, an increase of $9.5 million from the FY 2016 Enacted Level. Specific PRNS activities are described below.

Opioid Treatment Programs/Regulatory Activities (PRNS non-add)
FY 2017 Request: $8.7 million
(Reflects level funding from the FY 2016 Enacted Level)
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.

See page 197 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $8.7 million, the same as the FY 2016 Enacted Level. In FY 2017, SAMHSA proposes funding pilot regional medication-assisted treatment (MAT) Centers of Excellence in two HHS regions. The Centers of Excellence will provide community-specific training and technical assistance to support the delivery of quality services in areas of MAT expansion and facilitate program development through stakeholder collaboration. SAMHSA plans to continue PCSS-MAT to support professional development and expansion of a well-trained workforce, capable of delivering high quality MAT for all FDA approved medications, in a manner that complements the efforts of the MAT Centers of Excellence. In addition, SAMHSA intends to support technical assistance contracts including the Data Waiver Processing and Support contract.

Screening, Brief Intervention and Referral to Treatment (PRNS non-add)
FY 2017 Request: $30.0 million
(Reflects $16.9 million decrease from the FY 2016 Enacted Level)
The Screening, Brief Intervention and Referral to Treatment (SBIRT) program requires state grant recipients to implement the SBIRT model at all levels of primary care and medical facilities, including hospitals, trauma centers, Federally Qualified Health Centers, and other

relevant settings. Research and clinical experience support the use of SBIRT to intervene early with alcohol and other substance use disorders, which leads to early referral and treatment. The purpose of the SBIRT training grants is to develop primary care practices in order to enhance the delivery system that includes SBIRT as a part of standard medical practice. This program provides medical residents, students of dentistry, physician assistants, and pharmacists, nurses, social workers, counselors the opportunity to learn the elements of SBIRT and incorporate them as part of their permanent practice.

See page 200 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $30.0 million, a decrease of $16.9 million from the FY 2016 Enacted Level.

Targeted Capacity Expansion (PRNS non-add)
FY 2017 Request: $61.3 million
(Reflects $25.0 million increase from the FY 2016 Enacted Level)
The Targeted Capacity Expansion (TCE) program began in FY 1998 to help communities expand or enhance their ability to provide rapid, strategic, comprehensive, integrated, and community-based responses to a specific and well-documented substance abuse capacity problem. As part of these efforts, SAMHSA's *Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT PDOA)* seeks to expand or enhance MAT and other clinically appropriate services for persons with opioid use disorders.

See page 204 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request includes a total of $61.3 million, an increase of $25.0 million from the FY 2016 Enacted Level. This amount includes $50.1 million for the MAT PDOA grant program, an increase of $25.1 million from the FY 2016 Enacted Level. The $25.1 million increase will focus specifically on MAT expansion/enhancement efforts. The funding will enable SAMHSA to support 23 new MAT PDOA state grants at $1.0 million to expand or enhance MAT utilizing FDA-approved medications in combination with psychosocial services, recovery support services, and coordination/integration of HIV/hepatitis C direct services. The program will target states that demonstrated a dramatic increase in treatment admissions for opioid use disorders and that experienced the highest rates of treatment admissions for opioid use disorders.

Cohort Monitoring and Evaluation of MAT Outcomes (Mandatory; PRNS non-add)
FY 2017 Request: $30.0 million (FY 2017: $15.0 million, FY 2018: $15 million)
Public health and substance abuse treatment agencies will evaluate the short, medium, and long-term outcomes of substance abuse treatment programs in order to increase effectiveness reducing opioid use disorders, overdose, and death. This proposal would prospectively monitor the treatment outcomes of patients with opioid addiction entering medication-assisted treatment programs, providing valuable insight into the effectiveness of treatment programs employing different treatment modalities under real-world conditions and help identify opportunities to

improve treatment for patients with opioid addiction. Systematic information on the outcomes of patients who undergo medication-assisted treatment is currently lacking. Cohort monitoring is commonly used to monitor treatment of patients with infectious diseases, such as tuberculosis treatment, and drives accountability for patient outcomes; a similar approach could be useful to improving addiction treatment. This funding is part of the Administration's $1.0 billion initiative to address prescription drug abuse and heroin use.

See page 209 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $30.0 million in new mandatory funds. This includes $15.0 million in FY 2017 and $15.0 million in FY 2018 for a new program, Cohort Monitoring and Evaluation of Medication-Assisted Treatment Outcomes. These funds would evaluate the outcomes of substance abuse treatment programs. This effort intends to increase MAT effectiveness by reducing opioid use disorders, overdose, and death.

Buprenorphine-Prescribing Authority Demonstration (PRNS non-add)
FY 2017 Request: $10.0 million
(New program in FY 2017: Reflects $10.0 million increase from the FY 2016 Enacted Level)
Access to medication-assisted treatment is widely considered inadequate to meet the current need for the treatment of opioid use disorder.[207] The Food and Drug Administration has approved Buprenorphine, in various formulations, for the treatment of opioid use disorder. Its effectiveness in treating addiction and reducing mortality is well established. The Drug Addiction Treatment Act of 2000 (DATA 2000) excludes the prescription of buprenorphine by
advance practice nurses (APNs), physician assistants (PAs), and other non-physician advance practice providers authorized to prescribe controlled schedule III substances by the jurisdiction in which the practitioner is licensed.[208] To improve the public health response to the national crisis of opioid use disorder and overdose deaths, SAMHSA is proposing a services research demonstration program to determine the safety and effectiveness of alternative approaches to improving access to buprenorphine by allowing non-physician advance practice providers prescribing authority, in accordance with state law. In all cases, training will be provided to minimize risk of diversion.

See page 210 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request includes $10.0 million for a new program, Buprenorphine-Prescribing Authority Demonstration. SAMHSA intends to implement a services research demonstration project that will test the safety and effectiveness of allowing non- physician advance practice provider's buprenorphine prescribing authority, in accordance with

[207] 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.
[208] Health Resources and Services Administration (2015), Health of the Workforce. http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/chartbook

state law. SAMHSA will collaborate with professional organizations that represent APNs, PAs, and other non-physician advance practice providers as well as addiction psychiatrists and primary care physicians to determine the appropriate training and supervision requirements for advance practice providers in order to assure patient safety and well-being while minimizing diversion of buprenorphine.

Treatment Systems for Homeless (PRNS non-add)
FY 2017 Request: $36.4 million
(Reflects $4.9 million decrease from the FY 2016 Enacted Level)
SAMHSA's Treatment Systems for Homeless portfolio supports services, including short-term residential treatment and medication-assisted treatment, to those with substance use disorders or co-occurring substance use and mental disorders. These programs to address homelessness do not fund housing, but complement HUD's activities by supporting an array of integrated behavioral health treatment and recovery-oriented services and supports, including outreach, engagement, intensive case management, treatment for mental and/or substance use disorders, enrollment in mainstream benefits (Medicaid, SSI/SSDI, SNAP, etc.), and employment readiness services.

See page 223 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $36.4 million, a decrease of $4.9 million from the FY 2016 Enacted Level.

Minority AIDS – Treatment (PRNS non-add)
FY 2017 Request: $58.9 million
(Reflects $6.7 million decrease from FY 2016 Enacted Level)
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 228 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $58.9 million, a decrease of $6.7 million from the FY 2016 Enacted Level. This represents a shift in funding to the Mental Health appropriation. In FY 2017, this shift in funding will allow for the award of a new cohort of Minority AIDS Continuum of Care (CoC) grantees that will address the holistic behavioral health needs of those living with HIV. Three SAMHSA Centers will jointly administer the program. This funding will 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. SAMHSA also plans to fund 86 grant continuations and support three contracts for evaluation and technical assistance. SAMHSA will also award 57 new TCE-HIV grants. SAMHSA also

plans to award five new TCE-HIV: Minority Women grants. With these efforts, SAMHSA expects to serve 4,500 clients through the TCE-HIV: High Risk Population program and 3,000 clients in the TCE-HIV Minority Women program.

Criminal Justice Activities (PRNS non-add)
FY 2017 Request: $61.9 million
(Reflects $16.1 million decrease from the FY 2016 Enacted Level)
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 substance use disorders and/or co-occurring substance use and mental disorders. This includes Treatment Drug Courts and the Offender Re-Entry Programs.

See page 231 in the CSAT chapter for the start of the full description of this program.

Drug Court Activities
FY 2017 Request: $50.0 million
(Reflects level funding from the FY 2016 Enacted Level)
SAMHSA plans to support 91 Drug Court continuations grants, five contracts, and 63 Drug Court new grants. These programs will continue to provide comprehensive treatment and recovery support services for adolescents and adults with substance use disorders who come into contact with the criminal justice system, as well as offenders re-entering the community. SAMHSA proposes to use this program to explore promising new approaches and identify potential models for replication. The Criminal Justice Drug Court grant program will serve over 4,000 clients in FY 2017, equal to the number served by the FY 2016 cohort.

See page 231 in the CSAT chapter for the start of the full description of this program.

Ex-Offender Re-Entry Program
FY 2017 Request: $11.9 million
(Reflects $16.1 million decrease from the FY 2016 Enacted Level)
SAMHSA plans to support 27 Offender Reentry Program continuation grants and one contract. The Other Criminal Justice/ Offender Reentry Program will serve 2,000 clients in FY 2017.

See page 233 in the CSAT chapter for the start of the full description of this program.

Crisis Systems (PRNS non-add)
FY 2017 Request: $5.0 million
(Reflects $5.0 million increase from the FY 2016 Enacted Level)
Behavioral health crises are critical times for intervention and treatment and to engage individuals in on-going treatment and the pursuit of recovery. Such crises often cause great disruption for individuals and those around them, including family members, teachers, law enforcement, and employers. This program seeks to increase the engagement with and functioning of individuals in crisis, increased support for families and caregivers, decreased use of emergency room and inpatient care, and increased understanding by the community of behavioral health issues and those who experience a behavioral health crisis.

See page 238 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $10.0 million, an increase of $10.0 million from the FY 2016 Enacted Level. This includes $5.0 million from the Substance Abuse Treatment appropriation and $5.0 million from the Mental Health appropriation.

In FY 2017, SAMHSA plans to award three grants to states and communities to develop and/or adopt sustainable, comprehensive, and coordinated community-based crisis response systems for children, youth, and adults with mental health and/or addiction problems including those with SMI. This effort will support the integration and expansion of services to fill gaps and enhance coordination within the comprehensive continuum of the crisis response services, while minimizing the risk for re-traumatization of individuals and families served.

Other PRNS Treatment Programs (PRNS non-add)
FY 2017 Request: $56.1 million
(Reflects level funding from the FY 2016 Enacted Level)
The FY 2017 budget includes resources of $56.1 million for several other Treatment Capacity programs including: Pregnant and Postpartum Women; Recovery Community Services Program; Children and Families; and Addiction Technology Transfer Centers. The FY 2017 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 Cooperative Agreements (Mandatory)
FY 2017 Request: $920.0 million. (FY 2017: $460.0 million, FY 2018: $460.0 million)
The State Targeted Response Cooperative Agreements program will award grants to states based on their need and the strength of the strategies proposed to close the opioid use disorder treatment gap. Proposed strategies must be evidence-based and focused on the main factors preventing individuals from seeking and successfully completing treatment, and achieving recovery. This new effort would address commonly cited barriers to receiving treatment by reducing the cost of treatment, expanding access to treatment, engaging patients in treatment, and addressing stigmas associated with accessing treatment.

See page 253 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $920.0 million in new mandatory funds as; $460.0 million in FY 2017 and $460.0 million in FY 2018. This is part of the Administration's $1.0 billion Expanding Access to Treatment Initiative to address opioid misuse epidemic by helping all Americans who want treatment to access treatment and get the help they need. This new grant effort would address commonly cited barriers to receiving treatment by reducing the cost of

treatment, expanding access to treatment, engaging patients in treatment, and addressing stigmas associated with accessing treatment. This funding is part of the Administration's $1.0 billion two-year initiative to increase access to treatment for prescription drug abuse and heroin use.

Substance Abuse Prevention and Treatment Block Grant
FY 2017 Request: $1.9 billion
(Reflects level funding from the FY 2016 Enacted Level)
The Substance Abuse Prevention and Treatment Block Grant Program (SABG) 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 to plan, carry out, and evaluate substance abuse prevention, treatment and recovery support services provided for individuals, families, and communities impacted by substance abuse and substance use disorders.

See page 255 in the CSAT chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $1.9 billion and is level with the FY 2016 Enacted Level. Despite the wide-scale opportunity to obtain insurance coverage created by the Affordable Care Act, significant gaps in coverage, as well as the subsequent reliance on the public behavioral health safety net remain. The SABG helps address this gap. SABG funds will also continue to support certain services (e.g., recovery support efforts) 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 2017 Request is $114.2 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 2017 Request: $86.4 million
(Reflects $0.9 million increase from the FY 2016 Enacted Level)
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 269 in the HSPS chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $86.4 million, an increase of $0.9 million from the FY 2016 Enacted Level. 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 2017 Request: $6.7 million
(Reflects $1.0 million decrease from the FY 2016 Enacted Level)
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 275 in the HSPS chapter for the start of the full description of this program.

Budget Request
The FY 2017 request of $6.7 million will support the President's *Now is the Time* 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 2017 Request: $8.9 million
(Reflects a decrease of $.2 million from the FY 2016 Enacted Level)
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 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 281 in the HSPS chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $8.9 million, a decrease of $.2 million from the FY 2016 Enacted Level. SAMHSA will use these funds for system development, training and TA to support operations, NREPP, and SPARS.

Agency-Wide Initiatives
FY 2017 Request: $11.3 million
(Reflects $5.0 million increase from the FY 2016 Enacted Level)
Agency-Wide Initiatives provides funding for across Agency initiatives such as Minority Fellowship Program which improves the quality of mental health and substance abuse prevention and treatment delivered to ethnic minorities by providing stipends to post-graduate students and other Behavioral Health Workforce programs. 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.

Behavioral Health Workforce

Minority Fellowship Program
As SAMHSA implements the *Leading Change 2.0* Strategic Initiatives for 2015-2018, the new Strategic Initiative on Workforce Development provides the opportunity for a concerted focus on developing the behavioral health workforce. To increase the visibility of this issue and to manage and administer workforce programs more efficiently, SAMHSA is realigning the Minority Fellowship Program (MFP) to Agency-Wide Initiatives.

See page 285 in the HSPS chapter for the start of the full description of this program.

Peer Professional Workforce Development
The Peer Professional Workforce Development program's goal is to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-masters-level addiction counselors working with youth ages 16 to 25.

See page 287 in the HSPS chapter for the start of the full description of this program.

Behavioral Health Workforce Data and Development
As a result of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act, more than 60 million Americans have received first-time or expanded access to coverage for services for mental and substance use disorders.

See page 288 in the HSPS chapter for the start of the full description of this program.

Budget Request
The FY 2017 Budget Request is $11.3 million, an increase of $5.0 million from the FY 2016 Enacted Level. This funding will continue support for the Minority Fellowship Program. The request also includes an increase for a new program entitled Peer Professional Workforce Development, which will award up to 19 grants to provide tuition support and further the

capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs.

Data Request and Publication User Fees
FY 2017 Request: $0.8 million
(Reflects level funding from the FY 2016 Enacted Level)
The FY 2017 Budget Request is $0.8 million and is equal to the FY 2016 Enacted Level. 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.

SAMHSA
Prevention and Public Health Fund
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Prevention and Public Health Fund
Summary of the Request

(Dollars in thousands)

Prevention and Public Health Fund	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
GLS - Youth Suicide Prevention-States	$12,000	$12,000	$10,000	-$2,000
Health Surveillance	---	---	17,830	+17,830
Total, Prevention and Public Health Fund	**$12,000**	**$12,000**	**$27,830**	**+$15,830**

Budget Request

The FY 2017 Budget Request for the Prevention and Public Health Fund is $27.8 million, an increase of $15.8 million from the FY 2016 Enacted Level. The FY 2017 Prevention and Public Health Fund request includes the following:

- $10.0 million for Suicide Prevention, and
- $17.8 million for Health Surveillance

Suicide Prevention: GLS Youth Suicide Prevention-States

Program Description and Accomplishments

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. These grants develop and implement youth suicide prevention and early intervention strategies involving public-private collaboration among youth-serving institutions.

For a complete description of the GLS Youth Suicide Prevention-States program, see page 91.

Funding History

Fiscal Year	Total Amount	PPHF Funds
FY 2013	$32,448,000	---
FY 2014	$35,427,000	$5,800,000
FY 2015	$35,427,000	$12,000,000
FY 2016	$35,427,000	$12,000,000
FY 2017	$35,427,000	$10,000,000

Budget Request

The FY 2017 Budget Request is $35.4 million and is the same as the FY 2016 Enacted Level. This includes $25.4 million from Budget Authority and $10.0 million from the Prevention and Public Health Fund. This is a $2.0 million decrease in Prevention and Public Health Funds relative to FY 2016 Enacted Level. SAMHSA requests funding 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.

Health Surveillance

Program Description and Accomplishments

The Health Surveillance budget supports many of the critical behavioral health data systems, national surveys, and surveillance activities for Health and Human Services undertaken by SAMHSA to support SAMHSA grantees, the field, and the public.

For a complete description of the programs supported by Health Surveillance budget, see page 269.

Funding History

Fiscal Year	Total Amount	PPHF Funds
FY 2013	$45,421,000	$14,733,000
FY 2014	$47,258,000	---
FY 2015	$47,258,000	---
FY 2016	$47,258,000	---
FY 2017	$47,258,000	$17,830,000

Budget Request

The FY 2017 Budget Request is $47.3 million. This is the same as the FY 2016 Enacted Level. This includes $29.4 million from PHS Evaluation Funds and $17.8 million from Prevention and Public Health Funds. This funding will support the continuation of the National Survey on Drug Use and Health, National Registry of Evidence-based Programs and Practices, Behavioral Health Services Information System, Community Early Warning and Monitoring System, and the Analytic Support Center contracts.

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SAMHSA
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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[1,2,3,4,5]	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel compensation:				
Full-time permanent (11.1).....	$46,871	$51,338	$52,159	+$821
Other than full-time permanent (11.3).....	2,449	2,649	2,692	+42
Other personnel compensation (11.5).....	568	626	636	+10
Military personnel (11.7).....	3,667	4,347	4,417	+70
Special personnel services payments (11.8).....	230	---	---	---
Subtotal personnel compensation:	**53,786**	**58,960**	**59,904**	**+943**
Civilian benefits (12.1).....	14,882	16,264	16,752	+488
Military benefits (12.2).....	1,898	2,252	2,320	+68
Subtotal Pay Costs:	**70,566**	**77,477**	**78,976**	**+1,499**
Travel and transportation of persons (21.0).....	1,223	1,130	628	-502
Transportation of things (22.0).....	15	35	16	-19
Rental payments to GSA (23.1).....	9,765	9,824	6,116	-3,708
Rental payments to Others (23.2).....	---	217	---	-217
Communication, utilities, and misc. charges (23.3).....	523	496	521	+25
Printing and reproduction (24.0).....	2,029	1,678	1,497	-181
Other Contractual Services:				
Advisory and assistance services (25.1).....	29,337	37,750	50,205	+12,455
Other services (25.2).....	167,398	171,667	142,902	-28,765
Purchase of Goods & Svcs. from Govt. Accts (25.3)...	32,366	34,516	28,935	-5,580
Operation and maintenance of facilities (25.4).....	1,650	1,568	1,493	-75
Research and Development Contracts (25.5).....	---	---	---	---
Operation and maintenance of equipment (25.7).....	142	220	174	-46
Subtotal Other Contractual Services:	**230,893**	**245,720**	**223,708**	**-22,012**
Supplies and materials (26.0).....	2,305	679	296	-384
Equipment (31.0).....	434	393	278	-115
Grants, subsidies, and contributions (41.0).....	3,133,292	3,258,621	3,794,578	+535,957
Interest and dividends (43.0).....	---	---	---	---
Subtotal Non-Pay Costs	**3,380,479**	**3,518,792**	**4,027,637**	**+508,845**
Total Direct Obligations	**$3,451,045**	**$3,596,269**	**$4,106,613**	**+$510,344**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds and Mandatory Funds.

[3] Does not include user fees.

[4] 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.

[5] 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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel compensation:				
Full-time permanent (11.1).....	$784	$970	$986	+$16
Other than full-time permanent (11.3).....	85	106	107	+2
Other personnel compensation (11.5).....	6	8	8	---
Military personnel (11.7).....	---	---	---	---
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	**875**	**1,083**	**1,101**	**+17**
Civilian benefits (12.1).....	272	337	347	+10
Military benefits (12.2).....	---	---	---	---
Subtotal Pay Costs:	**1,147**	**1,421**	**1,448**	**+27**
Travel and transportation of persons (21.0).....	56	176	177	+1
Transportation of things (22.0).....	---	---	---	---
Rental payments to GSA (23.1).....	2,732	1,135	220	-916
Rental payments to Others (23.2).....	---	82	---	-82
Communication, utilities, and misc. charges (23.3).....	---	188	204	+16
Printing and reproduction (24.0).....	165	297	299	+2
Other Contractual Services:				
Advisory and assistance services (25.1).....	14,006	18,051	18,166	+115
Other services (25.2).....	56,405	60,190	60,572	+382
Purchase of Goods & Svcs. from Govt. Accts (25.3)...	14,000	16,437	16,542	+104
Operation and maintenance of facilities (25.4).....	---	770	775	+5
Research and Development Contracts (25.5).....	---	---	---	---
Operation and maintenance of equipment (25.7).....	2	10	10	---
Subtotal Other Contractual Services:	**84,413**	**95,458**	**96,064**	**+606**
Supplies and materials (26.0).....	---	---	---	---
Equipment (31.0).....	103	106	107	+1
Grants, subsidies, and contributions (41.0).....	961,261	1,039,026	1,144,209	+105,183
Interest and dividends (43.0).....	---	---	---	---
Subtotal Non-Pay Costs	**1,048,730**	**1,136,468**	**1,241,279**	**+104,811**
Total Direct Obligations	**$1,049,877**	**$1,137,889**	**$1,242,727**	**+$104,838**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds and Mandatory 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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
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	4	-1
Rental payments to GSA (23.1)	1,281	416	81	-335
Rental payments to Others (23.2)	---	30	---	-30
Communication, utilities, and misc. charges (23.3)	4	69	75	+6
Printing and reproduction (24.0)	478	457	367	-90
Other Contractual Services:				
Advisory and assistance services (25.1)	4,380	4,366	3,505	-862
Other services (25.2)	32,814	33,535	26,916	-6,619
Purchase of Goods & Svcs. from Govt. Accts (25.3)	1,580	2,925	2,348	-577
Operation and maintenance of facilities (25.4)	10	69	55	-14
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	---	146	117	-29
Subtotal Other Contractual Services:	**38,784**	**41,042**	**32,941**	**-8,101**
Supplies and materials (26.0)	---	4	3	-1
Equipment (31.0)	---	140	113	-28
Grants, subsidies, and contributions (41.0)	134,600	168,985	161,096	-7,889
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**175,148**	**211,148**	**194,680**	**-16,468**
Total Direct Obligations	**$175,148**	**$211,148**	**$194,680**	**-$16,468**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds and Mandatory 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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel compensation:				
Full-time permanent (11.1).....	$2,839	$2,479	$2,519	+$40
Other than full-time permanent (11.3).....	315	275	280	+4
Other personnel compensation (11.5).....	16	14	15	+1
Military personnel (11.7).....	129	130	132	+2
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	**3,299**	**2,899**	**2,945**	**+46**
Civilian benefits (12.1).....	1,005	877	904	+26
Military benefits (12.2).....	51	52	54	+2
Subtotal Pay Costs:	**4,355**	**3,828**	**3,903**	**+74**
Travel and transportation of persons (21.0).....	158	134	130	-4
Transportation of things (22.0).....	2	---	---	---
Rental payments to GSA (23.1).....	3,827	1,007	191	-816
Rental payments to Others (23.2).....	---	73	---	-73
Communication, utilities, and misc. charges (23.3).....	519	167	178	+11
Printing and reproduction (24.0).....	1,302	814	788	-26
Other Contractual Services:				
Advisory and assistance services (25.1).....	9,050	13,569	28,137	+14,568
Other services (25.2).....	41,539	42,645	41,289	-1,356
Purchase of Goods & Svcs. from Govt. Accts (25.3)...	8,845	7,127	6,901	-227
Operation and maintenance of facilities (25.4).....	1,617	654	634	-21
Research and Development Contracts (25.5).....	---	---	---	---
Operation and maintenance of equipment (25.7).....	140	37	36	-1
Subtotal Other Contractual Services:	**61,191**	**64,034**	**76,997**	**+12,964**
Supplies and materials (26.0).....	161	49	47	-2
Equipment (31.0).....	230	2	2	---
Grants, subsidies, and contributions (41.0).....	2,028,374	2,040,578	2,469,913	+429,335
Interest and dividends (43.0).....	---	---	---	---
Subtotal Non-Pay Costs	**2,095,764**	**2,106,857**	**2,548,245**	**+441,389**
Total Direct Obligations	**$2,100,119**	**$2,110,685**	**$2,552,148**	**+$441,463**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds and Mandatory 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[1,2,3,4,5]	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel compensation:				
Full-time permanent (11.1)	$43,248	$47,888	$48,655	+$766
Other than full-time permanent (11.3)	2,049	2,269	2,305	+36
Other personnel compensation (11.5)	545	604	614	+10
Military personnel (11.7)	3,539	4,217	4,285	+67
Special personnel services payments (11.8)	230	---	---	---
Subtotal personnel compensation:	**49,611**	**54,978**	**55,858**	**+880**
Civilian benefits (12.1)	13,606	15,050	15,501	+451
Military benefits (12.2)	1,846	2,200	2,266	+66
Subtotal Pay Costs:	**65,063**	**72,228**	**73,625**	**+1,397**
Travel and transportation of persons (21.0)	1,009	820	321	-499
Transportation of things (22.0)	14	30	12	-18
Rental payments to GSA (23.1)	1,924	7,266	5,625	-1,641
Rental payments to Others (23.2)	---	32	---	-32
Communication, utilities, and misc. charges (23.3)	---	72	63	-9
Printing and reproduction (24.0)	85	110	43	-67
Other Contractual Services:				
Advisory and assistance services (25.1)	1,900	1,764	397	-1,367
Other services (25.2)	36,641	35,297	14,125	-21,172
Purchase of Goods & Svcs. from Govt. Accts (25.3)	7,941	8,025	3,145	-4,881
Operation and maintenance of facilities (25.4)	23	75	29	-45
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	---	26	10	-16
Subtotal Other Contractual Services:	**46,505**	**45,187**	**17,707**	**-27,480**
Supplies and materials (26.0)	2,144	627	246	-381
Equipment (31.0)	101	145	57	-88
Grants, subsidies, and contributions (41.0)	9,057	10,031	19,360	+9,329
Interest and dividends (43.0)	---	---	---	---
Subtotal Non-Pay Costs	**60,838**	**64,319**	**43,433**	**-20,886**
Total Direct Obligations	**$125,901**	**$136,547**	**$117,058**	**-$19,489**

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds and Mandatory Funds.

[3] Does not include user fees.

[4] 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.

[5] 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
Total PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation Funds	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel Compensation:				
Full Time Permanent (11.1).....	$8,128	$9,385	$9,535	+$150
Other than Full-Time Permanent (11.3).....	537	322	607	+285
Other Personnel Compensation (11.5).....	94	67	111	+44
Military Personnel Compensation (11.7).....	948	774	787	+12
Special personnel services payments (11.8).....	143	---	---	---
Subtotal Personnel Compensation:	**9,850**	**10,548**	**11,040**	**+491**
Civilian Personnel Benefits (12.1).....	2,599	2,994	3,084	+90
Military Personnel Benefits (12.2)	514	419	432	+13
Subtotal Pay Costs:	**12,963**	**13,961**	**14,555**	**+594**
Travel (21.0).....	73	51	568	+517
Transportation of things (22.0).....	10	---	---	---
Rental payments to GSA (23.1).....	360	---	---	---
Communications, Utilities and Misc. Charges (23.3)...	100	---	---	---
Printing and Reproduction (24.0).....	416	391	394	+4
Other Contractual Services:				
Advisory and assistance services (25.1).....	---	---	1,300	+1,300
Other services (25.2).....	113,775	113,426	143,988	+30,562
Purchase of Goods & Svcs. from Govt. Accts (25.3)...	3,102	5,796	8,791	+2,996
Operation and maintenance of equipment (25.7).....	7	5	9	+4
**Subtotal Other Contractual Services:..... **	**116,884**	**119,227**	**154,089**	**+34,862**
Supplies and Materials (26.0).....	7	8	8	+1
Equipment (31.0).....	40	29	56	+26
Grants, Subsidies, and Contributions (41.0).....	2,815	---	43,865	+43,865
Subtotal Non-Pay Costs	**120,704**	**119,706**	**198,980**	**+79,274**
Total Reimbursable Obligations	**$133,667**	**$133,667**	**$213,535**	**+$79,868**

Substance Abuse and Mental Health Services Administration
Mental Health Services
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel compensation:				
Full-time permanent (11.1)	$1,585	$1,720	$1,748	+$28
Other than full-time permanent (11.3)	2	2	2	---
Other personnel compensation (11.5)	14	15	16	+1
Military personnel (11.7)	295	199	202	+3
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	**1,895**	**1,936**	**1,967**	**+31**
Civilian benefits (12.1)	482	523	539	+16
Military benefits (12.2)	161	109	112	+3
Subtotal Pay Costs:	**2,538**	**2,568**	**2,618**	**+50**
Travel and transportation of persons (21.0)	16	38	41	+4
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	31	+3
Other Contractual Services:				
Advisory and assistance services (25.1)	---	---	---	---
Other services (25.2)	18,457	18,398	20,195	+1,797
Purchase of Goods & Svcs. from Govt. Accts (25.3)	---	---	---	---
Operation and maintenance of equipment (25.7)	---	---	---	---
Subtotal Other Contractual Services:	**18,457**	**18,398**	**20,195**	**+1,797**
Supplies and materials (26.0)	6	8	8	+1
Equipment (31.0)	---	---	---	---
Grants, subsidies, and contributions (41.0)	---	---	8,146	+8,146
Subtotal Non-Pay Costs	**18,501**	**18,471**	**28,421**	**+9,950**
Total Reimbursable Obligations	**$21,039**	**$21,039**	**$31,039**	**+$10,000**

Substance Abuse and Mental Health Services Administration
Substance Abuse Prevention
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel compensation: Full-time permanent (11.1).....	$---	$---	$---	$---
Other than full-time permanent (11.3).....	---	---	---	---
Other personnel compensation (11.5).....	---	---	---	---
Military personnel (11.7).....	---	---	---	---
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	---	---	---	---
Civilian benefits (12.1).....	---	---	---	---
Military benefits (12.2).....	---	---	---	---
Subtotal Pay Costs:	---	---	---	---
Travel and transportation of persons (21.0).....	---	---	---	---
Transportation of things (22.0).....	---	---	---	---
Rental payments to GSA (23.1).....	---	---	---	---
Communication, utilities, and misc. charges (23.3).....	---	---	---	---
Printing and reproduction (24.0).....	---	---	---	---
Other Contractual Services: Advisory and assistance services (25.1).....	---	---	8,423	+8,423
Other services (25.2).....	---	---	---	---
Purchase of Goods & Svcs. from Govt. Accts (25.3)...	---	---	---	---
Operation and maintenance of equipment (25.7).....	---	---	**8,423**	**+8,423**
Subtotal Other Contractual Services:	---	---	---	---
Supplies and materials (26.0)	---	---	---	---
Equipment (31.0)	---	---	8,045	+8,045
Subtotal Non-Pay Costs	---	---	**16,468**	**+16,468**
Total Reimbursable Obligations	**$---**	**$---**	**$16,468**	**+$16,468**

Substance Abuse and Mental Health Services Administration
Substance Abuse Treatment
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class - PHS Evaluation	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel compensation:				
Full-time permanent (11.1).....	$3,461	$4,383	$4,453	+$70
Other than full-time permanent (11.3).....	127	161	164	+3
Other personnel compensation (11.5).....	41	52	53	+1
Military personnel (11.7).....	227	230	233	+4
Special personnel services payments (11.8)	143	---	---	---
Subtotal personnel compensation:	**3,999**	**4,825**	**4,903**	**+77**
Civilian benefits (12.1).....	1,073	1,359	1,400	+41
Military benefits (12.2).....	121	122	126	+4
Subtotal Pay Costs:	**5,193**	**6,307**	**6,428**	**+122**
Travel and transportation of persons (21.0).....	9	---	---	---
Transportation of things (22.0).....	10	---	---	---
Rental payments to GSA (23.1).....	---	---	---	---
Communication, utilities, and misc. charges (23.3)....	---	---	---	---
Printing and reproduction (24.0).....	393	363	364	+1
Other Contractual Services:				
Advisory and assistance services (25.1).....	---	---	---	---
Other services (25.2).....	72,625	71,883	72,079	+196
Purchase of Goods & Svcs. from Govt. Accts (25.3).	1,798	2,644	2,651	+7
Operation and maintenance of equipment (25.7).....	7	2	2	+
Subtotal Other Contractual Services:	**74,430**	**74,529**	**74,732**	**+203**
Supplies and materials (26.0).....	---	---	---	---
Equipment (31.0).....	3	2	2	---
Grants, subsidies, and contributions (41.0).....	1,162	---	27,674	+27,674
Subtotal Non-Pay Costs	**76,007**	**74,893**	**102,772**	**+27,878**
Total Reimbursable Obligations	**$81,200**	**$81,200**	**$109,200**	**+$28,000**

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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel compensation:				
Full-time permanent (11.1)	$3,082	$3,282	$3,334	+$53
Other than full-time permanent (11.3)	408	159	441	+282
Other personnel compensation (11.5)	39	---	43	+43
Military personnel (11.7)	427	346	351	+6
Special personnel services payments (11.8)	---	---	---	---
Subtotal personnel compensation:	**3,956**	**3,787**	**4,170**	**+383**
Civilian benefits (12.1)	1,044	1,112	1,145	+33
Military benefits (12.2)	232	188	193	+6
Subtotal Pay Costs:	**5,232**	**5,086**	**5,508**	**+422**
Travel and transportation of persons (21.0)	48	14	526	+513
Transportation of things (22.0)	---	---	---	---
Rental payments to GSA (23.1)	360	---	---	---
Communication, utilities, and misc. charges (23.3)	100	---	---	---
Printing and reproduction (24.0)	---	---	---	---
Other Contractual Services:				
Advisory and assistance services (25.1)	---	---	1,300	+1,300
Other services (25.2)	22,693	23,145	43,291	+20,147
Purchase of Goods & Svcs. from Govt. Accts (25.3)	1,304	3,152	6,140	+2,989
Operation and maintenance of equipment (25.7)	---	4	8	+4
Subtotal Other Contractual Services:	**23,997**	**26,300**	**50,739**	**+24,439**
Supplies and materials (26.0)	1	---	---	---
Equipment (31.0)	37	28	54	+26
Grants, subsidies, and contributions (41.0)	1,653	---	---	---
Subtotal Non-Pay Costs	**26,196**	**26,342**	**51,320**	**+24,978**
Total Reimbursable Obligations	**$31,428**	**$31,428**	**$56,828**	**+$25,400**

Substance Abuse and Mental Health Services Administration
Salaries and Expenses Tables
Direct Budget Authority – Object Class

(Dollars in thousands)

Object Class - Direct Budget Authority[1,2,3,4,5]	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Personnel compensation:				
Full-time permanent (11.1)	$46,871	$51,338	$52,159	+$821
Other than full-time permanent (11.3)	2,449	2,649	2,692	+42
Other personnel compensation (11.5)	568	626	636	+10
Military personnel (11.7)	3,667	4,347	4,417	+70
Special personnel services payments (11.8)	230	---	---	---
Subtotal personnel compensation	**53,786**	**58,960**	**59,904**	**+943**
Civilian benefits (12.1)	14,882	16,264	16,752	+488
Military benefits (12.2)	1,898	2,252	2,320	+68
Subtotal Pay Costs:	**70,566**	**77,477**	**78,976**	**+1,499**
Travel (21.0)	1,223	1,130	628	-502
Transportation of things (22.0)	15	35	16	-19
Rental payments to Others (23.2)	---	217	---	-217
Communication, utilities, and misc. charges (23.3)	523	496	521	+25
Printing and reproduction (24.0)	2,029	1,678	1,497	-181
Other Contractual Services:				
Advisory and assistance services (25.1)	29,337	37,750	50,205	+12,455
Other services (25.2)	167,398	171,667	142,902	-28,765
Purchase of Goods & Svcs. from Govt. Accts (25.3)	32,366	34,516	28,935	-5,580
Operation and maintenance of facilities (25.4)	1,650	1,568	1,493	-75
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	142	220	174	-46
Subtotal Other Contractual Services:	**230,893**	**245,720**	**223,708**	**-22,012**
Supplies and materials (26.0)	2,305	679	296	-384
Subtotal Non-Pay Costs	**236,988**	**249,954**	**226,665**	**-23,289**
Total Salary and Expenses	**307,554**	**327,431**	**305,641**	**-21,790**
Rental Payments to GSA (23.1)	9,765	9,824	6,116	-3,708
Grand Total, Salaries & Expenses and Rent	**$317,319**	**$337,255**	**$311,757**	**-$25,498**
Direct FTE	492	535	535	---

[1] Does not include PHS EVAL Funds.

[2] Includes Prevention and Public Health Funds and Mandatory Funds.

[3] Does not include user fees.

[4] 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.

[5] 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
Salaries and Expenses Tables
PHS Evaluation Funds – Object Class

(Dollars in thousands)

Object Class[1]	FY2015 Final	FY2016 Enacted	FY2017 President's Budget	FY2017 +/- FY2016
Personnel compensation:				
Full-time permanent (11.1)	$8,128	$9,385	$9,535	+$150
Other than full-time permanent (11.3)	537	322	607	+285
Other personnel compensation (11.5)	94	67	111	+44
Military personnel (11.7)	948	774	787	+12
Special personnel services payments (11.8)	143	---	---	---
Subtotal personnel compensation	**9,850**	**10,548**	**11,040**	**+491**
Civilian benefits (12.1)	2,599	2,994	3,084	+90
Military benefits (12.2)	514	419	432	+13
Subtotal Pay Costs:	**12,963**	**13,961**	**14,555**	**+594**
Travel (21.0)	73	51	568	+517
Transportation of things (22.0)	10	---	---	---
Rental payments to Others (23.2)	---	---	---	---
Communication, utilities, and misc. charges (23.3)	100	---	---	---
Printing and reproduction (24.0)	416	391	394	+4
Other Contractual Services:				
Advisory and assistance services (25.1)	---	---	1,300	+1,300
Other services (25.2)	113,775	113,426	143,988	+30,562
Purch. Goods & Svcs. Govt. Accts (25.3)	3,102	5,796	8,791	+2,996
Operation and maintenance of facilities (25.4)	---	---	---	---
Research and Development Contracts (25.5)	---	---	---	---
Operation and maintenance of equipment (25.7)	7	5	9	+4
Subtotal Other Contractual Services:	**116,884**	**119,227**	**154,089**	**+34,862**
Supplies and materials (26.0)	7	8	8	+1
Subtotal Non-Pay Costs	**117,489**	**119,676**	**155,059**	**+35,383**
Total Salary and Expenses	**130,452**	**133,638**	**169,614**	**+35,976**
Rental Payments to GSA (23.1)	360	---	---	---
Grand Total, Salaries & Expenses and Rent	**$130,813**	**$133,638**	**$169,614**	**+$35,976**
Reimbursable FTE[1]	92	100	100	---

[1] Does not include Other reimbursable FTEs (30) and associated Object Class Cost.

Detail of Full Time Equivalent Employee (FTE)

	FY 2015 Actual Civilian	FY 2015 Actual Military	FY 2015 Actual Total	FY 2016 Est. Civilian	FY 2016 Est. Military	FY2016 Est. Total	FY 2017 Est. Civilian	FY 2017 Est. Military	FY2017 Est. Total
Health Surveillance and Program Support...									
Direct:.....	419	34	453	458	40	498	458	40	498
Reimbursable:.....	39	9	48	41	7	48	41	7	48
Total:.....	458	43	501	499	47	546	499	47	546
Mental Health Services.....									
Direct:.....	9	0	9	11	0	11	11	0	11
Reimbursable:.....	18	4	22	19	3	22	19	3	22
Total:.....	27	4	31	30	3	33	30	3	33
Substance Abuse Prevention.....									
Direct:.....	0	0	0	0	0	0	0	0	0
Reimbursable:.....	16	2	18	17	3	20	17	3	20
Total:.....	16	2	18	17	3	20	17	3	20
Substance Abuse Treatment.....									
Direct:.....	29	1	30	25	1	26	25	1	26
Reimbursable:.....	31	3	34	37	3	40	37	3	40
Total:.....	60	4	64	62	4	66	62	4	66
OPDIV FTETotal.....	**561**	**53**	**614**	**608**	**57**	**665**	**608**	**57**	**665**

Detail of Positions

	FY 2015 Final	FY 2016 Enacted	FY 2017 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	16	18
Subtotal	13	16	18
Total, SES salaries	**$2,894,871**	**$3,609,236**	**$4,125,357**
GM/GS-15/EE	72	74	74
GM/GS-14	128	125	125
GM/GS-13	208	227	227
GS-12	52	69	69
GS-11	20	20	21
GS-10	1	3	3
GS-09	11	14	14
GS-08	22	22	21
GS-07	20	19	17
GS-06	10	14	14
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	548	591	589
Total, GS salaries	**$56,965,048**	**$62,649,324**	**$63,767,618**
CC-08/09	1	1	1
CC-07	0	0	0
CC-06	16	16	16
CC-05	19	20	20
CC-04	18	16	16
CC-03	4	4	4
CC-02	0	0	0
CC-01	0	0	0
Subtotal	58	57	57
Total, CC salaries	**$5,526,494**	**$5,431,209**	**$5,518,109**
Total Positions [1]	**620**	**665**	**665**
Average ES level	ES	ES	ES
Average ES salary	$155,500	$155,500	$155,500
Average SES level	SES	SES	SES
Average SES salary	$222,682	$225,577	$229,186
Average GS grade	13.5	13.6	13.6
Average GS salary	$103,951	$106,006	$108,264
Average CC level	5.2	5.2	5.2
Average CC salaries	$95,284	$95,284	$96,809

[1] This figure represents on-board staff.

Programs Proposed for Elimination

The following table shows the programs proposed for elimination in the FY 2017 Budget Request. Termination of this program allows SAMHSA to redirect approximately $23.1 million from the FY 2016 Enacted Level to continue activities for mental health programs that have demonstrated success when addressing youth violence. The following is a brief summary of the program and rationale for its elimination.

(Dollars in thousands)

Program	FY 2016 Enacted
Youth Violence Prevention	$23,099

Youth Violence Prevention

SAMHSA's Youth Violence Prevention program uses the Safe Schools/Healthy Students (SS/HS) Initiative to reduce violence. SS/HS 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.[209] 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.

The FY 2017 Budget Request proposes eliminating the youth violence prevention program in FY 2017. SAMHSA is requesting to reallocate funding from this program to *Now is the Time*-Project Advancing Wellness and Resilience in Education (*NITT*-Project AWARE). The reallocation of these funds to *NITT*-Project AWARE will continue to bring to scale program activities, practices, and lessons learned in the youth violence prevention arena and address current and emerging issues. The reallocation of these funds will enable SAMHSA to avoid duplication among programs with like purposes.

[209] http://www.samhsa.gov/grants/block-grants/sabg

FTEs Funded by the Affordable Care Act

Substance Abuse and Mental Health Services Administration

(Dollars in thousands)

Program	Section	FY2013			FY2014			FY2015			FY2016			FY2017		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
Primary and Behavioral Health Care Integration																
Discretionary																
Mandatory	4002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suicide Prevention																
Discretionary																
Mandatory	4002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Surveillance																
Discretionary																
Mandatory	4002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Physicians' Comparability Allowance (PCA) Worksheet

Substance Abuse and Mental Health Services Administration

(Whole dollars)

		PY 2015 (Actual)	CY 2016[1] (Estimates)	BY 2017 (Estimates)
1) Number of Physicians Receiving PCAs		5	5	5
2) Number of Physicians with One-Year PCA Agreements		---	---	---
3) Number of Physicians with Multi-Year PCA Agreements		5	5	5
4) Average Annual PCA Physician Pay (without PCA payment)		$144,342	$144,342	$144,342
5) Average Annual PCA Payment		$18,600	$18,600	$18,600
	Category I Clinical Position	---	---	---
6) Number of Physicians	Category II Research Position	---	---	---
Receiving PCAs by Category	Category III Occupational Health	---	---	---
(non-add)	Category IV-A Disability Evaluation	---	---	---
	Category IV-B Health and Medical Admin.	5	5	5

[1]FY 2016 data will be approved during the FY 2017 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

N/A

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

$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 currently has two medical officer vacancies. The GS position was vacated on 6/3/2015 and the SES position was vacated on 10/3/2014. The SES slot request package was prepared for Departmental approval. Management is evaluating the GS position due to a reorganization.

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

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Substance Abuse and Mental Health Services Administration
SIGNIFICANT ITEMS IN OMNIBUS, HOUSE, AND SENATE REPORTS

FY 2016 Consolidated Appropriations Act Report Language
(Omnibus – PL 114-113)

Item – Pages 43-44

Mental Health Programs – SAMHSA is directed to work with the Government Accountability Office (GAO) in implementing the recommendations provided in GAO reports GA0-15-113 and GA0-15-405, issued in February and May of 2015, respectively. The agreement directs SAMHSA to provide a detailed update and timeline on the progress of these recommendations 90 days after enactment of this Act. Furthermore, the agreement directs SAMHSA to develop a grants compliance plan that will ensure that SAMHSA's grants process is in accordance with the Department's grants manual. The compliance plan shall include periodic, and random, internal audits of grant files to confirm all the necessary documentation is accounted for and that the compliance plan is meeting its objectives. SAMHSA shall provide any additional grants training necessary to prevent these issues from arising in the future.

Action taken or to be taken

SAMHSA is taking concrete steps to implement the recommendations provided in GAO reports GA0-15-113 (serious mental illness) and GA0-15-405 (grants management).

SAMHSA is undertaking extensive efforts to enhance the management of its grant programs. These activities are in keeping with best practices and lessons learned over the last several years related to the implementation of strong grants management and business operations. These efforts include:

- Continuous quality improvement,
- Developing and updating policies and procedures,
- Updating its Government Project Officer Handbook which highlights the importance of sound documentation in grant files,
- Implementing periodic sampling of grant files to ensure completeness, accuracy, and timeliness of documentation,
- Implementing new systems to manage grants and collect performance data, and
- Implementing staff training.

Item – Page 44

Mental Health Block Grants – The agreement directs SAMHSA to continue its collaboration with National Institute of Mental Health (NIMH) to ensure that funds from the set-aside are only used for programs showing strong evidence of effectiveness and targets the first episode of psychosis. SAMHSA shall not expand the use of the set-aside to programs outside of those that address first episode psychosis. Within six months after enactment of this Act, the agreement

directs SAMHSA to provide a detailed table showing at a minimum each State's allotment, name of the program being implemented, and a short description of the program.

Action taken or to be taken

SAMHSA supports states' efforts to address the identification and referral of individuals experiencing first episode psychosis (FEP) in order to substantially reduce the duration of untreated psychosis. SAMHSA has been involved for some time in an ongoing collaboration with NIMH directed toward the goals of the FEP model.

SAMHSA will continue to work with NIMH to assure that states have access to information relating research-based early intervention programs to address serious mental illness. SAMHSA continues to work closely with NIMH support and collaboration, which has been recognized on several occasions for the positive outcomes of this joint relationship. Further, SAMHSA will provide Congress with a detailed table showing at a minimum each state's allotment, name of the program being implemented, and a short description of the program.

Item – Pages 44-45

Project AWARE – Of the amount provided for Project AWARE, the agreement provides an additional $10,000,000 for discretionary grants to communities that have recently faced civil unrest. These grants should focus on high risk youth and family populations in these communities and surrounding areas that have experienced significant exposure to trauma and can benefit from additional evidence-based violence prevention and community youth engagement programs as well as linkages to trauma-informed behavioral health services. SAMHSA should prioritize funding grants from communities that have formed partnerships between key stakeholders including State and local governments (including multiple cities and counties if impacted); public or private universities and colleges; and non-profit community- and faith-based organizations. The agreement includes related funding in the Department of Education. The Department of Education and SAMHSA should coordinate extensively in the administration of these resources.

Action taken or to be taken

SAMHSA will ensure that the Funding Opportunity Announcement (FOA) for these new Project AWARE grants to communities that have recently faced civil unrest focus on high risk youth and family populations in these communities and surrounding areas that have experienced significant exposure to trauma and can benefit from additional evidence-based violence prevention and community youth engagement programs as well as linkages to trauma-informed behavioral health services. In addition, SAMHSA will work with the Department of Education to coordinate the administration of this funding.

Item – Page 45

Childhood Trauma – The agreement encourages SAMHSA to more broadly disseminate information regarding evidence-based interventions for the prevention and treatment of childhood trauma so more children can benefit from proven practices.

Action taken or to be taken

SAMHSA will continue to build on the strong work of the National Child Traumatic Stress Initiative (NCTSI) Network and will improve and enhance the capacity of the NCTSI to deliver core practices developed by the NCTSN to children and youth in need. SAMHSA will more broadly disseminate information on effective interventions and preventions for childhood trauma through a multilayered approach that includes increased outreach and marketing to providers, researchers, family members, and consumers for in person training, web-based information and training, webinars, technical assistance, and through direct assistance.

Data collected through FY 2013 demonstrate that the current grantees in the NCTSN have provided trauma-informed treatment to nearly 25,000 children, adolescents, and family members. Based on these capacity-building efforts, SAMHSA projects that number to grow to over 40,000 individuals served in FY 2016, and will continue striving to reach more children and families in need.

Item – Pages 45-46

Assisted Outpatient Treatment – The agreement includes $15,000,000 to implement section 224 of the Protecting Access to Medicare Act of 2014 (Public Law 113-93), the Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness. The agreement requests a report in the FY 2017 budget request on planned uses of this funding.

Action taken or to be taken

SAMHSA includes in its FY 2017 Budget Justification to Congress a report on how it plans to implement section 224 of the Protecting Access to Medicare Act of 2014. SAMHSA will release a Funding Opportunity Announcement in FY 2016 for Section 224, the Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness. Grants will be up to $1.0 million per year for the implementation of Assisted Outpatient Treatment programs. SAMHSA plans to award up to 20 grants.

Item – Page 47-48

Targeted Capacity Expansion – The funding provided will increase the number of States that receive funding from 11 to 22, and SAMHSA should target States with the highest rates of admissions and that have demonstrated a dramatic increase in admissions for the treatment of opioid use disorders. 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, 28 states saw an increase in admissions for treatment for heroin dependence during the past two

years. 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.

Since the passage of the Drug Addiction Treatment Act of 2000, SAMHSA has led the nation in educating physicians, patients and treatment systems on the use of medication-assisted treatment. To keep pace with advancements in science and research, the agreement directs SAMHSA to update all of its public-facing information and treatment locators such that all evidence-based innovations in counseling, recovery support, and abstinence-based relapse prevention medication-assisted treatments are fully incorporated.

Action taken or to be taken

SAMHSA, through the Center for Substance Abuse Treatment, will release a Funding Opportunity Announcement for grants to states to expand medication-assisted treatment services for persons with opioid use disorder. The program will target those states experiencing: the highest rates of primary treatment admissions for heroin and opiates per capita; and a dramatic increase in admissions for treatment of opiates and heroin in recent years. SAMHSA will 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.

As requested, SAMHSA will update all of its public-facing information and treatment locators such that all evidence-based innovations in counseling, recovery support, and abstinence-based relapse prevention medication-assisted treatments are fully incorporated.

Item – Page 48

Criminal Justice Activities – SAMHSA is directed to ensure that all Drug Treatment Court funding is allocated to serve people diagnosed with a substance use disorder 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 is further directed to expand training and technical assistance to drug treatment court grant recipients to ensure evidence-based practices are fully implemented.

Action taken or to be taken

SAMHSA's FY 2016 Drug Treatment Court grant funding will continue to be utilized to provide services for individuals "diagnosed with a substance use disorder as their primary condition." Additionally, Drug Treatment Court applicants are required to include a letter of support from the State Substance Abuse Agency Director or designated representative that provides support for the application and confirms that the proposal conforms to the framework of the state strategy of substance abuse treatment." Additionally, in FY 2016, SAMHSA will continue to provide

technical assistance to its drug treatment court grantees to highlight evidence-based practices and ensure effective service provision.

Item – Page 49

Substance Abuse Prevention – The agreement directs that all of the funding appropriated explicitly for substance abuse prevention purposes both in the Center for Substance Abuse Prevention's PRNS lines as well as the funding from the 20 percent prevention set-aside in the SABG be used only for bona fide substance abuse prevention programs and not for any other purpose.

Action taken or to be taken

SAMHSA can confirm that substance abuse prevention funds in both CSAP's PRNS line and funding from the 20 percent prevention set-aside in the Substance Abuse Prevention and Treatment Block Grant are used solely to fund substance abuse prevention programs and strategies.

Specifically, the FY 2015-2016 SABG Block Grant application states, as per statute, that "the 20% set aside funds of the SABG Block Grant must be used only for substance abuse primary prevention activities by the state." SAMHSA's State Project Officers monitor state expenditures to confirm that states are spending at least 20 percent of the total SABG award on primary substance abuse prevention programs, practices and strategies. Similarly, grantees funded through PRNS lines are also required to expend grant funds on substance abuse prevention strategies and infrastructure development. SAMHSA's Project Officers also monitor these grant expenditures to ensure that grant funds are spent appropriately and on allowable items.

Item – Page 50

Combating Opioid Abuse – The agreement provides $12,000,000 for discretionary grants to States to prevent 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.

Action taken or to be taken

SAMHSA appreciates Congress providing funding for Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths. These grantees will be required to develop a dissemination plan and a training course tailored to meet the needs of their community. The course would use SAMHSA's Opioid Overdose Prevention Toolkit as a guide, and include a comprehensive prevention program, which will focus on prevention, treatment and recovery services to decrease the likelihood of drug overdose recurrence.

SAMHSA will continue 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.

SAMHSA's Strategic Prevention Framework for Prescription Drugs will raise awareness about the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program will also focus on raising community awareness and bringing prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and their patients.

Item – Page 50

Overdose Fatality Prevention – 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 health care 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.

Action taken or to be taken

Addressing the issue of prescription drug abuse and misuse as well as preventing opioid overdose deaths is a top priority for SAMHSA. In terms of grants to prevent prescription drug/opioid overdose related deaths, Congress funded in FY 2016 a $12.0 million grant program that has the potential to significantly reduce the number of opioid-related overdose deaths. This funding will help states purchase naloxone, equip first responders in high-risk communities, support education on the use of naloxone and other overdose death prevention strategies, provide the necessary materials to assemble overdose kits, as well as cover expenses incurred from dissemination efforts. SAMHSA's Opioid Overdose Prevention Toolkit should be used as the guide for the development of a comprehensive strategy that will include evidence-based programs to intervene and prevent the likelihood of drug overdose recurrence. The Centers for Disease Control and Prevention will evaluate this grant program for its efficacy in reducing overdose deaths from opioids.

In addition, state agencies that administer the Substance Abuse Block Grant may use the block grant funds (other than primary prevention set-aside funds) to purchase naloxone and the necessary materials to assemble overdose kits and to cover the costs associated with the dissemination of such kits.

SAMHSA will continue to encourage states to use their block grant funds for opioid safety education and training. This would include initiatives to improve access for licensed health care professionals, including paramedics, to emergency devices used to rapidly reverse the effects of opioid overdoses. SAMHSA has advised states that the Substance Abuse Block Grant funds can be used to purchase naloxone and the necessary materials to assemble overdose kits and to cover the costs associated with the dissemination of such kits.

Item – Pages 51-52

Behavioral Workforce Education and Training – The agreement directs SAMHSA to share information concerning pending grant opportunity announcements with State licensing organizations and all the relevant professional associations. Furthermore, SAMHSA is directed to ensure that funding is distributed relatively equally among the participating health professions and to consider strategies such as issuing separate funding opportunity announcements for each participating health profession. In addition, the agreement directs SAMHSA to include doctoral psychology schools in the funding opportunities to support doctoral level students completing their practicums, which are necessary to move on to internships. Awards shall be given to meritorious applications for doctoral psychology interns first, before doctoral psychology schools applying to support practicums.

Action taken or to be taken

In FY 2016, SAMHSA will work with the Health Resources Services Administration, who administers the Behavioral Health Workforce Education and Training Grant Program, to ensure that the Funding Opportunity Announcement adequately addresses the issues raised by the Committee.

FY 2016 Senate Appropriations Committee Report Language
(S.Rept. 114-74)

Item – Page 109

Substance Abuse and Mental Health Services Administration – The Committee urges SAMHSA to continue to prioritize all HIV/AIDS funding to target racial and ethnic minority communities.

Action taken or to be taken

SAMHSA will continue to prioritize its HIV/AIDS funding to target racial and ethnic minority communities. SAMHSA currently funds projects under the Minority AIDS Initiative that implement the goals of the National HIV/AIDS Strategy. The Center for Substance Abuse Prevention provides funding for substance abuse prevention services and HIV testing programs. Tow Centers, the Center for Substance Abuse Treatment and the Center for Mental Health Services, fund projects that support substance abuse/mental health treatment services, HIV testing, and referral to quality HIV care.

Item – Page 110

Mental Health – The Committee directs the administrator of SAMHSA to work with GAO in implementing the recommendations provided in the GAO reports. The Committee expects a detailed update and timeline on the progress of these recommendations 90 days after enactment of this act. Furthermore, the Committee directs SAMHSA to develop a grants compliance plan

that will ensure that SAMHSA's grants process is in accordance with the Department's grants manual. The compliance plan shall include periodic, and random, internal audits of grant files to confirm all the necessary documentation are accounted for and that the compliance plan is meeting its objectives. Furthermore, SAMHSA shall provide any additional grants training necessary to prevent these issues from arising in the future.

Action taken or to be taken

See response to the Omnibus Report Language for "Mental Health Programs" on page 347.

Item – Page 111

Access to Mental Health Services for Veterans – The Committee is aware of the success achieved in localities that use locally customized web portals to assist veterans struggling with mental and substance use issues. These portals provide veterans with a directory of local mental health providers and services in addition to all military and Veterans' Affairs funded programs. They also provide quick access to local crisis intervention and emergency care programs; comprehensive job search and support; a peer social networking platform, and personal health records. The Committee encourages SAMHSA to expand and maintain the capacity of locally customized internet-based Web portals nationwide.

Action taken or to be taken

SAMHSA encourages all our grantees to address the behavioral health needs of returning veterans and their families in designing and developing their programs and to consider prioritizing this population for services where appropriate. SAMHSA will continue to encourage its grantees to utilize and provide technical assistance regarding locally-customized web portals that assist veterans and their families with finding behavioral health treatment and support.

Item – Page 111

Primary and Behavioral Healthcare Integration – The Committee continues to direct SAMHSA to ensure that new Integration grants awarded for fiscal year 2016 are funded under the authorities in section 520K of the PHS Act.

Action taken or to be taken

SAMHSA will ensure that new Primary and Behavioral Healthcare Integration grants awarded for FY 2016 are funded under the authorities in section 520K of the PHS Act.

Item – Pages 111-112

Community Mental Health Services Block Grant – 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 targets 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 2017 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.

Action taken or to be taken

See response to the Omnibus Report Language for "Mental Health Block Grants" on page 347.

Item – Page 113

Oral Fluid Guidelines – The Committee commends SAMHSA for the progress made on issuing oral fluid guidelines for the Federal Workplace Drug Testing Programs and supports the development of oral fluid as an alternative specimen for drug testing. The Committee urges SAMHSA to publish the guidelines expeditiously and to implement the guidelines in partnership with stakeholders.

Action taken or to be taken

The Proposed Oral Fluid Mandatory Guidelines for the Federal Workplace Drug Testing Programs were published in the Federal Register in May 2015. SAMHSA has reviewed comments and revisions have been completed for the issuance/implementation in early 2017. An interagency forum and planning meeting was held in September 2015 to discuss the state of the science regarding drugged driving testing standards, standard cutoff concentrations for point of collection devices, and the feasibility of using oral fluid for roadside testing.

Item – Page 113

Addiction Technology Transfer Centers – The Committee continues to direct SAMHSA to ensure that ATTCs maintain a primary focus on addiction treatment and recovery services.

Action taken or to be taken

The ATTCs will continue to maintain primary focus on addiction treatment and recovery.

Item – Page 113

Combating Opioid Abuse – Of the amount provided for Targeted Capacity Expansion, the Committee recommendation includes $18,000,000 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 rates of admissions and that have demonstrated a dramatic increase in admissions for the treatment of opioid use disorders.

Action taken or to be taken

See response to the Omnibus Report Language for "Targeted Capacity Expansion" on page 349.

Item – Pages 113-114

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. The Committee expects CSAT to ensure that non-State substance abuse agency applicants for any drug treatment court grant in its portfolio continue to demonstrate extensive evidence of working directly and extensively with the corresponding State substance abuse agency in the planning, implementation, and evaluation of the grant.

Action taken or to be taken

See response to the Omnibus Report Language for "Criminal Justice Activities" on page 350.

Item – Page 114

Screening, Brief Intervention, and Referral to Treatment – The Committee continues to direct SAMHSA to ensure that funds provided for SBIRT are used for existing evidence-based models of providing early intervention and treatment services to those at risk of developing substance abuse disorders.

Action taken or to be taken

The SBIRT program requires grant recipients to implement the SBIRT model at all levels of primary care and medical facilities, including hospitals, trauma centers, Federally Qualified Health Centers, and other relevant settings. Research and clinical experience support the use of SBIRT to intervene early with alcohol and other substance use disorders, which leads to early referral and treatment. SBIRT also identifies individuals with more serious conditions and diverts them from costly emergency services to general practitioners. Funds may be used for screening of substance use and co-occurring disorders, evidence-based client-centered brief interventions such as motivational interviewing, and brief treatment and referral to specialty care for individuals exhibiting signs of dependency. Evaluation findings also indicate that the value of SBIRT is that it makes an "invisible" clinical issue visible by providing the tools to identify and address alcohol and drug use disorders at every point in public health, from primary care to specialty care.

Item – Page 114

Substance Abuse Prevention and Treatment Block Grant - To increase transparency, the Committee directs SAMHSA to include in their fiscal year 2017 CJ details on where SAMHSA acquires the data used for the formula and how SAMHSA utilizes this information to make funding level determinations. It is imperative that SAMHSA uses the most recent and accurate

data available and should work with States to better understand the best sources for this information. SAMHSA shall also include an evaluation on whether the current formula should be updated in the future.

Action taken or to be taken

The Office of Applied Studies (OAS) at SAMHSA annually determines the allocation of funding to states and territories for the Substance Abuse Prevention and Treatment Block Grant (SABG), and the Mental Health Services Block Grant (MHBG). The allocations are made in accordance with SAMHSA's legislative authorities. Over time, the underlying bases of the calculations, particularly that for SABG and MHBG, have undergone changes primarily because of changes in legislation. SAMHSA's guidebook: Block Grants and Formula Grants: A Guide for Allotment Calculations presents the formulas for the SABG and MHBG allotment calculations and reflects the rules laid out in the initial legislation or subsequent reauthorizations.

In general, the methodology of allotment determination for the programs involves following three common steps: 1) setting aside a certain percentage of the appropriated amount for SAMHSA's use to cover the costs of data collection, technical assistance, and program evaluation; 2) calculating baseline allotments based on certain factors; and 3) adjusting the allotments, if necessary, so that statutory minimum allotment constraints are satisfied.

For the SABG, state baseline allotment calculations, when warranted, are based on the relative share of the Population-at-Risk, Cost-of-Services, and Fiscal Capacity Indexes, while the territory allotments are based solely on the relative share of the population. For the MHBG, similar factors are used in state and territory allotment calculations, except that the Population-at-Risk Index is replaced by the Weighted Population-at-Risk in state baseline allotment calculations, and different statutory minimum allotments apply.

It is important to note that baseline allotments are not necessarily the final allotments, and may require adjustment so that the statutory minimum allotment constraints are satisfied. Statutory minimum allotments vary across calculations and are not the same for state and territories in each calculation.

Item – Page 114

***Substance Abuse Prevention* –** The Committee directs that all of the money appropriated explicitly for substance abuse prevention purposes in both CSAP's PRNS lines as well as the funding from the 20 percent prevention set-aside in the SABG be used only for bona fide substance abuse prevention programs and strategies and not for any other purposes.

Action taken or to be taken

See response to the Omnibus Report Language for "Substance Abuse Prevention" on page 351.

Item – Page 115

Combating Opioid Abuse – The Committee provides $6,000,000 for grants to prevent opioid overdose related deaths. As part of the new initiative to Combat Opioid Abuse, this new program will help States equip and train first responders with the use of devices that rapidly reverse the effects of opioids. 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.

Action taken or to be taken

See response to the Omnibus Report Language for "Combating Opioid Abuse" on page 351.

Item – Page 115

Strategic Prevention Framework State Incentive Grant (SPF-SIG) and Partnerships for Success (PFS) – 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.

Action taken or to be taken

The SPF-SIG and PFS programs will continue to address the nation's top emerging substance abuse priorities, such as prescription opioid drugs and other opioids, underage drinking, marijuana, and intoxicative inhalants using appropriate prevention strategies as well as providing support for grantees to strengthen substance abuse prevention infrastructure and capacity using the strategic prevention framework. Applicants for the FY 2016 PFS cohort will also be encouraged to address these issues or other emergent, data driven substance abuse prevention targets. SAMHSA will not use any SPF funds for the Building Behavioral Health Coalitions initiative.

Item – Page 115

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.

Action taken or to be taken

SAMHSA ensures that the Sober Truth on the Prevention of Underage Drinking Act grant program's funds are used for making grants to eligible communities and not for any other purpose or activities.

Item – Page 116

Behavioral Health Workforce Education and Training – The Committee directs SAMHSA and HRSA to ensure that funding is distributed relatively equally among the participating health professions, including paraprofessionals, master's level social workers, counselors, marriage and family therapists, and doctoral psychology interns. The Committee directs SAMHSA and HRSA to consider other strategies to achieve this relative distribution such as issuing separate funding opportunity announcements for each participating health profession. In addition, the Committee directs SAMHSA and HRSA to include doctoral psychology schools in the funding opportunities to support doctoral level students completing their practicums which are necessary to move on to internships. SAMHSA and HRSA shall award meritorious applications for doctoral psychology interns first, before doctoral psychology schools applying to support practicums.

Action taken or to be taken

See the response to the Omnibus Report Language for "Behavioral Health Workforce Education and Training" on page 353.

FY 2016 House Appropriations Committee Report Language
(H.Rept. 114-195)

Item – Page 83

Childhood Trauma – The Committee encourages SAMHSA to more broadly disseminate information regarding evidence-based interventions for the prevention and treatment of childhood trauma so more children can benefit from proven practices.

Action taken or to be taken

See response to the Omnibus Report Language for "Childhood Trauma" on page 349.

Item – Page 83

Mental Health First Aid – The Committee directs SAMHSA to make competitive funding opportunities for this program available to all qualified community mental health education programs. Consistent with a broad public safety approach, SAMHSA is directed to include as eligible grantees local law enforcement agencies, fire departments, emergency medical services units and hospital systems. SAMHSA is encouraged to allow training for veterans, armed services personnel and their family members within the Mental Health First Aid program.

Action taken or to be taken

Under Project AWARE, Mental Health First Aid funding will promote widespread dissemination of the Mental Health First Aid curriculum. Youth Mental Health First Aid prepares teachers and other individuals who work with youth to help schools and communities to understand,

recognize, and respond to signs of mental illness or substance abuse in children and youth. In 2014, SAMHSA awarded Mental Health First Aid funds through competitive grants to State Education Agencies and Local Education Agencies. Grant recipients will be required to work with their respective mental health and juvenile justice counterparts, as well as other community-based organizations, to ensure that teachers and a broad array of community actors receive training in the Youth Mental Health First Aid model.

In FY 2015, SAMHSA awarded $8.6 million in Project AWARE-Community grants. The purpose of this program is to support the training of teachers and a broad array of actors who interact with youth through their programs at the community level, including parents, law enforcement, faith-based leaders, and other adults, in Mental Health First Aid or Youth Mental Health First Aid.

Item – Page 84

Tribal Behavioral Health Grant – The Committee expects SAMHSA to ensure that the activities conducted under the American Indian and Alaskan Native Suicide Prevention program are effectively coordinated with the Tribal Behavioral Health Grants. These two grant programs must work as an integrated whole to accomplish the goal of reducing suicides and drug abuse amongst Native American youth. Prior to the announcement of the TBHG grant opportunities, SAMHSA is directed to brief the Committee regarding the criteria for grant awards. Following the award of the grants, SAMHSA is directed to provide a briefing within 120 days to review the progress made and any unforeseen challenges that arise.

Action taken or to be taken

SAMHSA will work to ensure that that Committee is briefed on the criteria for grant awards of the Tribal Behavioral Health Grants prior to the Funding Opportunity Announcement and on progress made and any unforeseen challenges that arise post-award.

Item – Page 84

Mental Health Block Grant – 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.

Action taken or to be taken

See response to the Omnibus Report Language for “Mental Health Black Grants” on page 347.

Item – Page 85

Addiction Technology Transfer Centers (ATTCs) – The Committee once again rejects the Administration’s request to reduce funding for the ATTCs. SAMHSA is directed to ensure that ATTCs maintain a primary focus on addiction treatment and recovery services.

Action taken or to be taken

See response to the Senate Report Language for "Addiction Technology Transfer Centers" on page 355.

Item – Pages 85-86

Targeted Capacity Expansion – The Committee expects SAMHSA to provide a briefing within 45 days of enactment regarding how it intends to execute these activities and carry out the two mandates described below.

The United States has seen a 500 percent increase in admissions to treatment for prescription drug abuse since 2000. Moreover, according to a recent study, 28 states saw an increase in admissions to treatment for heroin dependence during the past two years. The fiscal year 2015 Consolidated and Further Continuing Appropriations Act provided funding for Targeted Capacity Expansion specifically for prescription drug and heroin treatment. 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.

Since the passage of the Drug Addiction Treatment Act of 2000, SAMHSA has led the nation in educating physicians, patients and treatment systems on the use of medication-assisted treatment. To keep pace with advancements in science and research, SAMHSA is directed to update all of its public-facing information and treatment locators such that all evidence-based innovations in counseling, recovery support, and abstinence-based relapse prevention medication-assisted treatments are fully incorporated.

Action taken or to be taken

See response to the Omnibus Report Language for "Targeted Capacity Expansion" on page 349.

Item – Page 86

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 SAHMHSA to expand training and technical assistance to drug treatment court grant recipients to ensure evidence-based practices are fully implemented.

Action taken or to be taken

See response to the Omnibus Report Language for "Criminal Justice Activities" on pages 350.

Item – Page 86

Oral Fluid Drug Testing – The Committee supports the development of oral fluid as an alternative specimen for drug testing and commends SAMHSA for the progress made to issue oral fluid guidelines for the Federal Workplace Drug Testing Programs. The Committee urges SAMHSA to publish the guidelines expeditiously and to implement the guidelines in partnership with stakeholders.

Action taken or to be taken

See response to the Senate Report Language for "Oral Fluid Guidelines" on page 355.

Item – Page 87

Mental and Behavioral Health Education and Training Program – The Committee directs SAMHSA to share information concerning pending grant opportunity announcements with State licensing organizations and all the relevant professional associations.

Action taken or to be taken

See response to the Omnibus Report Language for "Behavioral Health Workforce Education and Training" on page 353.

SAMHSA
SAMHSA-Specific Requirements
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HIV Continuum of Care

SAMHSA Strengthening HIV Continuum of Care through Behavioral Health/Substance Abuse & Primary Care Integration Grants should show how SAMHSA intends to build new evidence and strengthen capacity for rigorous evaluation and data analytics.

The National HIV/AIDS Strategy and Implementation Plan

SAMHSA currently funds projects under the Minority AIDS Initiative (MAI) that implement the goals of the National HIV/AIDS Strategy. The Center for Substance Abuse Prevention (CSAP) provides funding for substance abuse prevention services and HIV testing programs. The Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS) funded projects that support substance abuse/mental health treatment services, HIV testing and referral to quality HIV care.
In 2011, SAMHSA joined with the Department of Health and Human Services' (HHS) Office of HIV/AIDS and Infectious Disease Policy and other HHS agencies to better coordinate a national response to the HIV epidemic under the "HHS 12 Cities Project". Consistent with this coordinated effort, SAMHSA funded 11 cooperative agreements from FY 2011-FY 2014 under the Minority AIDS Initiative-Targeted Capacity Expansion: Integrated Behavioral Health/Primary Care Network Cooperative Agreements (MAI-TCE Program). The purpose of this program is to facilitate the development and expansion of culturally competent and effective integrated behavioral health and primary care networks, which include HIV services and medical treatment, within racial and ethnic minority communities in the 12 Metropolitan Statistical Areas (MSAs) and Metropolitan Divisions (MDs) most impacted by HIV/AIDS.

In FY 2014, SAMHSA's CMHS, CSAP, and CSAT supported a pilot HIV Continuum of Care grant program. The purpose of this jointly funded program is to integrate care (behavioral health treatment, prevention, and HIV medical care services) for racial/ethnic minority populations at high risk for behavioral health disorders and high risk for or living with HIV. This includes substance use prevention and treatment service programs, community mental health programs, and HIV integrated programs that either can co-locate or have fully integrated HIV prevention and medical care services. In addition, this program provides substance use and HIV primary prevention services in local communities served by the behavioral health program. Because of the significant co-morbidity of viral hepatitis with HIV infection and since viral hepatitis occurs in up to 20 percent of those with either substance use disorders or serious mental illness, five percent of the allocated funds support services to prevent, screen, test, and refer to treatment as clinically appropriate those at risk for or living with viral hepatitis.

In FY 2014, SAMHSA's Centers for Mental Health Services, Substance Abuse Prevention, and Substance Abuse Treatment supported the MAI Continuum of Care Pilot (MAI CoC). The MAI CoC supports behavioral health screening, primary prevention, and treatment for racial and ethnic minority populations with or at high risk for mental and substance use disorders and HIV/AIDS. MAI CoC supports substance use disorder (SUD) treatment, primary prevention and 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. In addition, approximately 20

percent and 23 percent of those with SMI such as schizophrenia, bipolar disorder, and major depression are infected with hepatitis C virus and hepatitis B virus, respectively, while between 14 and 36 percent of those who misuse alcohol are infected with hepatitis C virus.[210,211]

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 use disorder 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 2014, SAMHSA awarded 34 four-year HIV Continuum of Care grants and a technical assistance contract. 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, SAMHSA supports the continuation of 34 HIV Continuum of Care grants, and evaluation and technical assistance contracts.

The primary purpose of the HIV Consolidated Evaluation is to conduct a comprehensive process and outcome evaluation of all SAMHSA HIV programs that entails in-depth evaluation development and implementation of a cooperative agreement for a period of four years. The evaluation results will be used to inform program development and refine the approach used in SAMHSA's HIV portfolio.

Expected outcomes for the HIV Continuum of Care programs include: 1) increased HIV testing to identify behavioral health clients who are unaware of their HIV status; 2) increased diagnosis of HIV among behavioral health clients; 3) increased number of clients who are linked to HIV medical care; 4) increased number of behavioral health clients who are retained in care; 5) increased number of behavioral health clients who are receiving antiretroviral therapy (ART); 6) improved adherence to behavioral treatment and ART; 7) increased number of behavioral health clients who have sustained viral suppression; and 8) increased adherence and retention in behavioral health (both substance use and mental disorders) treatment.

Data generated from the HIV Continuum of Care grant program will help to inform SAMHSA's efforts to continue the co-location and integration of HIV/primary care with either substance use or community mental health treatment programs. By integrating HIV care into behavioral health settings, people living with HIV/AIDS and mental and substance use disorders (M/SUDs) will have greater access to treatment for these conditions. Integrated care programs developed as a result of this grant program will make it possible for behavioral health and HIV care needs to be addressed in one setting. This will result in effective, person-centered, treatment that will reduce the risk of HIV transmission, improve outcomes for those living with HIV/AIDS, and ultimately reduce new infections.

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[210] Bhattacharya R, Shuhart MC. Hepatitis C and alcohol: interactions, outcomes, and implications. J Clin Gastroenterol. 2003; 36(3):242-52.

[211] 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).

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