Government Performance and Results Act Plan and Report

I. Letter From the Administrator

In accordance with the Government Performance Results Act of 1993, I am pleased to present SAMHSA's Final FY 2005 Annual Performance Plan, Revised Final FY 2004 Plan and FY 2003 Performance Report. In keeping with HHS and OMB guidance, the GPRA plan and report are consolidated with the budget document. SAMHSA's mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness.

To accomplish its mission, SAMHSA administers a combination of competitive, formula and block grant programs, and data collection activities. Programs are carried out through the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Office of Applied Studies (OAS). Reauthorization for SAMHSA and its programs will be considered in the next Congressional session.

SAMHSA provides services indirectly through grants and contracts. SAMHSA's resources enable service capacity expansion and the implementation of evidence-based practices. The agency seeks to engage all communities in providing effective services by facilitating access to the latest information on evidence-based practices and accountability standards.

Programs in CMHS, CSAP, and CSAT continue to support and implement agency goals of Accountability, Capacity, and Effectiveness. Data from the Office of Applied Studies are relied upon by the Office of National Drug Control Policy (ONDCP) and other partners. SAMHSA's programs are increasing access to, and effectiveness of, treatment and prevention services in support of the President's priorities. GPRA data demonstrate that the return on investments is significant. Not only do these investments result in improvements to the Nation's public health, but they also reduce public health care costs. Many of SAMHSA's programs are beginning to use cost data to improve the efficiency and effectiveness of programs and monitor the usage of services.

Managing for high program performance is a top priority for SAMHSA and HHS. Performance data are being utilized to improve the efficiency and effectiveness of our grant programs. SAMHSA continues to improve its performance planning. For example, in the 2005 budget submission, a number of significant improvements have been made in our ability to report GPRA data, including: (1) decreasing the total number of measures, (2) adding efficiency measures for all programs, and (3) initiating aggregated reporting. In addition, SAMHSA has also set long-term measures for programs reviewed through the OMB PART process and is finalizing Performance Partnership Grant (PPG) goals developed with State partners.

I am proud to report to you and the Nation on SAMHSA's results for fiscal year 2003 GPRA goals and to set performance plans for fiscal years 2004 and 2005.

Charles G. Curie, M.A., A.C.S.W.
Administrator, Substance Abuse and Mental Health Services Administration

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II. Executive Summary

This document includes the Substance Abuse and Mental Health Service Administration (SAMHSA) Final FY 2005 Annual Performance Plan, Revised Final FY 2004 Plan and FY 2003 Performance Report including the most recent performance data on FY 2003 and earlier performance goals. Resources for achieving performance goals are shown for each program. In order to keep the GPRA plan at a manageable length, SAMHSA generally does not include new programs in the GPRA plan unless they exceed $10 million in funding, grants have been awarded, and data collection is underway.

Key improvements in this year's GPRA plan, which contribute to the integration of budget and performance, are outlined below:

- Aligning the GPRA and budget documents by Center and by the Program Priority Matrix areas;
- Combining both documents into one volume for easier reference and use of performance information to support appropriations requests, as directed in the HHS guidance;
- Removing from the document small programs (<$10 million) and aggregating reporting for those programs with other efforts where possible;
- Presenting a new, highly aggregated method for reporting CSAT's PRNS activities;
- Reducing the number of performance measures from 86 to 47, a 45% reduction to a more manageable and useful number,
- Increasing the proportion of measures focusing on outcomes to 83%;
- Ensuring that every program has at least one efficiency measure;
- Including long-term OMB PART measures for the programs reviewed; and,
- Including full cost data for all reported GPRA programs (a table explaining the full cost methodology is included at the end of the overview section).

A. Agency Vision and Mission

SAMHSA's vision as an agency of the Federal Government is "A Life in the Community for Everyone." SAMHSA's mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. SAMHSA was established in 1992 and reauthorized in 2000. SAMHSA administers a combination of competitive, formula, and block grant programs and data collection activities. Programs are carried out through the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Office of Applied Studies (OAS). Authorization for SAMHSA and these programs will be considered in the next Congressional session. A package of legislative proposals has been submitted under separate cover. SAMHSA provides services indirectly through grants and contracts. SAMHSA's resources enable service capacity expansion and the implementation of evidence-based practices. The agency seeks to engage all communities in providing effective services by facilitating access to the latest information on evidence-based practices and accountability standards.

The SAMHSA draft Strategic Plan identifies the agency goals as Accountability, Capacity, and Effectiveness. A chart showing the vision, mission, goals and objectives may be found in the overview of the budget section. The FY 2004 and FY 2005 budget submissions align the budget request with the three goals. In FY 2005, SAMHSA has categorized performance measures according to the Capacity and Effectiveness goals.

SAMHSA's matrix of program priorities and cross-cutting principles has guided the agency's daily operations and overall program and management decisions for the past two years. The program categories used in the FY 2004 and FY 2005 budget requests align the budget request with the matrix. The updated matrix is included in the budget section.

SAMHSA's planning and budget decisions emphasize alignment with HHS goals. All of SAMHSA's activities support HHS strategic objectives 1.4, 1.5, and all managerial objectives.

SAMHSA's proposed FY 2005 budget emphasizes two Presidential priorities: the fourth year of the President's Drug Treatment Initiative, and implementing the recommendations for the President's New Freedom Commission on Mental Health. The budget summary table may be found at the beginning of this document. SAMHSA does not generally include programs in the GPRA plan until grants have been awarded and data collection has been initiated. Once baseline data are available and targets have been set, performance data guide appropriations.

B. Overview of the Plan and Performance Report

Summary of Measures, Results and Agreements with OMB

SAMHSA has 47 total measures for 18 reported programs in 2005, with a 45% reduction in measures from the number reported in 2004. Data has been collected for 13 of the remaining 2003 measures. For the results reported, specific targets have been met or exceeded for 21 measure indicators, and not met for 2 indicators, for a 91% positive result on the data reported to date. Data on 29 measures remains unreported. Data will be reported against remaining 2003 targets in subsequent budget submissions as it is collected. SAMHSA has 17 efficiency measures for 2005. Long-term outcome efficiency measures have been developed through the OMB PART process and integrated into the performance tables. The OMB PART review focused on the block grant programs for FY 2003, and was a significant factor in adding long-term measures for these programs.

SAMHSA is continuing efforts to improve its block grant measures and data collection. In the past several years, Federal and State substance abuse and mental health agencies have been working closely to design and begin to implement Performance Partnerships. As a first step they have agreed on core performance measures. Second, they have begun to discuss the specific ways in which they can use those performance measures to help improve performance measurement. The specific goals of such performance management, consistent with the goals in SAMHSA's Strategic Plan, are to improve the accountability, capacity and effectiveness of the substance abuse prevention and treatment system and of the mental health service system. The ultimate goals are to ensure that fewer individuals will suffer from substance abuse and serious

mental disorders and to ensure that those with substance abuse and serious mental disorders will have a better chance of participating actively in their communities. A report to Congress is under final review. This report on Performance Partnership Grants contains proposed measures and strategies for assisting the States to improve their data infrastructure for reporting performance.

Program Performance Report Summary Table

	Measures in Plan	Outcome Measures[1]	Output Measures	Efficiency Measures[1]	Results Met	Results Not Met
2000	39	*	*	*	32	4[2]
2001	134	*	*	*	*	NA[2]
2002	90	42	45	45	50	15[2]
2003	83	27	27	29	11	2 (18 not rpt.)[3]
2004	86	27	1	20	NA	NA
2005	47	39	1	17	NA	NA

*An archival study has been initiated to report these numbers.

1 Some measures serve as both outcome and efficiency measures, so that they may not sum to the total numbers in the plan.

2 Measures from 2000 – 2002 measures were dropped from reporting to reduce numbers reported.

3 Long-term measures do not have 2003 targets set.

Full Cost Accounting

Starting in the FY 2005 submission, each program is reporting full cost information using the HHS standard methodology. Reporting full cost information includes two types of information. First, the full cost for each program is reported along with the requested budget amount. Second, SAMHSA has estimated the percentage of full cost that is attributable to each measure. This information is contained in a full cost table that follows each performance table. A table describing the distribution of full costs to all performance measures is also included in section H of the appendix. In regards to this information, SAMHSA does not report GPRA data for programs smaller than $10 million dollars, so that full cost information is not reported for all of SAMHSA's programs. However, full-cost information is provided for most of SAMHSA appropriated dollars.

Narrative Description of Report

Improvements in the FY 2005 SAMHSA Performance Plan are described on Page 3 of this section. Concurrently, the Plan is being reviewed, reorganized, and revised, preparatory to full integration with the budget submission in FY 2006.

In FY 2005, the GPRA plan and report are provided as the final section of the budget document. In this submission, SAMHSA is moving toward greater aggregation in program reporting. An example is the reporting of CSAT's PRNS programs. Small activities have, for the most part, been dropped from the plan. These changes further implement performance based budgeting consistent with HHS and OMB guidance. Because SAMHSA's budget line item structure aligns

with SAMHSA's three primary programmatic areas (mental health services, substance abuse prevention, and substance abuse treatment), the budget narrative and GPRA plan continue to be organized by those programmatic areas. Consistent with HHS guidance, all of our reported programs include efficiency measures and show full cost reporting.

SAMHSA is prepared to submit a fully integrated performance budget for FY 2006. SAMHSA is in the process of incorporating performance planning and reporting within its budget plan. Mental health services, substance abuse prevention, and substance abuse treatment will remain SAMHSA's perfo rmance program areas. Each performance program area will contain goals, measures, and indicators consistent with SAMHSA's strategic goals: Accountability, Capacity, and Effectiveness. For additional information, see page 4 of the Budget Overview section of this submission.

SAMHSA programs continue to demonstrate effective performance. Performance highlights are located throughout the budget narrative as well as in this report. In general, programs are producing annual performance data and annual performance targets have been met. Certain programs present performance challenges either in collecting performance data or in reaching performance targets. Where there is a pattern of missed targets, corrective action plans have been included.

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IV. PERFORMANCE PLAN AND REPORT

A. Introduction

Mission Statement

SAMHSA's vision as an agency of the Federal Government is "A Life in the Community for Everyone." SAMHSA's mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness.

Description of Agency

SAMHSA administers a combination of competitive and formula/block grant programs and data collection activities. Programs are carried out through the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Office of Applied Studies (OAS). Reauthorization for SAMHSA and these programs will be considered in the next Congressional session. SAMHSA is located in Rockville, Maryland.

Narrative Description of Report

This report is organized by SAMHSA's three Centers and is aligned with the Strategic Plan framework, which includes the goals of Accountability, Capacity and Effectiveness (ACE) and the Matrix priority areas.

Key for Performance Table Symbols

HP	**Healthy People Goals and Objectives**
HHS SP	**HHS Strategic Plan Goals**

OMB PART Reviews Summary

SAMHSA's programs reviewed with the OMB PART in 2002, for the 2004 budget, scored relatively high compared to all programs reviewed. In the second year of the OMB Program Effectiveness Review, the two Block Grant programs, Substance Abuse Prevention and Treatment and Mental Health, were reviewed. The SAPT Block Grant program did not score as well as those that were previously reviewed. However, SAMHSA is taking vigorous action in implementing corrective action plans.

Through the OMB PART process, SAMHSA has set both efficiency and long-term measures. HHS has defined efficiency measures broadly to include measures that track the conversion of resources into goods or services. Efficiency measures are identified throughout the report in the performance report with an "E" symbol in the reference column. Annual outcome measures are marked with an "O" symbol. SAMHSA has aligned the PART measures and current GPRA

measures for programs that have been reviewed. Review findings and corrective actions plans can be found within the budget narratives of the programs that have been reviewed for the 2004 and the 2005.

Priority Initiatives

The budget section contains a discussion of proposed activities and budget requests related to the following priority initiatives:

- President's Drug Treatment Initiative – FY 2005 is the fourth year of this five year initiative to increase substance abuse treatment capacity.

- Mental Health Systems Transformation – Implementation of the findings of the President's New Freedom Commission on Mental Health, including a proposed "State Incentive Grant for Transformation" program.

- Strategic Prevention Framework – A new approach to identifying and implementing improved prevention services.

- Performance Partnership Grants – Transformation of the current Block Grants in order to improve State and federal accountability and increase State flexibility in use of funds.

- Strategic Planning – SAMHSA's draft Strategic Plan directly supports HHS Strategic Objectives 1.4, 1.5 and 3.5 and all management objectives identified in Goal 8.

B. Discussion and Performance Analysis

Mental Health Services

Mental Health programs included in this report are:

1. Child Traumatic Stress Initiative
2. Safe Schools/Healthy Students
3. HIV/AIDS Minority Mental Health Services
4. Comprehensive Community Mental Health Services for Children and Their Families
5. Protection and Advocacy for Individuals with Mental Illness
6. Projects for Assistance in Transition from Homelessness (PATH)
7. Community Mental Health Services Block Grant

Programs of Regional and National Significance (PRNS)

Children's Priority Area

1. Child Traumatic Stress Initiative

Performance Goals (Effectiveness)	Targets	Actual Performance	Reference
1. Increase the number of children and adolescents reached by improved services. (E)	FY 05: 46,468 FY 04: 42,255 FY03: Baseline FY02: Preliminary baseline data*	FY 05: TBR 12/05 FY 04: TBR 12/04 FY 03: 40,000 FY 02: 5933*	**HHS SP 2, 3.5**
2. Improve children's outcomes (O) (Developmental)	FY 05: TBD 3/05 FY 04: TBD 3/04 FY03: Estab. baseline	FY 05: TBR 3/06 FY 04: TBR 3/05 FY 03: TBR 3/04	
Total Funding	**2005: $30,000** **2004: $29,823** **2003: $29,805**		

*Preliminary data that represents only one-quarter of program direct services for FY 2002; this was start-up year for the program.

Full Cost Table

1. Child Traumatic Stress Initiative **Incorporates:**	**2003**	**2004**	**2005**
Measure 1.1 (100%)	$32.0	$32.2	$32.1
Measure 1.2			
Total Full Cost *($'s in Millions)*	$32.0	$32 .2	$32.1

Program Description and Context

Intervention in the aftermath of trauma is perhaps the most significant clinical issue in child and adolescent mental health. Promising interventions for child trauma have been identified, but much needs to be done to provide these services to children and their families. The purpose of the National Child Traumatic Stress Initiative (NCTSI) is to improve treatment and services for all children and adolescents in the United States who have experienced traumatic events. The NCTSI seeks to: 1) improve the quality, effectiveness, and availability of therapeutic services delivered to traumatized children and adolescents, 2) further the understanding of the individual, familial, and community impact of child and adolescent traumatic stress and the methods used to prevent its consequences, and 3) reduce the frequency and consequences of traumatic events on children and adolescents through greater public recognition of the issue, deeper understanding of their sequelae, and improved prevention and treatment services.

As part of NCTSI, the National Center for Child Traumatic Stress (NCCTS) was established to coordinate a national effort to increase services and raise the standard of care for traumatized children. The program has established 54 treatment development and community service centers to treat children who have experienced trauma. Reporting for 2003 shows an average of over 10,000 traumatized children and their families in 18 states directly benefiting from services delivered as a result of the NCTSI. These data provide a baseline of approximately 40,000 children and adolescents served, and have been used to set performance targets for FY 2004 and FY 2005. Many thousands more will benefit from the improvement in treatments, the proliferation of training opportunities, and the many technical, educational and practical information resources that will be made available through the NCTSI Resource Center.

Performance Analysis

Measure 1. Increase the number of children and adolescents reached by improved services

The number of clients who directly and indirectly receive improved services is an important measure of the success of program aimed at children and adolescents who have experienced trauma. Once performance trends are known, targets may be set more aggressively. However, current performance is remarkable in terms of the high numbers of children who have been helped. Further, achieving future targets will result in a significant reduction in trauma related problems in children and adolescents across the Nation. The target of setting a baseline for this measure was achieved in 2003.

Measure 2: Improve Children's Outcomes

This outcome measure is developmental. Targets will be set when baseline data are available.

2. Youth Violence: Safe Schools/Healthy Students

Program Description and Context

The Safe Schools/Healthy Students (SS/HS) initiative was authorized by Congress under the Omnibus Consolidated and Emergency Supplemental Appropriation Act of 1999, Public Law 105-277. The program is an unprecedented collaboration among the Departments of Health and Human Services, Justice, and Education to encourage the development of comprehensive, community-wide strategies to promote healthy child development and prevent school violence and substance abuse. Performance measures are currently under development and will be available by March 2004.

Sites funded through the Initiative are required to establish a comprehensive, integrated strategy to promote healthy students and families in a safe school and community environment by establishing formal partnerships across three traditionally disparate sectors – education, mental health, and justice. Each local strategic plan addresses six required elements across the three sectors: (1) school safety, (2) safe school policies, (3) alcohol and other drugs and violence prevention and early intervention programs, (4) school and community mental health programs' preventive and treatment services, (5) early childhood psychosocial and emotional development programs, and (6) educational reform.

SAMHSA has held meetings with its partners DOJ and DOE to identify performance measures. A preliminary measure and indicators have been identified and are in the process of being cleared by DOE management. DOE is the lead partner for collecting GPRA data.

Full Cost Table

2. Safe Schools/Healthy Students reported by Dep't of Education** **Incorporates:**	**2003**	**2004**	**2005**
1.1* (100%)	$85.6	$82.9	$82.3
Total Full Cost *($'s in Millions)*	$85.6	$82.9	$82.3

*This measure and its indicators remain developmental

HIV/AIDS and Hepatitis C Priority Area

3. HIV/AIDS Minority Mental Health Services

Performance Goals (Capacity)	Targets	Actual Performance	Reference
1. Increase the number of clients served (E, O)	FY 05: TBR 6/04 FY 04: TBR 6/04 FY 03: Establish baseline	FY 05: TBR 6/06 FY 04: TBR 6/05 FY 03: TBR 6/04	**HHS SP 3.5**
Total Funding:	**2005: 9,510** **2004: 9,454** **2003: 9,510**		

Full Cost Table

3. HIV/AIDS Minority Mental Health Services **Incorporates:**	**2003**	**2004**	**2005**
3.1 (100%)	$10.2	$10.2	$10.2
3.2			
Total Full Cost Funding *($'s in Millions)*	$10.2	$10.2	$10.2

Program Description and Context

The HIV/AIDS Minority Mental Health Services Program is a five-year grant program to increase capacity to provide culturally competent mental health treatment services to individuals and communities of color living with HIV/AIDS, within a sustained continuum of services in community-based environments. The program will also identify types and frequency of mental health treatment services utilized by different groups, and pinpoint the types of mental health treatment providers needed in both traditional and non-traditional environments. The program specifically targets African American, Latino/Hispanic, and other racial and ethnic minority populations. The new grantees reflect a diverse range of service providers, including grassroots and indigenous community-based organizations.

Performance Analysis

Measure 1: Increase the number of clients served

This is an important outcome measure for the program consistent with the program goal. Grantees will be monitored to ensure that appropriate performance is achieved. The target of establishing a baseline was not met. Given circumstances beyond CMHS control through the closing of the MHHSC Coordinating Center responsible for collecting client data, FY 2003 client data are not yet available. However, a new Coordinating Center award was made in August 2003, and either through retrieval of already collected data or through resubmissions of data by

the sites, FY 2003 data will be available by FY 2004 to develop an accurate baseline number for this program.

Children's Priority Area

4. Comprehensive Community Mental Health Services for Children and Their Families

Performance Goals (Capacity)	Targets	Actual Performance	Reference
1. Increase in number of children receiving services (E)	FY 05: 9,120 FY 04: 8,000 FY 03: Establish baseline	FY05: TBR 10/05 FY04: TBR10/04 FY03: 7,032	**HHS SP 3.5** **HP 18-07 18-10**
2. Improve children's outcomes: (O)			**HHS SP 3.5**
(a) Increase in the percentage of children attending school 75% or more of time after 12 months	FY 05: 80% FY 04: 80% FY 03: 82.6% FY 02: 82.6%	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 75% FY 02: 76.7%	**HP18-07 18-10**
(b) Increase percentage of children with no law enforcement contacts at 6 months	FY 05: 53% FY 04: 50% FY 03: 47% FY 02: Establish new baseline	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 50.5%	
(c) Decrease utilization of inpatient facilities at 12 months (E,O)	FY 05: -3.65 days FY 04: -3.65 days FY 03: -3.00 days FY 02: Establish new baseline	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: -3.48 FY 02: -2.95	
(d) Decrease inpatient costs	FY 05: -$6,326,097 FY 04: -$6,326,097 FY 03: Establish new baseline	FY 05 TBR 10/05 FY 04: TBR 10/04 FY 03: -$6,024,855	
<u>Long-Term Measures</u> 3. Improve children's outcomes (60% of grantees will exceed a 30% improvement in outcomes)	FY 10: 30% FY 04: Estab. baseline	FY 10: TBR 10/11 FY 04: TBR 4/04	
4. Increase percent of systems of care sustained post Federal funding (80% of systems of care will be sustained post-funding)	FY 10: 80% FY 04: Estab. baseline	FY 10: TBR 10/11 FY 04: TBR 4/04	
5. Percentage of grantees that decrease inpatient care costs (25% of systems of care will exceed a 10% decrease in inpatient care)	FY 10: 25% FY 04: Estab. baseline	FY 10: TBR 10/11 FY 04: TBR 4/04	

Total Funding	**2005 $106,013** **2004 $102,353** **2003 $98,053**		

Full Cost Table

4. Comprehensive Community Mental Health Services for Children & Their Families **Incorporates:** *($'s in Millions)*	**2003**	**2004**	**2005**
4.1 (60%)	$60.3	$62.9	$65.0
4.2 (20%)	$20.0	$20.9	$21.7
4.3 (20%) (a) (b)	$20.0	$20.9	$21.7
4.4			
4.5			
4.6			
Total Full Cost Funding *($'s in Millions)*	**$100.3**	**$104.7**	**$108.4**

Program Description and Context

The Children's Mental Health Services Program supports the development of systems of care for children who have a serious emotional disturbance or diagnosable mental disorder. It is estimated that nationally, two-thirds of children with these disorders do not receive mental health services. At least one-third of children ages 12-21 who are served through the CMHS-funded systems of care appear to have dual mental and substance use problems. Findings from the National Evaluation suggest that the Program's unique approach especially benefits dually diagnosed children.

Program funds are available through competitive cooperative agreements to States, political subdivisions of States, Territories, and Indian Tribes or tribal organizations. Funds build on the existing services infrastructure so that the array of services required to meet the needs of the target population is available and accessible. Grants are limited to a total of 6 years, with an increasing non-Federal matching requirement over the term of the award to promote sustainability of the local systems of care beyond the grant period. It is estimated that over 18 of the first 22 (82%) grant communities initially funded in fiscal years 1993 and 1994 have continued to be sustained as service delivery systems since the federal program funds ended in fiscal years 1999 and 2000.

From 1993-2003, CMHS has funded grants in 46 States and 2 territories, and provided services to approximately 59,850 children. The program has served children in 274 of the 3,142 counties (9%) in the United States.

Performance Analysis

The Children's Mental Health program was reviewed by OMB through the PART process in 2002 for the FY 2004 budget, and received a "moderately effective" score. During this process, the program developed several long-term goals addressing clinical outcomes, sustainability, and cost-efficiency. These measures have been added to the table of measures.

Measure 1: Increase number of children receiving services (Measure modified in FY 2003)

This measure now reflects the total number of children served across sites, rather than the average number of children served per grantee.

A new numerical target of 8,000 has been set for fiscal year 2004. This target takes into consideration that from FY 2002 to FY 2003, 25 new cooperative agreements were funded representing over 40% of all sites funded during FY 2003. The newly funded grant sites are not expected to generate large numbers of children served until they are well into their third or fourth years of funding when the sites have had significant time to develop their new systems and services.

Measure 2: Improve children's outcomes:

(a) Increase percentage of children attending school 75% or more of the time after 12 months

The target was not met. The percentage of children achieving school attendance of 75% or more or the time has declined over the past several fiscal years. Because funding for some grantees funded in earlier cycles ended and new grantees were funded during these years, the mix of communities and types of children served has changed based on the program focus of each community. It is speculated that observed declines in this measure are related to changes in the specific characteristics of children served across the varying cohorts of communities represented in each fiscal year. Additional analytic work is needed to identify the specific child characteristics that may be related to school attendance, such as the level of mental health need.

(b) Increase percentage of children with no law enforcement contacts at 12 months

Target exceeded.

(c) Decrease utilization of inpatient facilities at 12 months

Target exceeded; FY 2004 target was increased by 5 percent.

(d) Decrease inpatient costs

Indicator (d) was added as a new indicator for FY 2003. The baseline was established with FY 2003 data. The FY 2004 and FY 2005 targets were established based on a 5% increase in savings due to a projected decrease in inpatient hospitalization utilization days from FY 2003 to FY 2004.

Long Term Measures

Measure 3: Increase the percentage of children with improved behavioral and emotional symptoms

80% of grantees will exceed a 30% improvement in behavioral and emotional symptoms among children receiving services. Data to be reported in 2011.

Measure 4: Increase percent of systems of care sustained post Federal funding

80% of systems of care will be sustained 5 years post funding. Data to be reported in 2011.

Measure 5: Percentage of grantees that decrease inpatient care costs

30% of systems of care will exceed a 10% decrease in overall inpatient care costs. Data to be reported in 2011.

Mental Health Systems Transformation Priority Area

5. Protection and Advocacy for Individuals with Mental Illness

Performance Goals (Capacity)	Targets	Actual Performance	Reference
1. Increase the number of persons served (O, E)	FY05: 22,000 FY04: 21,000 FY 03: 20,000 FY 02: 19,000 FY 01: Baseline	FY 05: TBR 7/06 FY 04: TBR 7/05 FY 03: TBR 7/04 FY 02: 18,566 FY 01: 17, 620	**HHS SP 3.5**
2. Increase the percentage of substantiated incidents reported to State P&A systems that are favorably resolved (O)	FY 05: 84% FY 04: 82% FY 03: 80% FY 02: 77% FY 01: 76% FY 00: 75%	FY 05: TBR 7/06 FY 04: TBR 7/05 FY 03: TBR 7/04 FY 02: 86% FY 01: 88% FY 00: 84% FY 99: Baseline: 75%	
Total Funding:	**2005: $34,620** **2004: $34,620** **2003: $33,779**		

Full Cost Table

5. Protection & Advocacy for Individuals w/ Mental Illness **Incorporates:**	**2003**	**2004**	**2005**
5.1 (50%)	$17.1	$17.5	$17.5
5.2 (50%)	$17.1	$17.5	$17.5
Total Full Cost Funding *($'s in Millions)*	$34.2	$35.0	$35.0

Program Description and Context

Protection and Advocacy for Individuals with Mental Illness (PAIMI) provides formula grant awards to support protection and advocacy (P&A) systems designated by the governor of each State, the Territories, and the Mayor of the District of Columbia. P&A systems investigate complaints of abuse, neglect and civil rights violations of PAIMI-eligible individuals with severe mental illness and severe emotional disturbance who reside in hospital or residential care settings. P&A Systems have the authority to investigate complaints at both public and private residential care and treatment facilities as well as non-medical community-based facilities for children and youth to ensure the enforcement of the U.S. Constitution and Federal and State laws. The program supports SAMHSA's Capacity goal by expanding the availability of protection and advocacy services. The program served 18,566 people in FY 2002.

Performance Analysis

Measure 1: Increase the number of persons served

The number served in 2002 narrowly missed the target. The expanded facility reporting required by the Children's Health Act of 2000 resulted in more P&A systems having to utilize legal remedies to gain access to clients, facilities and records, as they attempt to investigate incidents of seclusion, restraint and related deaths which slows investigations thus reducing the number served. The Healthcare Insurance Portability and Accountability Act (HIPAA) also puts constraints on the ability of P&A systems to investigate complaints which also slows investigations.

Measure 2: Increase the percentage of substantiated incidents of abuse, neglect, or rights violations reported to State P&A systems that are favorably resolved

The program substantially exceeded its FY 2002 target. Accordingly, targets for future years have been raised.

Homeless Priority Area

6. Projects for Assistance in Transition from Homelessness (PATH)

Performance Goals (Capacity)	Targets	Actual Performance	Reference
1. Increase number of persons contacted (E,O)	FY 05: 154,500 FY 04: 147,000 FY 03: 137,000 FY 02: 132,500 FY 01: 124,000 FY 00: 117,000 FY 99: 102,000	FY 05: TBR 7/07 FY 04: TBR 7/06 FY 03: TBR 7/05 FY 02: TBR 7/04 FY 01: 125,730 FY 00: 109,000 FY 99: 123,000 FY 98: 115,000 FY 97: 105,000 FY 96: Baseline 105,000	**HHS SP 3.5**
2. Increase percentage of persons contacted who become enrolled in services (O)	FY 05: 47% FY 04: 46% FY 03: 45% FY 02: 44% FY 01: 35% FY 00: 33% FY 99: 30%	FY 05: TBR 7/07 FY 04: TBR 7/06 FY 03: TBR 7/05 FY 02: TBR 7/04 FY 01: 43% FY 00: 42% FY 99: 36% FY 98: 37% FY97: 41% FY96: Baseline 41%	**HP-18-3**
3. Long term: Increase the percentage of enrolled homeless persons with serious mental illnesses who receive case management services.	FY 05: 73%	FY 05: TBR 7/07 FY 00 Baseline: 68%	
4. Long term: Increase the percentage of enrolled homeless persons with serious mental illnesses who receive community mental health services.	FY 05: 65%	FY 05: TBR 7/07 FY 00 Baseline: 44%	
5. Long term: Maintain cost of enrolling a person in services. (E)	FY 05: $668.00	FY 05: TBR 12/07 FY 03 Baseline: $668.00	
Total Funding:	**2005: $55,251** **2004: $49,760** **2003: $43,073**		

Full Cost Table

6. Projects for Assistance in Transition from Homelessness (PATH) **Incorporates:**	**2003**	**2004**	**2005**
6.1	22.0	25.3	28.1
6.2	22.0	25.3	28.1
6.3			
6.4			
6.5			
Total Full Cost Funding *($'s in Millions)*	$44.0	$50.7	$56.2

Program Description and Context

The Projects for Assistance in Transition from Homelessness (PATH) formula grant program, established in 1991, primarily supports SAMHSA's Capacity goal by expanding the availability of services to homeless individuals with serious mental illnesses. The program distributes Federal funds to each State, the District of Columbia, and certain US territories to support a broad array of individualized services to this vulnerable population. The program directly supports the Secretary's Initiative as well as SAMHSA's Homelessness priority area.

The goal of the PATH program is to provide services that will enable homeless persons with serious mental illnesses to be placed in appropriate housing and to receive formal mental health treatment and other resources to improve their mental health functioning. The statute specifies the range of services that may be supported by States under the program: outreach; screening and diagnostic services; habilitation and rehabilitation; community mental health services; alcohol or drug treatment (for those with co-occurring disorders); staff training; case management; supportive and supervisory services in residential settings; and referrals for primary health care, job training, and education. Some housing services may be provided as well. States have considerable flexibility in designing programs, and are required to match funds with one dollar for every three dollars received in Federal funds. In recent years, State and local support has been more than three times the amount required by the match.

Performance Analysis

Measure 1: Number of persons contacted.

The target was exceeded for 2001. As data reporting methods improve, the reported number of persons contacted has become more accurate. The program is taking several steps to improve the accuracy of reported data, including improvements in software, strengthened verification of questionable numbers, and increased training of State and local PATH-funded staff.

Measure 2: Increase percentage of persons contacted who become enrolled in services

The percentage of persons contacted who actually enrolled in services rose from 36% in FY 1999 to 42% in FY 2000, and to 43% in FY 2001. This increase considerably exceeded the target of 35% (targets for future years have been revised upward). Targets may appear conservative, however, the focus of this measure is the chronic homeless population, who are very difficult to reach. During OMB PART review in 2002, the long-term target of 47% was acknowledged as realistic given the enormous difficulties of serving this often intractable population.

Data Note: Most States award their annual PATH funds late in the fiscal year. Accordingly, there is an unavoidable data lag as States collect and compile data prior to submitting the data to SAMHSA. It is also important to note that this data lag also delays the apparent impact of any budget increase or decrease on performance data.

Long Term Measures

Measure 3: Increase the percentage of enrolled homeless persons with serious mental illnesses who receive case management services.

Baseline and targets set.

Measure 4: Increase the percentage of enrolled homeless persons with serious mental illnesses who receive community mental health services.

Baseline and targets set.

Measure 5: Maintain cost of enrolling a person in services.

Baseline and targets set.

Mental Health Systems Transformation Priority Area
7. Community Mental Health Services Block Grant

Performance Goals (Capacity)	Targets	Actual Performance	Reference
1. Number of people served (E,O)	FY 05: 4,405,386 FY 04: 4,361,769 FY 03: 4,318,584 FY 02: Baseline	FY 05: TBR 4/06 FY 04: TBR 4/05 FY 03: TBR 4/04 FY 02: 4,275,826*	**HHS SP 3.5**
<u>Long term target</u>:	FY 08: >5% over baseline	FY 08: TBR 12/08 *Preliminary data	
2. Reduce rate of readmissions to State psychiatric hospitals (a) within 30 days; and, (b) within 180 days. (O)	FY 05 Adults: (a) 6.5% (b) 15.5% Children/Adolescents: (a) 6.4% (b) 12.9% FY 04 Adults: (a) 6.6% (b) 15.7% Children/Adolescents: (a) 6.5% (b) 13.1% FY 03 Adults: (a) 8% (b) 18% Children/Adolescents: Baseline FY 02 Adults: Baseline	FY 05: TBR 4/06 FY 05: TBR 4/06 FY 04: TBR 4/05 FY 04: TBR 4/05 FY 03 Adults: (a) 6.8%* (b) 15.9%* Children/adolescents: (a) 6.7%* (b) 13.3%* FY 02 Adults: (a) 8.20%* (b) 18.10%*	
<u>Long term targets</u>:	FY 08 Adults: (a) 7.6% (b) 17.0% Children/adolescents: (a) 6.1% (b) 12.2%	FY 08: TBR 12/08 *Preliminary data	
3. Increase rate of consumers/family members reporting positively about outcomes (O) (a) Adults (b) Children/adolescents	FY 05: (a) 71.5% (b) 64.5% FY 04: (a) 71% (b) 64% FY 03: (a) 70.5% (b) 63.5% FY 02: Baseline	FY 05: TBR 4/06 FY 04: TBR 4/05 FY 03: (a) 72%* (b) 64%* FY 02: (a) 70%* (b) 63%*	
<u>Long term targets</u>:	FY 08: (a) 73% (b) 65%	FY 08: TBR 12/08 *Preliminary data	

4. Increase the number of (a) SAMHSA-identified evidence-based practices (EPBs) in each state and (b) the percentage of service population coverage for each EPB. (E) (Developmental) Long term target:	FY 05: TBR 4/04 FY 04: TBR 4/04 FY03: Establish baseline FY 08: TBR 4/04 FY 04: Estab. Baseline	FY 05: TBR 4/06 FY 04: TBR 4/05 FY 03: TBR 4/04 FY 08: 12/08 FY 04: 4/04	
Total funding:	**2005: $436,070** **2004: $434,690** **2003: $437,140**		

Full Cost Table

7. Community Mental Health Services Block Grant **Incorporates:**	**2003**	**2004**	**2005**
7.1 (60%)	$265.6	$264.2	$265.3
7.2 (20%)	$88.6	$88.3	$88.5
7.3 (20%)	$88.6	$88.3	$88.5
7.4			
Total Full Cost Funding *($'s in Millions)*	$442.8	$440.7	$442.2

Program Description and Co ntext

The Community Mental Health Services Block Grant addresses SAMHSA's goal of increasing capacity as well as the goal of promoting effective services. The Program assists the 59 eligible and participating States and Territories in moving care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) from costly and restrictive inpatient hospital care to the community. States have considerable latitude in determining how they will use funds. The program also provides strong support to the Effectiveness goal through the implementation of best practices. The Block Grant program supports multiple SAMHSA priority areas, including co-occurring disorders; children and families; and Mental Health Systems Transformation.

States vary widely in their ability to report mental health data depending upon data infrastructure and reporting capacity. Since its inception, CMHS has worked with States to improve data collection and reporting. Efforts have included working to develop performance measures, participant counts, and other program data. Some of these measures were piloted in the 16-State Project, which was designed to develop uniform data and unduplicated counts of people served by the State Mental Health Authority. Core measures for the Block Grant program were implemented on a voluntary basis in an effort to capture the data available at that time. Despite efforts to establish standard data definitions, these were not available through FY 2001.

Consequently, the data reported were not meaningful when aggregated or comparable across States or across time. These data issues have led to difficulty in quantitatively demonstrating the efficiency and effectiveness of the Block Grant program. In FY 2002, the Block Grant application contained a set of OMB-approved performance measures with more precise definitions, in an effort to obtain more uniform data.

The Children's Health Act of 2000 included a requirement to provide $6 million in PRNS funding for the enhancement of the States' and Territories' data infrastructure. Forty-seven States have now received grants to improve their ability to develop data standards for uniform, comparable, high-quality statistics on mental health services administered with Block Grant funds. Preliminary data that are the result of these grants are now being reported for GPRA measure 1,2 and 3.

The Children's Health Act further requires the Secretary, in conjunction with the States and other interested groups, to develop plans for creating more flexibility and accountability for States in the use of mental health and substance abuse block grant funds based on outcome and other performance measures.

In responding to this mandate, CMHS has worked with the States to develop three goals for performance measurement that describe the State Mental Health Authority (SMHA) Public Mental Health System, develop continued quality improvement (CQI) benchmarks for the SMHA Public Mental Health System, and improve the performance of the SMHA Public Mental Health System. Some of the measures will be replaced by Performance Partnership Measures in 2005. It is expected that all of these efforts will improve States' ability to report data on mental health services and recipients.

Performance Analysis

Measure 1 : Number of people served.

Preliminary data representing the actual number of people served by State mental health systems are now available. The baseline of 4,275,826 is now set with FY 2003 data and the FY 2004 target is set for 4,318,584. Previously, the number of persons served by the MHBG funds was estimated. CMHS continues to derive the estimate based on the average dollars spent by Medicaid clients for outpatient care. According to the estimate, 220,000 persons will be served by the block grant in FY 2005.

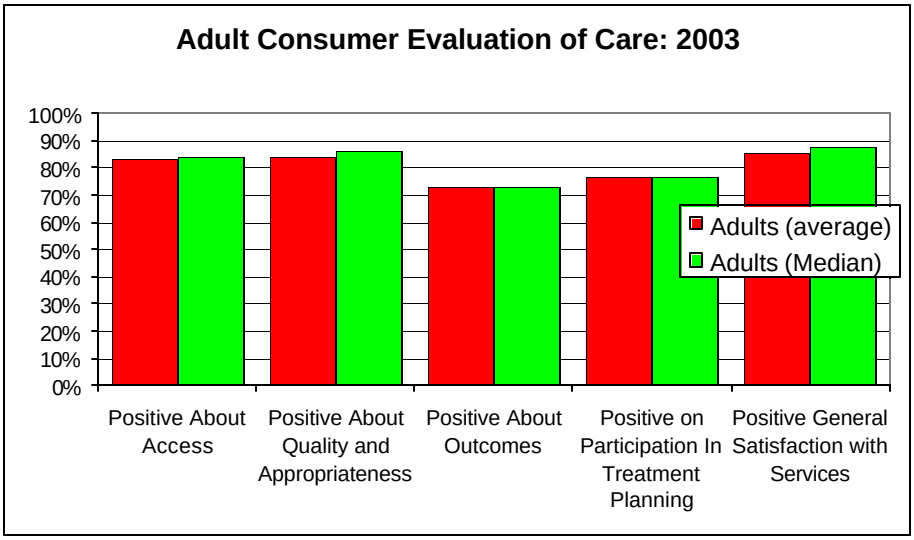
Measure 2: Reduce rate of readmissions to State psychiatric hospitals

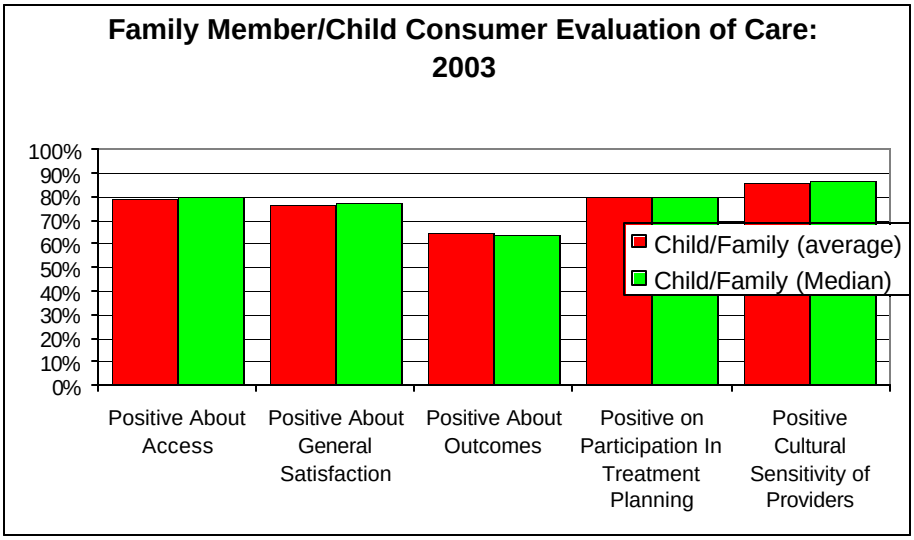
Both targets for this measure have been exceeded. Data reported is preliminary. For the indicator tracking adults, 36 States have reported. For the measure tracking children and adolescents, 28 States have reported. Success in community placement from inpatient settings and decreased need for inpatient care indicates that systems of care are working to support patients in the community.

Utilization of inpatient/residential treatment at 12 months is now computed differently. Prior to FY 2002, years, this measure included only children who already had a history of inpatient or residential care (only 5% of the children served by the program). The measure was re-defined to document in service use among the entire population of children served across the program's system-of-care communities. The sample of children for this measure no longer is a cumulative sample across grant years, but represents the sample of children for whom the CMHS evaluation contractor had received information on 12-month assessments conducted during a one-year period from 7/1/01 to 6/30/02. Accordingly, a new baseline has been established and future year targets have been revised. Note that because all children are included, most of whom will have no inpatient treatment, the baseline targets represent a much smaller average number of days.

Measure 3: Increase rate of consumers/family members reporting positively about outcomes

The targets for adults and children were exceeded, however, this is preliminary data and more complete data is needed before targets can be appropriately raised. The graphs below show consumer assessment of care as positive for both adults and children. This data represents 36 States reporting for adults and 28 States reporting for children.





Measure 4: Increase the number of (a) SAMHSA-identified evidence-based practices (EPBs) in each state and (b) the percentage of service population coverage for each EPB.

This long-term measure was developed as part of the OMB PART process. In order to operationalize this measure, a pilot study will be conducted in FY04 on the relationship between Evidence Based Practices and cost for baseline data.

Substance Abuse Prevention

Substance abuse prevention programs included in this report are:

8. State Incentive Grants
9. Centers for the Application of Prevention Technologies (CAPT)
10. Substance Abuse Prevention and HIV Prevention in Minority Communities
11. Synar Amendment
12. 20% Substance Abuse Prevention and Treatment Block Grant Prevention Set-Aside

Prevention Framework Priority Area

8. State Incentive Grants (Basic SIGs Program[1])

Performance Goals (Capacity)	Targets	Actual Performance	Reference
1. Increase State collaboration rating in the following areas: (a) prevention service delivery (b) prevention legislation/policies (c) use of prevention related resources	FY 05: a) 85% b) 43% c) 24% FY 04: 50% increase over baseline a) 84%, b) 42%, c) 23% FY03: 40% increase over baseline a) 79%, b) 40% c) 21% FY02: 35% increase over baseline a) 76%, b) 38% c)20% FY01: 30% increase over baseline a) 73%, b) 36% c) 19%	FY 05: TBR 9/06 FY 04: TBR 9/05 FY 03: TBR 9/04 FY 02:* a) 56% b) 40% c) 68% FY 01: a) 57% b) 52% c) 67%) FY 98: Baseline (a) 56% (b) 28% (c) 15%	**HHS SP 1**
2. Increase the number of science based programs being implemented by local sub recipients in SIG states (O,E)	FY 06: TBR 10/04 FY 05: 1,300 FY 04: 1,250 FY 03: 1,017 FY 02: 977 FY 01: Estab. baseline	FY 06: TBR 10/07 FY 05: TBR 9/06 FY 04: TBR 9/05 FY 03: TBR 9/04 FY 02: 1,055* FY 01: 818	
Total Funding:	**2005: $18,269** **2004: $31,316** **2003: $57,371**		

*Based on 29 States reporting. [1] The measures reported here are for the SIG Basic program only. Efforts to develop measures that will cover all of the SIG program line have been initiated.

Full Cost Table

8. State Incentive Grants (SIGs) **Incorporates:**	**2003**	**2004**	**2005**
8.1 (40%)	$25.91	$14.24	$8.32
8.2 (60%)	$38.87	$21.36	$12.5
Total Full Cost Funding *($'s in Millions)*	$64.78	$35.61	$20.80

***Numbers requested on 1/20/04**

Program Description and Context

State Incentive Grants (SIGs) are CSAP's Targeted Capacity Expansion mechanism for building prevention capacity. The SIG program improves States' capacity to address prevention needs in the States. These systems enable States to better utilize prevention resources, implement effective prevention program models, and coordinate prevention among different agencies and funding streams. Eighty-five percent of program funds provided under the SIG grants are channeled to local community-based and faith-based organizations, community partnerships and coalitions, workplace-based prevention and early intervention programs, local governments, schools, and school districts. A total of 44 States have received SIG awards as of FY 2003.

The SIG program is improving prevention programming in communities across the country by supporting the implementation of a wide array of programs that have been shown to be effective in preventing youth substance abuse. In 2004, CSAP will fund an estimated 1,300 community-based organizations to implement or enhance substance abuse prevention programs. It is estimated that these supported organizations implement more than 3,250 local prevention programs. An indicator of success is that the first five SIG States continue to support the prevention programs initiated under the SIG, even though SIG funding has ended. In addition, many States are better using their Block Grant funds by requiring that these funds also support science-based prevention programs.

Performance Analysis

Measure 1: Increase State collaboration rating in the following areas: (a) prevention service delivery (b) prevention legislation/ policies and (c) use of prevention related resources

This measure tracks performance in three important domains. A specific scaling instrument is used to score the collaboration from 1 – 100 percent. For FY 2002, the SIG program continued to exceed its target in two of the three collaboration measures, prevention legislation/policies and use of prevention resources. The target for prevention service delivery was not met, largely because a number of newer SIGs were included in the measure, and collaboration on service delivery requires a great deal of coordination and planning which newer programs require more time to achieve. To improve performance, CSAP will be working closely with the States to improve collaboration efforts in the ongoing implementation of the SIG, and raising awareness of the importance of improved collaboration and coordination that are the cornerstones of the systems change intended by the SIG.

Measure 2: Increase the number of science-based programs being implemented by local sub-recipients in SIG states

This measure is important in increasing the effectiveness of prevention services. In FY 2002, this measure was exceeded. FY 2004 and 2005 targets have been revised based on actual data on the number of subrecipients funded.

In addition to these results on the measures, SIG States have been successful in identifying and leveraging prevention funds. Preliminary information shows that some SIG States have coordinated up to 10 times the federal grant amount through matching funds.

9. Centers for the Application of Prevention Technologies (CAPTs)

Performance Goals (Capacity)	Targets	Actual Performance	Reference
1. Increase the number of persons served (E)	FY 06: TBR 12/05 FY05: TBR 12/04 FY04: 12,000 (See narrative) FY03: Additional data being collected to set target FY 02: Baseline	FY 06: TBR 12/06 FY 05 TBR 12/05 FY 04: TBR 12/04 FY 03: 20,275 FY 02: 18,207 (revised to include additional data)	**HHS SP-1**
2. Increase the number of systemic change outcomes in prevention systems. (O) (Replaces Measure 3 from FY 2003 GPRA plan)	FY 06: TBR 12/05 FY05: TBR 12/04 FY04: TBR 30 (See narrative) FY03: Additional data being collected to set target FY 02: Baseline	FY 06: TBR 12/06 FY 05 TBR 12/05 FY 04: TBR 12/04 FY 03: 48 FY 02: 79	
Total Funding:	**2005: $11,800** **2004: $11,104** **2003: $10,484**		

Full Cost Table

9. Centers for the Application of Prevention Technologies (CAPTs) **Incorporates:**	**2003**	**2004**	**2005**
9.2 (50%)	$5.9	$6.3	$6.7
9.1 (50%)	$5.9	$6.3	$6.7
Total Full Cost Funding *($'s in Millions)*	$11.84	$12.63	$13.44

Program Description and Context

The Centers for the Application of Prevention Technologies (CAPTs) are SAMHSA/CSAP's primary knowledge application program supporting CSAP's mission to bring effective substance abuse prevention to every community. The CAPTs form the cornerstone of CSAP's efforts to move prevention science into effective services. The CAPTs, through five regional technical assistance centers, serve State Incentive Grantees and their local sub-recipients, other States, many Tribes and US Territories, all 47 recipients of the US Department of Education Grants to reduce alcohol abuse grantees, and community-based organizations and coalitions. In FY 2004, the CAPTs will also serve Weed and Seed grantees for the U.S Department of Justice. The CAPTs promote state-of-the-art prevention technologies through three core strategies: 1) Establishment of a technical assistance network using local experts for each region, 2) Development of training activities, and 3) Innovative use of communication media (e.g., teleconferencing, online events, video conferencing, and Web-based support).

In FY 2003, the CAPT program was converted from the cooperative agreement funding mechanism to contracts. The program is currently in a transition period to establish a greater degree of consistency across the CAPT regions.

The CAPT data collection system has undergone revisions implemented in FY 2002 and operational for 2003 GPRA measures. Baseline data for the revised measures is reported using the new system. The new national CAPT data collection system reflects a number of conclusions about the most accurate and effective way to assess the work of the CAPTs. For example, the Technical Assistance (TA) database now focuses on overall TA services provided, and includes selected client ratings (satisfaction with and utility of CAPT service provided). The Event database now allows an examination of participant ratings (satisfaction with event and likelihood of using the information received). The new Systemic Outcomes database captures information on substantive changes that are related to the work of the CAPTs. This redesigned data system represents a significant commitment to tracking the impact of CAPT work.

Performance Analysis

Measure 1: Increase the number of persons served to build state/community level prevention capacity

The number of persons served in FY 2003 was 20,275, 11% higher than the previous year. As of January 2004, only 3 of the 5 contracts for regional CAPTs have been awarded. FY 2004 targets have been set lower because they are based on 3 rather than 5 CAPT centers, and to account for the transition from cooperative agreements to contracts.

Measure 2: Increase number of systemic change outcomes in prevention systems at the local, county, regional, state, national, or multi-national level.

In FY 2003, there were 48 additional systemic outcomes, representing a decrease from the baseline year. This short-term decrease is to be expected because, once system changes are implemented, these changes are refined and modified over time to obtain the desired outcome. Efforts are then devoted to maintaining and managing the implementation of the change. In addition, the number of newly funded SIGs has decreased, and the new SIG enhancements have only just been funded. Thus, it is more likely that increases in systems outcomes will occur in the future when the newly funded SIGs are able to document the CAPT's contributions to their systems.

HIV/AIDS and Hepatitis C Priority Area

10. Substance Abuse Prevention and HIV Prevention in Minority Communities

Performance Goals (Capacity)	Targets	Actual Performance	Reference
1. Increase perception of risk for substance use/abuse for youth (O)	FY 06: Cohort 2 ended. See narrative for discussion of data collection for Cohort 3. FY 05: TBR 9/04 FY 04: See narrative for discussion of data collection issues FY 03 Establish new baseline	FY 06: Cohort 2 ended. See narrative for discussion of data collection for Cohort 3. FY 05: TBR 12/05 FY 04: See narrative for discussion of data collection issues FY 03: TBR 5/04 See narrative for discussion of data collection issues	**HHS SP –1 HP 1 26-10 26-11d 26-14, 26-15**
2. Increase the number of integrated HIV service programs (O, E)	FY 06: TBR Cohort 2 ended. See narrative for discussion of data collection for Cohort 3 FY 05: TBR 9/04 FY 04: See narrative for discussion FY 03: See narrative for discussion FY 02: 55 services FY 01: Increase service by 30% FY 00: Establish baseline	FY 06: Cohort 2 ended. See narrative for discussion of data collection for Cohort 3. FY 05: TBR 9/06 FY 04: TBR 9/04 FY 03: TBR 5/04. See narrative for discussion FY 02: TBR 5/04. See narrative for discussion FY 01: Cohort 1- (a) youth: 100% increase (b) women: 100% increase (c) women and their children: 100% increase FY 00: Cohort 1-Baseline.: (a) youth: 1 (b) women: 0 (c) women and their children: 0	
Total Funding:	**2005: $44,988** **2004: $39,654** **2003: $39,799**		

Full Cost Table

10. Substance Abuse Prevention and HIV Prevention in Minority Communities **Incorporates:**	**2003**	**2004**	**2005**
10.1 (20%)	$8.9	$9.0	$9.0
10.2 (80%)	$36.0	$36.0	$36.07
Total Full Cost Funding *($'s in Millions)*	$44.94	$44.99	$45.09

Program Description and Context

The goal of this program is to increase the capacity of communities serving the target populations to deliver evidence-based substance abuse prevention and HIV prevention services. Prior to this initiative, few programs integrated prevention services in the fields of substance abuse and HIV. Substance abuse prevention and HIV prevention healthcare services need to be delivered in a comprehensive system to address the dual epidemics of substance abuse and HIV. Outcomes are anticipated to include decreasing the number of substance abuse-related HIV infections while decreasing the consequences of substance abuse. Increased service capacity will help address the health emergency within the communities targeted by the National Minority AIDS Initiative.

This multi-disciplinary approach disseminates integrated prevention models to meet the needs of racial/ethnic communities. The most critical challenge is the promotion of education of public health providers in substance abuse and HIV/AIDS to increase integrated prevention intervention strategies to address multiple risks, reducing known risk factors that cross domains.

Performance Analysis

Measure 1: Increase perception of risk for substance use/abuse for youth receiving services which integrate substance abuse prevention and HIV prevention. Operationalized as the youth receiving services which integrate substance abuse prevention and HIV prevention.

SAMHSA is currently re-evaluating data collection for the HIV. FY 03 baseline data are now expected to be available in May 2004. Future targets will be set beginning with FY 2005.

Measure 2: Increase the number of service programs that integrate substance abuse prevention and HIV prevention services

SAMHSA is currently re-evaluating data collection for the HIV program. FY 03 data are now expected to be available in May 2004. Future targets will be set beginning with FY 2005.

Prevention Framework Priority Area

11. Synar Amendment Implementation Activities (Section 1926)

Performance Goals (Accountability)	Targets	Actual Performance	Reference
1. Increase number of States* whose retail sales violations is at or below 20% (O)	FY 06: 52 States FY 05: 52 States FY 04: 50 States FY 03: 50 States FY 02: 35 States FY 01: 26 States (Was 36 States) FY 00: 26 States	FY 06: TBR 7/06 FY 05: TBR 7/05 FY 04: TBR 7/04 FY 03: 46 States FY 02: 42 States FY 01: 30 States FY 00: 25 States FY 99: 21 States FY 98: 12 States FY 97 Baseline: 4 States	
Total Funding:	**See SAPTBG program for budget information.**		

*States include the 50 States, the District of Columbia, and Puerto Rico

Full Cost Table*

11. Synar Amendment Implementation Activities (Sec. 1926) **Incorporates:**	**2003**	**2004**	**2005**
11.1 (100%)			
11.2			
Total Full Cost Funding *($'s in Millions)*			

***Full Costs are assigned to the SAPTBG through which this program is funded. See table on page 40.**

Program Description and Context

The goal of this program is to reduce the availability of tobacco products to youth under the age of 18. The program monitors State compliance with the requirement of the Synar legislation and its implementing regulation to enact and enforce laws to restrict the sale and distribution of tobacco products to minors. CSAP provides assistance to the States to enhance their ability to comply with Synar regulations. All States have established data collection and enforcement procedures to comply with Synar regulations, and many States are receiving technical assistance to improve their established procedures. CSAP also supports the States in reducing retail sales of tobacco to youth by providing guidance on policy and in assisting States with the identification of tobacco retail outlet lists. In addition, CSAP also provides guidance to improve collaboration between State and local authorities responsible for Synar compliance.

Performance Analysis

Measure 1: Increase number of States whose retail sales violations is at or below 20%

In FY 03, the target was not met; only 46 States/Territories achieved a sales violation rate of 20 percent or less. However, five additional States with violation rates slightly above the 20 percent target were found in compliance with the law by SAMHSA because their reported rates were within the required 95 percent confidence level of +/- 3 percentage points. Thus, a total of 51 States/territories were found in compliance with the Synar requirements. Further, 41 States reported sales violation rates of 15 percent or under, showing that those States achieved significantly better results than those required by law.

States that did not achieve the Synar goal of 20 percent or below reported that they experienced problems in implementing Synar due in part to budget reductions, which resulted in limited resources for program implementation and reductions in staff support. To ensure that these States meet the overall Synar goal, CSAP will continue to provide them with technical assistance services in the areas of enforcement, strategic resource allocation, program coordination and collaboration, and technology implementation, including individual State consultations with Synar Project Officers. In addition, CSAP is planning a multi-state technical assistance meeting early in Spring 2004 to assist these States with strategies to ensure program success and sustainability.

States continue to be required to achieve a 20% target rate beyond FY 2003. States that fail to achieve a 20 percent retailer violation rate with a sample margin of error of +/- 3 percentages points may receive a penalty of a 40% reduction in their total Block Grant funds.

Prevention Priority Area

12. 20% Prevention Set-aside, Substance Abuse Prevention and Treatment (SAPT) Block Grant

Performance Goals (Capacity)	Targets	Actual Performance	Refer-ence
1. Increase satisfaction with technical assistance (O)	FY 06: Maintain at 90% FY 05: Maintain at 90% FY 04: Maintain at 90% FY 03: Maintain at 90% FY 02: 90%satisfied; 80% response rate; 50% "outstanding" FY 01: 90% satisfied; 80% response rate; 40% "outstanding" FY 00: 90%; 60% response rate	FY 06: TBR 11/06 FY 05: TBR 11/05 FY 04: TBR 11/04 FY 03: 94% satisfied FY 02: 90% satisfied; 50% response rate FY 01: revised satisfaction survey under development FY 00: 90%; 60% response FY 99: 94%; 100% response FY 97 Baseline:90% satisfactory; 60% response; 25% outstanding	**HHS SP -1**
2. Increase services provided within cost bands (developmental) (E)	FY 06: TBR 10/05 FY 05: Establish baseline	FY 06: TBR 12/06 FY 05: TBR 10/05	

3. Youth who have not used illicit substances in the past year (O) (Developmental)	FY 06: TBR 10/05 FY 05: Establish baseline	FY 06: TBR 12/06 FY 05: TBR 10/05	
4. Perception of harm of drug use among program participants (O) (Developmental)	FY 06: TBR 10/05 FY 05: Establish baseline	FY 06: TBR 12/06 FY 05: TBR 10/05	
5. Changes in non-use and in use among program participants in the past 30 days (Developmental)	FY 06: TBR 10/05 FY 05: Establish baseline	FY 06: TBR 12/06 FY 05: TBR 10/05	
Total Funding:	**See SAPTBG program for budget information.**		

Full Cost Table

12. 20% Prevention Set-aside, Substance Abuse Prevention and Treatment (SAPT) Block Grant **Incorporates:**	**2003**	**2004**	**2005**
12.1 (100%)	$353.0	$358.2	$368.8
12.2			
12.3			
12.4			
Total Allocated Full Cost *($'s in Millions)*	**353.0**	**358.2**	**368.8**

Program Description and Context

As required by legislation, 20 percent of Block Grant funds allocated to States must be spent on substance abuse primary prevention services. CSAP administers the primary prevention components of the SAPT Block Grant Prevention service funding varies significantly from State to State. Some States rely solely on the set-aside to fund their entire prevention system; others use the funds to target gaps and enhance existing program efforts. CSAP requires under regulation that the States use their Block Grant funds to support a range of prevention services and activities in six key areas to ensure that each State offers a comprehensive system for preventing substance abuse. The six areas are information dissemination, community-based process, environmental strategies, alternative activities, education, and problem identification and referral. SAPT Block Grant funds are the foundation of most States' prevention systems, driving their prevention planning processes and setting standards for their overall prevention systems.

Development of performance measures continues to be an area of highest priority for CSAP. Performance information is used throughout the Center. Accomplishments have placed the agency in a strategic position to implement key provisions of Public Law 106-310, the Children's Health Act of 2000. This law requires CSAP to develop a plan for creating flexibility and accountability for States based on a common set of performance measures.

Performance Analysis

SAMHSA is working toward transforming the Block Grant into Performance Partnership Grants (PPGs). The PPGs will require greater accountability in exchange for State flexibility to design, implement, and evaluate community-based substance abuse prevention programs.
The PPGs include the development of performance measures to support planning in the Block Grant. At present, SAMHSA is finalizing a report on Performance Partnership Grants that was required by the Children's Health Act, and that identifies core measures.

Measure 1: Increase satisfaction with technical assistance

Performance was 94%, exceeding the target.

Measure 2: Services Provided within Cost-bands (Efficiency Measure under Development)

CSAP is developing an efficiency measure, and is considering developing cost bands for different types of prevention services. Baseline data are expected 10/05.

Measure 3: Percent of youth who have not used illicit substances (substances other than alcohol or tobacco) in the past year

This will be a key long-term outcome measure for the Performance Partnership Grant program, as required by PART. The data source will be 12th graders as measured by Monitoring the Future. Program-level data may also be reported. Baseline data are expected 10/05.

Measure 4: Perception of harm of drug use among program participants

This will be an annual measure for the Performance Partnership Grant program as required by PART. Baseline data are expected 10/05.

Measure 5: Changes in non-use and in use among program participants in the past 30 days (Developmental)

Prevention programs often include those who have not yet used substances, as well as those who have begun using. Thus, the programs aim not only to reduce use, but also to prevent or delay use among those who have not yet started. This measure will reflect the percentage of participants whose use of substances either declined or stayed the same from the start of the program through 6-month follow-up.

Substance Abuse Treatment

Programs included in this report are:

13. Targeted Capacity Expansion
14. Best Practices: Knowledge Application
15. Substance Abuse Prevention and Treatment Block Grant
16. Screening and Brief Intervention Referral to Treatment
17. Access to Recovery Voucher Program
18. Substance Abuse Set-Aside Data Activities

Treatment Capacity Priority Area

13. Targeted Capacity Expansion

Performance Goals (Capacity)	Targets	Actual Performance	Reference
1. Increase the number of clients served. (Annual) (E) <u>Long-term</u> Increase the number of clients served	FY 05: 30,158 FY 04: 29,567 FY 03: Maintain at 21,000 FY 02: Maintain at 21,000 FY 06: 30,761	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 28,988 FY 02: 7,792 clients FY 06: TBR 10/06	**HHS SP -1**
2.Increase the percentage of adults receiving services who: (O) (a) were currently employed or engaged in productive activities; (b) had a permanent place to live in the community; (c) had no/reduced involvement with the criminal justice system. (d) experienced no/reduced alcohol or illegal drug related health, behavioral, social, consequences	 FY 05: 47% FY 04: 45% FY 03: Maintain at 35% FY 02: 35% FY 05: 91 % FY 04: 89% FY 03: Maintain at 35% FY 02: 35% FY 05: 98% FY 04: 96% FY 03: Maintain at 35% FY 02: 35% FY 05: 85% FY 04: 83% FY 03: Maintain at 35% FY 02: 35%	 FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 42.9% FY 02: 63% FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 87.4% FY 02: 63% FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 94.6% FY 02: 63% FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 81.5% FY 02: 63%	**HP 2** **26-10c**

(e) had no past month substance use (Annual)	FY 05: 65% FY 04: 63% FY 03: Maintain at 35% FY 02: 35%	FY 05: TBR 10/05 FY 04: TBR 10/04	
Effectiveness 3. Increase the number of people who report no past month substance use (O) (Long Term; Developmental)	FY 06: +8% FY 03: Baseline	FY06: TBR: 10/06 FY 03: Baseline 61.1%	
Efficiency (E) 4. Increase the percentage of grantees in appropriate cost bands (Long Term; Developmental)	FY 06: +60%* FY 03: Estab. Baseline	FY 06: TBR 10/06 FY 03: TBR 10/04*	
Total Funding: **Note: FY 2005 includes $4.3M from the PHS evaluation fund**	**2005: $468,538** **2004: $370,826** **2003: $263,947**		

* See narrative for a discussion of how these were set.

Full Cost Table

13. Targeted Capacity Expansion **Incorporates:**	**2003**	**2004**	**2005**
13.1 (80%)	$226.0	$313.5	$392.3
13.2 (20%)	$56.5	$78.4	$98.1
13.3			
13.4			
Total Full Cost Funding *($'s in Millions)*	$282.49	$391.89	$490.32

CSAT has made considerable effort to move in the direction of coordinating performance and budget data by the introduction of an automated GPRA data collection and reporting system across all of its discretionary programs. With the introduction of the current GPRA data entry and reporting system, all data are now collected and reported near real time by summary to date as well as by fiscal years. Given the implementation of this new system, all of the Targeted Capacity Expansion (TCE) services program tables included in this report have been revised. The apparent discontinuity in the FY03 and later targets for TCE is the result of a shift in FY04 to using revised targets that are consistent with our long-term PART goals.

For FY05 CSAT has set four standard performance measures for the TCE program budget line: two performance measures for the services activities and two performance measures for the

knowledge application activities. For this submission, CSAT has aggregated the reporting for programs so that there is one narrative and four measures tracking performance for the entire TCE program budget line. This has reduced the number of TCE measures from 21 to 6. We expect also each year to select programs of special interest for additional descriptive reporting. For example, in FY04, as data become available, we expect to include additional descriptive reporting on the new FY 2003 Screening and Brief Intervention, Referral and Treatment (SBIRT) and later, on the new FY 2004 Access to Recovery program.

The 2002 OMB PART review of CSAT PRNS programs identified the need to develop long-term goals. These goals relate to the SAMHSA agency level goals for accountability, capacity and effectiveness. The goals are listed in the performance table.

Program Description and Context

Targeted Expansion program, begun in 1998, is designed to enhance or expand a community's ability to provide a comprehensive, integrated, creative, and community-based response to a targeted, well-documented substance abuse treatment capacity problem. The program addresses gaps in treatment capacity by supporting rapid and strategic responses to demands for substance abuse treatment services (including both alcohol and drugs) in communities with serious, emerging drug problems. The program also builds quality improvements into the treatment system, supporting SAMHSA's Effectiveness goal as well as the Capacity goal. Grantees include State, regional, and local government entities.

CSAT recognizes the disparity between the needs of certain under-served and under-represented minority populations and the ability to provide them treatment services. Within this budget line are the following programs:

TCE Programs Included in this Budget Line

General Population	Drug Courts	Rehabilitation and Restitution
HIV/AIDS	ADM disorders and violence	Strengthening Minority Communities
Addiction treatment for Homeless	Adolescent Residential Treatment/ Youth	Comprehensive Community Treatment programs
Strengthening Communities	Adolescent Treatment Models	Co-occurring Disorders Study

As discussed in the introduction, for the 2005 OMB submission, CSAT is aggregating performance reporting for the TCE services activities programs in this GPRA submission.

Performance Analysis

Measure 1: Increase the number of clients served

CSAT's primary mission is to bring effective alcohol and drug treatment to every community. The number of people served reflects the extent to which CSAT funding has supported the provision of service. This is measured through the GPRA Core Client Outcome Tool. The

target of 21,000 set for FY 03 was exceeded, with an actual performance nearly 30,000 clients served.

Measure 2: Employed or engaged in productive activities; had a permanent place to live in the community; had no/reduced involvement with criminal justice system; experienced no/reduced alcohol or illegal drug related health, behavioral, social consequences; had no past month substance abuse

Indicators are reported at 6 months as a percentage. The target for each indicator was met for FY 03. Future targets are set based on the performance in FY03.

Measure 3: Increase the number of people who report no past month substance use

The target for this long term effectiveness measure is currently set at an increase of at least 8% over baseline in FY 2006.

Measure 4: Increase the percentage of grantees in appropriate cost bands.

The target for this long term efficiency measure is currently set at an increase of 60% over baseline for FY 2006. This target was based on preliminary estimates of grantee performance in the past. However, in the absence of more final data CSAT will report this information in October 6 as we are moving toward collecting better quality cost measures.

Treatment Capacity

14. Program Title: Best Practices

Performance Goals (Effectiveness)	Targets	Actual Performance	Reference
1. Increase the training provided (a) Number of individuals trained per year. (Annual) (E)	FY 05: 22,148 FY 04: 21,714 FY 03: Baseline	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 21,289	**HHS SP -1**
(b) Increase number of events by 2006 (Long Term)	FY 06: TBR 12/03	FY 06: TBR 10/06	

2. Increase the percentage of participants who: (O) (a) would rate the quality of the events as good, very good, or excellent	FY 05: 85.4% FY 04: 83.4% FY 03: 80% FY 02: 70%	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 81.4% FY 02: 86.3%	
(b) shared any of the information from the events with others	FY 05: 22.98% FY 04: 20.98% FY 03: 80%* FY 02: 70%	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 18.98% * FY 02: 86.3%	
(c) have used information from "Best Practice" events or activities to promote or effect change. (Annual) <u>Long-Term</u> By 2006, increase by 8% the number of participants who have used information from Best Practice events or activities to promote or effect change	FY 05: 20.7% FY 04: 18.7% FY 03: 80%* FY 02: 70% FY 06: +8%	FY 05: TBR 10/05 FY 04: TBR 10/04 FY 03: 16.74%* FY 02: 86.3% FY 06: TBR 10/06	
<u>Efficiency (E)</u> 3. Increase the percentage of grantees in appropriate cost bands	FY 05: TBR 12/04 FY 04: TBR 12/04 FY 03: Establishing Baseline	FY 05: TBR 10/06 FY 04: TBR 10/05 FY 03: TBR 12/04	
Total Funding:	**2005: $48,494** **2004: $48,392** **2003: $53,331**		

*Note: The apparent discontinuity in the FY03 and later targets is the result of a shift in FY04 to using revised targets that are consistent with our long-term PART goals.

Full Cost Table

14. Best Practices **Incorporates:**	**2003**	**2004**	**2005**
14.1 (50%)	$24.2	$25.6	$25.4
14.2 (50%)	$24.2	$25.6	$25.4
14.3			
Total Full Cost Funding *($'s in Millions)*	$48.4	$51,141	$50,741

Program Description and Context

The Best Practices Program was created to promote the adoption of best practices to improve the effectiveness of substance abuse treatment. This budget program combines the Addiction

Technology Transfer Centers, Practice Improvement Collaboratives, Community Action Grants, Conference Grants, Recovery Community Support Programs and the STAR program. A key component in transferring addiction related technology is to provide evidence-based education and training to substance abuse treatment professionals.

These programs produce addiction-related publications to keep treatment professionals updated on the latest research and other cutting-edge issues that impact their work. These programs also provide ongoing education opportunities for the substance abuse field. Some of the innovative technologies utilized to provide education and training include: symposia, institutes, exhibit booths, newsletters, Web sites, meetings and technical assistance. Customers include a variety of professionals in fields such as addiction treatment, public health, and mental health, community corrections, social work, and criminal justice. These professionals connect with these programs individually or via Single State Authorities, academic institutions, community-based and managed care organizations, professional associations, and community organizations.

Program Performance Analysis

Measure 1: Increase: (a) the number of individuals trained per year and (b) the number of events per year.

This is a key measure tracking CSAT's mission of promoting effective treatment through the adoption of evidence-based practices. Tracking the number of individuals trained and training events is critical in documenting the delivery of service and dissemination of relevant information to the field. This is measured through the Core GPRA Customer Satisfaction Training Tool.

The baseline of 21, 289 participants reflects the actual performance of FY 03.

Measure 2: Increase percentage of stakeholders who (a) would rate the quality of the events as good, very good, or excellent; (b) shared any of the information from the events with others; (c) have used information from "Best Practice" events or activities to promote or effect change.

The FY 03 target of 80% satisfaction with the event was exceeded; however, the targets measuring use and sharing of the information were not met in FY 03. The reason for this is that targets needed to be reset so that they were consistent with those set in the OMB PART Review.

Measure 3: Increase the percentage of grantees in appropriate cost bands.

The target is currently set at 60% by the year 2006 with an annual incremental increase of 2% above the baseline set in the PART review. This is measured through the baseline number of clients served and a proportion (80%) of the budget dollars for the program going towards services for clients within these programs. The remaining 20% is for evaluation, and business expenditures such as overhead. This target was based on preliminary estimates of grantees performance in the past. However, in the absence of more final data, CSAT will report this information in October of 2006 as we are moving toward collecting better quality cost measures.

Treatment Capacity Priority Area

15. Substance Abuse Prevention and Treatment Block Grant

Performance Goals Strategic Goal: Capacity	Targets	Actual Performance	Reference
1. Number of Clients served: (E) Note: Baseline, targets, and proxy performance data currently provided by TEDS data set (see text), which reports admissions data.	FY 05: 1,963,851 FY 04: 1,925,345 FY 03: 1,884,654 FY 02: 1,751,537 FY 01: 1,635,422 FY 00: 1,525,688	FY 05: TBR 9/07 FY 04: TBR 9/06 FY 03: TBR 9/05 FY 02: TBR 9/04 FY 01: 1,739,796 FY 00: 1,599,701 FY 99: 1,587,510 FY 98: 1,564,156 FY 97: 1,537,143	**HHS SP -1**
2. Increase the number of States and territories voluntarily reporting performance measures in their SAPT Block Grant application.	FY 05: 25 FY 04: 25 FY 03: 25 FY 02: 25 FY 01: 25 FY 00: 19 Baseline established	FY 05: TBR 9/06 FY 04: TBR 9/05 FY 03: TBR 9/04 FY 02: 26 States/Territories reported some or all information. FY 01: 25 States reported some or all information. FY 00: 24 States reported some or all information FY 99: 0 States	
3. Increase the percentage of States that express satisfaction with Technical Assistance (TA) provided. (O)	FY 05: Maintain at 97% FY 04: Maintain at 97% FY 03: Maintain at 97% FY 02: Maintain at 97% FY 01: 97% FY 00: 90% FY 99: 85% Baseline established	FY 05: TBR 9/06 FY 04: TBR 9/05 FY 03: TBR 9/04 FY 02: 92% FY 01: 97% FY 00: 97% FY 99: 96%	
4. Increase the percentage of TA events that result in systems, program or practice change. (O)	FY 05: Maintain at 95% FY 04: Maintain at 95% FY 03: Maintain at 95% FY 02: 95% FY 01: 85% FY 00: 70% FY 99: 66% Baseline established	FY 05: TBR 9/06 FY 04: TBR 9/05 FY 03: 91% FY 02: 97% FY 01: 96% FY 00: 84% FY 99: 66%	

5. Increase the percentage of Block Grant applications that include needs assessment data.	FY 05: 97% FY 04: 95% FY 03: 93% FY 02: 90% FY 01: 85% FY 00: 80% FY 99: 72% Baseline established	FY 05: TBR 9/06 FY 04: TBR 9/05 FY 03: TBR 9/04 FY 02: 100% FY 01: 88% FY 00: 80% FY 99: 72%	
6. Increase the percentage of States that indicate satisfaction with CSAT customer service, throughout the entire Block Grant process. (O)	FY 05: 98% FY 04: 98% FY 03: 96% FY 02: 95% FY 01: 93% FY 00: 91%	FY 05: TBR 9/06 FY 04: TBR 9/05 FY 03: TBR 9/04 FY 02: 95% FY 01: 91% FY 00: 91%	
7. Increase the percentage of States reporting satisfaction with CSAT's responsiveness to State suggestions on services. (O)	FY 05: Maintain at 96% FY 04: Maintain at 96% FY 03: 96% FY 02: 95% FY 01: 94% FY 00: 93%	FY 05: TBR 9/06 FY 04: TBR 9/05 FY 03: TBR 9/04 FY 02: 91% FY 01: 90% FY 00: 93%	
8. Increase the percentage of states in appropriate cost bands (Efficiency measure)	FY 05: 60% FY 04: Establish Baseline	FY 05: TBR 8/05 FY 04: TBR 10/05* *See narrative discussion	
9. Percentage of clients reporting change in abstinence at discharge (Long-term)	FY 08: TBR 10/05 FY 05: Establish Baseline	FY 08; TBR 10/08 FY 05: TBR 10/05	
Total Funding:	**2005: $1,753,932** **2004: $ 1,779,146** **2003: $ 1,832,235**	**(Note: Funding also includes PHS Evaluation Funds)**	

Full Cost Table

15. Substance Abuse Prevention and Treatment Block Grant **Incorporates:**	**2003**	**2004**	**2005**
15.1 (40%)	$564.8	$573.1	$590.1
15.2 (10%)	$141.2	$143.3	$147.5
15.3 (10%)	$141.2	$143.3	$147.5
15.4 (10%)	$141.2	$143.3	$147.5
15.5 (10%)	$141.2	$143.3	$147.5
15.6 (10%)	$141.2	$143.3	$147.5
15.7 (10%)	$141.2	$143.3	$147.5
15.8			
15.9			
Total Full Cost Funding *($'s in Millions)*	**$1,412.1**	**$1,432.7**	**$1,475.2**

Program Description and Context

The SAPT Block Grant, the cornerstone of State's substance abuse programs, is an integral part of the President's Drug Treatment Initiative. Block Grant funding accounts for approximately 40% of public funds expended for prevention and treatment. The SAPT Block Grant is allocated to the States by a formula prescribed in the Public Health Service Act. The grant provides States the flexibility to plan, carry out, and evaluate substance abuse services. More than 10,500 community-based organizations receive SAPT Block Grant funding from the States.

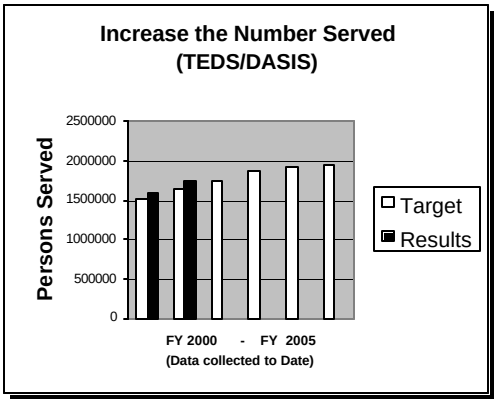
Program Performance Analysis

CSAT has approached performance measures development using a two-pronged strategy. First, CSAT piloted the collection of performance-based measures through grants to States and Territories. Second, CSAT is promoting consensus-building efforts among key stakeholders to refine the measures. CSAT also piloted State capacity to collect data on a small subset of the core measures beginning with the FY00 Substance Abuse Prevention and Treatment (SAPT) Block Grant application. This effort resulted in FY03 in 26 States/Territories voluntarily reporting some or all of these performance measures (see Measure 2).

Three barriers to effective performance measurement remain. First, the cost of conducting client outcome studies is significant even on a small representative sample. Second, there is a need to develop data infrastructure and management within State systems. Third, State capacity to utilize performance measurement varies. A CSAT study through the National Association of State Alcohol and Drug Abuse Directors (NASADAD) found that 1) 24 of the 56 States reviewed reported that they were able to submit data for analysis; and 2) periodicity of studies conducted, methodologies, and measure definitions used, vary significantly across the States.
Note that in FY 2005, $8.6 million in SAPTBG set-aside funds will provide data infrastructure support to States.

Measure 1: Number of clients served.

The FY 2001 target was exceeded. An estimated 1,739,796 clients were served. Future targets have been adjusted upward.



The number of client admissions reported is counted annually in the fiscal year being reported. The availability of TEDS data, like other major public health data sets such as births and deaths, reflects a 2 year lag period. Tracking numbers served is a critical component of any cost-benefit analysis.

Reporting of the exact number of clients served in Block Grant funded facilities remains under development. Tracking the unduplicated number of clients served by each State, which is the ideal way of reporting these data, requires that systems employ a unique client identifier. States are working toward providing unduplicated counts. Twenty-three States and Territories were able to report unduplicated counts in FY02. Some States are unable to report this information due to laws prohibiting the use of unique client identifiers and data system limitations. Therefore, the targets projected for the SAPT Block Grant continue to be based on the number of client admissions reported by TEDS data source.

Measure 2: Increase the number of States and territories voluntarily reporting performance measures in their SAPT Block Grant application.

The FY03 target was exceeded. Thirty-three States and the Virgin Islands reported on some or all of the measures, exceeding the target of 25, This is the fourth year States and Territories could report voluntarily on performance measures in their SAPT Block Grant application. A significant factor that may have affected State's interest in submitting these voluntary data is the evolving nature of the data elements. The FY03 Block Grant Application OMB approval will expire on July 31, 2004, including collection of this critical information on nine outcome measures. States may be waiting for final guidance from SAMHSA to finalize the Performance Partnership Grant plan before committing additional resources to collecting these data. The Performance Partnership Grant would focus on State systems accountability by requiring States to collect data in core client indicator areas and optional State-selected indices, measure current performance, set targets and adjust State system activities and priorities based on States performance relative to these targets.

Measure 3: Increase % of States that express satisfaction with Technical Assistance provided.

Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA's technical assistance provided over the past 12 months. CSAT conducts an annual customer satisfaction survey with the States/Territories on the block grant activities. The data source is an OMB-approved Customer Service Survey that is mailed annually to State Substance Abuse Directors to complete and is forwarded to CSAT contractor for data analysis and a final report is prepared. Reliability and validity were assessed as part of survey design, development, and pilot implementation, and were determined to be high. The survey supports service improvements by allowing for a modification of the program process to better respond to customer needs. In FY02, 49 of the 60 jurisdictions, including the District of Columbia, and Puerto Rico (excluding the Pacific Basin, Red Lake and Virgin Islands) were surveyed.

The FY02 target of 97% was not met. The overall satisfaction was found to be 92%. States reported that CSAT technical assistance improves their credibility within their state. Combining

the two highest categories (to a great extent and to some extent), the overall satisfaction was found to be 92%. Although the achieved results narrowly missed the target, ninety percent of the States reported overall satisfied or very satisfied with technical assistance received by CSAT.

Measure 4: Increase % of Technical Assistance events that result in systems, program or practice change.

The target was narrowly missed. We have modified our technical assistance approval process that prioritizes technical assistance that focus on program improvements and systems change as a top priority. We expect that the performance will improve to previous target levels.

Measure 5: Increase percentage of Block Grant applications that include needs assessment data.

Section 1929 of the Block Grant legislation requires States to submit an assessment of the need in the State for authorized activities by the States and locality.

The data source is the annual uniform SAPT Block Grant Electronic Application System that generates aggregated reports on State's submission of treatment Needs Assessment Summary Matrix (TNASM) (form 8) and State Use of Needs Assessment Information (SUNAI) (form 10). States are required to report needs assessment data on the TNASM form. Reliability and validity of states and territories reporting on Form 10 was piloted and assessed in the FY99 SAPT block grant application that determined the baseline of 72%.

The FY02 target was exceeded. All of the States and Territories (100%) (met and exceeded target by 15%) reported in their FY03 SAPTBG application on some or all of the needs assessment summary data matrix form using the last calendar year for which the State have the data. States and Territories also reported on multiple uses of State needs assessment data on the SUNAI (form 10). Many States view state needs assessment data as a planning tool that assists in management decisions about resource and/or method allocation to better serve communities in greatest need of substance abuse services. A majority of the States (86%) use needs assessment data for services planning and public information. While 69% of the States use needs assessment data for legislative initiatives, a number of states continue to use needs assessment data to allocate new funding (58%) and/or allocate historical funding (48%) to treatment providers.

Measure 6: Increase percentage of States that indicate satisfaction with CSAT customer service, throughout the entire Block Grant process.

Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA's service to the States throughout the entire Block process. CSAT conducts an annual customer satisfaction survey covering the past 12 months. The survey results support service improvements by altering program processes to better respond to customer needs.

The data source is the same as used in measures 3 and 4.

Measure 6: The FY02 performance target was met. The actual performance on this measure was 95%. In FY02, CSAT and CSAP developed new procedures for staff to follow that

streamlined the review process of SAPTBG applications to improve efficiency of internal operations. In FY03 a CSAT and CSAP Block Grant Re-Engineering Workgroup was established to develop new guidelines for working with the States under the new performance partnership grant application plan. This process is expected to result in further improvement in satisfaction with CSAT customer service.

Measure 7: Increase percentage of States reporting satisfaction with CSATs responsiveness to State suggestions on services.

This measure reports State's satisfaction with CSATs responsiveness to State suggestions on services. CSAT conduct an annual customer satisfaction survey with the States/Territories on the block grant activities. The survey supports service improvements by altering the program process to better respond to customer needs. The data source is the same used for measures 3, 4, and 6.

The FY02 performance target of 95% was not met. The customer satisfaction data reported 91% of states are satisfied or very satisfied with the responsiveness of CSAT to State suggestions by combining the two highest categories (satisfied and very satisfied). The actual performance level achieved remains relatively high.

Measure 8: Increase the percentage of States in appropriate cost bands (efficiency measure)

The long-term 2006 target is current set at 60% with an annual incremental increase of 2% above the baseline estimated for the OMB PART review. The cost bands were estimated based on guidance provided by an expert panel looking at a series of national studies. The baseline was estimated to be approximately 54%, however, there is no empirical program data to support this. The program data is expected to be captured by the FY 2005 application.

Measure 9: Percentage of clients reporting change in abstinence at discharge (long-term).

The measure is based on State reports within the annual block grant application that are reported annually on October 1. The FY06 and FY07 targets will be set based on data received in the annual application on October 1, 2005.

16. Screening and Brief Intervention, Referral and Treatment

Performance Goals Strategic Goal: (Capacity)	Targets	Actual Performance	Reference
1. Increase the number of clients served. (E)	FY 05: TBR 11/04 FY 04: TBR 11/04 FY 03: Establish baseline	FY 05: TBR 10/06 FY 04: TBR 10/05 FY 03: TBR 10/04	**HHS SP -1**
2. Increase the percentage of clients receiving services who: had no past month substance use (O)	FY 05: TBR 11/04 FY 04: TBR 11/04 FY 03: (Establish baseline	FY 05: TBR 10/06 FY 04: TBR 10/05 FY 03: TBR 10/04	
Total Funding:	**See PRNS program for budget information.**		

Full Cost Table*

This program is funded out of PRNS, therefore, full costs are assigned to the block grant program measures on page 80.

16. Screening, Brief Intervention, Referral & Treatment (SBIRT) **Incorporates:**	**2003**	**2004**	**2005**
16.1 (50%)			
16.2 (50%)			
Total Full Cost Funding *($'s in Millions)*			

Program Description and Context

Screening, Brief Intervention, Referral and Treatment (SBIRT) is a new program initiated at the end of FY03. Data collection for this program has not yet begun as the grants were not awarded until late in FY03. There is an emerging body of research and clinical experience that supports use of the SBIRT approach as providing effective early intervention for those persons who are nondependent users of illicit drugs. These cooperative agreements are to expand and enhance

State substance abuse treatment service systems by developing the State's continuum of care to include screening, brief intervention, referral, and treatment (SBIRT) in general medical and other community settings (e.g., community health centers, school-base health clinics and student assistance programs, occupational health clinics, hospitals, emergency departments); supporting clinically appropriate treatment services for nondependent substance users (i.e., persons with a Substance Abuse Disorder diagnosis) as well as for dependent substance users (i.e., persons with a Substance Dependence Disorder diagnosis); improving linkages among community agencies performing SBIRT and specialist substance abuse treatment agencies; and identifying systems and policy changes to increase access to treatment in generalist and specialist settings. It is estimated that approximately 7 States/Indian Tribes received awards in FY 2003.

Program Performance Analysis

Measure 1: Increase the number of clients served.

The number of people served reflects the extent to which CSAT funding has supported the provision of service. This will be measured through the collection of Core GPRA Client Outcome Tool data.

Measure 2: Increase the percentage of clients receiving services who had no past month substance use.

The percentage of clients receiving services who had not used substances in the past month at 6 months post admission reflects the extent to which CSAT funding has supported the provision of effective service. This will be measured through the collection of Core GPRA Client Outcome Follow Up Tool.

17. Access to Recovery Voucher Program

Program Description and Context

This measures for this program are developmental and will be included in a performance table when complete.

As envisioned, Access to Recovery (ATR) will be a voucher program administered by the States. The initiative would allow individuals seeking clinical treatment and recovery support services to exercise choice among qualified community provider organizations, including those that are faith-based. An initial assessment will be conducted for each individual to determine the appropriate level of service for that individual, which would include a range of possibilities including recovery support services, brief interventions and more intensive clinical treatment. This increase is part of the President's commitment to provide an additional treatment services over five years. This program will complement the State Targeted Capacity Expansion Program. Both are key components of the Presidential initiative to increase substance abuse treatment capacity, consumer choice, and access to a comprehensive continuum of treatment options, including faith-based programmatic options. The measures for this program are developmental,

and will be included in a performance table when complete. First grants are expected to be awarded in FY 2004.

Substance Abuse National Data Collection

Surveys conducted by OAS are the only source of national data on the extent of substance abuse in the general population and the characteristics of the treatment system. They also provide critical information for evaluating the success of Federal and State substance abuse programs.

18 Program Title: Substance Abuse National Data Collection

Performance Goals (Accountability)	Targets	Actual Performance	Reference
1: Availability and timeliness of data for the: (a) National Survey on Drug Use and Health (b) Drug Abuse Warning Network (c) Drug and Alcohol Services Information System (O,E)	FY 05: (a) 8 months; (b) 9 months; (c) 16 months FY 04: (a) 8 months; (b) 9 months; (c) 16 months FY 03: (a) 8 months; (b) 9 months; (c) 16 months FY 02: (a) 8 months; (b) 9 months; (c) 16 months FY 01:: (a) 8 months; (b) 9 months; (c) 16 months	FY05:TBR September 2005 FY04:TBR September 2004 FY03: (a) 8 months; (b) 8 months; (c)11months FY 02: (a) 8 months; (b) 8 months; (c) 13 months FY 01: (a) 8 months; (b) 7 months; (c) 12 months FY 98: Baseline: (a) 8 months (b) 12 months; (c) 13 months	
Total Funding: Req:	**See SAPTBG set-aside for budget information.**		

Full Cost Table

18. Substance Abuse National Data Collection	**2003**	**2004**	**2005**
Incorporates:			
18.1			
Total Full Cost Funding *($'s in Millions)*			

This program is funded out of the SAPTBG, therefore, full costs are assigned to the block grant program measures on page 80.

Program Description and Context

The National Survey on Drug Use and Health (NSDUH) is conducted under the legislative authorization of Section 505 of the Public Health Service Act (42 U.S.C. 290aa-4) which authorizes data collection for monitoring the prevalence of use of illicit substances and the abuse of licit substances in the United States population. The goal of the NSDUH is to provide critical estimates of the prevalence of substance abuse at the national level and in the 50 States and the District of Columbia. This survey collects annual data on substance abuse based on a nationwide probability sample of the civilian population age 12 and older. The survey provides data on the extent of substance abuse and perceptions of risk in the population, and the sociodemographic characteristics, criminal, and other behavioral activities of individuals with a substance abuse problem. The product of this initiative is important, accurate, and timely data to be used as performance measures by the Office of National Drug Control Policy and other Federal and State agencies engaged in efforts to reduce substance abuse.

The Drug Abuse Warning Network (DAWN) is authorized by Section 505(c)(1)(A) and (B) of the Public Health Service Act (42 USC 290aa-4), which require the annual collection of data on the number of individuals admitted to emergency rooms of hospitals as a result of the abuse of alcohol or other drugs and the number of deaths occurring as a result of substance abuse, as indicated in reports by coroners. The goal of this program is to provide timely estimates of drug-related emergency department visits at the national level, and for 21 large metropolitan areas. DAWN data are especially important in detecting new or emerging problems and establishing priorities for area surveillance.

The Drug and Alcohol Services Information System (DASIS) is authorized by of Section 505(c)(1)(C) through (F) of the public Health Service Act (42 USC 290aa-4) which require annual collection of information on the services available for substance abuse treatment in the United States, and on the characteristics of patients admitted to treatment. This program provides both national and State level information on the substance abuse treatment system. DASIS contains information on the characteristics and services of all known treatment programs in the country, and information on patients admitted to treatment programs receiving public funds.

DASIS also provides data necessary for the calculation of the treatment gap, a performance measure used by the Office of National Drug Control Policy to assess progress in the effort to reduce substance abuse. Information from DASIS is also used to compile the National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs, which is used extensively for treatment referrals

Program Performance Analysis

All three surveys have consistently met their targets for availability of data, despite the complexity of collecting, editing, and processing large data sets.

Part V.

APPENDIX TO THE PERFORMANCE PLAN

A. Linkage from SAMHSA GPRA Plan to SAMHSA and HHS Strategic Plans

A new SAMHSA strategic plan is under development, and the HHS Strategic Plan has been revised. The following table indicates the HHS goals and objectives SAMHSA programs support.

FY 2005 GPRA LINKAGE TABLE

(Dollars in thousands)

HHS STRATEGIC OBJECTIVE	FY 2003 Actual	FY 2004 Estimate	FY 2005 Estimate[3]
GOAL 1: Reduce the major threats to the health and well-being of Americans			
Objective 1.4 Reduce substance abuse			
Substance Abuse Block Grant[1]	**$ 1,753,932**	**$1,779,146**	**$1,832,235**
CSAT PRNS[1]	**$317,278**	**$419,219**	**$517,032**
CSAP PRNS[1]	**$197,111**	**$198,458**	**$196,018**
Objective 1.5 Reduce tobacco use, especially among youth Synar Amendment Implementation	No direct appropriation	No direct appropriation	No direct appropriation
GOAL 3: Increase the percentage of the Nation's children and adults who have access to regular health care and expand consumer choices			
Objective 3.5 Expand access to health care services for populations with special needs			
CMHS Block Grant	**$437,140**	**$434,690**	**$436,070**
CMHS PRNS	**$244,443**	**$240,796**	**$270,548**
Total:	**$2,949,904**	**$3,072,309**	**$3,251,903**

[1] Note: the Substance Abuse Block Grant and CSAT/CSAP PRNS addresses both 1.4 and 1.5, as well as other objectives. Multiple objectives are met by SAMHSA funding lines, but a best fit to one objective has been implemented in the table.

B.1 Changes and Improvements in SAMHSA's GPRA Plan Over Previous Year

SAMHSA has substantially rewritten the GPRA plan and report for the 2003-2005 planning and reporting cycle. In addition to eliminating a considerable amount of text, specific improvements include:

- reduction in the number of measures being reported from 2004 to 2005, emphasizing outcome and efficiency measures;
- dropping reporting on programs under $10 million to focus on SAMHSA's larger priority programs;
- integration of budget and performance information in one document;
- integration of OMB PART developed measures into the performance tables;
- following through on the performance measurement commitments made in the FY 2002 plan, obtaining needed data;
- ongoing development of new long-term measures in conjunction with the OMB PART review, and
- identification of measures that contribute to Healthy People 2010 goals.

B.2 Summary Table of Changes to FY 2004/2005 Goals /Targets from Previous FY

Summary: For the 2005 OMB submission, additional measures were dropped to comply with HHS and OMB reduction guidance. Programs under $10 million were also dropped from full reporting to focus on SAMHSA's larger priorities and to further reduce reported measures to comply with OMB and HHS guidance. The smaller programs that were previously included in the GPRA report, are now included in a small programs table along with basic program and performance information. Long-term and efficiency measures developed through the OMB PART were added to performance tables.

Center for Mental Health Services	
Statewide Family Network/ Statewide Consumer Network	Program and measures dropped from GPRA report in the FY 2005 OMB submission.
Circles of Care	Program and measures dropped from GPRA report in the FY 2005 OMB submission.
National Mental Health Information Center	Program and measures dropped from GPRA report in the FY 2005 OMB submission.
Community Action Grants for Service Systems Change	Program and measures dropped from GPRA report in the FY 2005 submission.
HIV/AIDS Minority Mental Health Services	.Measure 2,3 and 4 dropped in FY 2003.
Comprehensive Community Mental Health Services for Children and their Families	Measure 1 modified for FY 03 to reflect total number of children receiving services rather than average number per grant; measure 2 dropped in FY 2003; measures 5, 6 and 7 to dropped in FY 03; combined in FY 2003 PART long term measures added in FY 2005 submission.

Housing Initiative II	Program and measures dropped from the GPA report in the 2005 submission.
Protection and Advocacy	Measure 2 dropped in FY 03.
PATH	Measure 2 dropped in FY 03. Long term PART measures added in FY 2005 submission..
Community Mental Health Services Block Grant	Measures 1, 2, 3 and 6 dropped in FY 03; two new OMB PART measures added in FY 05:
Safe Schools/Healthy Students Initiative	Program added to plan. Department of Education has the lead for GPRA reporting.

Center for Substance Abuse Prevention	
SIG Program	Measure 2 dropped in FY 2005 submission.
NCADI program	Program and measures dropped from the GPRA report in FY 2005 submission.
National Public Education Effort	Program and measures dropped from GPRA report in the FY 2005 submission.
Synar Program	Measure 2- Measure met, dropped in FY 2003.
HIV Prevention Initiative	Measure 2 dropped in FY 2003.
Youth Connect High-Risk	Program and measures dropped from GPRA report in FY 2005 submission.
Family Strengthening	Program and measures dropped from GPRA report in the OMB submission.
Starting Early Starting Smart	Program and measures dropped from GPRA report in the FY 2005 submission.
Centers for the Application of Prevention Technologies	Measure 1- dropped in FY 2003.
Community Initiated Prevention Intervention Studies	Program and measures dropped from GPRA report in the FY 2005submission.
Workplace Managed Care	Program and measures dropped from GPRA report in the FY 2005 submission.
Substance Abuse Prevention and Treatment Block Grant:	Measure 1: Target met- 100% of all states and jurisdictions. Dropped in 2003. Measures 2-6 are being dropped in FY03. The OMB PARTs measure have been added in the FY 2005 submission.

Center for Substance Abuse Treatment	
TCE: General Populations	CSAT TCE programs are reporting aggregated performance data in the FY 2005 submission. The measures and indicators have not changed from the TCE measures utilized in FY 2004.
TCE: Women with ADM Disorders	Reporting has been aggregated in the FY 2005 submission.
TCE: Comprehensive Community Treatment	Reporting has been aggregated in the FY 2005 submission.
TCE: Practice Improvement Collaborative	Collaborative reporting has been aggregated in the FY 2005 submission.
TCE: Community Action Grant	Reporting has been aggregated in the FY 2005 submission.
TCE: Strengthening Communities - Youth	Reporting has been aggregated in the FY 2005 submission.
TCE: Addictions Treatment for the Homeless	Reporting has been aggregated in the FY 2005 submission.
Best Practices	Best Practices programs are reporting aggregated performance data in the FY 2005 submission.
Best Practices: Addiction Technology Transfer Centers	Reporting has been aggregated in the FY 2005 submission.
Best Practices: Knowledge Application	Reporting has been aggregated in the FY 2005 submission.
Opioid Treatment	Program and measures dropped in FY 2005 submission. Program and measures dropped from GPRA report in the OMB submission.
SAPT Block Grant	Long-term OMB PART measures added in FY 2005. Sections have been added to the FY 2005 budget for two new programs.

Substance Abuse National Data Collection	
NSDUH (National Survey on Drug Use and Health)	Reporting on three indicators is now consolidated in one measure.

President's Management Agenda	Performance reporting now occurs through other channels.

C. Partnerships and Coordination

SAMHSA shares responsibility for long-term performance outcomes such as reduction in the national rates of substance abuse with many different Federal, State, Community and non-profit partners. SAMHSA's established networks with its grantees and external partners contribute

significantly to the effectiveness of the agency. Partners and stakeholders include participation from multiple sectors:

- State and local governments, which administer the public mental health and substance abuse service systems;

- Non-profit treatment providers, such as community mental health clinics, substance abuse clinics and other community organizations;

- Other grantees or interested parties, such as hospitals, universities, community agencies and research institutes;

- Foundations, such as the Robert Wood Johnson Foundation, the Casey Family Foundation, and the Kaiser Family Foundation; and

- Current or former consumers/clients and their families.

- Faith-based and Community based Organizations

Examples of Key Federal Partners Include:

- The Office of National Drug Control Policy (ONDCP) coordinates the Federal agencies involved in the national drug control effort.

- National Institutes of Health (NIH) - NIH institutes closely work with SAMHSA and are vital partners in the "Science to Services" initiative. Primary links are with the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the National Institute of Mental Health. SAMHSA works closely with the Institutes to identify interventions demonstrated to be effective through research and evaluation. The Science to Service process brings together researchers, service providers, consumers and families, and government officials at all levels to speed the introduction of evidence-based practices into the community. It also brings these groups together to identify areas where clinical service needs are great and where research presently does not give adequate direction, thereby providing focus for Institute research agendas and SAMHSA Science to Service transmission activities.

- Department of Education - (DOE) Provides leadership for disseminating evidence based strategies in elementary, secondary and post-secondary education for reducing youth and young adult substance abuse. This includes ensuring that professional counseling programs integrate science based material into the curriculum. DOE has formed a collaboration with SAMHSA and other partners called the " The Safe and Drug-Free Schools Program." This program is designed to prevent violence in and around schools, and strengthen programs that prevent the illegal use of alcohol, tobacco, and drugs.

- Department of Justice (DOJ) - DOJ includes the Drug Enforcement Agency, the FBI, and the Office of the U.S. Attorney. DOJ is involved in interdiction and prosecutions relating

to the supply of illegal drugs. Reducing the supply of highly addictive drugs such as cocaine and heroin is important in reducing substance abuse of illegal drugs.

D. Data Verification and Validation

CMHS –-Methods for Verification and Validation

Program	Verification and Validation Information
HIV/AIDS Minority Mental Health Services	Data for this program will be obtained from grantee program records and management information systems.
4. Comprehensive Community Mental Health Services for Children and Their Families	The number of children served is obtained from grantees. The scale used to assess inpatient-residential treatment was an adapted version of the Restrictive of Living Environments Scale and Placement Stability Scale (ROLES) developed by Hawkins and colleagues (1992). An analysis showed that the percentage of agreement between data from the ROLES and data from a management information system in one grantee community was 76%. Data on children's outcomes are collected from a multi-site outcome study. Delinquency is reported using a self-report survey. Validity analyses were conducted for school attendance and law enforcement contacts. School attendance was found to have a positive relationship with school performance. Children who attended school frequently also had some tendency to receive good grades. The correlation between the two was .313 ($p = .000$). Data on family satisfaction with services were derived from the Family Satisfaction Questionnaire (FSQ), a measure widely used and recognized for its reliability and validity. Validity analyses indicated that there was a positive correlation of .263 ($p = .000$) between the FSQ, a care giver-reported instrument, and youth self-reported satisfaction. Data on clinical outcomes were derived from Reliable Change Index (RCI) scores (Jacobson & Truax, 1991), calculated from entry into services to six months for the Total Problem scores of the Child Behavior Checklist (CBCL, Achenbach, 1991). The Reliable Change Index (RCI) is a standardized method developed by Jacobson and his colleagues to measure change between two data points. The RCI has a clear-cut criterion for improvement that has been psychometrically tested and found to be sound (Jacobson & Truax, 1991).
5. Protection and Advocacy for Individuals with Mental Illness	Data sources for all PAIMI measures are the annual Program Performance Reports and Advisory Council Reports submitted annually by each of the P&A systems as required by the PAIMI Act. The information provided in the annual reports is checked for reliability during on-site PAIMI program visits, annual reviews, and budget application reviews. The information provided in each State's annual Program Performance Reports and Advisory Council Reports is reliable.
6. Projects for Assistance in Transition from Homelessness (PATH)	The source of the information is data submitted annually to CMHS by States, which obtain the information from local human service agencies that provide services. To improve the quality of the data, CMHS has developed additional error checks to screen data and contacts States and local providers concerning accuracy when data is reported outside expected ranges. CMHS has also issued guidance to all States and localities on data collection and monitors compliance with data collection through increased site visits to local PATH-funded agencies.

	PATH adopted quality control measures have eliminated much double counting of clients and will continue to improve data quality.
10. Community Mental Health Services Block Grant	New measure have been implemented on data reported through the annual Block Grant application. States have been supported by Data Infrastructure Grants, which provide definitions and standards.

CSAP - Methods for Verification and Validation

Program	Information
11. Synar Amendment Implementation Activities	Analyses of compliance rates are performed each year based on data reported in the SAPT block grant applications. The data source is the Synar report, part of the SAPT block grant application submitted annually by each State. States must certify that Block Grant data are accurate. The validity and reliability of the data are ensured through technical assistance, conducting random unannounced checks, and the confirmation of the data by scientific experts, site visits and other similar steps. CSAP is able to provide leadership and guidance to States on appropriate sample designs and other technical requirements, based on scientific literature and demonstrated best practices for effective implementation of Synar. Data sources for the baseline and measures are derived from State project officers' logs and from organizations that were awarded State technical assistance contracts. The analysis is based upon the actual requests/responses received, therefore providing a high degree of reliability and validity.
8. State Incentive Grants (SIGs)	States have agreed to use the same instruments and to collect the same types of data. Data will be collected through several mechanisms: State grantees, local (local community or provider project level) and school and community-based surveys. Data are being sent to a CSAP data retrieval system for entry and analysis. Quality of the data is expected to be high. States are responsible for local evaluations of a representative sample of these programs. In addition to the States' own evaluations of local programs, over the three years of their grants each State will report data from local subgroups of SIG funds to CSAP on a semi-annual basis for the national cross-site evaluation. The cross-site evaluation team is in the process of completing site visits during which they will evaluate program fidelity, adaptation, and implementation issues. Working toward performance based budgeting, CSAP is establishing and refining the SIG data collection system to gather information which will directly link cost to program participation. The next reporting cycle will include a measure which links States' SIG expenditures to the number of participants in SIG programs/activities. A baseline will be established for FY 2002.
10. Substance Abuse Prevention and HIV Prevention Initiative Program	It is expected that youth receiving substance abuse prevention services will have an increased perception of risk for substance abuse. These attitudes are expected to result in lower substance use. This program will use the SAMHSA GPRA cross-cutting instrument, which uses measures from reliable and valid instruments. Perception of risk has been shown to have high concurrent validity with drug and alcohol use and other negative behaviors. It is also expected that youth receiving integrated substance abuse prevention and HIV prevention services who have not yet begun sexual activity will delay their first sexual encounter, thus reducing their risk of HIV.

	The SAP/HIV program has developed a survey instrument using questions from established instruments to measure this goal. Data is being collected from individual sites on number, types, and quality of services.
9. Centers for the Application of Prevention Technologies (CAPTs)	The national CAPT data collection system reflects a number of critical decisions about the most accurate and effective way to assess the work of the CAPTs. For example, the Technical Assistance (TA) database now focuses on overall TA services provided, and includes selected client ratings (satisfaction with and utility of CAPT service provided). The Event database now allows an examination of participant ratings (satisfaction with event and likelihood of using the information received). In future reports, these client satisfaction data will be provided. The new Systemic Outcomes database captures information on substantive changes that are in some way related to the work of the CAPTs. This redesigned data system represents a significant commitment to tracking the impact of CAPT work. Each CAPT follows a quality control protocol prior to collecting and submitting data, and CSAP has established an external quality control system through a support contractor overseen by CSAP staff.
12. 20% Prevention Block Grant Set-Aside	Data are carefully collected, cleaned , analyzed and reported through a data coordinating center.

CSAT Verification and Validation of Data Section

Program	**Information**
15. Substance Abuse Prevention and Treatment Block Grant	The number of clients served is a critical measure for the Block Grant program, particularly in light of the national goal to narrow the substance abuse treatment gap. TEDS admissions data have been used as proxy data to set targets and track results. However, the TEDS data represent admissions to treatment, not the total number of individual clients served. A person who presents for treatment twice during the data collection cycle will be included twice in the TEDS data set. TEDS admissions data do not capture either the total national demand for substance abuse treatment or the prevalence of substance use in the general population; data only represents admissions to treatment at facilities within the scope of TEDS data collection. SAMHSA has been working intensively with the Office of National Drug Control Policy to improve estimation methodology for the number of clients served, while efforts with States focus on improving their ability to collect unduplicated client counts. While still developmental, data for the planned Performance Partnership Grant measures will be collected by community-based providers using standard instruments which will be administered to clients by trained interviewers. Data will be forwarded to the SSA's for analysis and subsequent reporting to CSAT, using the Annual Block Grant Application as a reporting vehicle. Adoption by the States of these measures, following further developmental work, is an appropriate current measure for this critical activity. Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA's technical assistance. CSAT conducts an annual customer satisfaction survey with the States/Territories on the block grant activities. The survey supports service improvements and helps the Block Grant program to be more responsive to customer needs. Reliability and validity were assessed as part of survey development, and implementation, and were determined to be high.

	An effective measure of the impact of technical assistance is positive changes that result and are maintained in those systems, programs or practices addressed during the course of the technical assistance activity. Selected measures have been included in a tracking system used with those receiving CSAT TA. The validity and quality of data were assessed in the survey design and development process and found to be high. One of the statutory requirements for the SAPTBG is that states base their planning for the use of Block Grant funds on needs assessments within the state. Data are collected via the annual Block Grant Application System. A 1998 GAO report identified some problems with the completeness and accuracy of the data reported by the States, and recommended that CSAT develop a plan for making improvements. Validity of the data under this system is reviewed as part of the approval of funding and specific feedback provided to individual States. In addition, reviews of the data are done as part of a cyclical block grant compliance review process required by statute.

E. Program Evaluation and GPRA Measurement

SAMHSA continuously conducts program evaluation and performance measurement to ensure effectiveness and efficiency of its program investments. In addition, SAMHSA also conducts management evaluations to improve efficiency and effectiveness. Evaluation studies enable focus on broader questions to develop needed information for management. Evaluation findings directly support agency policy development and program management. Collaboration on evaluation with ASPE and other Op Divs has been facilitated through SAMHSA's participation and support of the Research Coordination Council.

SAMHSA evaluates each of its service programs so as to provide information to program managers about the accountability of Federal funds. Currently, SAMHSA is cooperating with NIH in developing a Sciences to Services initiative to speed best practices into use. Evaluation of these Sciences to Services programs is needed to monitor effectiveness in different populations and conditions.

Evaluation findings demonstrate the extent to which grant programs have achieved their overall objectives, and provide information for program and policy development, as well as to refine strategies and performance objectives for future years. This evaluation policy helps SAMHSA achieve its goal of continually informing policy and program development with knowledge culled from past performance. This results in programs building on the success of preceding programs, in effect bench marking, so that SAMHSA can enhance the quality and relevance of publicly-funded substance abuse and mental health services.

Section F. Aggregated Full Cost Table

Performance Program Summary Table
Estimated Full Cost by Program

($'s in Millions)

Performance Program Area	FY 2003	FY 2004	FY 2005
1. Child Traumatic Stress Initiative	32.00	32.20	32.10
2. Safe Schools/Healthy Students	85.60	82.90	82.30
3. HIV/AIDS Minority Mental Health Services	10.18	10.20	10.20
4. Comp. Commun. Mental Health for Children & Families	100.30	104.70	108.44
5. Protection & Advocacy	34.20	35.00	35.00
6. Projects for Assistance in Transition from Homelessness (PATH)	44.00	50.70	56.20
7. Community Mental Health Block Grant	442.80	440.70	442.22
8. State Incentive Grants	65.30	39.00	22.70
9. Center for Application of Prevention Technologies	11.80	12.60	13.40
10. Substance Abuse Prevention and HIV Prevention Initiative	44.90	44.90	45.09
11. Synar Amendment[1]	---	---	---
12. 20% SAPT Block Grant Set-Aside	353.01	358.16	368.80
13. Targeted Capacity Expansion Programs	282.49	391.89	490.32
14. Best Practices Programs	57.14	51.11	50.67
15. Substance Abuse Block Grant	1,412.05	1,432.65	1,475.22
16. Screening, Brief Intervention, Referral and Treatment (SBIRT)[2]	---	---	---
17. Access to Recovery[2]	---	---	---
18. Substance Abuse Set-Aside Data Activities[2]	---	---	---
19. Samaritan Initiative	---	---	10.00
Total Full Cost of Performance Program Areas[3]	**$2,975.8**	**$3,086.7**	**$3,242.7**

1. The full cost of Synar activities are included with the Center for Substance Abuse Prevention PRNS.

2. The full cost for these activities is included with the PRNS program line.

3. SAMHSA is in the process of changing its reported performance measures toward significant aggregation of performance and full cost information that should result in a higher distribution of full costs against performance measures in 2006.

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