DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2009

Substance Abuse and Mental Health Services Administration

Online Performance Appendix

Introduction

The Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS') performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through HHS agencies' FY 2009 Congressional Justifications and Online Performance Appendices, the Agency Financial Report and the HHS Performance Highlights. These documents can be found at: http://www.hhs.gov/budget/docbudget.htm and http://www.hhs.gov/afr/.

The Performance Highlights briefly summarizes key past and planned performance and financial information. The Agency Financial Report provides fiscal and high-level performance results. The FY 2009 Department's Congressional Justifications fully integrate HHS' FY 2007 Annual Performance Report and FY 2009 Annual Performance Plan into its various volumes. The Congressional Justifications are supplemented by the Online Performance Appendices. Where the Justifications focus on key performance measures and summarize program results, the Appendices provide performance information that is more detailed for all HHS measures.

The SAMHSA Congressional Justification and Online Performance Appendix can be found at http://www.samhsa.gov/Budget/FY2009/index.aspx.

Summary of Performance Targets and Results Table
SAMHSA

FY	Total Targets	Results Reported		Targets		
		Number	%	Met	Not Met	% Met
2004	43	43	100%	29	14	67%
2005	55	54	99%	29	25	54%
2006	75	74	99%	37	37	50%
2007	82	48	59%	25	23	52%
2008	109					
2009	113					

Performance Detail

Mental Health Services – Programs of Regional and National Significance

Suicide Prevention

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target (FY 2012)
				Target	Actual	Target	Actual			
Long-Term Objective: Reduce the number of youth suicide deaths and attempts.										
2.3.57	Reduce the number of suicide deaths	32,439	Apr-08		Apr-09	31,084	Apr-10	30,984	Apr-08	30, 584
2.3.58	Increase the number of students exposed to mental health and suicide awareness campaigns on college campuses					Baseline	662,774	662,774	662,774	
2.3.59	Increase the total number individuals trained in youth suicide prevention					Baseline	75,186	97,742	127,065	

SAMHSA's Suicide Prevention portfolio includes campus, state, and tribal activities related to the FY 2004 Garrett Lee Smith Memorial Act, as well as a Suicide Prevention Hotline, Suicide Prevention Resource Center and an American Indian/Alaska Native Suicide Prevention Initiative.

Baseline data have been reported for new outcome and output measures. The number of suicide deaths represents national data. The number of individuals trained includes mental health professionals as well as teachers, police officers, social service providers, advocates, coaches, and other individuals who frequently interact with youth. The output measures reflect data from the Suicide Prevention Hotline.

Youth Violence (Safe Schools/Healthy Students-SS/HS)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
3.2.04	Increase the number of children served			Base line	1,062,963	1,062,963	1,098,214	1,062,963	1,062,963	
3.2.05	Improve student outcomes and systems outcomes: (a) Decrease the number of violent incidents at schools [1] (1) Middle schools			Base line	30.8%	30%	36.6%	36%	36%	
3.2.06	2) High schools			Base line	24.2%	24%	29.8%	29%	29%	
3.2.07	(b) Decrease students' substance use[2] (1) Middle schools			Base line	16.9%	16%	16%	16%	16%	
3.2.08	(2) High schools			Base line	35.3%	35%	35%	35%	35%	
3.2.09	(c) Improve students' school attendance[3]			Base line	92.6%	93%	95.1%	93%	93%	
3.2.10	(d) Increase mental health services to students and families[4]			Base line	45.5%	46%	46%	46%	46%	

[1]Average percentage from sites reporting on students who have experienced some sort of violent incident at least once.
[2]Average percentage of sites reporting students' use of alcohol at least once in the last 30 days.
[3]Average attendance rate reported by sites.
[4] Average percentage of students receiving services following a mental health referral.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
3.2.21	Percentage of grantees that provided screening and / or assessments that is coordinated among two or more agencies or shared across agencies.					Base-line	66.1 %	67.1%	68.1%	
3.2.22	Percentage of grantees that provide training of school personnel on mental health topics					Base-line	64.4%	65.4%	66.4%	
	Appropriated Amount ($ Million)	$94.3	$94.2		$93.2		$93.2	$93.0	$75.7	

Number of children served (3.2.04): The performance target for this measure was set at an approximate target level, and the 3% deviation from that level is slight. There was no effect on overall program or activity performance

Improve student outcomes and systems outcomes: (a) Decrease the number of violent incidents at Middle schools and High Schools (3.2.05-3.2.06): Data collection for this program was just beginning last year, and preliminary baselines were set for measures based on FY 2006 data available for only 6.3 percent of the total number of children served or 67,361. Actual FY2006 baseline data for 3.2.05 (38%) and 3.2.06 (28.9%) suggests that the initial baseline underestimated levels of violence, and as a result the FY 2007 target was not met (a seven percentage point deficiency is reported). Targets were revised for FY2008 and FY 2009 based on actual FY2006 and FY2007 data.

Trauma-Informed Services (National Child Traumatic Stress Initiative - NCTSI)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective: Increase the specialized adaptation of effective treatment and service approaches for communities across the country										
3.2.01	Increase the number of children and	51,296	50,660	39,600	33,910	33,910	31,446	33,910	16,955	

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
	adolescents receiving trauma-informed services									
3.2.02	Improve children's outcomes		37%	37%	35%	37%	56%	37%	37%	
3.2.03	Dollars Spent per person served *		$497	$493	$741	$480	$774**	$774	$774	

**This measure was approved by OMB in May 2006 as an interim efficiency measure until a final PRNS-wide efficiency measure is developed.*
**Corrected from previously reported result

In FY 2007, the reported number of children receiving services (measure 3.2.01) was 31,446, 7 percent lower than the projected target of 33,910. Nineteen of 32 currently funded Category III centers, which are the primary service delivery systems in the National Child Traumatic Stress Network, began the final year of their awards. Typically, grantees in their final year may have modest service numbers drop due to "draw-down" activities. Further, direct service provision may not be a grantee's primary strategy for increasing access of children and their families to trauma-informed interventions. This measure has had a downward trend over the last four years. In FY 2007, CMHS implemented a web-based GPRA data collection system called Transformation Accountability (TRAC). The NCTSI began using the TRAC in early FY 2008 and will ensure the capture of an unduplicated count of children served, thus the reported numbers are expected to be lower. Future targets have been adjusted based on data from the new system.
The target for improving children's outcomes was exceeded considerably in FY 2007, after declining slightly from 2005 to 2006. The program is examining this result, which appears to be anomalous compared with those of the last two years. Targets have been kept at stable levels until additional years of data are obtained.

Dollars Spent per person served. The efficiency measure simply divides the budget for the program by the number served. As discussed above, the number of children served decreased in FY 2007 due to fluctuations in the grant cycle, and that direct service provision may not be a grantee's primary strategy for increasing access of children and their families to trauma-informed interventions. Future targets are based on anticipated fluctuations in the grant cycle.

Remaining Capacity Activities

PRNS Combined Capacity (includes Jail Diversion, Older Adults, and HIV/AIDS)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective: Capacity programs include services program, which provide funding to implement service improvements using evidence based practices, and infrastructure programs, which identify and implement needed changes.										
1.2.01	Rate of consumers reporting positively about outcomes (State mental health system)	71%	71%*	73.5%	71%	74%	Sept-08	71%	71%	
1.2.02	Rate of family members reporting positively about outcomes (State mental health system)	65%	73%*	71%	73%	71.5%	Sept-08	74%	74%	
1.2.03	Rate of consumers reporting positively about outcomes (program participants) **					Baseline	98%	98%	98%	
1.2.04	Rate of family members reporting positively about outcomes (program participants) **					Baseline	Dec-08	Dec-08	Dec-08*	
1.2.05	Increase the percentage of clients receiving services who report improved functioning					Baseline	93%*	93%*	93%*	
1.2.07	Percentage of people in		44 %							2015: 50 percent

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
	the United States with serious mental illnesses in need of services from the public mental health system, who receive services from the public mental health system									

*Due to a transcription error, the result for 2005 was incorrectly reported in previous GPRA reports. The correct result is reported here.
**Due to the implementation of the TRAC reporting system in FY 2007, data received by December 2007 is incomplete.
*** Data for this measure is collected from programs serving children , which did not begin using the TRAC system until FY 2008.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
Long-Term Objective 3:										
1.2.06	Number of a) evidence based practices (EBPs) implemented	2.3 per state**	3.9	3.3	3.9	3.8	Sept-08	4.0	4.0	
1.2.08	Number of b) Adults - percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice)	9.3%***	9.7%	10.3%	9.5%	10.8%	Sept-08	10.8%	10.8%	
1.2.09	Number of c) Children -	1.7%***	3.4%	2.3%	2.2%	2.6%	Sept-08	2.6%	2.6%	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
	percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice)									
	Appropriated Amount ($ Million)	$67.4	$107.2		$83.7		$80.2	$101.3	$25.8	

* **National average of evidence-based practices per state, based on 35 states reporting
***Excludes Medication Management and Illness Self-Management, which continue to undergo definitional clarification

Measures 1.2.01 and 1.2.02 reflect the results for the *nationwide public mental health system*, as reflected in data from the Uniform Reporting System, and includes people receiving services in state psychiatric hospitals as well as those receiving services through community mental health programs The performance target for consumers and family members reporting positively about outcomes were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

The last two annual measures, although worded identically to the long-term measure, reflect results for *participants in CMHS PRNS service programs*. Baseline data for consumers has been reported. Baseline data for family members will be reported for FY 2008 because data for these measures is collected from programs serving children, which did not begin using the TRAC system until FY 2008.

The evidence-based practices measures reflect the program's efforts to improve the efficiency and effectiveness of mental health services. For FY 2006, the target for the number of evidence based practices was exceeded for States reporting. The evidence based practice percentage of coverage for adults was missed by just .08 percent and for children; the target was missed by just one-tenth of one percent. These targets were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

A study to recommend a cost efficiency measure will be conducted FY 2008. It is expected that baseline data will be available by October 2009. This measure is expected to be applied to all program activities.

Co-occurring State Incentive Grants

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
1.2.18	Increase the percentage of treatment programs that (a) Screen for co-occurring disorders				See narrative	Base line	Nov-09	Nov-09	Nov-09	
1.2.19	(b) Assess for co-occurring disorders				See narrative	Base line	Nov-09	Nov-09	Nov-09	
1.2.20	(c) Treat co-occurring disorders through collaborative, consultative, and integrated models of care.				See narrative	Base line	Nov-09	Nov-09	Nov-09	
1.2.21	Increase percentage of clients who experience reduced impairment from their co-occurring disorders following treatment				See narrative	Base line	Nov-09	Nov-09	Nov-09	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
1.2.17	Increase the number of persons with co-occurring disorders served.				See narrative	Base line	Nov-09	Nov-09	Nov-09	
	Appropriated Amount ($ Million)	$15.4	$19.8		$18.6		$13.9	$7.9	$.4	

This program is jointly administered by CMHS and CSAT.

The first three years of these grants focus on infrastructure development and enhancements. After this period, grantees may implement service pilot programs, which will generate data for the above outcome measures. Although baseline data was originally expected to be reported by December 2006, it has been delayed due to refinements needed in the data collection instrument and procedures.

Comprehensive Community Mental Health Services for Children and Their Families (Children's Mental Health Initiative)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long term Objective: Improve the accessibility and effectiveness of services for children and youth with serious mental health challenges and their families.										
3.2.11	Increase the percent of funded sites that will exceed a 30 percent improvement in behavioral and emotional symptoms among children receiving services for 6 months (LT)									60% (FY 2010)
3.2.12	Improve children's outcomes and systems outcomes (a) Increase percentage attending school 80% or more of time after 12 months	90.9%	80.2%	84%	89.7%	84%	87%	84%	84%	
3.2.13	Improve children's outcomes and systems outcomes (b) Increase percentage	67.6%	68.3%	68%	69.3%	70%	71%	69%	69%	

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
	with no law enforcement contacts at 6 months									
3.2.14	(c) Decrease average days of inpatient facilities among children served in systems of care (at 6 months)	-2.03	-1.75	-3.65	-1.00	-2.00	-1.78	-2.00	-2.00	
3.2.15	Long Term Goal: Percent of systems of care that are sustained 5 years post Federal Funding							80%		
3.2.17	Decrease in inpatients care costs per 1,000 children served			Base-line	$1,335,000	$2,670,000	$2,376,000	$2,670,000	$2,670,000	

	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
3.2.16	Increase number of children receiving services	10,521	9,200	9,120	10,339	9,120	10,871	10,000	10,000	
	Appropriated Amount ($ in Millions)	$102.3	$105.1		$104.0		$104.0	$102.2	$114.4	

The FY 2007 target for school attendance, measure 3.2.12, was set at an approximate level, and the deviation from that level is slight. The target was exceeded by 3 percent. Targets have been maintained level for a number of reasons: Grantees vary in the populations they serve, and those grantees that serve high-risk and/or older children may be less able to achieve these high levels of school attendance. Performance for this measure will vary somewhat depending on the mix of grantees and individuals served in any given year. However, the actual figure obtained for FY 2007 indicates that the program performed better than the average population of children and youth in the United States; this despite the fact that children and youth served by the program

experience serious mental health challenges that are likely to impede their school attendance. Performance on this measure has fluctuated over the last four years with no clear trend.

The FY 2007 target for no law enforcement contact was set at an approximate level, and the deviation from that level is slight. The FY 2007 target was exceeded by 1 percent. However, grantees vary in the populations they target, and those grantees that serve youth in the juvenile justice system may be less able to achieve reductions in law enforcement contacts. Performance for this measure will vary somewhat depending on the mix of grantees and individuals served in any given year. The FY 2008 and 2009 targets are set at approximately the average performance level of the last four years.

The performance target for reduction in days of inpatient care (measure 3.2.14) was set at an approximate target level, and the deviation from that level is slight. The FY 2007 target was nearly achieved. However, there was almost 80 percent improvement, which is equal to a reduction of .78 days as compared to the result obtained in FY 2006. Grantees funded in FY 2005 serve proportionately larger numbers of very young children who generally have shorter and less frequent hospitalizations. Given this change in populations served, and the sensitivity of the measure to the length of hospitalization *prior to service intake*, the targets for this measure remain stable through 2009.

The efficiency measure reflects per-unit changes in costs. The performance target for measure 3.2.17 was set at an approximate target level, and the deviation from that level is slight. The FY 2007 target for reduction in costs of inpatient care was nearly achieved. However, there was almost 73 percent improvement as compared to the result obtained in FY 2006. One of the main goals of the program is to provide least restrictive services to children and youth served by the grantees. More restrictive services, like inpatient hospitalization, are also among the most expensive to provide. The 2007 result may be due to the reduction in in-hospital days as reported in measure 3.2.14. Since that indicator may vary, as discussed above, targets have been kept level.

The FY 2007 target for the number of children served was exceeded by 19 percent, reflecting a level of effort by grantee communities and a greater need for services. The 2007 target for the program was ambitious given that the program was funded at roughly the same level in FY 2007 as in the prior two years. In 2008, 16 grantees will complete their grant funding cycle and CMHS expects to award approximately 17 new grants. The first year of the grant is a planning year, and grantees do not enroll children in services, Numbers served are expected to decline through 2009 and rise beginning in 2010.

Protection and Advocacy for Individuals with Mental Illness

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective: Protect and advocate for the rights of people with mental illnesses.										
3.4.08	Increase percentage of complaints of alleged **abuse** and not withdrawn by	82	78	84	84	85	Jul-08	84	84	2012: 88 %

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
	the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement (same as long-term measure)									
3.4.09	Increase percentage of complaints of alleged **neglect** substantiated and not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement (same as long-term measure)	82	83	89	88	84	Jul-08	85	85	2012: 94 %
3.4.10	Increase percentage of complaints of alleged **rights violations** substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, or elimination of other barriers to personal decision-making, as a result of PAIMI involvement (same as long-term measure)	95	87	95	85	90	Jul-08	90	90	2012: 97 %
3.4.11	Percent of interventions on behalf of groups of PAIMI-eligible individuals that were concluded			Base line	95	95	Jul-08	95	95	2013: 97 %

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
	successfully (same as long-term measure)									
3.4.12	Increase in the number of people served by the PAIMI program	22,120	21,371	23,500	18,998	23,500	Jul-08	22,325	22,325	
3.4.13	Ratio of persons served/impacted per activity/intervention	354	411	410	407	420	Jul-08	420	420	
3.4.14	Cost per 1,000 individuals served/impacted	2,431	2,072	2,100	2,316	2,000	Jul-08	2,000	2,000	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
3.4.19	The number attending public education/constituency training and public awareness activities							Baseline	Oct 08	
	Appropriated Amount ($ Million)	$34.6	$34.3		$34.0		$34.0	$34.8	$34.0	

Measure 3.4.08, Increase percentage of complaints of alleged abuse and not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement (same as long-term measure), Target was met.

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

Measure 3.4.10, percentage of cases of alleged rights violations resolved in client"s favor. Target was not met. Using what appears to have been an atypical outcome for FY 2004, the targets set for this measure were overly ambitious for FY 2005 (95%) and FY 06 (95%) as demonstrated by the actuals for FY 2005 (87%) and FY 2006 (85%). Targets for FY 2007 – 2009 are still ambitious at 90% compared to the 4-year average of 86%.

Measure 3.4.12, increase in the number of people served by the PAIMI program. Target was not met. This measure is the most volatile because of the number of factors that can influence the outcome. Part of this volatility is inherent in the nature of the PAIMI Program which includes both an individual case and systemic focus. This balance shifts

over time from a more individual case emphasis to a more systemic emphasis not only within individual programs but nationally across all programs as well. Also, the case-mix can impact this outcome, as individuals with more complex and extensive needs will require more time and resources which will reduce the total number of persons that can be served. Finally, although the program does education and outreach, the number of persons served is ultimately determined by the number of persons who seek services which may vary over time. Because of all of these factors, the targets for FY 2008 – 2009 have been maintained at 22,325, which is still well above the 4-year average of 21,059.

Efficiency measures: 3.4.13 ratio of persons served/impacted per activity/intervention and 3.4.14, Cost per 1,000 individuals served/impacted were not met. Since each of these measures includes number of persons served in their calculation, they are subject to the same factors as described above for number of persons served.

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

Mental Health Services - Projects for Assistance in Transition from Homelessness (PATH)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective : Expand the availability of services to homeless individuals with serious mental illnesses.										
3.4.15	Increase the percentage of enrolled homeless persons who receive community mental health services		41%		38%					2010: 40 percent
3.4.16	Increase number of homeless persons contacted[1]	156,766	148,679	157,000	148,655	157,500	Jul-08	150,000	150,000	

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
3.4.17	Increase percentage of contacted homeless persons with serious mental illness who become enrolled in services (same as long-term measure)	37%	40%	45%	40%	45%	Jul-08	45%	45%	2010: 45 percent
3.4.18	Maintain average Federal cost of enrolling a homeless person with serious mental illness in services ($668 by FY 2005)	$581*	$668*	$668	$623	$668	Jul-08	$668	$668	

*Data have been corrected from previous submissions.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
3.4.20	Provide training for PATH providers on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits.							Baseline	Oct 09	
	Appropriated Amount ($ Million)	$49.8	$54.8		$54.2		$54.2	$53.3	$59.6	

The target for Measure 3.4.16 was not met for FY 2006. The number of individuals served is a key measure for all SAMHSA programs that fund services. For the PATH program, outreach to homeless individuals creates the opportunity for appropriate services. The missed target is due to the program's recent focus on SSI/SSDI Outreach, Access, Recovery (SOAR) which trains PATH providers on how to ensure homeless clients are properly enrolled in the benefit programs. Once trained, providers spend significantly more time with clients in this process which subsequently reduces the total number served, but ultimately results in better outcomes because clients are more likely

to receive appropriate benefits and thus have more resources to avoid homelessness. Targets have subsequently been changed to reflect this new focus.

Measure 3.4.17 reflects the PATH program's legislative intent that it will provide a link to, and depend upon, community-based services, particularly mental health services, funded primarily by States. The program missed the 2006 target of 45 percent with performance at 40 percent. The program maintained the 2005 performance level in 2006 which is a three percent increase in performance over 2004.

A new long-term target has been set at 45 percent. In addition, the program will conduct a study in 2008 to explore the feasibility of utilizing the Department of Housing and Urban Development Homeless Management Information System to assist in obtaining outcome data from PATH-funded efforts. The PATH program and HUD are currently working to define data elements for outreach to individuals who are homeless.

Mental Health Services – Community Mental Health Services Block Grant

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective 1: Support existing public services and encourage the development of creative and cost-effective systems of community-based care for people with serious mental disorders.										
2.3.07	Reduce* rate of readmissions to State psychiatric hospitals (a) within 30 days; and, (b) within 180 days (same as long-term measure) Adults: 30 days	9%	9%	8.3%	9.4%	8.7%	Sept-08	8.5%	8.5%	
2.3.08	Adults: 180 days	20.3%	19.6%	19.2%	19.6%	19.1%	Sept-08	19.0%	19.0%	
2.3.09	Children/adolescents: 30 days	6.5%	6.6%	6.0%	6.4%	5.9%	Sept-08	5.8%	5.8%	
2.3.10	Children/adolescents: 180 days	14.7%	14.5%	13.6%	14.2%	14.0%	Sept-08	13.9%	13.9%	
2.3.15	Increase rate of consumers/family members reporting positively about outcomes (same as long-term measures) (a) Adults	71%	71%	74%	71%	73%	Sept-08	72%	72%	
2.3.16	(b) Children/adolescents	65%	73%	67%	73%	68%	Sept-08	73%	73%	
2.3.17	Number of persons receiving evidence-based practices per $10,000 of mental health block grant dollars spent	3.27	3.95	4.01	5.7	4.03	Sept-08	4.03	4.03	

* Successful result is performance *below* target

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target / Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
2.3.11	Number of a) evidence based practices (EBPs) implemented	2.3 per state	3.9	3.3	3.9	3.9	Sept-08	4.0	4.0	
2.3.12	b) Adults -	9.3%	9.7%	10.3%	9.5%	10.4%	Sept-	10.5%	10.5%	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target / Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
	percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice)**						08			
2.3.13	c) Children - percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice)	1.7%	3.4%	2.3%	2.2%	3.4%	Sept-08	3.5%	3.5%	
2.3.14	Increase number of people served by the public mental health system	5,696,526	5,878,035	5,725,008	5,979,379	5,753,633	Sept-08	5,800,000	5,800,000	
	Appropriated Amount ($ Million)	$434.6	$432.7		$427.9		$428.2	$420.7	$420.7	

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

Measure 2.3.07, Reduce rate of readmissions to State psychiatric hospitals for adults within 30 Days was not met. Readmission rates were slightly above target levels. It appears that the initial targets for FY 2003 – FY 2005, which were set from the FY 2002 baseline, may have been too ambitious since the targets have not been met in any of the previous fiscal years. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2006 was increased to 8.3%, but this also proved to be too ambitious. Future targets have been increased but also demonstrate a gradual decrease in the expectation that the rates for readmission for adults within 30 days will decline over time as states make adjustments to service planning in response to the existing rates.

Measure 3.2. 08, Readmission rate for adults within 180 days: The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

Measure 2.3.09, Readmission rate for children within 30 days: The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

Measure 2.3.10, Readmission rate for children within 180 days: The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

Measures 2.3.15 and 2.3.16 reflect the rate of consumers (adults) and family members (children) reporting positively about outcomes. The performance target for these measures were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance The target for adults was slightly missed, and the target for children was slightly exceeded. Future targets for children have been raised.

The evidence-based practices measures reflect the program's efforts to improve the efficiency and effectiveness of mental health services. The efficiency measure was exceeded. For FY 2006, the target for the number of evidence based practices was exceeded. The evidence based practice percentage of coverage for adults was missed by just .08 percent and for children; the target was missed by just one-tenth of one percent. These targets were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

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

Substance Abuse Prevention – Programs of Regional and National Significance

CSAP PRNS (Combined programs)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective: 1: to prevent, reduce and /or delay substance use and substance use related problems										
2.3.18	Percent of services within cost bands for universal, selected, and		50%	50%	67%	55%	41%	60%	65%	

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
	indicated interventions : Combined PRNS programs									

This CSAP PRNS efficiency measure was approved by OMB in December 2005 and was based on the original State Incentive Grant and HIV programs. The measure will continue to be reported for combined PRNS programs. The FY 2007 result of 41% is 14% below the projected target of 55%. SAMHSA received cost band results from HIV cohort 6 grantees at the end of this year, but data are incomplete. Sixty-one out of 81 grantees reported on this measure. Furthermore, this particular cohort of grantees appears to implement environmental (population-based) interventions as well as direct services. Grantees who did so, did not include numbers served by environmental strategies in their calculations, therefore the numbers served is underestimated and the resulting cost per participant is overestimated. Plans are being developed to provide technical assistance and training to these grantees at the upcoming grantee meeting. Findings on this measure from the SPF SIG program are expected in October 2008 because at the state level, and again at the community level, all five steps of the Strategic Prevention Framework must be completed. This causes a substantial time lag before these efficiency data can be reported.

Strategic Prevention Framework State Incentive Grants

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target (FY 2010)
				Target	Actual	Target	Actual			
Long-Term Objective: To change systems and outcomes at the state level, to prevent, reduce and/or delay substance abuse and its associated problems by promoting resilience and facilitating recovery so that there is a life in the community for everyone										
2.3.19	30-day use of alcohol among youth age 12-17		18.6 %							15 %
2.3.20	30-day use of other illicit drugs age 12 and up		8.6 %							5 %
2.3.21	Percent of SPF SIG States showing a decrease in state level estimate of percent of survey respondents who report 30-day use of alcohol a) age 12-20					Base line	47.1%	51.8%	51.8%	
2.3.22	b) age 21 and up					Base line	29.4%	32.3%	32.3%	
2.3.23	Percent of SPF SIG states showing a decrease in state level estimates of survey respondents who report 30-day use of other illicit drugs a) age 12-17					Baseline	55.9%	61.5%	61.5%	
2.3.24	b) age 18 and up					Baseline	44.1%	48.5%	48.5%	
2.3.25	Percent of SPF SIG states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great a) age 12-17					Baseline	73.5%	80.9%	80.9%	
2.3.26	b) age 18 and up					Baseline	47.1%	51.8%	51.8%	

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target (FY 2010)
				Target	Actual	Target	Actual			
2.3.27	Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who somewhat disapprove or strongly disapprove of substance use.					Baseline	79.4%	87.3%	87.3%	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
2.3.28	Number of evidence-based policies, practices, and strategies implemented					Baseline	396^	470	470	
2.3.29	Percent of grantee states that have performed needs assessments		100%	100%	92.3%*	100%	100% ***	100%	100%	
2.3.30	Percent of grantee states that have submitted state plans		28%	50%	92.3%*	85%	96.2% ****	100%	62%[1]	
2.3.31	Percent of grantee states with approved plans		9%	25%	69.2% **	85%	88.5%*	100%	55%[2]	
	Appropriated Amount ($ Million)	$86.3	$88.0		$106		$105	$105	$95.4	

* Includes 100 percent of Cohort I and 40 percent of Cohort II
**Includes 85.7 percent of Cohort I and 0 percent of Cohort II
***Includes 100 percent of Cohorts I and II.
****Includes 100% cohort I and 80% cohort II.
^ reflects cohort I (327), cohort II (69)

[1]100% of cohorts 2 and 3, and 25% of cohort 4
[2] 100% of cohorts 2 and 3, and 10% of cohort 4

Since this program aims to change systems and outcomes at the state level, performance data for the SPF SIG outcome measures reflect the percentage of states that achieve increases or reductions on each indicator at the State level, using state estimates from the National Survey on Drug Use and Health. Baseline data have been reported for 2007 for the outcome measures and for the number of evidence-based practices.

For the output measures, the target for percent of grantee states that have performed needs assessments was met. The performance targets for percent of grantee states that have submitted state plans and percent of grantee states with approved plans were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Targets for some of the outcome measures are lower for 2009 because they include both earlier cohorts, which are expected to have completed these steps, and later cohorts, which are just beginning the Strategic Prevention Framework. Cohort One (21 States) was funded at the end of FY 2004 while Cohort Two (5 States) was funded in FY 2005. All States in Cohorts One and Two have now funded sub-recipient communities. Cohort Three (16 total, including 5 tribes and one jurisdiction) was funded in September 2006. All are in the process of submitting and receiving approval for their plans.

The impact of this program is already being felt throughout the states. For example, forty eight states now use SPF or the equivalent for prevention planning; 42 for building state capacity; 52 for planning; 34 for program implementation and 22 states use SPF or the equivalent for evaluation efforts.

All Other Capacity

Minority AIDS Initiative: Substance Abuse Prevention, HIV Prevention and Hepatitis Prevention for Minorities and Minorities Re-entering Communities Post-Incarceration

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective: to expand and sustain community-based organizations to provide substance abuse, HIV and hepatitis prevention services to local and re-entry (post incarceration) populations residing in communities of color.										
2.3.34	30-day use of other illicit drugs age 12 and up **			Baseline	15.7% ***	15% ***	8%	Retiring	Retiring	
2.3.35	Percent of program participants that rate the risk of substance abuse as moderate or great** (age 12-17)			Baseline	88.6%	89%	75.1%	75.8%	76.6%	
2.3.38	Percent of program participants that rate the risk of substance abuse as moderate or great b)age 18 and up					Baseline	83.4%	84.2%	85.1%	
2.3.39	Percent of participants who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease): a) age 12-20					Baseline	May-08	1% above baseline	2% above baseline	
2.3.40	b) age 21 and up					Baseline	May-08	1% above baseline	2% above baseline	
2.3.41	Percent of participants who report no alcohol use at pre-test who remain non-users at post-test (non-user stability): a) age 12-20					Baseline	May-08	1% above baseline	2% above baseline	

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
2.3.42	b) age 21 and up					Baseline	May-08	1% above baseline	2% above baseline	
2.3.43	Percent of participants who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease): a) age 12-17					Baseline	May-08	1% above baseline	2% above baseline	
2.3.44	b) age 18 and up					Baseline	May-08	1% above baseline	2% above baseline	
2.3.45	Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability): a) age 12-17					Baseline	May-08	1% above baseline	2% above baseline	
2.3.46	b) age 18 and up					Baseline	May-08	1% above baseline	2% above baseline	
2.3.47	Percent of program participants (age 12-17) who somewhat disapprove or strongly disapprove of substance use					Baseline	80.4%	81%	82%	
2.3.56	Number of individuals exposed to substance abuse/hepatitis education services					Baseline	May-08	1% above baseline	2% above baseline	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
2.3.48	Number of evidence-based policies, practices, and strategies					Baseline	May-08	81	85	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
	implemented by HIV program grantees									
	Appropriated Amount ($ Million)	$39.7	$39.8		$39.4		$39.4	$39.4	$39.4	

The goal of the HIV cohort VI program is to increase the capacity of communities serving the target populations to deliver evidence-based substance abuse prevention, HIV and Hepatitis prevention services. This program was redesigned to incorporate the Strategic Prevention Framework model.

The program is implementing SAMHSA's OMB-approved National Outcome Measures, including the efficiency measure. In addition, a new measure has been added to reflect the number of individuals exposed to substance abuse/hepatitis education services, to illustrate the performance of outreach and numbers served. Cohort VI began serving participants during FY 2007.

Some baseline data are somewhat delayed due to a system problem in the online data collection and reporting system Limited data for HIV Cohorts IV and V are available. Data for these cohorts were submitted voluntarily by grantees using data that had been collected for their own purposes since each grant's inception. The aggregate reporting makes it difficult to report the data separately by fiscal year. It is also impossible to calculate measures that require person-level matched data, such as non-user stability and user decrease. These HIV cohorts 4 and 5 aggregate data do not allow comparison of person-level changes. Data standards have been improved with subsequent cohorts.

The 2007 target for 30-day use of other illicit drugs age 12 and up was substantially exceeded. The result was based on limited data for HIV Cohorts IV and V. More complete and accurate data is expected for future cohorts. This measure is being replaced by several revised measures that will reflect use for both those who had used drugs before entering the program and those who had not.

Perceived risk, on the other hand, fell 14% short of the target with 75% rather than 89% perceiving moderate or great risk of substance abuse. This result was likely caused by the differences in program among the various cohorts and/or lack of data collection and reporting standardization.

Since both of these results are likely due to data issues rather than program activities, the impact on program participants is negligible. Plans are being developed to provide all HIV grantees with technical assistance and training in data collection and reporting at the next grantee meeting.

Performance data for the new measures is expected in May 2008. These baseline data are somewhat delayed due to a system problem in the online data collection and reporting system

All Other Science and Service

Centers for the Application of Prevention Technologies

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective 1: to provide technical assistance and training to grantee States, Tribal Organizations and Community based organizations										
2.3.33	Increase the percent of clients reporting that CAPT services substantively enhanced their ability to carry out their prevention work			Baseline	70%	75%	92%	88%	Retiring	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
2.3.32	Increase the number of persons provided TA services	19,911	28,160	31,000	28,123	32,000	24,121	22,800	Retiring	
	Appropriated Amount ($ Million)	$11.5	$15.1		$13.7		$12.2	$12.0	$4.4	

Ninety two percent of CAPT program recipients reported that their ability was enhanced by the training, exceeding the target of 75% by 17 percentage point. The target was ambitious given that it was considerably higher than the previous year's baseline of 70%. The CAPT's service delivery approach shifted in 2007 in accordance with SAMHSA/CSAP's mission to focus more on providing substantive technical assistance services designed to enhance the systemic capacity of prevention systems to implement the Strategic Prevention Framework. The result reflects the success of this approach.

The 2007 figure for the number of persons served is 24,121, which is lower than the target of 32,000 person-contacts by 7,879. The CAPT approach shifted from providing general training services to a more customized training-of-trainers (TOT) approach designed to enhance the systemic capacity of state training systems. These training-of-trainers events generally have fewer participants participating in longer, more intensive events, with these participants eventually extending the reach of CAPT services by providing additional training on the Strategic Prevention Framework within their states. The number of individuals receiving technical Assistance within their States from these CAPT-trained trainers is not captured in these figures.

Funding for the Center for the Application of Prevention Technologies, while eliminated in the PRNS program, will be funded at a reduced amount under the SAPTBG Set-Aside in FY 2009.

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

Synar Amendment Implementation Activities (Section 1926)*

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective: To reduce incidence and prevalence of substance abuse by providing assistance to States to improve State and community systems, activities and services and accountability										
2.3.49	Increase number of States** whose retail sales violations is at or below 20%	49	50	52	52	52	52	Retiring	Retiring	
2.3.62	Number of States reporting retail tobacco sales violation rates below 10%					Baseline	27	28	29	

*Synar activities are not a grant program, but are authorized under the 20% Prevention Set-aside.
**States include the 50 States, the District of Columbia, and Puerto Rico

Performance has steadily improved, and for the last two years, all States met or exceeded the 20 percent goal. The mean violation rate across all States/Territories was 10.42 percent. Further, 46 States/Territories reported sales violation rates of 15 percent or under, and 26 reported rates below 10 percent, showing that those States achieved significantly better results than those required by law.

Because of such significant improvement, CSAP has set a new program goal to encourage all States to reduce the sales rate to less than 10% which is in keeping with the initial intent of the legislation, to reduce minors access to tobacco products, and also consistent with research suggesting that to effectively reduce youth access requires rate lower than the 20% target. This in no way changes the required target rate of 20%, but provides CSAP and States with a program goal that fits the legislative intent.

20% Prevention Set-aside

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target (FY 2012)
				Target	Actual	Target	Actual			
Long-Term Objective: To reduce incidence and prevalence of substance abuse by providing assistance to States to improve State and community systems, activities and services and accountability										
2.3.50	Increase perception of harm of drug use*		72.3%	40%	73.2%	75%	73%	Retiring	Retiring	
2.3.51	Improvements in non-use (percent ages 12 and older who report that they have never used illicit substances)*		54.2%	55%	53.9%	56%	53.9%	Retiring	Retiring	
2.3.52	Improvements in use (30-day use)*		7.9%	7.4%	8.1%	6.9%	8.3%	Retiring	Retiring	5.8%
2.3.54	Number of participants served in prevention programs					Baseline	6,322,551	17,482,060	17,482,060	
2.3.55	Percent of services within cost bands for universal, selected, and indicated interventions					Baseline	49%**	54%	54%	
2.3.63	Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17)							Baseline Sept-08	9/2008	
2.3.64	Percent of states showing an									

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target (FY 2012)
				Target	Actual	Target	Actual			
	increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 18+)									
2.3.65	Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 12-20)									
2.3.66	Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 21+)							Baseline Sept-08	9/2008	
2.3.67	Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit							Baseline Sept-08	9/2008	

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target (FY 2012)
				Target	Actual	Target	Actual			
	drugs (age 12-17)									
2.3.68	Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 18+)									

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
2.3.53	Number of evidence-based policies, practices, and strategies implemented					Baseline	10,090**	11,000	12,000	
	Appropriated Amount ($ Million)	$356	$355		$352		$352	$352	$356	

* FY 2006 NSDUH does not report composite results. CSAP's Data Coordination and Consolidation Center therefore recalculated the baseline and FY 2006 results as the mean of the separate NSDUH results for each drug of the percent of respondents reporting perceived moderate to great risk of any of the drugs.
**Data received by December 2007 for FY 2007 is preliminary

The performance targets for perceived harm and non-use used measures were set at an approximate target. The deviations are slight and are within the range of the survey confidence interval. There was no measurable effect on overall program performance. Since these measures do not directly reflect the 20% Set-Aside, they are being retired and replaced with separate measures reflecting the percentage of States improving on State-level estimates from the National Survey on Drug Use and Health.

The performance target for 30-day use was not met. This measure reflects use of any illicit substance in the past 30 days, as measured by the National Survey on Drug Use and Health. The overall rate of current illicit drug use among persons aged 12 or older in 2006 (8.3 percent) was similar to the rate in 2005 (8.1 percent) and has remained stable since 2002 (8.3 percent). This measure, is being retired as an annual measure

for the 20% Set-Aside, and is being replaced by State-level measures as described above. Baseline data for the new measures will be reported in September 2008.

The remaining measures have reported baseline data for FY 2007 and have set targets for FY 2008 and 2009. The targets for numbers served reflect projections based on the 2007 baseline which aggregates the results from 28 voluntary state reports. The projection assumes that all states will report on this new data reporting requirement and takes into account the size of states who did/did not voluntarily report for 2007.

Substance Abuse Treatment – Programs of Regional and National Significance

Access to Recovery* (ATR)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year (FY 2010) Target
				Target	Actual	Target	Actual			
Long-Term Objective 1: Increase the quality of life as reflected by drug use, employment, housing, social connectedness and Criminal Justice involvement of clients served										
1.2.33	Increase the percentage of adults receiving services who: a) had no past month substance use		78%	79%	81.4%	81%	84.7%	80%	81%	82%
1.2.34	b) had improved family and living conditions		62%	63%	51%	52%	59.9%	52%	52%	52%
1.2.35	c) had no/reduced involvement with the criminal justice system		95%	95%	96.8%	97%	97.6%	96%	96%	97%
1.2.36	d) had improved social support		89%	90%	90%	90%	75.1%	90%	90%	91%
1.2.37	e) were currently employed or engaged in productive activities		56%	57%	50%	50%	61.7%	53%	53%	53%
1.2.38	f) had improved retention in treatment		22.8%	24%	30.2%	31%	35.6%	Retiring	Retiring	
1.2.39	Decrease the cost-per-client served						$1,605	$1,605	$1,588	$1,572

* Initial Access to Recovery grants were made in August 2004, close to the end of FY 2004. Services were not necessarily provided in the same year Federal funds were obligated. Thus, although the baseline reported for FY 2005 represented people served in FY 2005, most of the funding consisted of FY 2004 dollars. With the FY 2004

grants, it was estimated that 125,000 clients would be served over the three year grant period. The second cohort of grants was awarded in September 2007.
[1] The first cohort of grantees ended in FY 2007.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
1.2.32	Increase the number of clients gaining access to treatment		23,138	50,000	96,959	50,000	79,150	30,000	65,000	65,000
	Appropriated Amount ($ Million)	$99.4	$99.2		$98.2		$98.7		$99.7	

All FY 2007 targets for this program were met or exceeded except social support, which was missed. For all measures except 1.2.32 (number of clients), 1.2.36 (social support), and 1.2.37 (employment), the performance target was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

The target for number of clients served was substantially exceeded. Grantees performed exceptionally well once infrastructure and program processes were full in place. The targets for future years reflect the new cohort of grantees, which will be in their first year of service delivery in 2008 and thus are expected to serve fewer clients. The second cohort of grantees (to begin reporting performance data in FY 2008) will have a significant focus on methamphetamine users. These clients may require additional resources beyond those of other clients, which may result in a decrease in numbers served. Targets have been set in collaboration with OMB.

The target for improved social support was missed, although the actual performance of 75% reflects a significant achievement. CSAT is reviewing program information and consulting with grantees to determine the reason for the decline, and will continue to work with grantees in cohort 2 to improve data on this particular measure. Since the 2007 results appears to be an anomaly compared to the previous two years' results of 89% and 90%; targets are being maintained at an ambitious level until further information is obtained.

The 2007 target for employment was significantly exceeded, reflecting very active effort by grantees to ensure that clients improved their overall life quality. The target was set based on actual performance for the previous two years and was equal to the actual performance in 2006. The second cohort of grantees includes a significant emphasis on methamphetamine users, who are expected to present additional challenges for securing employment beyond those of other clients. Therefore the 2007 level of performance is not expected to continue in future years. Targets for 2008 and 2009 are still higher than the 2007 target and thus represent an ambitious level.

The first cohort of grantees ended in FY 2007. The second cohort of ATR grantees began providing services in FY 2008. Targets for FY 2008 are lower to allow the new grantees to develop the appropriate infrastructure. In addition, methamphetamine users in the second cohort may have more significant barriers than the ATR population at large; therefore, targets

have been kept at levels that are achievable but still ambitious. Targets for FY 2008 and FY 2009 were set in collaboration with OMB during ATR's PART review in CY 2007.

In conjunction with the ATR PART review, a new efficiency measure has been established. This new measure, cost-per-client served, will be implemented with the new cohort of ATR grantees that were awarded in September 2007. SAMHSA is developing further refinements in this efficiency measure

Screening, Brief Intervention, Referral and Treatment

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective 1: Expand screening for substance abuse and the provision of brief intervention and brief treatment in primary care settings										
1.2.41	Increase the percentage of clients receiving services who had no past month substance use		39.8%	41.8%	47.5%	48%	45.7%	48%	50%	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
1.2.40	Increase the number of clients served	69,161	155,267	156,820	182,770	184,597	138,267	139,650	139,650	
	Appropriated Amount ($ Million)	$23.4	$25.9		$29.6		$29.6		$56.2	

The targets for clients served for FY 2007 were missed due to problems experienced by one of the primary grants in the program involving their internal processes. CSAT has worked with the State to ensure that better processes are currently in place.

The target for number of clients receiving services who had no past month substance use was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

The target for clients served in FY 2007 was missed due to problems experienced by one of the primary grants involving their internal processes. CSAT has worked with the State to ensure that better processes are currently in place. Seven of the eleven current grantees are in the last year of funding in FY 2008 and are expected to serve fewer clients. Performance for programs funded with 2009 funds, which will be awarded at the end of FY 2009, will be reflected in 2010 performance data.

All other Capacity

Capacity Programs Included in this Budget Line

TCE/General Population	Family Drug Courts	Recovery Community Service – Recovery
HIV/AIDS/Outreach	Juvenile Drug Courts	Recovery Community Service – Facilitating
Addiction Treatment for Homeless Persons	Young Offender Re-entry Program	Co-Occurring State Incentive Grants
Assertive Adolescent and Family Treatment	Pregnant and Post-partum Women	Child and Adolescent State Incentive Grants

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective 1: Increase the quality of life as reflected by drug use, employment, housing, social connectedness and CJ involvement of clients served										
1.2.25	Had no past month substance use	63%	64.1%	67%	63%	63%	59%	63%	61% **	
1.2.27	Increase percentage of adults receiving services who: a) Were currently employed or engaged in productive activities	45%	48.9%	49%	52%	52%	57%	52%	50% **	
1.2.28	b) Had a permanent place to live in the community		49.2%*	51%	49.3%	53%	46%	51%	49% **	
1.2.29	c) Had no involvement with the criminal justice system	95%	96%	98%	96%	96%	96%	96%	94% **	
1.2.30	d) Experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences	82%	65%	67%	67%	67%	65%	67%	65% **	
1.2.31	Increase the percentage of grantees in appropriate cost bands	80%	81%	80%	81%	80%	Oct-08	80%	78% **	

*Targets for FY 2009 and FY 2010 are lower than actual data reported in previous years due to anticipated funding decreases.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
1.2.26	Increase the number of clients served	30,217	34,014	34,300	35,334	35,334	35,516	35,334**	31,659**	
	Appropriated Amount ($ Million)									

The target for criminal justice involvement was met. The targets for all other measures were set at an approximate target level and the deviation from that level is slight. Targets for clients served and employment were slightly exceeded. Targets for stable housing, abstinence, health consequences were not met by 7%, 4%, and 2% respectively.

Treatment Drug Courts

#	Key Outcomes	FY 2006		FY 2007		FY 2008	FY 2009	Out-Year (FY 2010)
		Target	Actual	Target	Actual	Target	Target	Target
Long-Term Objective 1: Increase the quality of life as reflected by drug use, employment, housing, social connectedness and CJ involvement of clients served								
1.2.56	Increase number of clients served	Baseline	1,437	1,250*	1,322	1,335	1,335	4,006
1.2.57	Had no past month substance use (same as long term measure)	Baseline	75.7	76.7	76.8	77.8	78.8	79.8
1.2.58	Increase percentage of adults receiving services who: a) Were currently employed or engaged in productive activities	Baseline	73.2	74.2	77.4	78.2	79.2	80.2
1.2.59	b) Had a permanent place to live in the community	Baseline	57.9	58.9	72.7	73.7	74.7	75.7
1.2.60	c) Had no involvement with the criminal justice system	Baseline	93.4	94.3	92.8	93.8	94.8	95.8
1.2.61	d) Experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences	Baseline	90.2	91.2	92.1	93.1	94.1	95.1

The target for number of clients served in FY 07 was decreased due to a decrease in funding. Targets for subsequent years are adjusted to reflect funding levels. The target for FY 07 number of clients served was exceeded.

FY 07 targets for abstinence from use, employment, housing, social consequences were met or exceeded. The target for criminal justice involvement was missed by slightly more than 1%, a slight deviation that did not affect program performance.

Science and Service

Science and Service Programs Included in this Budget Line

Knowledge Application Program	Addiction Technology Transfer Centers
Faith Based Initiatives	SAMHSA Conference Grants
Strengthening Treatment Access and Retention	

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective 1: Enhance knowledge dissemination through trainings, technical assistance and meetings										
1.4.01	Report implementing improvements in treatment methods on the basis of information and training provided by the program (same as long-term measure)	83%	87%	89%	93%	93%	90%	90%	90	
1.4.03	Increase the percentage of drug treatment professionals trained by the program who a) Would rate the quality of the events as good, very good, or excellent*	93.2%	95%	96%	96%	96%	95%	96%	96%	
1.4.04	b) Shared any of the information from the events with others	84%	86%	88%	87%	90%	89%	90%	92%	
1.4.05	Increase the percentage of grantees in appropriate cost bands	100%	100%	100%	100%	100%	Oct-08	100%	100%	

*Target equal to 2007 performance level

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
1.4.02	Increase the number of individuals trained per year	35,370	28,630	28,916	23,141	23,141	20,516	20,516	20,516*	20,516*
	Appropriated Amount ($ Million)	$46.4	$36.7		$29.3		$29.6		$14.1	

All targets except number of persons trained were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

The target for persons trained was missed by 2,600 clients (approximately 11%). This is due to a reduction in programs relating to Science and Service in FY 2007. Several grant programs were in their wind-down phase during FY 2007. The number of individuals trained has declined each year for the past four years. Targets have been adjusted to reflect that these grants game to a natural end.

Substance Abuse Treatment - Substance Abuse Prevention and Treatment Block Grant

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target FY 2012
				Target	Actual	Target	Actual			
Long-Term Objective: Expand capacity to provide services nationwide to those affected with substance use disorders										
1.2.42	Percentage of clients reporting change in abstinence at discharge		43 %					46 %	Retiring	
1.2.48	Percentage of clients reporting abstinence from drug use at discharge				68.3%	68.3%	Nov-08	69.3%	69.3%	
1.2.49	Percentage of clients reporting abstinence from alcohol at discharge				73.7%	73.7%	Nov-08	74.7%	74.7%	
1.2.46	Increase the percentage of Technical Assistance events that result in systems, program or	82%	100%	95%	100%	Retiring	Retiring	Retiring	Retiring	

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target FY 2012
				Target	Actual	Target	Actual			
	practice change									
1.2.47	Increase the percentage of States in appropriate cost bands		100%	100%	65%	67%	Oct-08	70%	70%	
1.2.50	Percentage of clients reporting being employed/in school at discharge				40.9%		42.9%	42.9%	42.9%	
1.2.51	Percentage of clients reporting no involvement with the Criminal Justice System				88.9%		88.9%	88.9%	88.9%	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
1.2.43	Number of admissions to substance abuse treatment programs receiving public funding**	1,875,026	1,849,528	1,983,490	1,861,869	2,003,324	Oct-09	1,881,515*	1,881,515*	2,005,220
1.2.44	Increase the number of States and Territories voluntarily reporting performance measures in their SAPT Block Grant application.	36	37	40	53	55	Oct-08	Retiring	Retiring	
1.2.45	Increase the percentage of States and Territories that express satisfaction with Technical Assistance (TA) provided	88%	91%	97%	83%	97%	Oct-08	97%	85%*	

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
	Appropriated Amount ($ Million)	$1,779.1	$1,775.6		$1,757.4		$1,758.6	$1,758.7	$1,778.6	

*Targets for FY 2008 and 2009 are lower than targets or actual data reported in previous years due to the impact of budget for the SAPT Block Grant.
**Formerly Number of Clients Served. Wording change approved by OMB 12/4/07. FY 2008 and 2009 target change approved 1/9/08.

FY 2006 is the most recent year for which data is available for this program.

The long-term measure of change in abstinence at discharge is retiring and being replaced with two annual measures; one reflects abstinence from drug use at discharge and one reflects abstinence from alcohol at discharge. Baseline data have been reported.

New measures have also been added for employment and criminal justice involvement.

The number of admissions measure is one of SAMHSA's National Outcome Measures, which, when fully implemented, will provide more direct and accurate data on number of clients served by reporting an unduplicated count of clients. The unduplicated reporting will be phased in among the States. As States begin to report unduplicated counts, the Treatment Episode Data Set might show that that the number of admissions has gone down, since readmissions of the same individual in the reporting period would be counted as a single client served. Targets may be adjusted to reflect this change. The performance target was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Measure 1.2.46, Increase the percentage of Technical Assistance events that result in systems, program or practice change, was exceeded for 2006. The performance target was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance. This measure is retiring because the program's limited technical assistance resources are being redirected to National Outcome Measures implementation, instead of systems change. Further, technical assistance is not the main purpose of the program.

The target for percent of grantees in appropriate cost bands was missed for 2006. A substantial number of the States have and are in the process of implementing new or modified data collection systems in response to the mandated National Outcome Measures reporting. These new systems have been focusing on quality of client change data and have not yet refined the cost reporting portions. CSAT expects that once refinements are made to this component of these systems, an increase in this figure will be seen.

The target for the number of States and Territories voluntarily reporting performance measures in their SAPT Block Grant application was substantially exceeded. Performance has steadily increased over the last four years. The target for 2007 has been increased. Since reporting of performance measures is now mandatory, the measure for voluntary reporting is being retired.

The target for technical assistance satisfaction was missed for 2006. The actual data were derived from a new survey on Technical Assistance implemented in FY 2007 The data are preliminary, resulting from a subset of States reporting overall impact of Technical Assistance. Thirty-three of sixty states have submitted their responses to the survey with overall satisfaction reported at 83%. It is expected that the overall percentage will increase as the remaining data are received.

National Surveys

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual			
4.4.01	Availability and timeliness of data for the: a) National Survey on Drug Use and Health (NSDUH)	8 mos.	8 mos.	8 mos.	8 mos.	8 mos.	8 mos.	8 mos.	8 mos.	
4.4.02	b) Drug Abuse Warning Network (DAWN)	8 mos.	12 mos.	15 mos.	16 mos.	12 mos.	14 mos.	10 mos.	10 mos.	
4.4.03	c) Drug and Alcohol Services Information System (DASIS)	11 mos.	13 mos.	15 mos.	9 mos.	15 mos.	8 mos.	10 mos.	10 mos.	

The target for the National Survey on Drug Use and Health was met. The performance target for the Drug Abuse Warning System was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance. The target for the Drug and Alcohol Services Information System was exceeded due to greater efficiency.

Discussion of SAMHSA's Strategic Plan

SAMHSA's activities support the Agency strategic goals of Accountability, Capacity, and Effectiveness, as well as the Department's strategic objectives. All SAMHSA activities support at least one HHS strategic objective; most support more than one. SAMHSA's Accountability activities primarily support Strategic Objective 4.4; Capacity activities primarily support 1.2, 1.4, 2.3, 2.4, 3.1, 3.2, 3.3, and 3.4; and Effectiveness Activities primarily support 1.3.

- Strategic Objective 1.2 Increase health care service availability and accessibility: The Substance Abuse Prevention and Treatment Block Grant (treatment portion), most discretionary treatment programs and other direct service programs primarily support this objective.
- Strategic Objective 1.3 Improve health care quality, safety and cost/value: SAMHSA's Effectiveness activities, including the National Registry of Evidence-based Programs and Practices and the SAMHSA Health Information Network primarily support this objective. SAMHSA also works toward improved cost/value in all its programs through its efficiency measures.
- Strategic Objective 1.4 Recruit, develop, and retain competent health care workforce: Most of SAMHSA's Science and Service activities support this objective.
- Strategic Objective 2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery: Most substance abuse prevention activities, including the 20% prevention set-aside of the Substance Abuse Prevention and Treatment Block Grant and the Strategic Prevention Framework State Incentive Grants support this objective. The Community Mental Health Services Block Grant, and Suicide Prevention activities also primarily support this objective. Many other SAMHSA activities contribute to this objective.
- Strategic Objective 2.4 Prepare for and respond to natural and man-made disasters: SAMHSA's Disaster activities support this objective.
- Strategic Objective 3.1 Promote the economic independence and social well-being of individuals and families across the lifespan: Most of SAMHSA's activities contribute to improving the social well-being of individuals with or at risk for substance abuse and mental illness, and their families. Social connectedness is one of SAMHSA's National Outcome Measures.
- Strategic Objective 3.2 Protect the safety and foster the well being of children and youth: SAMHSA's Youth Violence Prevention program Children and Family programs; and Children's Mental Health Program primarily support this initiative.
- Strategic Objective 3.3 Encourage the development of strong, healthy and supportive communities: the Strategic Prevention Framework State Incentive Grants and other prevention efforts, contribute to this objective.
- Strategic Objective 3.4 Address the needs, strengths and abilities of vulnerable populations: SAMHSA's Seclusion & Restraint activities, homelessness prevention programs; Projects for Assistance in Transition from Homelessness, and Protection and Advocacy for Individuals with Mental Illness primarily support this objective.
- Strategic Objective 4.4 Communicate and transfer research results into clinical, public health and human service practice: SAMHSA's National Surveys support

this objective. The National Registry of Evidence-based Programs and Practices and the SAMHSA Health Information Network also contribute to this objective.

	SAMHSA Strategic Goals		
	Accountability: Measure and Report Program Performance	Capacity: Increase Service Availability	Effectiveness: Improve Service Quality
HHS Strategic Goals			
1**. Health Care**: Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care			
1.1 Broaden health insurance and long-term care coverage			
1.2 Increase health care service availability and accessibility		**x**	
1.3 Improve health care quality, safety, and cost/value			**x**
1.4 Recruit, develop, and retain a competent health care workforce		**x**	
2. **Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness**: Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.			
2.1 Prevent the spread of infectious diseases			
2.2 Protect the public against injuries and environmental threats			
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery		**x**	
2.4 Prepare for and respond to natural and man-made disasters		**x**	
3. **Human Services**: Promote the economic and social well-being of individuals, families and communities			
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan		**x**	
3.2 Protect the safety and foster the well being of children and youth		**x**	
3.3 Encourage the development of strong, healthy and supportive communities		**x**	
3.4 Address the needs, strengths and abilities of vulnerable populations		**x**	
4. **Scientific Research and Development**: Advance scientific and biomedical research and development related to health and human services			
4.1 Strengthen the pool of qualified health and behavioral science researchers			
4.2 Increase basic scientific knowledge to improve human health and human development			
4.3 Conduct and oversee applied research to improve health and well-being			
4.4 Communicate and transfer research results into clinical,	**x**		

	SAMHSA Strategic Goals		
	Accountability: Measure and Report Program Performance	Capacity: Increase Service Availability	Effectiveness: Improve Service Quality
public health and human service practice			

Summary of Full Cost

(Allocated Budgetary Resources in Millions)

HHS Strategic Goals and Objectives	SAMHSA FY 2007	SAMHSA FY 2008	SAMHSA FY 2009
Strategic Goal 1: Health Care Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.			
1.1 Broaden health insurance and long-term care coverage.	**---**	**---**	**---**
1.2 Increase Health Care service availability and accessibility.	**2,251.1**	**2,279.8**	**2,164.4**
MENTAL HEALTH PRNS	279.8	315.9	172.6
Rate of consumers reporting positively about outcomes (State MH System)	35.0	39.5	21.6
Rate of family members reporting positively about outcomes (State MH System) 1/	35.0	39.5	21.6
Rate of family members reporting positively about outcomes (Program Participants) 1/	35.0	39.5	21.6
Number of evidence-based practices implemented	35.0	39.5	21.6
Percentage of coverage for each EBP (adults)	35.0	39.5	21.6
Percentage of coverage for each EBP (children)	35.0	39.5	21.6
Increase the percentage of clients receiving services who report improved functioning 1/	35.0	39.5	21.6
Percentage of people in the United States with serious mental health illnesses in need of services from the public mental health system, who receive services from the public mental health system	35.0	39.5	21.6
MENTAL HEALTH DRUG COURTS 2/	---	---	2.5
CO-OCCURRING SIGs	14.8	8.3	.5
Increase the percentage of treatment programs that screen for co-occurring disorders	3.0	1.7	.1
Increase the percentage of treatment programs that assess for co-occurring disorders	3.0	1.7	.1
Increase the percentage of treatment programs that treat co-occurring disorders through collaborative, consultative, and integrated models of care	3.0	1.7	.1
Increase percentage of clients who experience reduced impairment from their co-occurring disorders following treatment	3.0	1.7	.1
Increase the number of persons with co-occurring disorders served	3.0	1.7	.1
CSAT CAPACITY	388.9	391.0	344.0
Increase the number of clients served	55.6	55.9	49.1

HHS Strategic Goals and Objectives	SAMHSA FY 2007	SAMHSA FY 2008	SAMHSA FY 2009
Increase the percentage of adults receiving services who were currently employed or engaged in productive activities	55.6	55.9	49.1
Increase the percentage of adults receiving services who had a permanent place to live in the community	55.6	55.9	49.1
Increase the percentage of adults receiving services who had no involvement in the criminal justice system	55.6	55.9	49.1
Increase the percentage of adults receiving services who experience no/reduced alcohol or illegal drug related health, behavioral, or social consequences	55.6	55.9	49.1
Increase the percentage of adults receiving services who had no past month substance use	55.6	55.9	49.1
Increase the percentage of grantees in appropriate cost bands	55.6	55.9	49.1
TREATMENT DRUG COURTS	10.8	10.5	40.3
Increase the number of clients served	1.5	1.5	5.8
Increase the percentage of adults receiving services who were currently employed or engaged in productive activities	1.5	1.5	5.8
Increase the percentage of adults receiving services who had a permanent place to live in the community	1.5	1.5	5.8
Increase the percentage of adults receiving services who had no involvement in the criminal justice system	1.5	1.5	5.8
Increase the percentage of adults receiving services who experience no/reduced alcohol or illegal drug related health, behavioral, or social consequences	1.5	1.5	5.8
Increase the percentage of adults receiving services who had no past month substance use	1.5	1.5	5.8
Increase the percentage of grantees in appropriate cost bands	1.5	1.5	5.8
ACCESS TO RECOVERY	103.9	101.6	106.3
Increase the number of clients gaining access to treatment	13.0	12.7	15.2
Increase the percentage of adults receiving services who had no past month substance use	13.0	12.7	15.2
Increase the percentage of adults receiving services who had improved family and living conditions	13.0	12.7	15.2
Increase the percentage of adults receiving services who had no involvement in the criminal justice system	13.0	12.7	15.2
Increase the percentage of adults receiving services who had improved social support	13.0	12.7	15.2
Increase the percentage of adults receiving services who were currently employed or engaged in productive activities	13.0	12.7	15.2
Increase the percentage of adults receiving services who had improved retention in treatment	13.0	12.7	15.2
Decrease the cost per client served	13.0	12.7	---
SCREENING, BRIEF INTERVENTION, REFERRAL &	31.2	30.7	59.8

HHS Strategic Goals and Objectives	SAMHSA FY 2007	SAMHSA FY 2008	SAMHSA FY 2009
TREATMENT			
Increase number of clients served	15.6	15.3	29.9
Increase percentage of clients receiving services who had no past month substance use	15.6	15.3	29.9
SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT (80%)	1,421.7	1,421.9	1,438.4
Percentage of clients reporting change in abstinence at discharge	158.0	177.7	---
Percentage of clients reporting abstinence from drug use at discharge	158.0	177.7	205.5
Percentage of clients reporting abstinence from alcohol at discharge	158.0	177.7	205.5
Number of admissions to substance abuse treatment programs receiving public funding	158.0	177.7	205.5
Increase the percentage of States in appropriate cost bands	158.0	177.7	205.5
Percentage of clients reporting being employed/in school at discharge	158.0	177.7	205.5
Percentage of clients reporting no involvement with the Criminal Justice System	158.0	177.7	205.5
Increase the number of States and Territories voluntarily reporting performance measures in their SAPT Block Grant applications	158.0	---	---
Increase percentage of States and Territories that express satisfaction with technical assistance provided	158.0	177.7	205.5
1.3 Improve health care quality, safety and cost/value.	**---**	**---**	**---**
1.4 Recruit, develop, and retain a competent health care workforce.	**31.2**	**30.1**	**15.1**
CSAT SCIENCE AND SERVICE PROGRAMS	31.2	30.1	15.1
Increase the number of individuals trained per year	6.2	6.0	3.0
Increase the percentage of drug treatment professionals trained by the program who would rate the quality of events as good, very good or excellent	6.2	6.0	3.0
Increase the percentage of drug treatment professionals trained by the program who shared any of the information from the event with others	6.2	6.0	3.0
Increase the percentage of drug treatment professionals trained by the program who report implementing improvements in treatment methods on the basis of information and training provided by the program	6.2	6.0	3.0
Increase the percentage of grantees in the appropriate cost	6.2	6.0	3.0
Strategic Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.			
2.1 Prevent the spread of infectious diseases.	---	---	---
2.2 Protect the public against injuries and environmental threats.	---	---	---

HHS Strategic Goals and Objectives	SAMHSA FY 2007	SAMHSA FY 2008	SAMHSA FY 2009
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	**1,047.8**	**1,054.6**	**1,010.0**
SUICIDE PREVENTION	38.5	51.3	37.2
Reduce the number of suicide deaths	12.8	17.1	12.4
Increase the number of students exposed to mental health and suicide awareness campaigns on college campuses	12.8	17.1	12.4
Increase the total number of individuals trained in youth suicide prevention	12.8	17.1	12.4
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT	436.8	429.4	429.7
Reduce rate of readmissions to State psychiatric hospitals (Adults:30 days)	39.7	39.0	39.1
Reduce rate of readmissions to State psychiatric hospitals (Adults:180 days)	39.7	39.0	39.1
Reduce rate of readmissions to State psychiatric hospitals (Children:30 days)	39.7	39.0	39.1
Reduce rate of readmissions to State psychiatric hospitals (Children:180 days)	39.7	39.0	39.1
Number of evidence-based practices implemented	39.7	39.0	39.1
Percentage of coverage for each EBP (adults)	39.7	39.0	39.1
Percentage of coverage for each EBP (children)	39.7	39.0	39.1
Increase number of people served by the public mental health system	39.7	39.0	39.1
Increase rate of consumers/family members reporting positively about outcomes	39.7	39.0	39.1
Increase rate of family members reporting positively about outcomes	39.7	39.0	39.1
Number of person receiving evidence-based practices per $10,000 of mental health block grant dollars spent	39.7	39.0	39.1
SUBSTANCE ABUSE PREVENTION PRNS (combined programs)	43.4	46.6	26.9
Percent of services within cost bands for universal, selected, and indicated interventions	43.4	46.6	26.9
STRATEGIC PREVENTION FRAMEWORK SIGs	118.1	117.4	110.2
30-day use of alcohol among youth age 12-17	9.8	9.8	9.2
30-day use of other illicit drugs age 12 and up	9.8	9.8	9.2
Percent of grantee states that have performed needs assessments	9.8	9.8	9.2
Percent of grantee states that have submitted state plans	9.8	9.8	9.2
Percent of grantee states with approved state plans	9.8	9.8	9.2
Percent of SPF-SIG States showing a decrease in state level estimate of percent of survey respondents who report 30-day use of alcohol (12-20)	9.8	9.8	9.2
Percent of SPF-SIG States showing a decrease in state level estimate of percent of survey respondents who report 30-day use of alcohol (21+)	9.8	9.8	9.2

HHS Strategic Goals and Objectives	SAMHSA FY 2007	SAMHSA FY 2008	SAMHSA FY 2009
Percent of SPF-SIG states showing a decrease in state level estimates of survey respondents who report 30-day use of other illicit drugs (12-17)	9.8	9.8	9.2
Percent of SPF-SIG states showing a decrease in state level estimates of survey respondents who report 30-day use of other illicit drugs (18+)	9.8	9.8	9.2
Percent of SPF-SIG states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (12-17)	9.8	9.8	9.2
Percent of SPF-SIG states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (18+)	9.8	9.8	9.2
Percent of SPF-SIG states showing an increase in state level estimates of survey respondents (age 12-17) who somewhat disapprove or strongly disapprove of substance use	9.8	9.8	9.2
MINORITY AIDS INITIATIVE	44.2	44.2	45.5
30-day use of other illicit drugs age 12 and up	3.2	---	---
Percent of program participants age 12-17 that rate the risk of substance abuse as moderate or great	3.2	3.4	3.5
Percent of program participants age 18+ that rate the risk of substance abuse as moderate or great	3.2	3.4	3.5
Percent of participants who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease): age 12-20	3.2	3.4	3.5
Percent of participants who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease): age 21 and up	3.2	3.4	3.5
Percent of participants who report no alcohol use at pre-test who remain non-users at post-test (non-user stability): age 12-20	3.2	3.4	3.5
Percent of participants who report no alcohol use at pre-test who remain non-users at post-test (non-user stability): age 21 and up	3.2	3.4	3.5
Percent of participants who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease): age 12-17	3.2	3.4	3.5
Percent of participants who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease): age 18 and up	3.2	3.4	3.5
Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability): age 12-17	3.2	3.4	3.5
Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability): age 18 and up	3.2	3.4	3.5
Percent of program participants (age 12-17) who somewhat disapprove or strongly disapprove of substance use	3.2	3.4	3.5
Number of individuals exposed to substance abuse/hepatitis education services	3.2	3.4	3.5

HHS Strategic Goals and Objectives	SAMHSA FY 2007	SAMHSA FY 2008	SAMHSA FY 2009
Number of evidence-based policies, practices, and strategies implemented by HIV program grantees	3.2	3.4	3.5
PREVENTION SCIENCE AND SERVICE (CAPTS)	10.7	9.5	---
Increase the percent of clients reporting that CAPT services substantively enhanced their ability to carry out their prevention work	5.4	4.8	---
Increase the number of persons provided TA services	5.4	4.8	---
SYNAR AMENDMENT IMPLEMENTATION ACTIVITIES	.7	.7	.7
Increase number of States whose retail sales violation rate is at or below 20%			
Number of States reporting retail tobacco sales violation rates below 10%	---	---	---
20% PREVENTION SET-ASIDE	355.4	355.5	359.6
Increase perception of harm of drug use	59.2	---	---
Improvements in non-use	59.2	---	---
Improvement in 30-day use	59.2	---	---
Number of participants served in prevention programs	59.2	39.5	119.9
Percent of services within cost bands for universal, selected, and indicated interventions	59.2	39.5	119.9
Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17)	---	39.5	---
Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 18 and up)	---	39.5	---
Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 12-20)	---	39.5	---
Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 21 and up)	---	39.5	---
Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 12-17)	---	39.5	---
Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 18 and up)	---	39.5	---
Number of evidence-based policies, practices, and strategies implemented	59.2	39.5	119.9
Strategic Goal 3: Human Services Promote the economic and social well-being of individuals, families and communities.			
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.	---	---	---
3.2 Protect the safety and foster the well being of children and youth.	**223.6**	**226.5**	**209.6**

HHS Strategic Goals and Objectives	SAMHSA FY 2007	SAMHSA FY 2008	SAMHSA FY 2009
TRAUMA-INFORMED SERVICES (NCTSI)	31.3	34.9	17.4
Increase number of children and adolescents receiving trauma-informed services	10.4	11.6	5.8
Improve children's outcomes	10.4	11.6	5.8
Dollars spent per person served 3/	10.4	11.6	5.8
YOUTH VIOLENCE (Safe Schools/Healthy Students)	85.7	86.7	75.0
Increase number of children served	9.5	9.6	8.3
Decrease number of violent incidents at middle schools	9.5	9.6	8.3
Decrease number of violent incidents at high schools	9.5	9.6	8.3
Decrease students' substance use (middle schools)	9.5	9.6	8.3
Decrease students' substance use (high schools)	9.5	9.6	8.3
Improve students' school attendance	9.5	9.6	8.3
Increase mental health services to students and families	9.5	9.6	8.3
Percentage of grantees that provided screening and / or assessments that is coordinated among two or more agencies or shared across agencies.	9.5	9.6	8.3
Percentage of grantees that provide training of school personnel on mental health topics	9.5	9.6	8.3
COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN & THEIR FAMILIES	106.6	104.8	117.1
Increase percentage attending school 80% or more of the time after 12 months	17.8	17.5	19.5
Increase percentage with no law enforcement contacts at 6 months	3.0	17.5	19.5
Decrease average days of impatient facilities among children served in systems of care (at 6 months)	17.8	17.5	19.5
Percent of systems of care that are sustained 5 years post Federal Funding	17.8	17.5	19.5
Decrease in inpatients care costs per 1,000 children served	17.8	17.5	19.5
Increase number of children receiving services	17.8	17.5	19.5
3.3 Encourage the development of strong, healthy and supportive communities.	---	---	---
3.4 Address the needs, strengths and abilities of vulnerable populations.	**90.2**	**90.1**	**95.7**
PROTECTION & ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI)	35.0	35.9	35.0
Increase percentage of complaints of alleged abuse, substantiated and not withdrawn by the client, that resulted in positive change for the client in his/her environment, community, or facility, as a result of PAIMI involvement	5.0	4.5	5.0
Increase percentage of complaints of alleged neglect, substantiated and not withdrawn by the client, that resulted in positive change for the client in his/her environment, community, or facility, as a result of PAIMI involvement	5.0	4.5	5.0

HHS Strategic Goals and Objectives	SAMHSA FY 2007	SAMHSA FY 2008	SAMHSA FY 2009
Increase percentage of complaints of alleged rights violations, substantiated and not withdrawn by the client, that resulted in positive change for the client in his/her environment, community, or facility, as a result of PAIMI involvement	5.0	4.5	5.0
Percent of interventions on behalf of groups of PAIMI-eligible individuals that were concluded successfully (same as long-term measure)	5.0	4.5	5.0
Increase in the number of people served by the PAIMI program	5.0	4.5	5.0
Ratio of persons served/impacted per activity/intervention	5.0	4.5	5.0
Cost per 1,000 individuals served/impacted	5.0	4.5	5.0
The number attending public education/constituency training and public awareness activities	---	4.5	---
PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)	55.2	54.2	60.7
Increase the percentage of enrolled homeless persons who receive community mental health services	13.8	10.8	15.2
Increase number of homeless persons contacted	13.8	10.8	15.2
Increase percentage of contacted homeless persons with serious mental illnesses who become enrolled in services	13.8	10.8	15.2
Average Federal cost of enrolling a homeless person with serious mental illness in services	13.8	10.8	15.2
Provide training for PATH providers on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits	---	10.8	---
Strategic Goal 4: Scientific Research and Development Advance scientific and biomedical research and development related to health and human services.			
4.1 Strengthen the pool of qualified health and behavioral science researchers.	**---**	**---**	**---**
4.2 Increase basic scientific knowledge to improve human health and human development.	**---**	**---**	**---**
4.3 Conduct and oversee applied research to improve health and well-being.	**---**	**---**	**---**
4.4 Communicate and transfer research results into clinical, public health and human service practice.	**75.5**	**78.5**	**81.7**
BG SET-ASIDE NATIONAL SURVEYS NON-ADD	75.5	78.5	81.7
Availability and timeliness of data for National Survey on Drug Use and Health	48.9	52.0	54.8
Availability and timeliness of data for Drug Abuse Warning Network	17.2	17.2	17.5
Availability and timeliness of data for the Drug and Alcohol Services Information System	9.4	9.3	9.3
Total	**3,327.0**	**3,356.3**	**3,154.9**
1/ Includes Jail Diversion, Older Adults, and HIV/AIDS programs.			
2/ Performance measures for mental health drug courts will be reported in a future submission.			

HHS Strategic Goals and Objectives	SAMHSA FY 2007	SAMHSA FY 2008	SAMHSA FY 2009
3/This measure was approved by OMB in May 2006 as an interim efficiency measure until a "final" PRNS-wide efficiency measure is developed.			

List of Program Evaluations Completed During the Fiscal Year

Evaluation of the Impact of the Buprenorphine Waiver

Family Treatment Drug Court Evaluation

Outcome Findings for Mental Health and At-Risk Drinking from the Primary Care Research in Substance Use and Mental Health for the Elderly Multisite Study (PRISM-E)

Evaluation of Mentoring and Family Strengthening Youth Substance Abuse Prevention Initiatives

Ecstasy and Other Club Drugs Prevention Initiative

Cross-site Evaluation of the Crisis Counseling Program: 2005 Hurricanes Katrina/Rita/Wilma

What is the impact of building community consensus to adopt and implement evidenced-based or exemplary practices for those with Serious Mental Illness and Serious Emotional Disturbance?

Evaluation of Minority Substance Abuse and HIV Prevention Initiatives and Targeted Capacity Program: Cohort 3

Treatment Episode Data Set (TEDS) 1995-2005 - National Admissions to Substance Abuse Treatment Services

Treatment Episode Data Set (TEDS) Highlights 2005--National Results from the 2006 National Survey on Drug Use and Health (NSDUH): National Findings

Comparing Drug Testing and Self-Report of Drug Use among Youths and Young Adults in the General Population

National Survey of Substance Abuse Treatment Services: 2006 Data on Substance Abuse Treatment Facilities

State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health

Worker Substance Use and Workplace Policies and Programs

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year can be found at the HHS Policy Information Center, http://aspe.hhs.gov/pic/login/dataentry/index.cfm, including program improvement resulting from the evaluation.

Information on Use of Non-Parties

No non-Federal entities were involved in any significant role in the preparation of SAMHSA's 2009 Justification of Congressional Estimates or Online Performance Appendix.

Discontinued Performance Measures

Program	Measure Number	Measure	Last year of data reporting
Substance Abuse Prevention, HIV Prevention, and Hepatitis Prevention for Minorities and Minorities Re-Entering Communities Post-Incarceration	2.3.34	30-day use of other illicit drugs age 12 and up	FY 2007
Centers for the Application of Prevention Technologies	2.3.32	Increase the number of persons provided technical assistance services	FY 2008
Centers for the Application of Prevention Technologies	2.3.33	Increase the percent of clients reporting that CAPT services substantively enhanced their ability to carry out their prevention work	FY 2008
Synar Amendment Activities	2.3.49	Increase number of States whose retail violation rates is at or below 20%	FY 2007
20% Prevention Set-Aside	2.3.50	Increase perception of harm of drug use	FY 2007
20% Prevention Set-Aside	2.3.51	Improvements in non-use (percent ages 12 and older who report that they have never used illicit substances)	FY 2007
20% Prevention Set-Aside	2.3.52	Improvements in use (30-day use)	FY 2007
Access to Recovery	1.2.38	Increase the percentage of adults receiving services who had improved retention in treatment	FY 2007
Substance Abuse Prevention and Treatment Block Grant	1.2.46	Increase the percentage of technical assistance events that result in systems, program, or practice change	FY 2006
Substance Abuse Prevention and Treatment Block Grant	1.2.44	Increase the number of States and Territories voluntarily reporting performance measures in their SAPT Block Grant application	FY 2007

Data Source and Validation Tables

ID	Data Source	Data Validation
SUICIDE PREVENTION		
2.3.57	National Vital Statistics Report, Centers for Disease Control and Prevention	See Technical Notes in National Vital Statistics Reports http://www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_19.pdf : Data reporting for this survey has a 3 year lag time. The 2005 data is expected out in April 2008. Due to the lag in "number of suicide deaths" data reporting, measuring performance of the programs in real time or setting realistic targets for out years is difficult
2.3.58	Suicide Prevention Exposure, Awareness and Knowledge Survey (SPEAKS). This survey is part of the Garrett Lee Smith program cross-site evaluation, and is conducted annually.	Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
2.3.59	Training Exit Survey (TES) and a Training Activity Report (TAR) as part of the GLS cross-site evaluation	Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
YOUTH VIOLENCE (SAFE SCHOOLS/HEALTHY STUDENTS)		
3.2.04	Grantee reports	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things.
3.2.05	Data on children's outcomes were reported in the grantees' ED524 Bi-Annual Report submitted to their GPO every six months. The methods for collecting these measures varied by grantee, but were generally student self-report for the violence and substance use measures and school records for attendance and mental health services.	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things
3.2.06	Data on children's	Grantees implement various forms of data validation as part of

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

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

ID	Data Source	Data Validation
	outcomes were reported in the grantees' ED524 Bi-Annual Report submitted to their GPO every six months. The methods for collecting these measures varied by grantee, but were generally student self-report for the violence and substance use measures and school records for attendance and mental health services.	their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things
TRAUMA-INFORMED SERVICES (NATIONAL CHILD TRAUMATIC STRESS INITIATIVE)		
3.2.01	Data for number of children served are reported quarterly by grantees utilizing a program-wide electronic Service Utilization Form (eSUF).	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. ("Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected.) Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.
3.2.02	Baseline and follow-up data are collected through the Core Data Set (CDS), a secure web-based system, and three standardized behavioral/symptomology measures (CBCL, TSCC, and PTSD-RI) are used to assess improvement in children's outcomes. Data for training are based on General Adoption Assessment Survey (GAAS) results from the Adoption of Methods/Practices component of the	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. ("Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected.) Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.

ID	Data Source	Data Validation
	NCTSI National Cross-Site Evaluation.	
3.2.03	The Efficiency Measure is calculated by dividing the budget devoted to clinical services by the number of children and adolescents receiving trauma-informed services. Data for number of children served are reported quarterly by grantees utilizing a program-wide electronic Service Utilization Form (eSUF).	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. ("Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected.) Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.
MENTAL HEALTH PRNS CAPACITY—COMBINED PROGRAMS		
1.2.01	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
1.2.02	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
1.2.03	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.04	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.05	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.06	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
1.2.07	For the long term measure, the numerator is the number of people receiving services through the state public mental health system, as reported by the Uniform	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp.Data validation for the Co-Morbidity Study is available at http://archpsych.ama-assn.org/cgi/content/full/62/6/593

ID	Data Source	Data Validation
	Reporting System (http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics) The denominator is derived from the National Co-morbidity Study Replication (http://archpsych.ama-assn.org/cgi/content/full/62/6/593), census data, and the 1997 CMHS Client-Patient Sample Survey, as reported in Mental Health 2000 and Mental Health 2002 (see http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/)	
1.2.08	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
1.2.09	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
CO-OCCURRING SIGs		
1.2.17	Data are provided by grantees on GPRA data collection form	Data are subject to project officer review
1.2.18	Data are provided by grantees on GPRA data collection form	Data are subject to project officer review
1.2.19	Data are provided by grantees on GPRA data collection form	Data are subject to project officer review
1.2.20	Data are provided by grantees on GPRA data collection form	Data are subject to project officer review
1.2.21	Data are provided by grantees on GPRA data collection form	Data are subject to project officer review
COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN & THEIR FAMILIES		
3.2.11	Data on children's outcomes are collected from a multi-site outcome study. Data on clinical outcomes were	The Reliable Change Index is a standardized method developed by Jacobson and his colleagues to measure change between two data points. The Reliable Change Index has a clear-cut criterion for improvement that has been psychometrically tested and found to be sound (Jacobson & Truax, 1991).

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

ID	Data Source	Data Validation
	funding ends	
3.2.16	Grantee reports	Data are validated by evaluation contractor and subject to project officer review
3.2.17	The efficiency measure is computed by calculating the average decrease in days of inpatient facilities utilization per child at six months and multiplying the decrease by the average daily hospitalization charges. The cost savings figure is then converted to a rate per 1,000 children served by the program across all sites. The average daily hospitalization charges = $1,335. National estimates of average daily hospitalization charges were obtained from Health Care Utilization Project Nationwide Inpatient Sample (NIS) 2001	Data are validated b y evaluation contractor and subject to project officer review
PROTECTION & ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI)		
3.4.08	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation).	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews
3.4.09	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews

ID	**Data Source**	**Data Validation**
	individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation).	
3.4.10	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation).	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews
3.4.11	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation).	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews
3.4.12	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation).	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews
3.4.13	Data are derived from standardized annual Program Performance Reports in which	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews

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

ID	Data Source	Data Validation
	group advocacy non-litigation, facility monitoring services, class litigation). The cost measure is calculated by using the total PAIMI allotment as the numerator and the total number of persons served/impacted as the denominator.	
PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)		
3.4.15	Data are submitted annually to CMHS by States, which obtain the information from local human service agencies that provide services	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.
3.4.16	Data are submitted annually to CMHS by States, which obtain the information from local human service agencies that provide services	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.
3.4.17	Data are submitted annually to CMHS by States, which obtain the information from local human service agencies that provide services	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.
3.4.18	Data are submitted annually to CMHS by States, which obtain the information from local human service agencies that provide services	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.
3.4.20	Data are submitted annually to CMHS by States, which obtain the information from local human service agencies that provide services	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.
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT		
2.3.07	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp

ID	Data Source	Data Validation
2.3.08	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.09	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.10	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.11	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.12	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.13	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.14	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.15	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.16	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.17	Uniform Reporting System. This measure is calculated by dividing the number of adults with SMI and children/adolescents with SED who received evidence based practices during the FY by the MHBG allocation for the FY in question, multiplied by 10,000	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
CSAP PRNS—Combined Capacity Programs		
2.3.18	A literature review and archival grantee files were used to establish the baselines. Subsequent targets were developed using information from Expectmore.gov in conjunction with review of PRNS trends over time and	CSAP's Data Center (DCC) used a number of outside experts in prevention and economics to review existing materials and develop the prevention cost bands. Cost data and numbers served data are submitted by grantees and are examined by the DACCC to verify, validate and refine the cost band ranges. FY 2005 and 2006 ranges have been updated using the CPI for FY 2006. Grantees have been provided with administrative guidance in how to report data for the cost-band measure. TA contractors have received training in data collection and reporting for this measure and are now providing TA upon request.

ID	Data Source	Data Validation
	expert opinion.	
STRATEGIC PREVENTION FRAMEWORK SIGs		
2.3.19	Long term national measures are obtained from published National Survey on Drug Use and Health reports	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate
2.3.20	Long term national measures are obtained from published National Survey on Drug Use and Health reports	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate
2.3.21	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.
2.3.22	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.
2.3.23	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are

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	Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	complete and accurate.
2.3.24	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.
2.3.25	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.
2.3.26	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.

ID	**Data Source**	**Data Validation**
	estimates were received too late to use in calculations.	
2.3.27	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.
2.3.28	Output measures are obtained from grantee administrative reports	Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance monitoring.
2.3.29	Output measures are obtained from grantee administrative reports	Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance monitoring.
2.3.30	Output measures are obtained from grantee administrative reports	Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance monitoring.
2.3.31	Output measures are obtained from grantee administrative reports	Data related to state activities are submitted by states to the SPF SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance monitoring.
MINORITY AIDS INITIATIVE		
2.3.34	Data will be provided by grantees. A web-based data collection and reporting mechanism has been	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is

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	implemented and all grantees have received training in using the system.	transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.35	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.36	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.38	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.39	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.40	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC

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		Data Analysis Team for analysis and reporting.
2.3.41	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.42	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.43	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.44	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.45	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.46	Data will be provided by grantees. A web-based data collection	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data

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	and reporting mechanism has been implemented and all grantees have received training in using the system.	Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.47	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.48	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
2.3.56	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center. After data are entered, the DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DCCC Data Analysis Team for analysis and reporting.
CENTERS FOR THE APPLICATION OF PREVENTION TECHNOLOGIES		
2.3.32	CAPT Annual Reports. The reports reflect data from the national CAPT data collection system.	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.
2.3.33	CAPT Annual Reports. The reports reflect data from the national CAPT data collection system.	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.
SYNAR AMENDMENT IMPLEMENTATION ACTIVITIES		
2.3.49	The data source is the Synar report, part of the SAPT Block Grant application submitted	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

ID	Data Source	Data Validation
	annually by each State.	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.
2.3.62	The data source is the Synar report, part of the SAPT Block Grant application submitted annually by each State.	States must certify that Block Grant data are accurate. The validity and reliability of the data are ensured through technical assistance, conducting random unannounced checks, and the confirmation of the data by scientific experts, site visits and other similar steps. 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.
20% PREVENTION SET-ASIDE		
2.3.50	Outcome data are from the National Survey on Drug Use and Health.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data, as well as the entire SAPT application, are reviewed jointly by CSAT and CSAP project officers for accuracy and compliance. Discussions between project officers and states are scheduled to clarify ambiguities or inconsistencies in data which are resolved prior to approval. The DCCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted to the DCCC Government Project Officer who works with the Program Project Officers and grantees to identify a resolution. Communications are supported by regularly submitted program data inventories, preliminary reports and variable by variable cleaning sheets. The Data Management team then makes any required edits to the files. The edited files are then available to the DCCC Data Analysis Team for analysis and reporting. Grantees are instructed in the use of data collection protocols through grantee meetings and questionnaire administrative guides. The Block Grant Technical Assistance providers have also received training and have begun providing TA to the states..
2.3.51	Outcome data are from the National Survey on Drug Use and Health.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data, as well as the entire SAPT application, are reviewed jointly by CSAT and CSAP project officers for accuracy and compliance. Discussions between project officers and states

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

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

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

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

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

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1.2.36	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.37	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.38	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.39	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
SCREENING, BRIEF INTERVENTION, REFERRAL & TREATMENT		
1.2.40	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.41	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
CSAT CAPACITY—Combined programs		
1.2.25	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.26	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.27	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.28	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.29	Services	All data are automatically checked as they are input to SAIS.

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	Accountability Improvement System	Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.30	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.31	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
Treatment Drug Courts		
1.2.56	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.57	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.58	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.59	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.60	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.61	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
CSAT SCIENCE AND SERVICE PROGRAMS		
1.4.01	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.4.02	Services Accountability	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they

ID	Data Source	Data Validation
	Improvement System	are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.4.03	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.4.04	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.4.05	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT		
1.2.42	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.43	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
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	with the States/territories on the Block Grant activities	
1.2.45	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database
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1.2.48	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

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1.2.51	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
BLOCK GRANT SET-ASIDE NATIONAL SURVEYS		
4.4.01	Publication date of NSDUH report	Project officer review
4.4.02	Publication date of DAWN report	Project officer review
4.4.03	Publication date of DASIS report	Project officer review

Target vs. Actual Performance
Performance Measures with Slight Differences

"The performance target for the following measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance."

Program	Measure Unique Identifier
Youth Violence (Safe Schools/Healthy Students)	3.2.04
Youth Violence (Safe Schools/Healthy Students	3.2.09
PRNS Combined Capacity *	1.2.01
PRNS Combined Capacity *	1.2.02
PRNS Combined Capacity *	1.2.06
PRNS Combined Capacity *	1.2.08
PRNS Combined Capacity *	1.2.09
Children's Mental Health Initiative	3.2.12
Children's Mental Health Initiative	3.2.13
Children's Mental Health Initiative	3.2.14
Children's Mental Health Initiative	3.2.17
Protection and Advocacy for Individuals with Mental Illness*	3.4.09
Projects for Assistance in Transition from Homelessness*	3.4.18
Community Mental Health Services Block Grant*	2.3.07
Community Mental Health Services Block Grant*	2.3.08
Community Mental Health Services Block Grant*	2.3.09
Community Mental Health Services Block Grant*	2.3.10
Community Mental Health Services Block Grant*	2.3.11
Community Mental Health Services Block Grant*	2.3.13
Community Mental Health Services Block Grant*	2.3.14
Community Mental Health Services Block Grant*	2.3.15
Community Mental Health Services Block Grant*	2.3.16
20% Prevention Set-Aside	2.3.50
20% Prevention Set-Aside	2.3.51
Access to Recovery	1.2.33
Access to Recovery	1.2.34
Access to Recovery	1.2.35
Access to Recovery	1.2.38
Screening, Brief Intervention, Referral, and Treatment	1.2.41
Treatment—All Other Capacity	1.2.25
Treatment—All Other Capacity	1.2.26
Treatment—All Other Capacity	1.2.27
Treatment—All Other Capacity	1.2.28
Treatment—All Other Capacity	1.2.30
Treatment—All Other Capacity	1.2.31
Treatment Science and Service	1.4.01
Treatment Science and Service	1.4.03
Treatment Science and Service	1.4.04
Treatment Science and Service	1.4.05
Substance Abuse Prevention and Treatment Block Grant*	1.2.46
National Surveys	4.4.02

*FY 2006 data