DEPARTMENT of HEALTH and HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

FY 2012 Online Performance Appendix

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INTRODUCTION

The FY 2012 Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2012 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Summary of Performance and Financial Information Report (SPFI). These documents are available at http://www.hhs.gov/budget/.

The FY 2012 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2010 Annual Performance Report and FY 2012 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS SPFI summarizes key past and planned performance and financial information.

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MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the FY 2012 Online Performance Appendix for the Substance Abuse and Mental Health Services Administration (SAMHSA). The report represents the monitoring and management of SAMHSA programs in the area of substance abuse prevention, substance abuse treatment, and mental health services programs.

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

- Transforming Health Care
- Improving the Nation's Behavioral Health
- Achieving Excellence in Operations

The FY 2012 Budget includes substantial revisions to SAMHSA's performance measures reported in the Annual GPRA Plan and Annual GPRA Report. The resulting set of measures seeks to capture the following key items for each program: the number of services delivered or people served, a specific measure or two for each individual program area, and a measure that captures client recovery. Further, SAMHSA spent a good deal of time reviewing existing measures to ensure that they were meaningful and met the needs of both program management and policy-makers. This effort resulted in a reduction of measures from almost 200 (as published in the FY 2011 President's Budget) to around 100 measures in the FY 2012 President's Budget. Although this reduction changes the display of measures in the Annual GPRA Report/Plan, the majority of the measures that have been removed (including NOMS) will continue to be collected and used for program management purposes.

Work on SAMHSA's GPRA measures and other data collection activities are ongoing. SAMHSA is working with internal and external stakeholders on developing appropriate measures of recovery for those with mental or substance use disorders. As these efforts become more defined, the GPRA measures reported in the budget as well as those used for program management may be altered to bring them in line with other cross-cutting efforts.

As with the FY 2011 Appendix, SAMHSA has expanded the display of its performance tables to include targets for FY 2013. As many of SAMHSA's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, the performance tables throughout the two documents includes targets for the year impacted by the FY 2012 funding proposed here.

To the best of my knowledge, the performance data reported by SAMHSA for inclusion in the FY 2012 Online Performance Appendix is accurate, complete, and reliable.

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

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SUMMARY OF PERFORMANCE TARGETS AND RESULTS

The FY 2012 Budget includes substantial revisions to SAMHSA's performance measures reported in the Annual GPRA Plan and Annual GPRA Report. The resulting set of measures seeks to capture the following key items for each program: the number of services delivered or people served, a specific measure or two for each individual program area, and a measure that captures client recovery. Further, SAMHSA spent a good deal of time reviewing existing measures to ensure that they were meaningful and met the needs of both program management and policy-makers. This effort resulted in a reduction of measures from almost 200 (as published in the 2011 President's Budget) to around 100 measures in the FY 2012 President's Budget. Although this reduction changes the display of measures in the Annual GPRA Report/Plan, the majority of the measures that have been removed (including NOMS) will continue to be collected and used for program management purposes.

Work on SAMHSA's GPRA measures and other data collection activities are ongoing. SAMHSA is working with internal and external stakeholders on developing appropriate measures of recovery for those with mental or substance use disorders. As these efforts become more defined, the GPRA measures reported in the budget as well as those used for program management may be altered to bring them in line with other cross-cutting efforts.

Table 1: Summary of Performance Targets and Results[1]

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	144	142	99%	99	70%
2008	162	160	99%	110	69%
2009	184	180	98%	106	59%
2010	179	82	46%	50	61%
2011	93	0	N/A	0	N/A
2012	106	0	N/A	0	N/A
2013	83[2]	0	N/A	0	N/A

[1] Table completed using HHS Program Performance Tracking System, 1/19/2011

[2] Total does not include targets for measures that have yet to be established. In most circumstances this includes new programs where baseline data has not yet been collected.

PERFORMANCE DETAIL

PROGRAM MENTAL HEALTH BLOCK GRANT

Table 2: Measure 2.3.14: Number of people served by the public mental health system[3] (Output)

FY	Target	Result
2013	6,340,320	Sep 30, 2014
2012	6,300,000	Sep 30, 2013
2011	6,300,000	Sep 30, 2012
2010	6,300,000	Sep 30, 2011
2009	6,250,000	6,430,635 (Target Exceeded)
2008	6,200,000	6,332,983 (Target Exceeded)
2007	5,753,633	6,121,641 (Target Exceeded)

Table 3: Measure 2.3.11: Number of evidence based practices (EBPs)[4] (Output)

FY	Target	Result
2013	4.2 per State	Sep 30, 2014
2012	4.2 per State	Sep 30, 2013
2011	4.2 per State	Sep 30, 2012
2010	4.1 per State	Sep 30, 2011
2009	4.0 per State	4.3 per State (Target Exceeded)
2008	4.0 per State	4.2 per State (Target Exceeded)
2007	4.0 per State	4.0 per State (Target Met)

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

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

Table 4: Measure 2.3.15: Rate of consumers (adults) reporting positively about outcomes (Outcome)

FY	Target	Result
2013	72%	Sep 30, 2014
2012	72%	Sep 30, 2013
2011	72%	Sep 30, 2012
2010	72%	Sep 30, 2011
2009	72%	71.6% (Target Not Met)
2008	72%	72% (Target Met)
2007	73%	71% (Target Not Met)

Table 5: Measure 2.3.16: Rate of family members (children/adolescents) reporting positively about outcomes (Outcome)

FY	Target	Result
2013	67%	Sep 30, 2014
2012	73%	Sep 30, 2013
2011	73%	Sep 30, 2012
2010	73%	Sep 30, 2011
2009	73%	65.2% (Target Not Met but Improved)
2008	73%	64% (Target Not Met)

Table 6: Measure 2.3.81: Percentage of service population receiving any evidence based practice (Outcome)

FY	Target	Result
2013	7.2 %	Sep 30, 2014
2012	7.2 %	Sep 30, 2013
2011	7.2 %	Sep 30, 2012
2010	7.2 %	Sep 30, 2011
2009	6.6 %	7.2 % (Target Exceeded)
2008	7.9 %	6.6 % (Target Not Met)
2007	7.7 %	7.9 % (Target Exceeded)

Table 7: Data Source and Validation for Mental Health Block Grant

Measure	Data Source	Data Validation
2.3.14	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.
2.3.11 2.3.15 2.3.16 2.3.81	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The evidence-based practices measure reflects the program's efforts to improve the efficiency and effectiveness of mental health services. The use of EBPs allows mental health providers and programs to more reliably improve services, achieve optimal outcomes and has demonstrated a consistent, positive impact on the lives of people who have experienced mental health problems. For FY 2009, the target for the number of evidence based practices implemented was again exceeded (2.3.11). The percentage of service population receiving any evidence based practice (2.3.81) was also exceeded. Measure 2.3.14 provides a measure of the number of consumers served by the public mental health system. Targets for FY 2007, FY 2008, and FY 2009 were exceeded.

Measures 2.3.15 and 2.3.16 reflect the rate of consumers (adults) and family members (children) reporting positively about the outcomes of the services that they received in helping to the problems that brought them into treatment. The target for adults was slightly missed; the target for children was not met. The future target for children has been reduced on the basis of prior year performance.

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

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of

GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of MHBG measures was reduced leaving five measures in place. Measures 2.3.07 through 2.3.10 were all dropped given that the current rate of hospitalization is relatively infrequent given community alternatives. Measures 2.3.12 and 2.3.13 were combined (now measure 2.3.81) and reflects the evidence base practice coverage for both children and adults. Measure 2.3.17 was dropped due to the fact that many populations do not have established EBPs. Subsequently, some grantees had relatively little success with this measure despite having excellent consumer outcomes. The FY 2009 performance data were used to set the baselines for future targets.

MACRO PROGRAM SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

PROGRAM TREATMENT ACTIVITIES

Table 8: Measure 1.2.43: Number of admissions to substance abuse treatment programs receiving public funding (Output)

FY	Target	Result
2013	1,937,960	Nov 30, 2015
2012	1,881,515	Nov 30, 2014
2011	1,881,515	Nov 30, 2013
2010	1,881,515	Nov 30, 2012
2009	1,881,515	Nov 30, 2011
2008	1,881,515	2,272,250 (Target Exceeded)
2007	2,003,324	2,372,302 (Target Exceeded)[5]

Table 9: Measure 1.2.48: Percentage of clients reporting no drug use in the past month at discharge (Outcome)

FY	Target	Result
2013	74%	Nov 30, 2014
2012	70%	Nov 30, 2013
2011	70.3%	Nov 30, 2012
2010	70.3%	Nov 30, 2011
2009	69.3%	75.7% (Target Exceeded)
2008	69.3%	73.7% (Target Exceeded)
2007	68.3%	73.7% (Target Exceeded)

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

Table 10: Measure 1.2.49: Percentage of clients reporting no alcohol use in the past month at discharge (Outcome)

FY	Target	Result
2013	78%	Nov 30, 2014
2012	75%	Nov 30, 2013
2011	74.7%	Nov 30, 2012
2010	74.7%	Nov 30, 2011
2009	74.7%	81.5% (Target Exceeded)
2008	74.7%	78.2% (Target Exceeded)
2007	73.7%	80.9% (Target Exceeded)

Table 11: Measure 1.2.50: Percentage of clients reporting being employed/in school at discharge (Outcome)

FY	Target	Result
2013	43%	Nov 30, 2014
2012	43%	Nov 30, 2013
2011	43.9%	Nov 30, 2012
2010	43.9%	Nov 30, 2011
2009	42.9%	42.9% (Target Met)
2008	42.9%	37.2% (Target Not Met)
2007	N/A	42.9% (Historical Actual)

Table 12: Measure 1.2.51: Percentage of clients reporting no involvement with the Criminal Justice System (Outcome)

FY	Target	Result
2013	92%	Nov 30, 2014
2012	89%	Nov 30, 2013
2011	88.9%	Nov 30, 2012
2010	88.9%	Nov 30, 2011
2009	88.9%	92% (Target Exceeded)
2008	88.9%	92% (Target Exceeded)
2007	N/A	88.9% (Historical Actual)

Table 13: Measure 1.2.85: Percentage of clients receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2013	92.0 %	Nov 30, 2014
2012	92.0 %	Nov 30, 2013
2011	92.0 %	Nov 30, 2012
2010	92.0 %	Nov 30, 2011
2009	92.0 %	92.0 % (Target Met)
2008	N/A	91.0 % (Historical Actual)

Table 14: Data Source and Validation for Treatment Activities

Measure	Data Source	Data Validation
1.2.43	Data are collected through standard instruments and submitted through the Treatment Episode Set. Data are then uploaded to SAMHSA's State data repository, the Web Block Grant Application System (WEBBGAS). In addition, States can make direct updates to data in WebBGAS and are required to verify that the data in the system are correct.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.48 1.2.49 1.2.50 1.2.51 1.2.85	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.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

There are two measures of client abstinence. One reflects no past month use of from drugs at discharge and the other one reflects no past month use of alcohol at discharge. Discharge is defined as the date of last service and abstinence is defined as no reported use of either alcohol or drugs in the past 30 days. Baseline data have been reported and both measures exceeded their FY 2007 targets.

The target of number of admissions was exceeded in FY 2008 with a total of 2.3 million admissions reported. The number of admissions reflects the number of entrances into services provided under the block grant program.

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

The remaining outcome measures for this program had varied results. In FY 2008, the criminal justice measure exceeded the target. During the same year, the employment target was not met. A newly added measure of housing did not have a target set for FY 2009, but data show 91% of clients reported stable housing at discharge.

Data show promising outcomes for 2009. All targets were either met or exceeded for FY 2009.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. SAMHSA believes this new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA is focusing on client-level outcomes as a measure of effectiveness for this Program. The measures which have been retained provide an appropriate assessment of whether the Program has met its goals/objectives.

PROGRAM SYNAR AMENDMENT

Table 15: Measure 2.3.49: Number of States (including Puerto Rico) whose retail sales violations is at or below 20% (Outcome)

FY	Target	Result
2013	52	Aug 31, 2014
2012	52	Aug 31, 2013
2011	52	Aug 31, 2012
2010	52	Aug 31, 2011
2009	52	52 (Target Met)
2008	52	52 (Target Met)
2007	52	52 (Target Met)

Table 16: Measure 2.3.62: Number of States (excluding Puerto Rico) reporting retail tobacco sales violation rates below 10% (Outcome)

FY	Target	Result
2013	34[6]	Aug 31, 2014
2012	34[7]	Aug 31, 2013
2011	26	Aug 31, 2012
2010	25	Aug 31, 2011
2009	28	34 (Target Exceeded)
2008	29	22 (Target Not Met)
2007	28	26 (Target Not Met but Improved)

Table 17: Data Source and Validation for Synar Amendment

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

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

[6] The target rate for 2012 and 2013 have been increased. Although States continue to face funding cuts to their youth tobacco access enforcement programs due to weak economic conditions, SAMHSA anticipates that new funding available to States from the FDA as a result of the Tobacco Control Act will help to offset State budget cuts and greatly increase the amount and reach of enforcement of youth access laws taking place in States, which SAMHSA expects to result in lower RVRs.

[7] The target rate for 2012 and 2013 have been increased. Although States continue to face funding cuts to their youth tobacco access enforcement programs due to weak economic conditions, SAMHSA anticipates that new funding available to States from the FDA as a result of the Tobacco Control Act will help to offset State budget cuts and greatly increase the amount and reach of enforcement of youth access laws taking place in States, which SAMHSA expects to result in lower RVRs.

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

The Synar program has been successful in reducing youth access to tobacco through retail sources. While the national weighted average retailer violation rate for the 50 states and the District of Columbia (weighted by state population) was 40.1 percent in FY 1996, the rate steadily fell to 9.9 percent in FY 2007. However, the national weighted average retailer violation rate slightly rebounded in FY 2008 to 10.9 percent.

The increase in the RVR between FY 2007 and FY 2008 was most likely due to state budget cuts which resulted in a reduction in the number of enforcement inspections states conducted and reductions in the budgets of state comprehensive tobacco control programs. SAMHSA worked with states to address this issue. For example, SAMHSA held sessions at the 10th National Synar Workshop on topics such as how to maintain outcomes with less money and how to use local tobacco licensing to help fund enforcement. Additionally, Congress recognized the importance of funding rigorous enforcement of youth tobacco access laws by including a mechanism in the Family Smoking Prevention and Tobacco Control Act for the Food and Drug Administration (FDA) to contract with States to fund the enforcement of youth access laws. This funding will help to alleviate some of the barriers States face in enforcing youth access laws as a result of budget cuts. FDA began contracting with States to enforce youth tobacco access laws in the summer of 2010.

Because of these efforts and state efforts to focus attention on the issue of youth tobacco access, the national weighted average retailer violation rate fell in FY 2009, to 9.3 percent, the lowest reported level in the history of the Synar program.

Since FY 2005, all 50 states, the District of Columbia and Puerto Rico have been in compliance with the Synar requirements. (In FY 2006, although one State reported a RVR of 22.7 percent, which is 2.7 percent above its target RVR of 20 percent, the reported rate fell within the +/- 3 percent margin of error allowed for States that conduct a sample.)

Since each State has met the 20 percent requirement for the past five years, SAMHSA set a new program goal to encourage all states to reduce the sales rate to less than 10 percent which is in keeping with the initial intent of the Synar legislation, to reduce minors' access to tobacco products. It is also consistent with research[8] suggesting that effectively reducing youth access requires rates lower than the 20 percent target.

While this does not change the legally required target rate of 20 percent, it provides SAMHSA and States with a program goal that fits the legislative intent. The number of States reporting rates below 10 percent over the last four years are as follows: 25 States in FY 2006, 26 States in FY 2007, 22 States in FY 2008,

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

and 34 States in FY 2009.

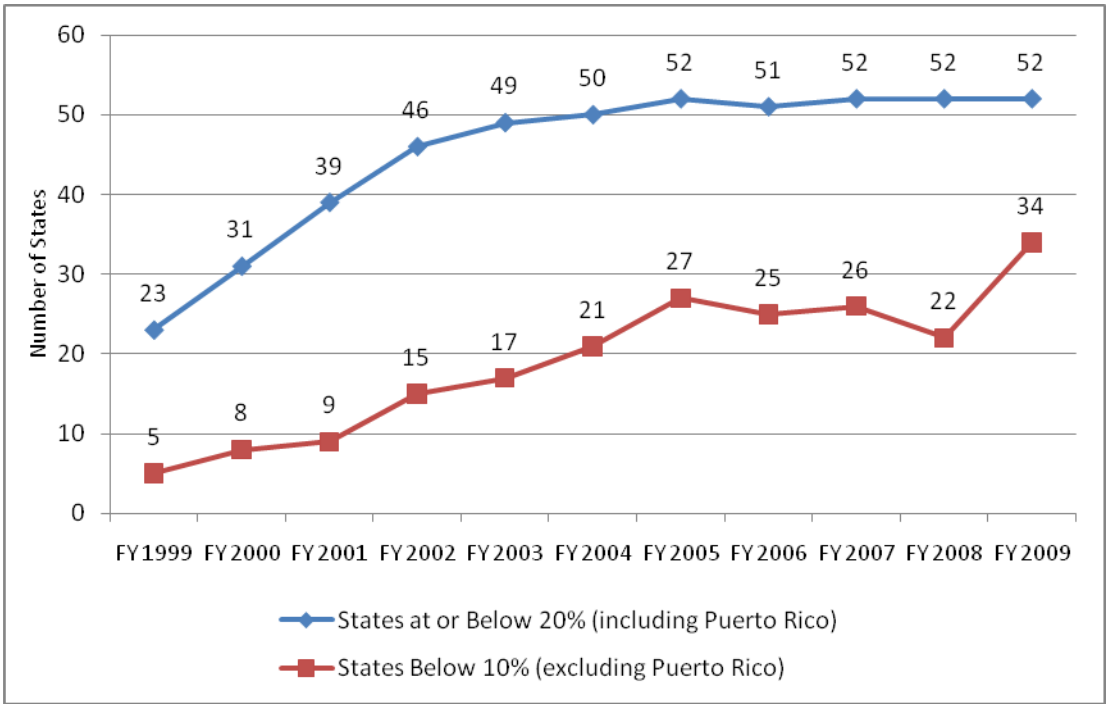

Figure 1: Synar Amendment data FY 1999-FY 2009

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

MACRO PROGRAM PREVENTION GRANTS

PROGRAM SUBSTANCE ABUSE-STATE PREVENTION GRANTS

Table 18: Measure 2.3.85: Number of persons served (Output)

FY	Target	Result
2013	TBD	Aug 31, 2014
2012	Set Baseline	Aug 31, 2013

Table 19: Measure 2.3.90: Percentage of youth age 12-20 who report drinking in the past month (HHS Strategic Plan measure) (Outcome)

FY	Target	Result
2015	23.8 %	N/A
2012	23.8 %	Aug 31, 2013
2009	N/A	27.2 % (Historical Actual)
2008	N/A	26.4 % (Historical Actual)

Table 20: Measure 2.3.97: Percentage of youth age 12-25 who report misuse of prescription drugs

FY	Target	Result
2013	TBD	Aug 31, 2014
2012	Set Baseline	Aug 31, 2013

Table 21: Data Source and Validation for Substance Abuse-State Prevention Grants

Measure	Data Source	Data Validation
2.3.85	Data source has not been finalized at this time, but most likely will be collected by the Prevention Management Reporting and Training System (PMRTS) online data reporting and collection system for prevention grantees.	All PMRTS data are automatically checked by the Data Information Technology Infrastructure Contract (DITIC) for completeness and accuracy as they are input and then they are submitted to the Data Analysis Coordination and Consolidation Center (DACCC) Data Management Team for additional completeness and accuracy checks, analysis and reporting. The Substance Abuse-State Prevention Grant (SA-SPG) data will be reviewed by SAMHSA's CSAP project officers for accuracy and compliance. Project officers and States and their grantees will discuss and resolve ambiguities or inconsistencies in the data prior to approval.

Table 22: Data Source and Validation for Substance Abuse-State Prevention Grants (continued)

Measure	Data Source	Data Validation
2.3.90 2.3.97	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.

In FY 2012, SAMHSA proposes to launch a new, consolidated prevention grant program for States. Known as the Substance Abuse-State Prevention Grant (SA-SPG), this new competitive grant program will build upon and expand the work previously funded under the 20 percent Prevention Set-Aside of the Substance Abuse Prevention and Treatment Block Grant (SABG); the Strategic Prevention Framework State Incentive Grants (SPF SIG); and the Partnerships for Success Grants (PFS).

The SA-SPGs will allow States to plan, implement, and evaluate comprehensive and integrated prevention programs targeting behavioral health goals such as State-wide reductions in substance use. States will use data-driven, *community-focused* strategic planning processes when creating and implementing their new SA-SPG programs. As a result, States will be required to allocate most of their SA-SPG funds to local communities that can organize and carry out activities that are in line with achieving each State's behavioral health goals.

The new SA-SPG program will hold States accountable for achieving targets associated with their goals. Performance measures included in this appendix are preliminary. As plans for the implementation of the new SA-SPG program are finalized, additional measures--including those used by previously funded program--will be evaluated and, if appropriate, added to this appendix.

PROGRAM BEHAVIORAL HEALTH-TRIBAL PREVENTION GRANTS

Table 23: Measure 2.3.92: Number of persons served (Output)

FY	Target	Result
2013	TBD	Aug 31, 2014
2012	Set Baseline	Aug 31, 2013

Table 24: Measure 2.3.93: Percentage of youth age 12-20 who report drinking in the past month (Outcome)

FY	Target	Result
2013	TBD	Aug 31, 2014
2012	Set Baseline	Aug 31, 2013

Table 25: Measure 2.3.98: Percentage of persons aged 12 and older who report suicidal ideation

FY	Target	Result
2013	TBD	Aug 31, 2014
2012	Set Baseline	Aug 31, 2013

Table 26: Data Source and Validation for Behavioral Health-Tribal Prevention Grants

Measure	Data Source	Data Validation
2.3.92 2.3.93	Data source has not been finalized at this time, but most likely will be collected by the Prevention Management Reporting and Training System (PMRTS) online data reporting and collection system for prevention grantees.	All PMRTS data are automatically checked by the Data Information Technology Infrastructure Contract (DITIC) for completeness and accuracy as they are input and then they are submitted to the Data Analysis Coordination and Consolidation Center (DACCC) Data Management Team for additional completeness and accuracy checks, analysis and reporting. The Behavioral Health-Tribal Prevention Grant (BH-TPG) data will be reviewed jointly by SAMHSA's CSAP and CMHS project officers for accuracy and compliance. Project officers and tribes will resolve ambiguities or inconsistencies in the data prior to approval.
2.3.98	TBD	TBD

In FY 2012, SAMHSA proposes to launch a separate consolidated prevention grant program for Tribes. This competitive grant program will build upon and expand the work previously funded under the Strategic Prevention Framework State Incentive Grants (SPF SIG). The Behavioral Health-Tribal Prevention Grant (BH-TPG) will allow Tribal grantees to plan, implement, and evaluate comprehensive and integrated prevention programs that target specific behavioral health goals such as population-specific reductions in substance abuse and mental illness. Tribes will use data-driven strategic planning processes to create their BH-TPG programs and will be required to allocate of the majority of funds toward organizing and implementing activities that will enable each Tribe to achieve their specific behavioral health goals.

The BH-TPG program will hold Tribes accountable for achieving targets associated with their behavior health goals. Performance measures included in this appendix are preliminary and reflect one of SAMHSA's priority areas. As plans for the implementation of the new BH-TPG program are finalized, additional measures--including those used by previously funded programs--will be evaluated and, if appropriate, added to this appendix.

PROGRAM MENTAL HEALTH-STATE PREVENTION GRANTS

Table 27: Measure 2.3.94: Number of persons served (Output)

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	Set Baseline	Dec 31, 2012

Table 28: Measure 2.3.95: Number of persons in the mental health and related workforce trained in specific mental-health related practices/activities as a result of the grant (Outcome)

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	Set Baseline	Dec 31, 2012

Table 29: Measure 2.3.96: Percentage of clients receiving services who report improved functioning (Outcome)

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	Set Baseline	Dec 31, 2012

Table 30: Measure: 2.3.99: Young people age 12-25 who experienced a Major Depressive Episode in the past 12 months

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	Set Baseline	Dec 31, 2012

Table 31: Data Source and Validation for Mental Health-State Prevention Grants

Measure	Data Source	Data Validation
2.3.94 2.3.95 2.3.96	TBD	TBD
2.3.99	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.

In FY 2012, SAMHSA proposes to launch a separate mental health prevention grant program. This competitive grant program will build upon and expand the work previously funded under the Strategic Prevention Framework State Incentive Grants (SPF SIG) and Project LAUNCH.

The MH-SPG program will hold States accountable for achieving targets associated with their behavior health goals. Performance measures included in this appendix are preliminary and reflect one of SAMHSA's priority areas. As plans for the implementation of the new MH-SPG program are finalized, additional measures may be added to this appendix.

MACRO PROGRAM INNOVATION AND EMERGING ISSUES – AGENCY-WIDE INITIATIVES

PROGRAM MILITARY FAMILIES INITIATIVE

Table 32: Measure 3.4.26: The number of behavioral health outcomes for military personnel and their families served through SAMHSA supported programs (HHS Strategic plan Measure) (Outcome)

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	Set Baseline	Dec 31, 2012

Table 33: Measure 3.4.27: Percentage of adults receiving services who report improved functioning (Outcome)

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	Set Baseline	Dec 31, 2012

Table 34: Measure 3.4.28: Percentage of children receiving services who report improved functioning (Outcome)

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	Set Baseline	Dec 31, 2012

Table 35: Measure 3.4.29: Percentage of adults receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	Set Baseline	Dec 31, 2012

Table 36: Data Source and Validation for Military Families Initiative

Measure	Data Source	Data Validation
3.4.26	TBD	TBD
3.4.27 3.4.28 3.4.29	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.

SAMHSA proposes funding in FY 2012 to address the behavioral health needs of military service personnel and their families served through the public health service system. This initiative supports the HHS Strategic Plan Objectives responding to the mental health and substance abuse needs of military

families and builds on the recent work at SAMHSA including a national conference on the behavioral health needs of returning veterans, returning veteran State policy academies and collaboration with the National Guard Bureau to address the behavioral health needs of guardsman and their families. The two-phased funding approach would support infrastructure development, including coordination and capacity building as well as direct service supports for prevention, treatment and recovery services for those communities most impacted by the needs of service members, veterans, and their families. A number of activities have already been implemented under the SAMHSA Military Families Strategic Initiative to improve access to and quality of behavioral health services offered to military members and their families. These activities include:

- Promotion of a public health model for psychological health services for military families that emphasizes prevention, resilience and when necessary, delivery of high quality recovery-oriented and specialized behavioral health care
- Coordination with TRICARE, Department of Defense, or Veterans Health Administration services to improve Military Families' access to community-based behavioral health care
- Improving the quality of behavioral health prevention, treatment, and recovery support services by helping providers respond to the needs and culture of Military Families through work with State and Territorial Mental Health and Substance Abuse Authorities to focus attention on needs of service members, veterans, and their families
- Promoting the behavioral health of Military Families with programs and evidence-based practices that support their resilience and emotional health

Baseline and targets will be set at the end of the first year of program operations, which is the end of FY 2012.

PROGRAM PREVENTION PREPARED COMMUNITIES

Table 37: Measure 3.3.04: Percent of funded communities with reduced school dropout rates (Outcome)

FY	Target	Result
2013	TBD	Aug 31, 2014
2012	Set Baseline	Aug 31, 2013

Table 38: Measure 3.3.05: Percent of funded communities with reduced rates of domestic violence (Outcome)

FY	Target	Result
2013	TBD	Aug 31, 2014
2012	Set Baseline	Aug 31, 2013

Table 39: Measure 3.3.06: Number of youth in funded communities who report that they talk with one or more parent/guardian at least 15 minutes everyday (Output)

FY	Target	Result
2013	TBD	Aug 31, 2014
2012	Set Baseline	Aug 31, 2013

Table 40: Data Source and Validation for Prevention Prepared Communities

Measure	Data Source	Data Validation
3.3.04 3.3.05 3.3.06	TBD	TBD

The Prevention Prepared Communities (PPC) is a new coordinated prevention effort between multiple federal agencies in conjunction with States, Tribes and prevention prepared communities. The PPC program will fund communities within States that have established collaborations, data collection and technical assistance infrastructure to enhance their current capacity for strategic planning and operation.

Performance measures for the PPC program are preliminary and reflect significant predictors of substance use. For example, dropout rates and domestic violence have been documented as significant risk factor for behaviors such as substance use, while family bonding continues to serve as a significant protective factor. As plans for the PPC are finalized, performance measures and targets will be re-evaluated and refined as necessary. As a result, baseline measures and subsequent targets will be established during the first year of the grant and performance data will be available no later than the end of the second year of the grant—thereby allowing for appropriate planning and implementation of the program.

MACRO PROGRAM INNOVATION AND EMERGING ISSUES - CMHS

PROGRAM YOUTH VIOLENCE PREVENTION

Table 41: Measure 3.2.04: Number of children served (Outcome)

FY	Target	Result
2013	2,328,500	Dec 31, 2013
2012	2,328,500	Dec 31, 2012
2011	2,328,500	Dec 31, 2011
2010	2,328,500	2,328,500 (Target Met)
2009	2,328,500	3,154,305 (Target Exceeded)
2008	1,062,963	2,328,500 (Target Exceeded)
2007	1,062,963	1,845,110 (Target Exceeded)

Table 42: Measure 3.2.10: Percentage of students who receive mental health services (Outcome)

FY	Target	Result
2013	66%	Dec 31, 2013
2012	66%	Dec 31, 2012
2011	66%	Dec 31, 2011
2010	66%	59.3% (Target Not Met)[9]
2009	66%	74.4% (Target Exceeded)
2008	46%	66% (Target Exceeded)
2007	46%	46% (Target Met)

[9] This number includes data from a large cohort of grantees funded in 2009. The 2010 result is derived from 60 new grantees and 27 continuing grantees. Full implementation of services does not occur until later in 1st year of program. Thus decrease may reflect the impact of the larger new cohort.

Table 43: Measure 3.2.29: Percentage of middle and high school students who have been in a physical fight on school property (Outcome)

FY	Target	Result
2013	27.0 %	Dec 31, 2013
2012	27.0 %	Dec 31, 2012
2011	27.0 %	Dec 31, 2011
2010	27.0 %	19.0 % (Target Exceeded)
2009	N/A	21.0 % (Historical Actual)
2008	N/A	31.0 % (Historical Actual)
2007	N/A	34.0 % (Historical Actual)

Table 44: Measure 3.2.30: Percentage of middle and high school students who report current substance abuse (Outcome)

FY	Target	Result
2013	20.0 %	Dec 31, 2013
2012	20.0 %	Dec 31, 2012
2011	20.0 %	Dec 31, 2011
2010	20.0 %	24.0 % (Target Not Met)
2009	N/A	19.0 % (Historical Actual)
2008	N/A	20.0 % (Historical Actual)
2007	N/A	22.0 % (Historical Actual)

Table 45: Data Source and Validation for Youth Violence Prevention

Measure	Data Source	Data Validation
3.2.04	Grantee reports	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things.

Table 46: Data Source and Validation for Youth Violence Prevention (continued)

Measure	Data Source	Data Validation
3.2.10 3.2.29 3.2.30	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.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

Since the baseline was set in 2006, the performance targets for measure 3.2.04, number of children served, have been consistently exceeded. Since the targets were set, more grants were awarded than had been anticipated and the resulting number of children served was significantly higher than the targets. The 2010 result can be attributed to the fact that the 2009 is made up of 60 new and 27 continuing grantees which SAMHSA expects to increase as this cohort becomes fully operational in its violence prevention activities in the future.

Targets for student outcomes in reduction in violence were exceeded in FY 2010. Violent incidents (3.2.08, 3.2.09, and 3.2.29) are defined by the percentage of students that have experienced violence at least once in the past 12 months as measured by a student survey item. This percentage has decreased from 2006 to 2010 by 34% for middle school students and 38% for high school students. Substance use (3.2.07, 3.2.08, and 3.2.30) is defined as the percentage of students that report having used alcohol in the past 30 days, increased slightly in 2010. For the "percentage of students who receive mental health services (3.2.10)" measure, the definition of mental health services is determined by the grantee with guidance from their project officer. This measure represents the percentage of students that receive services following a mental health referral and has decreased significantly in 2010 and can be attributed to the fact that the 2010 result is derived from 60 new grantees and 27 continuing grantees. Full implementation of services does not occur until later in first year of program. Thus this decrease may reflect the impact of the larger new cohort.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The Youth Violence Prevention targets for 2013 reflect the 2012 budget allocation. The overall number of Youth Violence Prevention measures was reduced. Measures 3.2.05 and 3.2.06 were combined (new measure 3.2.29) and measures 3.2.07 and 3.2.08 (new measure 3.2.30) to include both middle and high school students. Measure 3.2.09 had already been slated for retirement in 2010. Measures 3.2.21 and 3.2.22 were both dropped as the data source is not maintained by SAMHSA and the performance for these measures was at an acceptable level.

Table 47: Measure 3.2.02: Percentage of children receiving services showing clinically significant improvement (HHS Strategic Plan Measure) (Outcome)

FY	Target	Result
2015	79%	Dec 31, 2015
2013	43%[10]	Dec 31, 2013
2012	43%[11]	Dec 31, 2012
2011	43%[12]	Dec 31, 2011
2010	69%	43%[13] (Target Not Met)
2009	69%	47%[14] (Target Not Met)
2008	37%	42%[15] (Target Exceeded)
2007	37%	38%[16] (Target Exceeded)

Table 48: Measure 3.2.23: Unduplicated count of the number of children and adolescents receiving trauma-informed services (Outcome)

FY	Target	Result
2013	480 [17]	Dec 31, 2013
2012	1,922[18]	Dec 31, 2012
2011	3,217	Dec 31, 2011
2010	3,217	1,959 (Target Not Met but Improved)
2009	2,925	1,922 (Target Not Met but Improved)
2008	Set Baseline	975 (Baseline)

[10] Target reset from previously published actual. In 2010, an error was discovered in the syntax used to calculate the data for this measure. As a result of the error, actuals were inflated artificially. Targets have been revised to reflect these revised actuals.
[11] Ibid.
[12] Ibid.
[13] Actuals revised from previously reported results. In 2010, an error was discovered in the syntax used to calculate the data for this measure. As a result of the error, actuals were inflated artificially. Previous data for this measure has been rerun utilizing the corrected syntax.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Target has been reduced to reflect the reduced program funding expected in FY 2012.
[18] Target adjusted reflect 2009 actual.

Table 49: Measure 3.2.24: Number of child-serving professionals trained in providing trauma-informed services (Outcome)

FY	Target	Result
2013	23,800[19]	Dec 31, 2014
2012	95,186[20]	Dec 31, 2013
2011	100,800	Dec 31, 2012
2010	100,800	Dec 31, 2011[21]
2009	96,000	95,186 (Target Not Met but Improved)
2008	Set Baseline	91,517 (Baseline)

Table 50: Data Source and Validation for NCTSI

Measure	Data Source	Data Validation
3.2.02 3.2.23	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.2.24	Data for number of professionals trained is reported quarterly by grantees utilizing a program-wide Online Performance Monitoring Report (OPMR).	The contractor performs significant validation on data reported by the NCTSI Centers for the OPMR within NICON. "Validation" includes, but is not limited to range checks and checks on logical consistency across variables. In addition, many data entry forms only appear to NCTSN centers when the form is relevant. For example, data entry forms on financing will only appear at the end of the fiscal year. Similarly, there are numerous supplemental forms, such as information about direct services and training, that only appear based on answers to screening questions. This prevents the entry of invalid or inconsistent data.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The National Traumatic Stress Network (NCTSN) is a nationwide collaborative network of organizations involved in the evaluation, treatment, and support of children and their families impacted by traumatic stress. The Network includes three components: (A) the National Center for Child Traumatic Stress

[19] Target has been reduced to reflect the reduced program funding expected in FY 2012.

[20] Target adjusted reflect 2009 actual.

[21] FY 2010 data is not available due to transfer to TRAC system data collection. Data will be available for FY 2011.

(NCCTS, Category 1), (B) Intervention Development and Evaluation Centers (Category 2), and (C) Community Treatment and Services Centers (Category 3). The NCTSN is currently comprised of 61 funded Centers.

The NCTSI began using a web-based GPRA data collection system called Transformation Accountability (TRAC) System in FY 2008 which ensures the capture of an unduplicated count of children served. For Measure 3.2.01, this shift to the TRAC system led to the unavailability of the FY 2010 estimated number served data. In FY 2008, the baseline for the replacement number served (3.2.23) was 975. The FY 2010 target was not met. This result is significantly lower than the previously reported estimated number served due to the fact that not all grantees are fully utilizing the TRAC system. This is the result of factors such as delays in human subjects review at some sites and various staffing/budget constraints. SAMHSA expects compliance to continue to improve considerably over time as we are providing additional technical assistance and working aggressively with grantees to improve compliance with TRAC. The outcome for Measure 3.2.24, is not able to be reported this year as SAMHSA does not have this data for FY 2010 due to the fact that the grantee stopped collecting the data when it was discovered that OMB clearance had not been obtained for collecting this information. The 2013 target was decreased by approximately 75 percent to reflect the reduced program funding expected in 2012.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of NCTSI measures was reduced by two; leaving three measures in place. The two measures that were dropped had already been slated for retirement by 2010.

PROGRAM MENTAL HEALTH SYSTEM TRANSFORMATION GRANTS[22,23,24]

Table 51: Measure 1.2.11: Number of persons in the mental health and related workforce trained in specific mental-health related practices/activities as a result of the grant (Outcome)

FY	Target	Result
2013	2,000 [25]	Oct 31, 2013
2012	4,095	Oct 31, 2012
2011	746	Oct 31, 2011
2010	16,557	60,924 (Target Exceeded)
2009	8,218	52,748 (Target Exceeded)
2008	34,629	50,850 (Target Exceeded)
2007	Set Baseline	3,276 (Baseline)

[22] Program was formerly known as Mental Health State Incentive Grants for Transformation

[23] This program is still under development and performance measures will be added once the program is finalized. In the interim, targets for FY 2012 and FY 2013 have been included and are subject to change.

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

[25] Target has been reduced to reflect the reduced program funding expected in FY 2012.

Table 52: Data Source and Validation for Mental Health System Transformation Grants

Measure	Data Source	Data Validation
1.2.11	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.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

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

Performance target for Measure 1.2.11, the number of persons in the mental health care and related workforce who have been trained in service as a result of the grant, has increased significantly and targets have been exceeded each year since baseline. The variability in the MHT SIG program targets and results are due to the fact that one cohort is ending and another is beginning with a new focus on services with less emphasis on infrastructure development. The target set for 2013 reflects changes in program emphasis, beginning in 2010, to expand treatment capacity.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The Mental Health System Transformation Grants targets for FY 2013 reflect the FY 2012 budget allocation. The number of Mental Health System Transformation Grants measures was reduced; leaving one measure in place. The measures selected for deletion were those that no longer were appropriate for the redesigned program that focuses on consumer services.

Table 53: Measure 2.3.59: Total number of individuals trained in youth suicide prevention (Outcome)

FY	Target	Result
2013	35,371	Dec 31, 2013
2012	35,371	Dec 31, 2012
2011	35,371	Dec 31, 2011
2010	35,371	35,371 (Target Met)
2009	29,323	83,724 (Target Exceeded)
2008	97,742	101,669 (Target Exceeded)
2007	Set Baseline	75,186 (Baseline)

Table 54: Measure 2.3.60: Total number of youth screened (Output)

FY	Target	Result
2013	3,360	Dec 31, 2013
2012	3,360	Dec 31, 2012
2011	3,360	Dec 31, 2011
2010	3,360	3,729 (Target Exceeded)
2009	3,360	27,132 (Target Exceeded)
2008	Set Baseline	3,182 (Baseline)

Table 55: Measure 2.3.61: Number of calls answered by the suicide hotline (Output)

FY	Target	Result
2013	555,132	Dec 31, 2013
2012	555,132	Dec 31, 2012
2011	555,132	Dec 31, 2011
2010	555,132	664,932 (Target Exceeded)
2009	538,963	619,813 (Target Exceeded)
2008	Set Baseline	513,298 (Baseline)

Table 56: Data Source and Validation for Suicide Prevention Activities

Measure	Data Source	Data Validation
2.3.59	Training Exit Survey (TES) and a Training Activity Report (TAR) as part of the GLS cross-site evaluation	Evaluation coordinators have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
2.3.60	Data for the number of youth screened are reported in the Early Identification Referral and Follow-up (EIRF) Aggregate and Individual Forms for all grantees	Evaluation coordinators have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
2.3.61	The number of calls answered is reported in the National Suicide Prevention LifeLine Monthly Report	Specialists in information technology at the National Suicide Prevention LifeLine evaluation center validate phone records received from Sprint to determine the number of calls received and answered at 1-800-273-TALK.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

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

The number of individuals trained in youth suicide prevention (2.3.59) is also an important indicator of program penetration as well as increased suicidal awareness. The 2012 target has been reset to reflect the 2009 actual.

All targets for which data were available were exceeded for this program in 2010, except for Measure 2.3.57, which is to be discontinued in FY 2011 as the measure is a national measure of all suicides and too distant from program activities and outcomes of the SAMHSA Suicide Prevention Program which focuses on youth.

The FY 2013 target for 2.3.60 reflects proposed flat program funding in 2012.

SAMHSA's Suicide Prevention Hotline is monitored using the Number of Calls Answered by the Suicide Hotline (2.3.61). Baseline for this measure was captured in FY 2008 and exceeded its target in 2009 and 2010. There are plans to expand data collection for this program to capture client outcomes in the future.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and

consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of Suicide Prevention measures were reduced; leaving two measures in place. Measure 2.3.57 was discontinued as the measure was considered too distant from program activities and outcomes. Measure 2.3.58 was discontinued as it did not provide important information about the core purpose of the program.

PROGRAM MENTAL HEALTH HOMELESSNESS PREVENTION PROGRAMS[26]

Table 57: Measure 3.4.01: Number of clients served (Output)

FY	Target	Result
2013	2,734	Dec 31, 2013
2012	2,223	Dec 31, 2012
2011	2,262	Dec 31, 2011
2010	2,223	3,491 (Target Exceeded)
2009	2,145	878 (Target Not Met but Improved)
2008	Set Baseline	548 (Baseline)

Table 58: Measure 3.4.02: Percentage of adults receiving services who report improved functioning (Outcome)

FY	Target	Result
2013	68.4 %	Dec 31, 2013
2012	68.4 %	Dec 31, 2012
2011	68.4 %	Dec 31, 2011
2010	68.4 %	63.9 % (Target Not Met but Improved)
2009	68.4 %	54.8 % (Target Not Met)
2008	Set Baseline	68.4 % (Baseline)

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

Table 59: Measure 3.4.03: Percentage of adults receiving services who were currently employed (Outcome)

FY	Target	Result
2013	15.6 %	Dec 31, 2013
2012	15.6 %	Dec 31, 2012
2011	15.6 %	Dec 31, 2011
2010	15.6 %	13.7 % (Target Not Met but Improved)
2009	15.6 %	9.1 % (Target Not Met)
2008	Set Baseline	15.6 % (Baseline)

Table 60: Measure 3.4.05: Percentage of adults receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2013	74.2 %	Dec 31, 2013
2012	60.6 %	Dec 31, 2012
2011	60.6 %	Dec 31, 2011
2010	60.6 %	79.4 % (Target Exceeded)
2009	60.6 %	74.2 % (Target Exceeded)
2008	Set Baseline	60.6 % (Baseline)

Table 61: Measure 3.4.06: Percentage of adults receiving services who had improved social support (Outcome)

FY	Target	Result
2013	78 %	Oct 31, 2013
2012	78 %	Oct 31, 2012
2011	78 %	Oct 31, 2011
2010	78 %	70 % (Target Not Met but Improved)
2009	78 %	70 % (Target Not Met)
2008	Set Baseline	78 % (Baseline)

Table 62: Data Source and Validation for Mental Health Homelessness Prevention Grants

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

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The purpose of Services in Supportive Housing (SSH) program is to help prevent or reduce chronic homelessness by funding services for individuals and families experiencing chronic homelessness in coordination with existing permanent supportive housing programs and resources. Supportive housing provides consumers with long-term, community-based housing options by providing individuals and families who experience chronic homelessness the appropriate services and treatment needed to stay housed in a permanent setting. This housing approach combines housing assistance and intensive individualized support services to people with serious psychiatric conditions and those with co-occurring mental and substance use disorders. The SSH program began with the funding of nine sites in 2007 and five additional in 2008. The GPRA baselines were based on these 14 grantees. In 2009, an additional 43 grantees were funded, followed by five additional grantees in 2010. SAMHSA has now funded 62 grantees in 25 states.

The target for measure 3.4.01, number of clients served, was exceeded given this increase in the number of grantees. The targets for measures 3.4.02 and 3.4.03 were both not met but improved over FY 2009 performance. The target for measure 3.4.04, percentage of adults receiving services who had no/reduced involvement with the criminal justice system, was missed by just 0.7% and performance for the measure is showing nearly 100% of SSH consumers have had no criminal justice system contact in the past year. The target for measure 3.4.05, permanent housing, was exceeded. The target for measure 3.4.06, social connectedness, was not met by the largest margin compared to the other measures, but improved slightly over 2009 data. Improving and maintaining social connectedness in this population is challenging, but by providing housing *and* supportive services, the SSH program enables participants to grow and thrive in permanent housing which also facilitates the opportunity for increasing social connection and support. SAMHSA's technical assistance plan to SSH grantees for 2011 includes training on social connectedness via webinar and dedicated time on this topic during the annual grantee conference to be held April 26-28, 2011. SAMHSA expects that future data should show improvement as new grantees become fully operational. In addition, the SSH Technical Assistance Center has worked with SAMHSA and consumer leaders to develop the Services in Supportive Housing Consumer and Peer-Specialist Network (SSH CPN) to ensure consumer input into SSH programs and services. SSH programs nominate consumers who are receiving or have received services from an SSH program to participate in the SSH CPN. The Network schedules regular conference calls and plans to develop a Mission Statement, as well as to provide program guidance on consumer issues such as social connectedness.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of

GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of Services in Supportive Housing measures was reduced; leaving five measures in place. Measure 3.4.04 was discontinued due to the fact that criminal justice was considered not to be a primary focus of the program. Measure 3.4.07 was discontinued due to the method of data collection which had been having the provider ask the consumer how he or she felt about the provider's services. Data collection protocols have been revised for less bias.

PROGRAM MENTAL HEALTH - OTHER CAPACITY ACTIVITIES[27]

Table 63: Measure 1.2.05: Percentage of clients receiving services who report improved functioning (Outcome)

FY	Target	Result
2013	54%	Dec 31, 2013
2012	54%	Dec 31, 2012
2011	54%	Dec 31, 2011
2010	54%	52.7% (Target Not Met)
2009	54%	52.8% (Target Not Met but Improved)
2008	93%	50.5% (Target Not Met)
2007	Set Baseline	93% (Baseline)[28]

Table 64: Measure 1.2.82: Percentage of clients receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2013	67.7 %	Oct 31, 2013
2012	67.7 %	Oct 31, 2012
2011	67.7 %	Oct 31, 2011
2010	67.7 %	74.4 % (Target Exceeded)
2009	63.1 %	67.7 % (Target Exceeded)
2008	60.9 %	63.1 % (Target Exceeded)
2007	Set Baseline	60.9 % (Baseline)

[27] Includes the following programs: Jail Diversion, Older Adults, HIV/AIDS, Primary and Behavioral Health Care Integration, and Healthy Transitions

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

Table 65: Measure 1.2.83: Percentage of clients receiving services who are currently employed (Outcome)

FY	Target	Result
2013	14.0 %	Oct 31, 2013
2012	14.0 %	Oct 31, 2012
2011	14.0 %	Oct 31, 2011
2010	14.0 %	17.2 % (Target Exceeded)
2009	21.1 %	13.1 % (Target Not Met)
2008	17.7 %	21.1 % (Target Exceeded)
2007	Set Baseline	17.7 % (Baseline)

Table 66: Data Source and Validation for Mental Health – Other Capacity Activities

Measure	Data Source	Data Validation
1.2.05 1.2.82 1.2.83	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.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

Measure 1.2.05 is the percentage of clients receiving services who report improved functioning. The target was not met for FY 2010. This outcome is comprised of responses to questions about how effectively the consumer is able to deal with daily problems, the ability to control his or her life, the ability to deal with crisis, how well he or she is getting along with family members, how well he or she handles social situations and at work or school; and if symptoms are bothersome.

Measure 1.2.82, percentage of clients receiving services who had a permanent place to live in the community (Outcome), and Measure 1.2.83, percentage of clients receiving services who are currently employed (Outcome), have been added to the Other Mental Health Capacity reporting. Both targets were exceeded in FY 2010.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of Other Mental Health Capacity Activities measures was reduced leaving three measures in place. Measures 1.2.03, 1.2.06, 1.2.07, 1.2.08 and 1.2.09 were discontinued as these measures are too distant from actual program activities and the data sources are not maintained by SAMHSA.

Table 67: Measure 1.4.06: Number of people trained by CMHS Science and Service Programs (Output)

FY	Target	Result
2013	3,390	Dec 31, 2013
2012	4,237	Dec 31, 2012
2011	4,237	Dec 31, 2011
2010	4,237	5,835 (Target Exceeded)
2009	4,237	3,534 (Target Not Met)
2008	N/A	4,036 (Historical Actual)
2007	N/A	4,852 (Historical Actual)

Table 68: Measure 1.4.08: Percentage of participants who report implementing improvements in treatment methods on the basis of information and training provided by the program (Outcome)

FY	Target	Result
2013	TBD	Oct 31, 2013
2012	TBD	Oct 31, 2012
2011	Set Baseline	Oct 31, 2011

Table 69: Measure 1.4.09: Number of individuals trained by SAMHSA's Science and Services Program (HHS Strategic Plan Measure) (Output)

FY	Target	Result
2015	49,746	December 31, 2015
2010	N/A	38,624 (Historical Actual)[29]
2009	N/A	45,462 (Historical Actual)
2008	N/A	48,415 (Historical Actual)

[29] NOTE: Data are preliminary and do not reflect all program accomplishments during FY 2010. Reporting periods for component programs vary and, therefore, are complete for only a portion of them. Final data for all programs will be available in August 2011.

Table 70: Data Source and Validation for Mental Health – Science and Service Activities

Measure	Data Source	Data Validation
1.4.06	Participant's direct report on standardized questionnaires administered at the completion of each training course.	Historically Black Colleges and Universities (HBCU) data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database. HIV/AIDS Education and Statewide Family Network Training and Technical Assistance Center data validation procedures involve initial review and consultation with the site representative to resolve obvious discrepancies; double data entry and comparison; and several rounds of logical and edit checks. Note: These measures should be available through the TRAC system starting next year.
1.4.08	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.
1.4.09	SAMHSA Performance Measure Measurement System(s) (TRAC, SAIS, PMART)	To be determined

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

SAMHSA's Science and Service programs are complements to the Capacity programs. The mental health programs within Science and Service include Historically Black Colleges and Universities (HBCU) Center of Excellence. This program disseminates best-practices information to grantees and the field, helping to ensure that SAMHSA's Capacity programs build and improve services capacity in the most efficient, effective and sustainable way possible. The Science and Service programs are also an essential and cost-effective support to building effective capacity in communities that do not receive grant funds from SAMHSA. SAMHSA hopes to include additional data from more of its science and service activities in the future.

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

The target for Measure 1.4.06 was exceeded. The number trained includes the Mental Health Care Provider Education (MHCPE) HIV/AIDS education training and the Historically Black Colleges and Universities (HBCU) National Resource Center for Substance Abuse and Mental Health training. MHCPE provides the majority of the number trained for this measure.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of Science and Service measures was reduced; leaving one measure in place while a new measure was added. Measure 1.4.07, a client satisfaction measure, was discontinued as SAMHSA has determined that client satisfaction is not useful in assessing the impact of TA efforts. The FY 2010 performance data were used to set the baselines for future targets. One measure has also been added which captures training efforts across SAMHSA Science and Service programs.

MACRO PROGRAM INNOVATION AND EMERGING ISSUES - CSAP

PROGRAM MINORITY AIDS INITIATIVE[30,31,32]

Table 71: Measure 2.3.56: Number of individuals exposed to substance abuse/hepatitis education services (Output)

FY	Target	Result
2013	1,535	Aug 31, 2014
2012	1,535	Aug 31, 2013
2011	1,535[33]	Aug 31, 2012
2010	2,327	Aug 31, 2011
2009	2,305	3,431 (Target Exceeded)
2008	2,283	3,298 (Target Exceeded)
2007	Set Baseline	2,260 (Baseline)

Table 72: Measure 2.3.82: Percent of program participants that rate the risk of substance abuse as moderate or great (all ages) (Outcome)

FY	Target	Result
2013	94.4 %	Aug 31, 2014
2012	94.4 %	Aug 31, 2013
2011	94.4 %	Aug 31, 2012
2010	94.4 %	Aug 31, 2011
2009	Set Baseline	94.4 % (Baseline)

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

[31] HIV Cohort 7 serves different population groups so baseline data from this cohort will be established and entered in FY 2011.

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

[33] This measure is expected to decline and change from substance abuse/hepatitis education to substance abuse/HIV education in FY 2011 following the close–out of Cohort 6 grants and newer Cohorts not yet functioning at optimum levels. Cohort 7 and later cohorts are not focusing on hepatitis education, but rather focusing on HIV education.

Table 73: Measure 2.3.83: Percent of program participants who report no use of alcohol at pre-test who remain non-users at post-test (all ages) (Outcome)

FY	Target	Result
2013	91.2 %	Aug 31, 2014
2012	91.2 %	Aug 31, 2013
2011	91.2 %	Aug 31, 2012
2010	91.2 %	Aug 31, 2011
2009	Set Baseline	91.2 % (Baseline)

Table 74: Measure 2.3.84: Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (all ages) (Outcome)

FY	Target	Result
2013	92.6 %	Aug 31, 2014
2012	92.6 %	Aug 31, 2013
2011	92.6 %	Aug 31, 2012
2010	92.6 %	Aug 31, 2011
2009	Set Baseline	92.6 % (Baseline)

Table 75: Data Source and Validation for Minority AIDS Initiative Grants

Measure	Data Source	Data Validation
2.3.82 2.3.83 2.3.84	Data are provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by SAMHSA's integrated Data Analysis Coordination and Consolidation Center (DACCC). After data are entered, the DACCC Data Management Team reviews the data for completeness and accuracy. Information on any data problems identified is transmitted through the use of "cleaning sheets" to the Government Project Officer (GPO) and the grantee to resolve. The Data Management Team then makes any required edits to the files. The edited files are then sent to SAMHSA staff and the DACCC Data Analysis Team for analysis and reporting.

Table 76: Data Source and Validation for Minority AIDS Initiative Grants (continued)

Measure	Data Source	Data Validation
2.3.56	The number of persons provided direct technical assistance (TA) includes those served by several initiatives. These include: 1) the Center for the Application of Prevention Technology (CAPT) which provide TA to the SAMHSA CSAP discretionary program grantees, including the SPF-SIG, HIV and Methamphetamine grantees; and 2) the Fetal Alcohol Spectrum Disorders (FASD) Center of Excellence which provides TA to the FASD program.	Each of these activities uses a quality control protocol for collecting and submitting its data and is overseen by SAMHSA staff. These data are then submitted to the Data Analysis Coordination and Consolidation Center (DACCC) for cleaning, editing and analysis before being used by SAMHSA for performance reporting and other analyses. More information can be found on the following websites: http://captus.samhsa.gov/home.cfm; http://www.fasdcenter.samhsa.gov/.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The goal of the Minority AIDS Initiative (MAI) is to prevent and reduce the onset of substance abuse and transmission of HIV among at-risk minority populations by delivering evidence-based substance abuse and HIV prevention interventions[34] and building local community capacity. The target populations include reentry (i.e., racial/ethnic minorities who have been released from prisons and jails within the past 2 years); men having sex with men (MSM); Black, Latina, or Hispanic women; adolescents (age 12-17); young adults (age 18-24); and older adults (i.e. ages 50 and over).

The MAI GPRA measures are designed to assess the program's success in educating participants about the risks of substance abuse and its relation to HIV, improving participants' perceptions of risk, maintaining non-user stability and reducing past 30-day use among participants who are already using substances. Exposure to education and improving perceptions of risk are monitored by the MAI program as there is a growing body of evidence suggesting that awareness and perceptions are antecedents to usage. Rates of nonuser stability (i.e. participants who were nonusers at pretest and continued as nonuser at posttest) and user decrease (i.e. participants who were users at pretest and reported decrease in use at posttest) serve as proxies for determining the short-term impact of program activities on participant-level substance use.

Data for FY 2009 showed mixed results. The program was successful in meeting its targets of exposing individuals to education services and improving perceptions of risk among participants. The program met only one of its targets related to participant-level substance use. Data showed that the MAI program was able to meet its target of decreasing alcohol use between pretest and posttest among participants ages 21 and older. However, the MAI program did not meet the remaining targets related to improving rates of nonuser stability for alcohol or illicit drugs and decreasing illicit drug use between pretest and posttest.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the

[34] Examples of HIV EBP's include Voices/Voces and the Sista Program which is listed in the CDC Directory of Evidence Based Interventions (DEBI). More information on EBPs can be found in Identifying and Selecting Evidence-Based Interventions. Revised Guidance document for the Strategic Prevention Framework State Incentive Grant Program. HHS Pub. No. (SMA-4205). CSAP/SAMHSA, 2009. "http://www.samhsa.gov/shin"

190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. For the MAI Program, measures were reduced by consolidating several of the youth and adult measures into a single measure. As a result, the perceived risks from substance abuse youth and adult measures (2.3.35 and 2.3.38) have been merged into one new measure: 2.3.82; the alcohol non-user stability youth and adult measures (2.3.41 and 2.3.42) have been merged into one new measure: 2.3.83; and the illicit drug non-user stability youth and adult measures (2.3.45 and 2.3.46) have been merged into one new measure: 2.3.84. Baselines and targets for the new consolidated measures are based on FY 2009 performance data.

PROGRAM SOBER TRUTH ON PREVENTING UNDERAGE DRINKING (STOP ACT)

Table 77: Measure 3.3.01: Percentage of coalitions that report at least 5% improvement in the past 30-day use of alcohol in at least two grades[35] (Outcome)

FY	Target	Result
2013	46.7%	Aug 31, 2014
2012	46.7%	Aug 31, 2013
2011	41%	Aug 31, 2012
2010	41%	Aug 31, 2011
2009	40%	53.3% (Target Exceeded)
2008	Set Baseline	40% (Baseline)

Table 78: Measure 3.3.02: Percentage of coalitions that report improvement in youth perception of risk from alcohol in at least two grades (Outcome)

FY	Target	Result
2013	63.4%	Aug 31, 2014
2012	63.4%	Aug 31, 2013
2011	63.4%	Aug 31, 2012
2010	63.4%	Aug 31, 2011
2009	62.2%	53.8% (Target Not Met)
2008	Set Baseline	60.9% (Baseline)

[35] The FY 2010, 2011, 2012, and 2013 targets were based on the baseline number calculated last year using FY 2008 data (40.0%). This baseline is based on data submitted by these coalitions before they were awarded a STOP Act grant. Starting with FY 2009, CSAP is evaluating the impact of STOP Act funds on the outcome measures. To do this for the FY 2009 calculation, CSAP selected coalitions that submitted data collected after their STOP funds had a chance to make an impact. The cutoff point was 3 months after receipt of the grant award. Any data collected before that date were considered inappropriate for assessing the impact of STOP funds. Only 17 coalitions met this criterion in FY 2009 so the 53.3% is based on that very small number of grantees. Conversely, the baseline figure (40%) was based on data from a larger number of grantees, so CSAP has higher confidence in that number. Altering the targets through 2013 based on the small N in the 2009 data reported to date would probably result in targets that are not as realistic as the 41% based on a more representative sample of coalitions. For this reason, CSAP recommends keeping the targets as they are until more robust actuals can be collected.

Table 79: Measure 3.3.03: Percentage of coalitions that report improvement in youth perception of parental disapproval on the use of alcohol in at least two grades (Outcome)

FY	Target	Result
2013	56.7%	Aug 31, 2014
2012	56.7%	Aug 31, 2013
2011	56.7%	Aug 31, 2012
2010	56.7%	Aug 31, 2011
2009	55.6%	42.9% (Target Not Met)
2008	Set Baseline	54.5% (Baseline)

Table 80: Data Source and Validation for STOP Act

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

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The Sober Truth on Preventing Underage Drinking (STOP Act) program provides current or previously funded Drug Free Community (DFC) grantees with an additional $50,000 funding to support the implementation of environmental strategies aimed at preventing and reducing alcohol use among youth. The initial program, funded in FY 2008, provided 79 four-year grants to local communities. In FY 2009, 22 more grants were awarded. STOP Act grantees are required to report performance on core measures that are consistent with those used for the Drug Free Community program—as instructed by Congressional language. These measures include 30-day alcohol use; perception of risk of harm from alcohol use; and parental disapproval of alcohol use.

In FY 2009, results showed that the STOP Act program exceeded its performance target related to

reducing underage drinking. Based on available data, results showed that 53.3% of coalitions reported at least a 5% decrease of past 30-day use of alcohol in *at least* two grade levels—exceeding the target by over 13 percentage points (Target 40%; Actual 53.3%). However, the STOP Act program did not meet the remaining two performance targets regarding increasing youth perception of risk of harm from alcohol use (Target 62.2%; Actual 53.8%); as well as increasing youth perception of parental disapproval of alcohol use (Target 55.6%; Actual 42.9%).

To address participants' perception of risk, as well as rates of parental disapproval of alcohol use, STOP Act grantees have begun implementing community-wide information dissemination campaigns, town hall meetings with public and private partners, and are working collaboratively with other local organizations to implement a number of activities such as sobriety check points, parent-student education forums, and new social hosting ordinances. It is expected that, over time, these activities will increase participants' perceptions of risk, as well as rates of parental disapproval.

It is important to note that STOP Act grants are awarded annually and, as a result, stagger the years that grantees report their data. Therefore, performance data for FY 2009 reflect only a small number of grantees and, in turn, are not representative of the entire program (please see relevant footnotes for further details related to performance and future targets).

PROGRAM PREVENTION - SCIENCE AND SERVICE ACTIVITIES

Table 81: Measure 2.3.71: Number of people provided technical assistance (TA) services[36] (Output)

FY	Target	Result
2013	13,143	Aug 31, 2014
2012	13,143	Aug 31, 2013
2011	21,420	Aug 31, 2012
2010	21,117	Aug 31, 2011
2009	21,117	18,985 (Target Not Met)
2008	Set Baseline	22,889 (Baseline)[37]

[36] Updated to include Center for the Application of Prevention Technology (CAPT), Native American Center of Excellence (NACE), Fetal Alcohol Spectrum Disorders Center of Excellence (FASD), MEI, and Prevention Fellowships.

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

Table 82: Measure 2.3.74: Percentage of TA recipients who reported that the TA recommendations have been fully implemented[38] (Outcome)

FY	Target	Result
2013	60.2%	Aug 31, 2014
2012	60.2%	Aug 31, 2013
2011	54%	Aug 31, 2012
2010	54%	Aug 31, 2011
2009	54%	65.1% (Target Exceeded)
2008	Set Baseline	55.4% (Baseline)[39]

Table 83: Measure 2.3.75: Number of persons receiving prevention information directly[40] (Output)

FY	Target	Result
2013	368 [41]	Aug 31, 2014
2012	73,768	Aug 31, 2013
2011	550[42]	Aug 31, 2012
2010	120,223	Aug 31, 2011
2009	120,223	505 (Target Not Met)
2008	Set Baseline	122,992 (Baseline)[43]

[38] Includes only the CAPT.

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

[40] Includes Town Hall Meetings and FASD.

[41] The Town Hall Meetings (THM) are conducted only in even–numbered years, so the targets in odd–numbered years reflect only the direct TA activities of FASD.

[42] The Town Hall Meetings (THM) are conducted only in even–numbered years, so the targets in odd–numbered years reflect only the direct TA activities of FASD.

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

Table 84: Measure 1.4.09: Number of individuals trained by SAMHSA's Science and Services Program (HHS Strategic Plan Measure) (Output)

FY	Target	Result
2015	49,746	December 31, 2015
2010	N/A	38,624 (Historical Actual)[44]
2009	N/A	45,462 (Historical Actual)
2008	N/A	48,415 (Historical Actual)

Table 85: Data Source and Validation for Prevention – Science and Service Activities

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

The Science and Services Activities program is an essential and cost-effective mechanism of providing information, training, and technical assistance (TA) aimed at increasing capacity among grantees and other prevention practitioners. While these activities are not always construed as direct services programs,

[44] NOTE: Data are preliminary and do not reflect all program accomplishments during FY 2010. Reporting periods for component programs vary and, therefore, are complete for only a portion of them. Final data for all programs will be available in August 2011.

they play an important role in advancing the field of substance abuse prevention and treatment.

In FY 2009, available data show that the Science and Service Activities program has been successful in exceeding a number of performance targets related to satisfaction (Target 69.1%; Actual 84.3%), as well as implementation of recommendations (Target: 54%; Actual 65.1%). However, these data must be interpreted with caution as some activities (e.g. Town Hall Meetings) do not take place on an annual basis and, therefore, contribute to differences in targets and program performance between even and odd-numbered fiscal years (please see relevant footnotes). In addition, a shift toward the training of trainers over the direct training of grantees and providers may also contribute to differences in performance targets during upcoming fiscal years.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. For the Science and Service Activities program, two measures were discontinued — leaving three measures in place. Specifically, measure 2.3.72 (Percentage of TA recipients who reported that there are very satisfied with the TA they received) was discontinued because it is not useful in assessing the impact of TA efforts. Also, measure 2.3.73 (Percentage of TA recipients who reported their ability to provide effective services improved a great deal) was also discontinued because self-assessment of effectiveness is not useful in capturing the impact of TA efforts. One measure has also been added which captures training efforts across SAMHSA Science and Service programs. Currently, the Science to Service Activities program is under administrative review at SAMHSA's CSAP. Starting in FY 2012, measures may be changed and/or revised to reflect significant changes in this program.

MACRO PROGRAM INNOVATION AND EMERGING ISSUES - CSAT

PROGRAM SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

Table 86: Measure 1.2.40: Number of clients served (Output)

FY	Target	Result
2013	139,650	Oct 31, 2013
2012	139,650	Oct 31, 2012
2011	139,650	Oct 31, 2011
2010	139,650	275,473 (Target Exceeded)
2009	139,650	185,648 (Target Exceeded)
2008	139,650	192,840 (Target Exceeded)
2007	184,597	138,267 (Target Not Met)

Table 87: Measure 1.2.41: Percentage of clients receiving services who had no past month substance use (Outcome)

FY	Target	Result
2013	50%	Oct 31, 2013
2012	50%	Oct 31, 2012
2011	50%	Oct 31, 2011
2010	50%	34% (Target Not Met)
2009	50%	34% (Target Not Met)
2008	48%	46.5% (Target Not Met but Improved)
2007	48%	45.7% (Target Not Met)

Table 88: Data Source and Validation for Screening, Brief Intervention and Referral to Treatment

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

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The target for numbers served in FY 2008, FY 2009, and FY 2010 were substantially exceeded. This measure reflects the number of clients who were screened through the SBIRT program. These clients may have screened negative, required a brief intervention, a brief treatment or a referral to treatment.

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

Data show a general positive trend in number of clients served by year. From FY 2005 to FY 2006, there was an increase of approximately 27,000; from FY 2007 to FY 2010, there was a significant increase in the number of clients served. While FY 2008 to FY 2009 shows a decrease in number served, this is expected as a cohort of grantees ended during this time period. The outcome measure of abstinence has also had a general positive trend from FY 2005 to FY 2008; though this is not seen in FY 2009. In 2010, however, there was a decrease in the percent reporting abstinence at follow-up; data show that substance use rates upon intake to services was higher for clients served in this year as compared to previous years which serves to explain to trend.

PROGRAM ACCESS TO RECOVERY

Table 89: Measure 1.2.32: Number of clients gaining access to treatment[45] (Output)

FY	Target	Result
2013	70,750	Oct 31, 2013
2012	70,750[46]	Oct 31, 2012
2011	33,500	Oct 31, 2011
2010	65,000	69,552 (Target Exceeded)
2009	65,000	89,595 (Target Exceeded)
2008	30,000	50,845 (Target Exceeded)
2007	50,000	79,150 (Target Exceeded)

[45] 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.

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

Table 90: Measure 1.2.33: Percentage of adults receiving services who had no past month substance use (Outcome)

FY	Target	Result
2013	83%	Oct 31, 2013
2012	83%	Oct 31, 2012
2011	82%	Oct 31, 2011
2010	82%	82.9% (Target Exceeded)
2009	81%	81% (Target Met)
2008	80%	82.3% (Target Exceeded)
2007	81%	84.7% (Target Exceeded)

Table 91: Measure 1.2.35: Percentage of adults receiving services who had no/reduced involvement with the criminal justice system (Outcome)

FY	Target	Result
2013	96%	Oct 31, 2013
2012	96%	Oct 31, 2012
2011	96%	Oct 31, 2011
2010	96%	96.3% (Target Exceeded)
2009	96%	96% (Target Met)
2008	96%	96% (Target Met)
2007	97%	97.6% (Target Exceeded)

Table 92: Measure 1.2.36: Percentage of adults receiving services who had improved social support (Outcome)

FY	Target	Result
2013	91%	Oct 31, 2013
2012	91%	Oct 31, 2012
2011	91%	Oct 31, 2011
2010	91%	91.1% (Target Exceeded)
2009	90%	91% (Target Exceeded)
2008	90%	91.7% (Target Exceeded)
2007	90%	75.1% (Target Not Met)

Table 93: Data Source and Validation for Access to Recovery

Measure	Data Source	Data Validation
1.2.32 1.2.33 1.2.35 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.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

SAMHSA's CSAT uses a series of key output and outcome measures to assess the effectiveness of its Services Programs. The primary key output measure used is the number of clients served. This measure represents an unduplicated count of individuals who have received services through grants in Access to Recovery grants. All outcome measures are based on a follow-up assessment conducted six months post admission to the program. Abstinence from substance use is a key outcome of the program. This measure examines the substance use patterns of the clients. The percent reported reflects the percent of individuals who have reported no use of alcohol or illegal drugs in the past 30 days at follow-up six months post intake. The criminal justice measure refers to those clients who have reported no arrests in the past 30 days. The social connectedness/support measure tracks the percent of people who attend self-help or support groups in support of their recovery. These measures combined provide a holistic view of the effectiveness of the services being provided by this program.

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

Data in FY 2010 show that targets were met or exceeded for criminal justice status, number served, social support and abstinence from use. While the employment target was not met, there was an upward trend in employment from FY 2009 to FY 2010.

Data for the second cohort of ATR shows a positive trend in its key measure of number of clients served. This measure shows an increase in clients served of over 38,000 clients. Data show a decrease in number served from 2009 to 2010 though this is expected given the cohort of grantees in their last year of the program. Though data are available from FY 2005, trend data from that time through the present do not yield an appropriate comparison as a new cohort began in FY 2007.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the

190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA continued to report number of clients served, abstinence from use, criminal justice involvement and social support. These measures provide a comprehensive view of the program. The housing, employment, and cost per client measures will no longer be reported for ATR as the remaining measures provide a comprehensive assessment of the program.

PROGRAM TREATMENT SYSTEM FOR HOMELESSNESS (GBHI)

Table 94: Measure 3.4.22: Percentage of clients receiving services who had no past month substance use (Outcome)

FY	Target	Result
2013	67.4 %	Oct 31, 2013
2012	67.4 %	Oct 31, 2012
2011	67.4 %	Oct 31, 2011
2010	67.4 %	66 % (Target Not Met)
2009	66.9 %	66.4 % (Target Not Met)
2008	N/A	66.9 % (Historical Actual)

Table 95: Measure 3.4.23: Number of clients served (Output)

FY	Target	Result
2013	7,005	Oct 31, 2013
2012	7,005	Oct 31, 2012
2011	7,005	Oct 31, 2011
2010	7,005	5,398 (Target Not Met)
2009	5,730	6,935 (Target Exceeded)
2008	N/A	5,730 (Historical Actual)

Table 96: Measure 3.4.24: Percentage of clients receiving services who were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2013	32.7 %	Oct 31, 2013
2012	32.7 %	Oct 31, 2012
2011	32.7 %	Oct 31, 2011
2010	32.7 %	32 % (Target Not Met but Improved)
2009	34.7 %	31.7 % (Target Not Met)
2008	N/A	34.7 % (Historical Actual)

Table 97: Measure 3.4.25: Percentage of clients receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2013	25.6 %	Oct 31, 2013
2012	25.6 %	Oct 31, 2012
2011	25.6 %	Oct 31, 2011
2010	25.6 %	29.4 % (Target Exceeded)
2009	23.6 %	24.6 % (Target Exceeded)
2008	N/A	23.6 % (Historical Actual)

Table 98: Data Source and Validation for GBHI

Measure	Data Source	Data Validation
3.4.22 3.4.23 3.4.24 3.4.25	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.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013. The target for number served in FY 2013 has been set in accordance with funding for FY 2012.

SAMHSA's CSAT manages two grant portfolios under its Grants for the Benefit of Homeless Individuals (GBHI) program, both of which provide focused services to individuals with a substance use disorder or who have co-occurring disorders.

The data show a positive trend in housing from FY 2008 through FY 2010 with an increase from 23.6% to 29% in the percent reporting being stably housed. Data also show that the target for abstinence was met and the target for employment was nearly met (missed by less than 1%). The number of clients served target was not met; however, this is due to a cohort of grantees ending in FY 2010 and using this year as a wind-down period. Since the final year of the grant is typically spent working toward successful close-out, it is not unusual for fewer clients to be served.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA will continue to report clients served, abstinence from use, housing, and employment. These measures serve to demonstrate the program goals and objectives. The social support and criminal justice involvement measures have been discontinued as they do not reflect key goals of the program.

PROGRAM CRIMINAL JUSTICE - JUVENILE AND ADULT PROBLEM SOLVING DRUG COURTS

Table 99: Measure 1.2.63: Percentage of juvenile clients receiving services who were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2013	88%	Oct 31, 2013
2012	88%	Oct 31, 2012
2011	88%	Oct 31, 2011
2009	88%	89% (Target Exceeded)
2008	87%	86% (Target Not Met)
2007	87%	86% (Target Not Met)

Table 100: Measure 1.2.64: Percentage of juvenile clients receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2013	82%	Oct 31, 2013
2012	82%	Oct 31, 2012
2011	82%	Oct 31, 2011
2009	82%	79% (Target Not Met)
2008	81%	81% (Target Met)
2007	78%	80% (Target Exceeded)

Table 101: Measure 1.2.65: Percentage of juvenile clients receiving services who had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2013	95%	Oct 31, 2013
2012	95%	Oct 31, 2012
2011	95%	Oct 31, 2011
2009	93%	92% (Target Not Met)
2008	92%	94.3% (Target Exceeded)
2007	91%	91% (Target Met)

Table 102: Measure 1.2.67: Percentage of juvenile clients receiving services who had no past month substance use (Outcome)

FY	Target	Result
2013	73%	Oct 31, 2013
2012	73%	Oct 31, 2012
2011	73%	Oct 31, 2011
2009	73%	73% (Target Met)
2008	72%	69% (Target Not Met)
2007	69%	71% (Target Exceeded)

Table 103: Measure 1.2.70: Number of juvenile clients served (Output)

FY	Target	Result
2013	1463	Oct 31, 2013
2012	1463	Oct 31, 2012
2011	1463	Oct 31, 2011
2009	449	376 (Target Not Met)
2008	929	783 (Target Not Met)
2007	821	856 (Target Exceeded)

Table 104: Measure 1.2.72: Percentage of adult clients receiving services who were currently employed or engaged in productive activities[47] (Outcome)

FY	Target	Result
2013	57%	Oct 31, 2013
2012	57%	Oct 31, 2012
2011	57%	Oct 31, 2011
2010	57%	57% (Target Met)
2009	88%	63% (Target Not Met)

Table 105: Measure 1.2.73: Percentage of adult clients receiving services who had a permanent place to live in the community[48] (Outcome)

FY	Target	Result
2013	43%	Oct 31, 2013
2012	43%	Oct 31, 2012
2011	42%	Oct 31, 2011
2010	42%	42.3% (Target Exceeded)
2009	82%	41% (Target Not Met)

Table 106: Measure 1.2.74: Percentage of adult clients receiving services who had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2013	93%	Oct 31, 2013
2012	93%	Oct 31, 2012
2011	93%	Oct 31, 2011
2010	93%	93% (Target Met)
2009	93%	95% (Target Exceeded)

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

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

Table 107: Measure 1.2.76: Percentage of adult clients receiving services who had no past month substance use (Outcome)

FY	Target	Result
2013	73%	Oct 31, 2013
2012	73%	Oct 31, 2012
2011	73%	Oct 31, 2011
2010	73%	85.4% (Target Exceeded)
2009	73%	89% (Target Exceeded)

Table 108: Measure 1.2.79: Number of adult clients served[49] (Output)

FY	Target	Result
2013	5,265	Oct 31, 2013
2012	5,265	Oct 31, 2012
2011	5,265	Oct 31, 2011
2010	2,832	3,533 (Target Exceeded)
2009	960	1,183 (Target Exceeded)

Table 109: Data Source and Validation for Juvenile and Adult Problem Solving Drug Court Grants

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

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The Drug Court program funds several types of grants including those specifically for juvenile or adult

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

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

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

In the Adult Courts, targets for number served, criminal justice involvement, abstinence, and housing were all met or exceeded in FY 2010. Data show an upward trend in the number of clients served from FY 2009 to FY 2010 with over 3,000 clients being served in FY 2010.

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

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA has chosen to highlight key measures of the program which clearly illustrate the programs goals and objectives. The following measures have been selected for ongoing reporting: number served, abstinence from use, housing, employment and criminal justice involvement.

PROGRAM CRIMINAL JUSTICE - EX-OFFENDER RE-ENTRY PROGRAM

Table 110: Measure 1.2.80: Number of clients served (Outcome)

FY	Target	Result
2013	2,912	Oct 31, 2013
2012	2,912	Oct 31, 2012
2011	2,912	Oct 31, 2011
2010	1,312	1,772 (Target Exceeded)

Table 111: Measure 1.2.81: Percentage of clients who had no past month substance use (Outcome)

FY	Target	Result
2013	69%	Oct 31, 2013
2012	69%	Oct 31, 2012
2011	70%	Oct 31, 2011
2010	68.9%	77.5% (Target Exceeded)

Table 112: Measure 1.2.84: Percentage of clients receiving services who had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2013	96 %	Oct 31, 2013
2012	95 %	Oct 31, 2012
2011	95 %	Oct 31, 2011
2010	97 %	94.9 % (Target Not Met)

Table 113: Data Source and Validation for Ex-Offender Re-Entry Grants

Measure	Data Source	Data Validation
1.2.80 1.2.81 1.2.84	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

SAMHSA's CSAT uses a series of key output and outcome measures to assess the effectiveness of its Services Programs. The key output measure used is the number of clients served. This measure represents an unduplicated count of individuals who have received services through grants in Ex-Offender Re-Entry Program. All outcome measures are based on a follow-up assessment conducted six months post admission to the program. Abstinence from substance use is a key outcome of the program. This measure examines the substance use patterns of the clients. The percent reported reflects the percent of individuals who have reported no use of alcohol or illegal drugs in the past 30 days at follow-up. In addition, SAMHSA is measuring criminal justice as a key measure for this program.

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

FY 2010 data show that targets for abstinence and clients served were exceeded. While the target for criminal justice involvement was not met, data still yield a very positive outcome with 95% of clients reporting no criminal justice involvement at follow-up.

PROGRAM TREATMENT - OTHER CAPACITY[50]

Table 114: Measure 1.2.25: Percentage of adults receiving services who had no past month substance use (Outcome)

FY	Target	Result
2013	66%	Oct 31, 2013
2012	62%	Oct 31, 2012
2011	62%	Oct 31, 2011
2010	62%	67.9% (Target Exceeded)
2009	61%	66% (Target Exceeded)
2008	63%	62% (Target Not Met but Improved)
2007	63%	59% (Target Not Met)

Table 115: Measure 1.2.26: Number of clients served (Output)

FY	Target	Result
2013	34,784	Oct 31, 2013
2012	34,784	Oct 31, 2012
2011	34,784	Oct 31, 2011
2010	34,784	37,365 (Target Exceeded)
2009	31,659	32,939 (Target Exceeded)
2008	35,334	33,446 (Target Not Met)
2007	35,334	35,516 (Target Exceeded)

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

Table 116: Measure 1.2.27: Percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2013	47%	Oct 31, 2013
2012	47%	Oct 31, 2012
2011	47%	Oct 31, 2011
2010	51%	46% (Target Not Met but Improved)
2009	50%	44% (Target Not Met)
2008	52%	54.3% (Target Exceeded)
2007	52%	57% (Target Exceeded)

Table 117: Measure 1.2.28: Percentage of adults receiving services who had a permanent place to live in the community (Outcome)

FY	Target	Result
2013	49%	Oct 31, 2013
2012	49%	Oct 31, 2012
2011	49%	Oct 31, 2011
2010	49%	49% (Target Met)
2009	49%	44% (Target Not Met)
2008	51%	47% (Target Not Met but Improved)
2007	53%	46% (Target Not Met)

Table 118: Measure 1.2.29: Percentage of adults receiving services who had no involvement with the criminal justice system (Outcome)

FY	Target	Result
2013	96%	Oct 31, 2013
2012	95%	Oct 31, 2012
2011	95%	Oct 31, 2011
2010	95%	96% (Target Exceeded)
2009	94%	96% (Target Exceeded)
2008	96%	96% (Target Met)
2007	96%	96% (Target Met)

Table 119: Data Source and Validation for Treatment – All Other Capacity Activities

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

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

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

The targets for housing, abstinence, criminal justice status, number served and negative consequences were either met or exceeded.

Data on number served show a positive trend from FY 2005 to FY 2007. There was a slight downward trend from FY 2007 to FY 2008 and an increase from FY 2009 to FY 2010. Data on abstinence shows a

positive trend from FY 2005 to FY 2010 with a rate of 64.1% in FY 2005 and of 68% in FY 2010. While the target for employment was not met, data also show a positive trend in employment from 44% in 2009 to 46% in 2010. Given the national situation with respect to unemployment, this upward trend is encouraging despite the targets being missed.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The social consequences and cost band measures are being discontinued as these measures do not meaningfully reflect the program goals.

PROGRAM TREATMENT - SCIENCE AND SERVICE ACTIVITIES[51]

Table 120: Measure 1.4.01: Percentage of participants who report implementing improvements in treatment methods on the basis of information and training provided by the program (Outcome)

FY	Target	Result
2013	90%	Oct 31, 2013
2012	90%	Oct 31, 2012
2011	90%	Oct 31, 2011
2010	90%	96.2% (Target Exceeded)
2009	90%	82% (Target Not Met)
2008	90%	92% (Target Exceeded)
2007	93%	90% (Target Not Met)

Table 121: Measure 1.4.02: Number of individuals trained per year (Output)

FY	Target	Result
2013	20,516	Oct 31, 2013
2012	20,516	Oct 31, 2012
2011	20,516	Oct 31, 2011
2010	20,516	23,034 (Target Exceeded)
2009	20,516	22,943 (Target Exceeded)
2008	20,516	21,490 (Target Exceeded)
2007	23,141	20,516 (Target Not Met)

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

Table 122: Measure 1.4.09: Number of individuals trained by SAMHSA's Science and Services Program (HHS Strategic Plan Measure) (Output)

FY	Target	Result
2015	49,746	December 31, 2015
2010	N/A	38,624 (Historical Actual)[52]
2009	N/A	45,462 (Historical Actual)
2008	N/A	48,415 (Historical Actual)

Table 123: Data Source and Validation for Treatment – Science and Service

Measure	Data Source	Data Validation
1.4.01 1.4.02	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.
1.4.09	SAMHSA Performance Measure Measurement System(s) (TRAC, SAIS, PMART)	To be determined

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The output measure used for this program is number of participants trained, which reflects the total number of participants who attended a SAMHSA CSAT-funded training, meeting, or received technical assistance. The outcome measure used reflects whether or not information from the event has been used to make practice changes. The output and outcome targets were either met or exceeded, including: implementing improvements in treatment methods and increasing the number of clients served.

From FY 2005, there was a downward trend in number of clients served to the number served in FY 2006 and FY 2007. However, this is consistent with the number of programs included in this reporting group. From FY 2007 to FY 2009, there is a positive trend with 22,943 participants trained as compared to 20,516. FY 2010 data show that targets for application of information and number of participants trained were met. Data show that there was an upward trend in the number trained from 2007 through 2010 with the numbers increasing from over 20,000 to over 23,000. Data also show that there was stability in the percentage of those reporting satisfaction with the event with a consistent 95% reporting being satisfied with the quality of the event.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and

[52] NOTE: Data are preliminary and do not reflect all program accomplishments during FY 2010. Reporting periods for component programs vary and, therefore, are complete for only a portion of them. Final data for all programs will be available in August 2011.

consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA has elected to retain two key program measures: number of participants trained and application of the information. These measures will clearly indicate the extent to which information gained from trainings has been put to practical use. One measure has also been added which captures training efforts across SAMHSA Science and Service programs.

Table 124: Measure 3.2.16: Number of children receiving services (Output)[53]

FY	Target	Result
2013	4,930	Dec 24, 2013
2012	4,930[54]	Dec 31, 2012
2011	13,051	Dec 31, 2011
2010	13,051	4,930 (Target Not Met)
2009	13,051	10,762 (Target Not Met)
2008	10,000	13,051 (Target Exceeded)
2007	9,120	10,871 (Target Exceeded)

Table 125: Measure 3.2.25: Percentage of children receiving services who report social support (Outcome)

FY	Target	Result
2013	87.6 %	Dec 31, 2013
2012	87.6 %	Dec 31, 2012
2011	87.6 %	Dec 31, 2011
2010	87.6 %	85.7 % (Target Not Met)
2009	82.5 %	87.6 % (Target Exceeded)
2008	Set Baseline	82.5 % (Baseline)

[53] FY 2010 source for this measure has been transferred from the cross-site evaluation to the TRAC data collection system. The lower actual and subsequent targets are due to the fact that grantee use of the TRAC system is slower than expected.

[54] Target has been reset to reflect 2010 actual.

Table 126: Measure 3.2.26: Percentage of children receiving services who report improved functioning (Outcome)

FY	Target	Result
2013	50.2 %	Dec 31, 2013
2012	50.2 %	Dec 31, 2012
2011	50.2 %	Dec 31, 2011
2010	50.2 %	51.3 % (Target Exceeded)
2009	49.6 %	50.2 % (Target Exceeded)
2008	Set Baseline	49.6 % (Baseline)

Table 127: Measure 3.2.27: Number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the program (Output)

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	TBD	Dec 31, 2012
2011	Set Baseline	Dec 31, 2011

Table 128: Measure 3.2.28: Number of organizations that entered into formal written tier/intra-organizational agreements (e.g. MOUs/MOAs) to improve mental health-related practices/activities as a result of the grant (Output)

FY	Target	Result
2013	TBD	Dec 31, 2013
2012	TBD	Dec 31, 2012
2011	Set Baseline	Dec 31, 2011

Table 129: Data Source and Validation for Children's Mental Health Services

Measure	Data Source	Data Validation
3.2.16 3.2.25 3.2.26 3.2.27 3.2.28	TRAC	All data are automatically checked as they are input to 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.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The FY 2010 target for the number of children served (3.2.16) was not met, which reflects the data

collection moving from the cross-site evaluation to the SAMHSA TRAC system. In addition, in FY 2008, 16 grantees completed their grant funding cycle and SAMHSA awarded 18 new grants. In FY 2009, 6 grantees completed their grant funding cycle, and SAMHSA awarded 20 new grants. The first year of the grant is a planning year, and grantees do not enroll children in services. In addition, the communities funded in FY 2004 were in the final year of their funding cycle in FY 2010, when historically, enrollment into services declines. These trends in the currently funded group of grantees are likely to have a significant impact on the number of children and youth served in the CMHI program. The 2013 target reduction reflects data collection efforts moving from the cross-site evaluation to the SAMHSA Transformation Accountability (TRAC) system. This result is significantly lower than the previously reported estimated number served due to the fact that not all grantees are fully utilizing the TRAC system. This is the result of factors such as delays in human subjects review at some sites and various staffing/budget constraints.

The CMHI cross site evaluation has found that twenty-four months after enrollment in CMHI services, children and youth demonstrated a variety of improved clinical and functional outcomes. Many caregivers (40.3%) reported that their children's overall behavioral and emotional strengths had increased, and 47.7 percent reported that their children exhibited decreased maladaptive emotional and behavioral symptoms. In fact, the percentage of children and youth aged 6–18 whose emotional and behavioral problems were in the clinical range dropped from 83.1 percent at intake to 62.5 percent after 24 months.

In addition, many youth aged 11 and older (23.3%) reported that they experienced fewer symptoms of depression and 30.7 percent reported fewer symptoms of anxiety. The percentage of caregivers reporting that their children and youth had contemplated attempting suicide during the previous 6 months fell from 29.0 percent at intake to 14.0 percent at 24 months. Similarly, the percentage of caregivers reporting their children and youth had attempted suicide in the previous 6 months fell from 9.4 percent at intake to 2.8 percent at 24 months.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of CMHI measures was reduced to a total of five remaining measures. Of these five measures, four are new measures for the program as all GPRA data collection has been moved from the cross-site evaluation to the SAMHSA TRAC system. The FY 2010 performance data were used to set the baselines for future targets.

MACRO PROGRAM PROJECTS TO ASSIST IN THE TRANSITION FROM HOMELESSNESS

Table 130: Measure 3.4.15: Percentage of enrolled homeless persons who receive community mental health services (Outcome)

FY	Target	Result
2013	50%	Jul 31, 2014
2012	47%	Jul 31, 2013
2011	47%	Jul 31, 2012
2010	47%	Jul 31, 2011
2009	46%	49% (Target Exceeded)
2008	45%	47% (Target Exceeded)
2007	45%	37% (Target Not Met)

Table 131: Measure 3.4.16: Number of homeless persons contacted (Outcome)

FY	Target	Result
2013	182,000	Jul 31, 2014
2012	182,000	Jul 31, 2013
2011	182,000	Jul 31, 2012
2010	160,000	Jul 31, 2011
2009	151,000	165,954 (Target Exceeded)
2008	150,000	134,932 (Target Not Met)
2007	157,500	142,352 (Target Not Met)

Table 132: Measure 3.4.17: Percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome)

FY	Target	Result
2013	55%	Jul 31, 2014
2012	55%	Jul 31, 2013
2011	55%	Jul 31, 2012
2010	55%	Jul 31, 2011
2009	55%	50% (Target Not Met)
2008	55%	54% (Target Not Met)
2007	45%	55% (Target Exceeded)[55]

Table 133: Measure 3.4.20: Number of PATH providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits (Output)

FY	Target	Result
2013	5,420	Dec 31, 2013
2012	5,420	Dec 31, 2012
2011	5,420	Dec 31, 2011
2010	4,927	10,267 (Target Exceeded)
2009	4,927	5,104 (Target Exceeded)
2008	Set Baseline	4,927 (Baseline)

Table 134: Data Source and Validation for PATH

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

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

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

The PATH legislation mandates that the program targets persons with serious mental illness (SMI) who may also experience a co-occurring substance use disorder who are homeless or at risk of homelessness. Measure 3.4.15 reflects the PATH program's legislative intent to provide a link to mental health and community-based services.

In 2009, SAMHSA initiated efforts to change the way PATH grantees report on persons served/enrolled for the PATH annual report. Grantees reported on all persons served with Federal and State match funds and not just persons served with Federal PATH funds only (as was done in the past). This change was initiated in order to better align PATH data collection efforts with the U.S. Department of Housing and Urban Development's (HUD) Homeless Management Information System (HMIS), an outcome-based reporting system. This change in calculation resulted in exceeding the FY 2009 target.

Measure 3.4.16 captures the number of homeless persons contacted by PATH providers. Persistent and consistent outreach and the introduction of services at the client's pace are important steps to engaging homeless persons with serious mental illness (SMI) and to beginning the process of linking them to housing, mental health, substance abuse, case management and other supportive services. In FY 2009, the target was exceeded for this measure using the revised calculation referenced above.

Measure 3.4.17 is an indicator of the rate of enrollment for PATH-eligible individuals. PATH enrollment is defined as: The individual is determined to be "PATH Eligible," (i.e. experiencing Severe Mental Illness and homelessness or imminent risk of homelessness); the PATH worker established engagement with the individual (the individual has agreed to work towards a goal with the PATH worker); the PATH worker opened an individual file that contains demographic information, documentation of PATH eligibility, mutual agreement for the provision of services, and services provided.

In 2007, the calculation for this measure was revised to more accurately reflect only those eligible for services: persons who are experiencing serious mental illness and who are homeless or at imminent risk of homelessness. The new target was set at 55% and was not met in FY 2009 due in large part to staff reductions and stricter State definitions of enrollment. The calculation for this measure was revised to more accurately reflect the true outcome. Prior calculations used the entire number contacted in the calculation. The revised calculation uses only those eligible for services, which explains why the 2007 target was exceeded by 10 percent. The 2008 target was missed by one percent.

Measure 3.4.20 is a measure of a key output of the program: The number of PATH providers trained on Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR). The target for 2009 was exceeded, and 19,220 have been trained since the initiative began. This output is important in that once trained, PATH providers are better able to assist PATH clients in applying for and getting the income benefits for which they are eligible.[56]

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the

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

190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of PATH measures was reduced leaving four measures in place. Measure 3.4.18 was deleted as SAMHSA is reviewing its efficiency measures to determine the best approach to achieve meaningful efficiency outcomes.

MACRO PROGRAM REGULATORY AND OVERSIGHT FUNCTIONS

PROGRAM PROTECTION & ADVOCACY

Table 135: Measure 3.4.12: Number of people served by the PAIMI program (Outcome)

FY	Target	Result
2013	17,900[57]	Jul 31, 2014
2012	22,325	Jul 31, 2013
2011	22,325	Jul 31, 2012
2010	22,325	Jul 31, 2011
2009	22,325	16,951 (Target Not Met)
2008	22,325	17,468 (Target Not Met)
2007	23,500	18,694 (Target Not Met)

Table 136: Measure 3.4.19: Number attending public education/constituency training and public awareness activities (Output)

FY	Target	Result
2013	92,953[58]	Oct 31, 2014
2012	92,953[59]	Oct 31, 2013
2011	120,000	Oct 31, 2012
2010	120,000	Oct 31, 2011
2009	120,000	92,953 (Target Not Met but Improved)
2008	120,000	83,070 (Target Not Met)
2007	Set Baseline	119,423 (Baseline)

[57] Target was reduced to reflect most recent actual given previous two years of performance results were off nearly 30 percent and is not related to 2012 budget levels.

[58] Target was reduced to reflect most recent actual given previous two years of performance results were off nearly 30 percent and is not related to 2012 budget levels.

[59] Target was reduced to reflect most recent actual given previous two years of performance results were off nearly 30 percent and is not related to 2012 budget levels.

Table 137: Measure 3.4.21: Increase percentage of complaints of alleged **abuse, neglect, and rights violations** substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, or elimination of other barriers to personal decision-making, as a result of PAIMI involvement (Outcome)

FY	Target	Result
2013	87.0 %	Jul 31, 2014
2012	87.0 %	Jul 31, 2013
2011	87.0 %	Jul 31, 2012
2010	87.0 %	Jul 31, 2011
2009	N/A	88.0 % (Historical Actual)
2008	N/A	87.0 % (Historical Actual)
2007	N/A	86.0 % (Historical Actual)

Table 138: Data Source and Validation for Protection and Advocacy

Measure	Data Source	Data Validation
3.4.12 3.4.21	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.
3.4.19	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation). The cost measure is calculated by using the total PAIMI allotment as the numerator and the total number of persons served/impacted as the denominator.	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews.

As this program's grant awards are made late in the fiscal year, performance targets and results for any given fiscal year primarily reflect the outputs and outcomes associated with activities supported by funding from the prior fiscal year. Therefore, FY 2012 appropriated funding will be reflected in the targets set for FY 2013.

Measure 3.4.21 the percentage of complaints of alleged abuse, neglect and rights violations not

withdrawn by the client that resulted in positive change for the client in the safety or welfare of their environment, as a result of PAIMI involvement. This new measure is a combination of the three areas of focus.

Measure 3.4.12 is the number of people served by the PAIMI program. The FY 2009 target was not met. Performance for this measure is the most erratic because of the number of factors that can influence the outcome that are inherent in the nature of the PAIMI Program which includes both an individual case and systemic focus. This balance shifts over time from a more individual case emphasis to a more systemic emphasis not only within individual programs but nationally across all programs as well. Also, the case-mix can impact this outcome, as individuals with more complex and extensive needs will require more time and resources which will reduce the total number of persons that can be served. Finally, although the program provides education and outreach, the number of persons served is ultimately determined by the number of persons who seek services which may vary over time. Because of all of these factors, the target for FY 2013 has been adjusted downward. Our expectation, which appears to have been incorrect, was that individual PAIMI programs would continue to increase the number of individual clients that they serve. What appears to be happening is that with little additional funding and increasing demands, they are focusing more on systemic activities which impact a much broader population than the individual case work.

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

A baseline was set for measure 3.4.19, the number attending public education/ constituency training and public awareness activities, in FY 2007. The FY 2009 target was not met, although performance improved nearly 12% over FY 2008 performance. The FY 2012 and FY 2103 targets have been revised to reflect the most recent actual.

The first external evaluation in the 24-year history of the PAIMI program was completed in 2010. The evaluation found that individual PAIMI Programs provide those with psychiatric disabilities a voice in the exercise of their rights and are highly successful in achieving client and system goals and objectives. The PAIMI Program contributes to the transformation of this Nation's mental health system into a more open, adaptive system that promotes recovery. The PAIMI Act[60]allows each PAIMI Program to establish its own priorities and activities, as long as those activities further the cause of ensuring the rights of individuals with psychiatric disabilities under the U.S. Constitution and Federal and state statutes. Grantees report a high degree of goal achievement. Twenty percent of grantees sampled report that they met or partially met all projected goals and objectives. Overall, grantees reported having met 93 percent of targeted goals and objectives. However, only four of 20 P&A executive directors reported no cutbacks in goals due to insufficient resources.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the

[60] The Protection and Advocacy Act for Individuals with Mental Illness (PAIMI) Act of 1986, Public Law 99-319

190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. Measures 3.4.08, 3.4.09, and 3.4.10 were combined into one measure (now 3.4.21) as the results of the separate measures were similar. Measure 3.4.11 was deleted as performance was at a high level for the past several fiscal years. Measures 3.4 13 and 3.4.14 were deleted as SAMHSA is reviewing its efficiency measures to determine the best approach to achieve meaningful efficiency outcomes.

Table 139: Measure 2.3.76: Number of persons receiving prevention information indirectly from advertising, broadcast, or website[61] (Output)

FY	Target	Result
2013	1,250,000	Aug 31, 2014
2012	1,250,000	Aug 31, 2013
2011	906,707	Aug 31, 2012
2010	906,707	Aug 31, 2011
2009	906,707	1,443,077 (Target Exceeded)
2008	Set Baseline	1,211,382 (Baseline)[62]

Table 140: Measure 4.4.06: Percentage of persons reporting knowledge of how to find treatment services for mental and substance use disorders (Outcome)

FY	Target	Result
2012	TBD	Jun 1, 2013
2011	TBD	Jun 1, 2012
2010	Set Baseline	Jun 1, 2011

Table 141: Measure 4.4.07: Percentage of persons indicating they were screened by a health care provider for mental and substance use disorder (Outcome)

FY	Target	Result
2012	TBD	Jun 1, 2013
2011	TBD	Jun 1, 2012
2010	Set Baseline	Jun 1, 2011

Table 142: Measure 4.4.09: Percentage of parents reporting they are comfortable talking to their children about alcohol and drugs (Outcome)

FY	Target	Result
2012	TBD	Jun 1, 2013
2011	TBD	Jun 1, 2012
2010	Set Baseline	Jun 1, 2011

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

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

Table 143: Data Source and Validation for Public Awareness and Support Activities

Measure	Data Source	Data Validation
2.3.76	Participating Community-based organizations (CBOs) collect this information from the media.	These forms are sent with a coded postage-paid envelope, used for receipt tracking. Clarification of fields entered on the evaluation form is sought from the respondents and/or the website: http://www.stopalcoholabuse.gov/townhall/. The data are entered into SPSS and MS Word for analysis and then submitted to DACCC for cleaning, editing and analysis before being used by SAMHSA for analyses.
4.4.06 4.4.07 4.4.08 4.4.09	Data source under development.	SAMHSA will work with the contractor to ensure sufficient checks are in place to ensure the quality of the data. Details will be provided at a later date.

The use of communications and marketing principles and techniques is a well-established, science-based strategy capable of influencing a target audience to voluntarily accept, reject, modify, or abandon a behavior for the benefit of individuals, groups, or society as a whole. Opportunities for preventing or intervening early to mitigate the morbidity and mortality associated with mental and substance use disorders are often missed. Behavioral health is essential to health and public understanding of this concept is key to improving health status and reducing costs to families, communities, and governments. A transmedia approach will be used to reach diverse US populations, each having a distinct set of wants, needs, and communication channels in order to obtain these measurements.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures (measures 4.4.04 and 4.4.05 were deleted and measures 4.4.06, 4.4.07, 4.4.08, and 4.4.09 were added). This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. A summary table detailing these changes is attached to this document.

Table 144: Measure 4.4.10: Combined count of webpage hits, hits to the locator, and hits to SAMHDA for SAMHSA-supported data sets (Output)

FY	Target	Result
2012	6,000,300	Dec 31, 2012
2011	5,585,000	Dec 31, 2011
2010	5,195,000	3,716,660 (Target not met)
2009	Set Baseline	4,833,000 (Baseline)

Table 145: Measure 4.4.11: Number of evidence-based programs or practices in review (Output)

FY	Target	Result
2012	44	Aug 1, 2012
2011	42	Aug 1, 2011
2010	40	40 (Target Met)
2009	Set Baseline	40 (Baseline)

Table 146: Data Source and Validation for Performance and Quality Improvement Systems

Measure	Data Source	Data Validation
4.4.10	Data is collected from the contractors who manage the Treatment Locator and SAMHDA websites via standard tracking software measuring unique hits	These numbers are provided to the COTRs via email at the end of each month and on January second of the next year. Validation checks are reviewed at that time. Data are maintained by the COTRs for each project.
4.4.11	The number of evidence based practices under review are provided to the COTR via monthly progress reports and totaled at the end of each year.	Data are reviewed and filed in the COTRs working file with the original reports sent to the Government project file.

The National Surveys are implemented using multi-year or base and option year contracts and as a result have different funding schedules than grants. There is no delay between fiscal year funding and the performance year. As a result, FY 2013 targets have not been set for these performance measures as they have been for programs that are funded using grants.

CBHSQ has developed two new measures that focus on key activities within CBHSQ. 4.4.10 is a combined count of webpage hits to the treatment locator and Substance Abuse and Mental Health Data Archive (SAMHDA). Our baseline target for these combined measures is 4.5 million hits during calendar year 2010 ending December 31. This output provides information into a critical function of CBHSQ in

terms of disseminating information on where and what kinds of treatment are available across the nation and access to data collected through the National Surveys. Measure 4.4.11 is a new area for CBHSQ and provides information on the productivity of SAMHSA in relation to providing information to the public on evidence based programs and practices. The target of 40 new programs and practices was met 2010 and we expect to achieve a 5 percent increase each year. By FY 2012, we expect that this will set a maintenance target where we will not fall below 44 new programs and practices under review each year.

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. CBHSQ eliminated three GPRA measures on timeliness because they did not accurately reflect the mission of the Center.

DISCONTINUED PERFORMANCE MEASURES

PROGRAM MENTAL HEALTH BLOCK GRANT

Table 147: Measure 2.3.07: Reduce rate of adult readmissions to State psychiatric hospitals within 30 days (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	9.3%	Sep 30, 2011
2009	8.5%	9.3% (Target Not Met but Improved)
2008	8.5%	9.4% (Target Not Met but Improved)
2007	8.7%	9.8% (Target Not Met)

Table 148: Measure 2.3.08: Reduce rate of adult readmissions to State psychiatric hospitals within 180 days (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	20%	Sep 30, 2011
2009	19%	21.5% (Target Not Met but Improved)
2008	19%	21.8% (Target Not Met)
2007	19.1%	20.3% (Target Not Met)

Table 149: Measure 2.3.09: Reduce rate of Child/adolescent readmissions to State psychiatric hospitals within 30 days[63] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	6.5%	Sep 30, 2011
2009	5.8%	7.5% (Target Not Met but Improved)
2008	5.8%	8.2% (Target Not Met)
2007	5.9%	6.7% (Target Not Met)

[63] Successful result is below target.

Table 150: Measure 2.3.10: Reduce rate of Child/adolescent readmissions to State psychiatric hospitals within 180 days[64] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	14.5%	Sep 30, 2011
2009	13.9%	16.1% (Target Not Met but Improved)
2008	13.9%	17.1% (Target Not Met)
2007	14%	15.3% (Target Not Met)

Table 151: Measure 2.3.12: Adult: Percentage of adult population coverage for each (reported as percentage of service population receiving any evidence based practice)[65] (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	10.5%	Sep 30, 2011
2009	10.5%	8.6% (Target Not Met but Improved)
2008	10.5%	8% (Target Not Met)
2007	10.4%	9.4% (Target Not Met)

Table 152: Measure 2.3.13: Children: Percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice)[66] (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	3.5%	Sep 30, 2011
2009	3.5%	3.2% (Target Not Met but Improved)
2008	3.5%	3% (Target Not Met)
2007	3.4%	3.2% (Target Not Met but Improved)

[64] Successful result is below target.

[65] 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

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

Table 153: Measure 2.3.17: Number of persons receiving evidence-based practices per $10,000 of mental health block grant dollars spent (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	7.0	Sep 30, 2011
2009	6.5	7.2 (Target Exceeded)
2008	4.0	6.7 (Target Exceeded)
2007	4.0	6.5 (Target Exceeded)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. SAMHSA believes this new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of MHBG measures was reduced leaving five measures in place. Measures 2.3.07 through 2.3.10 were all dropped given that the current rate of hospitalization is relatively infrequent given community alternatives. Measures 2.3.12 and 2.3.13 were combined (now measure 2.3.81) and reflects the evidence base practice coverage for both children and adults. Measure 2.3.17 was dropped due to the fact that many populations do not have established EBPs. Subsequently, some grantees had relatively little success with this measure despite having excellent consumer outcomes.

MACRO PROGRAM SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

PROGRAM TREATMENT ACTIVITIES

Table 154: Measure 1.2.45: Increase the percentage of States and Territories that express satisfaction with Technical Assistance (TA) provided (Output)

FY	Target	Result
2010	Discontinued	N/A
2009	97%	Nov 30, 2010
2008	97%	Nov 30, 2009[67]
2007	97%	92% (Target Not Met but Improved)

[67] The data for the final years of this measure are unavailable.

Table 155: Measure 1.2.47: Increase the percentage of States in appropriate cost bands (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	68%	Nov 30, 2011
2009	68%	77% (Target Exceeded)
2008	67%	77% (Target Exceeded)
2007	67%	65% (Target Not Met)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. SAMHSA believes this new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA is focusing on client-level outcomes as a measure of effectiveness for this Program. The measures which have been retained provide an appropriate assessment of whether the Program has met its goals/objectives.

PROGRAM PREVENTION SET-ASIDE

Table 156: Measure 2.3.53: Number of evidence-based policies, practices, and strategies implemented (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	7,000	Aug 31, 2011
2009	7,000	17,290 (Target Exceeded)
2008	7,000	10,393 (Target Exceeded)
2007	11,000	17,056 (Target Exceeded)

Table 157: Measure 2.3.54: Number of participants served in prevention programs (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	17,482,060	Aug 31, 2011
2009	17,482,060	112,716,508 (Target Exceeded)
2008	17,482,060	70,647,674 (Target Exceeded)
2007	17,482,060	25,258,287 (Target Exceeded)

Table 158: Measure 2.3.63: Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	45.1%	Aug 31, 2011
2009	45.1%	58.8% (Target Exceeded)
2008	45.1%	47.1% (Target Exceeded)
2007	Set Baseline	45.1% (Baseline)

Table 159: Measure 2.3.64: Percent of states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 18+) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	27.5%	Aug 31, 2011
2009	27.5%	29.4% (Target Exceeded)
2008	27.5%	37.3% (Target Exceeded)
2007	Set Baseline	27.4% (Baseline)

Table 160: Measure 2.3.65: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 12-20) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	51%	Aug 31, 2011
2009	51%	72.5% (Target Exceeded)
2008	51%	52.9% (Target Exceeded)
2007	Set Baseline	51% (Baseline)

Table 161: Measure 2.3.66: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of alcohol (age 21+) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	37.3%	Aug 31, 2011
2009	37.3%	35.3% (Target Not Met)
2008	37.3%	47.1% (Target Exceeded)
2007	Set Baseline	37.3% (Baseline)

Table 162: Measure 2.3.67: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 12-17) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	52.9%	Aug 31, 2011
2009	52.9%	56.9% (Target Exceeded)
2008	52.9%	64.7% (Target Exceeded)
2007	Set Baseline	52.9% (Baseline)

Table 163: Measure 2.3.68: Percent of states showing a decrease in state level estimates of percent of survey respondents who report 30 day use of other illicit drugs (age 18+) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	33.3%	Aug 31, 2011
2009	33.3%	60.8% (Target Exceeded)
2008	33.3%	37.3% (Target Exceeded)
2007	Set Baseline	33.3% (Baseline)

Table 164: Measure 2.3.69: Percent of program costs spent on evidence-based practices (EBP) (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	71%	Aug 31, 2011
2009	71%	63.5% (Target Not Met)
2008	70%	75% (Target Exceeded)
2007	Set Baseline	69% (Baseline)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. As a result of this review, the 9 measures associated with the 20% Prevention Set-Aside for Other Activities of the SABG have been recommended for discontinuation as prevention activities will be part of a new, consolidated grant program in FY 2012 known as the Substance Abuse-State Prevention Grant. Measures used for the 20% Prevention Set-Aside will be considered, as appropriate, for assessing performance of the new Substance Abuse-State Prevention Grant program; however, performance measures for this new program are developmental and contingent upon funding.

MACRO PROGRAM PREVENTION GRANTS

PROGRAM STRATEGIC PREVENTION FRAMEWORK STATE INCENTIVE GRANTS[68]

Table 165: Measure 2.3.19: 30-day use of alcohol among youth age 12-17 (Outcome)

FY	Target	Result
2013	Discontinued	N/A
2010	15%	Dec 31, 2011

Table 166: Measure 2.3.20: 30-day use of other illicit drugs age 12 and up (Outcome)

FY	Target	Result
2013	Discontinued	N/A
2010	5%	Dec 31, 2011

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

Table 167: Measure 2.3.21: Percent of SPF SIG States showing a decrease in state level estimate of percent of survey respondents (age 12-20) who report 30-day use of alcohol (Outcome)

FY	Target	Result
2011	Discontinued[69]	N/A
2010	50.4%	Aug 31, 2011
2009	50.4%	70.2% (Target Exceeded)
2008	51.8%	55.9% (Target Exceeded)
2007	51.8%	47.1% (Target Not Met)

Table 168: Measure 2.3.22: Percent of SPF SIG States showing a decrease in state level estimate of percent of survey respondents (age 21 and up) who report 30-day use of alcohol (Outcome)

FY	Target	Result
2011	Discontinued[70]	N/A
2010	31.4%	Aug 31, 2011
2009	31.4%	36.2% (Target Exceeded)
2008	32.3%	47.1% (Target Exceeded)
2007	32.3%	41.2% (Target Exceeded)[71]

Table 169: Measure 2.3.23: Percent of SPF SIG states showing a decrease in state level estimates of survey respondents (age 12-17) who report 30-day use of other illicit drugs (Outcome)

FY	Target	Result
2011	Discontinued[72]	N/A
2010	59.8%	Aug 31, 2011
2009	59.8%	59.6% (Target Not Met)
2008	61.5%	67.6% (Target Exceeded)
2007	61.5%	55.9% (Target Not Met)

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

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

[71] Data revised from previously reported.

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

Table 170: Measure 2.3.24: Percent of SPF SIG states showing a decrease in state level estimates of survey respondents (age 18 and up) who report 30-day use of other illicit drugs (Outcome)

FY	Target	Result
2011	Discontinued[73]	N/A
2010	47.2%	Aug 31, 2011
2009	47.2%	59.6% (Target Exceeded)
2008	48.5%	38.2% (Target Not Met but Improved)
2007	48.5%	29.4% (Target Not Met)[74]

Table 171: Measure 2.3.25: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who rate the risk of substance abuse as moderate or great (Outcome)

FY	Target	Result
2011	Discontinued[75]	N/A
2010	78.7%	Aug 31, 2011
2009	78.7%	55.3% (Target Not Met but Improved)
2008	80.9%	47.1% (Target Not Met)
2007	80.9%	50% (Target Not Met)

Table 172: Measure 2.3.26: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 18 and up) who rate the risk of substance abuse as moderate or great (Outcome)

FY	Target	Result
2011	Discontinued[76]	N/A
2010	50.4%	Aug 31, 2011
2009	50.4%	29.8% (Target Not Met)
2008	51.8%	44.1% (Target Not Met but Improved)
2007	51.8%	29.4% (Target Not Met)

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

[74] Data revised from previously reported.

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

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

Table 173: Measure 2.3.27: Percent of SPF SIG states showing an increase in state level estimates of survey respondents (age 12-17) who somewhat disapprove or strongly disapprove of substance use (Outcome)

FY	Target	Result
2011	Discontinued[77]	N/A
2010	84.9%	Aug 31, 2011
2009	84.9%	70.2% (Target Not Met)
2008	87%	76.5% (Target Not Met but Improved)
2007	87.3%	67.6% (Target Not Met)

Table 174: Measure 2.3.28: Number of evidence-based policies, practices, and strategies implemented[78] (Output)

FY	Target	Result
2011	Discontinued[79]	N/A
2010	234	Aug 31, 2011
2009	234	1404 (Target Exceeded)
2008	470	731 (Target Exceeded)
2007	470	385 (Target Not Met)

Table 175: Measure 2.3.29: Percent of grantee states that have performed needs assessments (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	97%[80]	Aug 31, 2011
2009	100%	92% (Target Not Met)[81]
2008	100%	100% (Target Met)
2007	100%	100% (Target Met)

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

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

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

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

[81] Revised from previous reports.

Table 176: Measure 2.3.30: Percent of grantee States that have submitted State plans (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	60%[82]	Aug 31, 2011
2009	95.2%	84.3% (Target Not Met)[83]
2008	100%	95.2% (Target Not Met)[84]
2007	85%	96.2% (Target Exceeded)

Table 177: Measure 2.3.31: Percent of grantee States with approved plans (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	54%[85]	Aug 31, 2011
2009	85.7%	82.4% (Target Not Met)[86]
2008	100%	85.7% (Target Not Met)[87]
2007	85%	88.5% (Target Exceeded)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. As a result of this review, the 11 measures associated with the SPF SIG program have been recommended for discontinuation as prevention activities will be part of a new, consolidated grant program in FY 2012 known as the Substance Abuse-State Prevention Grant. Measures used for SPF SIG will be considered, as appropriate, for assessing performance of the new Substance Abuse State Prevention Grant program; however, performance measures for this new program are developmental and contingent upon funding.

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

[83] Revised from previous reports.

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

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

[86] Revised from previous reports.

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

PROGRAM PARTNERSHIPS FOR SUCCESS

Table 178: Measure 2.3.77: Increase the number of sub-recipient communities funded through the Partnerships for Success grants (Output)

FY	Target	Result
2010	Discontinued	N/A

Table 179: Measure 2.3.78: Increase the number of communities who report an increase in prevention activities that are supported by collaboration and leveraging of funding streams (Output)

FY	Target	Result
2010	Discontinued	N/A

Table 180: Measure 2.3.79: Increase the number of EBPs implemented by sub-recipient communities (Output)

FY	Target	Result
2010	Discontinued	N/A

Table 181: Measure 2.3.80: Increase the number of sub-recipient communities that improved on one or more targeted NOMs indicators (Outcome)

FY	Target	Result
2010	Discontinued	N/A

MACRO PROGRAM INNOVATION AND EMERGING ISSUES - CMHS

PROGRAM CO-OCCURRING STATE INCENTIVE GRANTS

Table 182: Measure 1.2.17: Increase the number of persons with co-occurring disorders served (Output)

FY	Target	Result
2010	Discontinued	N/A
2009	103,679	94,034 (Target Not Met)
2008	Set Baseline	103,679 (Baseline)

Table 183: Measure 1.2.18: Increase the percentage of treatment programs that **screen** for co-occurring disorders (Outcome)

FY	Target	Result
2010	Discontinued	N/A
2009	68%	29% (Target Not Met)
2008	Set Baseline	96.1% (Baseline)[88]

Table 184: Measure 1.2.19: Increase the percentage of treatment programs that **assess** for co-occurring disorders (Outcome)

FY	Target	Result
2010	Discontinued	N/A
2009	32%	17% (Target Not Met)
2008	Set Baseline	76.4% (Baseline)[89]

Table 185: Measure 1.2.20: Increase the percentage of treatment programs that **treat** co-occurring disorders through collaborative, consultative, and integrated models of care (Outcome)

FY	Target	Result
2010	Discontinued	N/A
2009	53%	6% (Target Not Met)
2008	Set Baseline	50.4% (Baseline)[90]

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

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

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

PROGRAM YOUTH VIOLENCE PREVENTION

Table 186: Measure 3.2.05: Decrease the percentage of **middle school** students who have been in a physical fight on school property[91] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	34%	22.9% (Target Exceeded)
2009	34.4%	23.8% (Target Exceeded)
2008	36%	34.4% (Target Exceeded)
2007	30%	36.6% (Target Not Met)

Table 187: Measure 3.2.06: Decrease the percentage of **high school** students who have been in a physical fight on school property[92] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	23%	15% (Target Exceeded)
2009	23.7%	16.1% (Target Exceeded)
2008	29%	23.7% (Target Exceeded)
2007	24%	29.8% (Target Not Met)

Table 188: Measure 3.2.07: Decrease the percentage of **middle school** students who report current substance use (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	13%	14.5% (Target Not Met)
2009	13.7%	13.3% (Target Exceeded)
2008	16%	13.7% (Target Exceeded)
2007	16%	16% (Target Met)

[91] Successful result is below target

[92] Successful result is below target

Table 189: Measure 3.2.08: Decrease the percentage of **high school** students who report current substance use (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	33%	33.6% (Target Not Met)
2009	33%	31.1% (Target Exceeded)
2008	35%	33% (Target Exceeded)
2007	35%	35% (Target Met)

Table 190: Measure 3.2.09: Increase the percentage of students attending school[93] (Outcome)

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

Table 191: Measure 3.2.21: Percentage of grantees that provided screening and/or assessments that is coordinated among two or more agencies or shared across agencies. (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	69%	63.3% (Target Not Met)[94]
2009	68.1%	73.9% (Target Exceeded)
2008	67.1%	62.4% (Target Not Met)
2007	Set Baseline	66.1% (Baseline)

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

[94] This number includes data from a large cohort of grantees funded in 2009. The 2010 result is derived from 60 new grantees and 27 continuing grantees. Full implementation of services does not occur until later in 1st year of program. Thus decrease may reflect the impact of the larger new cohort.

Table 192: Measure 3.2.22: Percentage of grantees that provide training of school personnel on mental health topics (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	67%	62.1% (Target Not Met)[95]
2009	66.4%	73.9% (Target Exceeded)
2008	65.4%	64% (Target Not Met)
2007	Set Baseline	64.4% (Baseline)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The overall number of Youth Violence Prevention measures was reduced. Measures 3.2.05 and 3.2.06 were combined (new measure 3.2.29) to include both middle and high school students. Measures 3.2.07 and 3.2.08 were also combined (new measure 3.2.30) for the same reason. Measure 3.2.09 had already been slated for retirement in 2010. Measures 3.2.21 and 3.2.22 were both dropped as the data source is not maintained by SAMHSA and the performance for these measures was at an acceptable level.

PROGRAM NATIONAL TRAUMATIC STRESS NETWORK (NCTSI)

Table 193: Measure 3.2.01: Increase the estimated number of children and adolescents receiving trauma-informed services[96] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	29,000	Dec 31, 2010[97]
2009	16,955	25,143 (Target Exceeded)
2008	33,910	28,878 (Target Not Met)
2007	33,910	31,446 (Target Not Met)

[95] This number includes data from a large cohort of grantees funded in 2009. The 2010 result is derived from 60 new grantees and 27 continuing grantees. Full implementation of services does not occur until later in 1st year of program. Thus decrease may reflect the impact of the larger new cohort.

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

[97] The NCTSI began using a web–based GPRA data collection system called Transformation Accountability (TRAC) System in FY 2008 and this shift to the TRAC system led to the unavailability of the FY 2010 estimated number served data.

Table 194: Measure 3.2.03: Dollars spent per person served[98,99] (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	$718	$20,827 (Target Not Met)[100]
2009	$718	$1,511 (Target Not Met)
2008	$774	$948 (Target Not Met)
2007	$480	$774 (Target Not Met)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of NCTSI measures was reduced by two; leaving three measures in place. The two measures that were dropped had already been slated for retirement by 2010.

PROGRAM MENTAL HEALTH SYSTEM TRANSFORMATION GRANTS[101,102,103]

Table 195: Measure 1.2.10: Increase the number of policy changes completed as a consequence of the Comprehensive Mental Health Plan (CMHP) (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	29	141 (Target Exceeded)
2009	31	191 (Target Exceeded)
2008	69	81 (Target Exceeded)
2007	Set Baseline	82 (Baseline)

98 Successful result is below target.

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

100 Result was derived from FY 2010 appropriation divided by the unduplicated number served (see Measure 3.2.23). Prior years used the duplicated numbers served.

101 Program was formally known as Mental Health State Incentive Grants for Transformation

102 This program is still under development and performance measures will be added once the program is finalized. In the interim, targets for FY 2012 and FY 2013 have been included and are subject to change.

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

Table 196: Measure 1.2.12: Increase the number of financing policy changes completed as a consequence of the CMHP (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	19	32 (Target Exceeded)
2009	18	47 (Target Exceeded)
2008	29	49 (Target Exceeded)
2007	Set Baseline	43 (Baseline)

Table 197: Measure 1.2.13: Increase the number of organizational changes completed as a consequence of the CMHP (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	64	192 (Target Exceeded)
2009	223	148 (Target Not Met but Improved)
2008	93	127 (Target Exceeded)
2007	Set Baseline	40 (Baseline)

Table 198: Measure 1.2.14: Increase the number of organizations that regularly obtain and analyze data relevant to the goals of the CMHP (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	794	448 (Target Not Met)
2009	239	6841 (Target Exceeded)
2008	562	102 (Target Not Met but Improved)
2007	Set Baseline	37 (Baseline)

Table 199: Measure 1.2.15: Increase the number of consumers and family members that are members of Statewide consumer- and family-run networks (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	3,510	0[104]
2009	15,445	11,702 (Target Not Met)[105]
2008	4,257	4,627 (Target Exceeded)
2007	Set Baseline	62,411 (Baseline)

Table 200: Measure 1.2.16: Increase the number of programs implementing practices consistent with the CMHP (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	1,227	786 (Target Not Met)
2009	633	1,256 (Target Exceeded)
2008	587	1,238 (Target Exceeded)
2007	Set Baseline	175 (Baseline)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of Mental Health System Transformation Grants measures was reduced; leaving one measure in place. The measures selected for deletion were those that no longer were appropriate for the redesigned program that focuses on consumer services.

[104] During FY 2010, there was a loss of 7,134 participants from Statewide networks.

[105] The 2009 result for 1.2.15 (82,113) was reported in error. The number reported was the target for the total number of consumers and family members that would be members of Statewide consumer– and family–run networks in 2009. The number should have been the number of consumers and family members added to the Statewide consumer– and family–run networks in 2009, which was 11,702.

PROGRAM SUICIDE PREVENTION

Table 201: Measure 2.3.57: Reduce the number of suicide deaths (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	30,684	Apr 30, 2013
2009	30,784	Apr 30, 2012
2008	30,984	Apr 30, 2011
2007	31,084	34,598 (Target Not Met)

Table 202: Measure 2.3.58: Increase the number of students exposed to mental health and suicide awareness campaigns on college campuses (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	681,425	684,525 (Target Exceeded)
2009	662,774	1,037,974 (Target Exceeded)
2008	662,774	681,425 (Target Exceeded)
2007	Set Baseline	662,774 (Baseline)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of Suicide Prevention measures were reduced; leaving two measures in place. Measure 2.3.57 was discontinued as the measure was considered too distant from program activities and outcomes. Measure 2.3.58 was discontinued as it did not provide important information about the core purpose of the program.

PROGRAM MENTAL HEALTH HOMELESSNESS PREVENTION PROGRAMS[106]

Table 203: Measure 3.4.04: Percentage of adults receiving services who had no/reduced involvement with the criminal justice system (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	98.2	97.5 (Target Not Met)
2009	98.2	97.5 (Target Not Met)
2008	Set Baseline	98.2 (Baseline)

Table 204: Measure 3.4.07: Increase the percentage of adults receiving services who report positively about perception of care (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	96.1 %	92.5 % (Target Not Met)
2009	96.1 %	94.5 % (Target Not Met)
2008	Set Baseline	96.1 % (Baseline)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of Services in Supportive Housing measures was reduced; leaving five measures in place. Measure 3.4.04 was discontinued due to the fact that criminal justice was considered not to be a primary focus of the program. Measure 3.4.07 was discontinued due to the method of data collection which had been having the provider ask the consumer how he or she felt about the provider's services. Data collection protocols have been revised for less bias.

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

PROGRAM MENTAL HEALTH/SUBSTANCE ABUSE SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

Table 205: Measure: Increase the number of individuals receiving a brief intervention for MH and/or SUD

FY	Target	Result
2013	Discontinued	N/A
2012	Discontinued	N/A

Table 206: Measure: Increase the number of individuals assessed and referred for specialty MH and/or SA treatment

FY	Target	Result
2013	Discontinued	N/A
2012	Discontinued	N/A

PROGRAM OTHER MENTAL HEALTH CAPACITY ACTIVITIES[107]

Table 207: Measure 1.2.03: Rate of consumers reporting positively about perception of care (program participants)[108] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	98%	94.4% (Target Not Met)
2009	98%	95.2% (Target Not Met but Improved)
2008	98%	94.8% (Target Not Met)
2007	Set Baseline	98% (Baseline)[109]

[107] Prior to 2008, includes Jail Diversion, Older Adults, HIV/AIDS, and Services in Supportive Housing programs. Beginning in 2009, data from Services in Supportive Housing will be reported under Homelessness Activities. In 2010, Primary and Behavioral Health Care Integration and Healthy Transitions was added.

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

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

Table 208: Measure 1.2.06: Number of evidence based practices (EBPs) implemented (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	4.1 per State	Dec 31, 2011
2009	4 per State	4.3 per State (Target Exceeded)
2008	4 per State	4.2 per State (Target Exceeded)
2007	3.8 per State	4 per State (Target Exceeded)

Table 209: Measure 1.2.07: Percentage of people in the United States with serious mental illnesses in need of services from the public mental health system who receive services from the public mental health system (Outcome)

FY	Target	Result
2015	Discontinued	N/A

Table 210: Measure 1.2.08: Number of Adults: percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice) (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	10.5%	Dec 31, 2011
2009	10.8%	8.6% (Target Not Met but Improved)
2008	10.8%	8% (Target Not Met)
2007	10.8%	9.4% (Target Not Met)

Table 211: Measure 1.2.09: Number of Children: percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice) (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	3.5%	Dec 31, 2011
2009	3.5%	3.2% (Target Not Met but Improved)
2008	3.5%	3% (Target Not Met)
2007	2.6%	3.2% (Target Exceeded)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and

consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of Other Mental Health Capacity Activities measures was reduced; leaving three measures in place. Measures 1.2.03, 1.2.06, 1.2.07, 1.2.08 and 1.2.09 were discontinued as these measures are too distant from actual program activities and the data sources are not maintained by SAMHSA.

PROGRAM MENTAL HEALTH - SCIENCE AND SERVICE ACTIVITIES[110],[111]

Table 212: Measure 1.4.07: Percentage of those trained by the program who report they were very satisfied with training (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	80%	71.8% (Target Not Met)
2009	80%	81.4% (Target Exceeded)
2008	N/A	76% (Historical Actual)
2007	N/A	79% (Historical Actual)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of Science and Service measures was reduced; leaving one measure in place while a new measure was added. Measure 1.4.07, a client satisfaction measure, was discontinued as SAMHSA has determined that client satisfaction is not useful in assessing the impact of TA efforts. The FY 2010 performance data were used to set the baselines for future targets. One measure has also been added which captures training efforts across SAMHSA Science and Service programs.

[110] Prior to 2008, includes HIV/AIDS education and Historically Black Colleges and Universities National Resource Center for Substance Abuse and Mental Health.

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

MACRO PROGRAM INNOVATION AND EMERGING ISSUES - CSAP

PROGRAM MINORITY AIDS INITIATIVE[112,113,114]

Table 213: Measure 2.3.35: Percent of program participants (age 12-17) that rate the risk of substance abuse as moderate or great (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	87%	Aug 31, 2011
2009	76.6%	90% (Target Exceeded)
2008	75.8%	90.1% (Target Exceeded)
2007	89%	87.6% (Target Not Met)

Table 214: Measure 2.3.38: Percent of program participants (age 18 and up) that rate the risk of substance abuse as moderate or great (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	93%	Aug 31, 2011
2009	85.1%	95.3% (Target Exceeded)
2008	84.2%	96.5% (Target Exceeded)
2007	Set Baseline	94.4% (Baseline)

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

[113] HIV Cohort 7 serves different population groups so baseline data from this cohort will be established and entered in FY 2011.

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

Table 215: Measure 2.3.39: Percent of participants (age 12-20) who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	76.6%	Aug 31, 2011
2009	76.6%	62.7% (Target Not Met but Improved)
2008	75.1%	58.1% (Target Not Met)
2007	Set Baseline	74.4% (Baseline)

Table 216: Measure 2.3.40: Percent of participants (age 21 and up) who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	60.8%	Aug 31, 2011
2009	60.8%	62.3% (Target Exceeded)
2008	59.6%	60.4% (Target Exceeded)
2007	Set Baseline	59% (Baseline)

Table 217: Measure 2.3.41: Percent of participants (age 12-20) who report no alcohol use at pre-test who remain non-users at post-test (non-user stability) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	95.3%	Aug 31, 2011
2009	95.3%	90.4% (Target Not Met)
2008	93.4%	93.7% (Target Exceeded)
2007	Set Baseline	92.5% (Baseline)

Table 218: Measure 2.3.42: Percent of participants (age 21 and up) who report no alcohol use at pre-test who remain non-users at post-test (non-user stability) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	92%	Aug 31, 2011
2009	92%	91.5% (Target Not Met but Improved)
2008	90.2%	90.3% (Target Exceeded)
2007	Set Baseline	89.3% (Baseline)

Table 219: Measure 2.3.43: Percent of participants (age 12-17) who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	92.3%	Aug 31, 2011
2009	92.3%	58.3% (Target Not Met)
2008	90.5%	67.3% (Target Not Met)
2007	Set Baseline	89.6% (Baseline)

Table 220: Measure 2.3.44: Percent of participants (age 18 and up) who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	70.6%	Aug 31, 2011
2009	70.6%	62.2% (Target Not Met but Improved)
2008	69.2%	59.1% (Target Not Met)
2007	Set Baseline	68.5% (Baseline)

Table 221: Measure 2.3.45: Percent of participants (age 12-17) who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	94.9%	Aug 31, 2011
2009	94.9%	90.9% (Target Not Met)
2008	93%	96% (Target Exceeded)
2007	Set Baseline	92.1% (Baseline)

Table 222: Measure 2.3.46: Percent of participants (age 18 and up) who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability) (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	94.6%	Aug 31, 2011
2009	94.6%	93% (Target Not Met)
2008	92.7%	93.4% (Target Exceeded)
2007	Set Baseline	91.8% (Baseline)

Table 223: Measure 2.3.47: Percent of program participants (age 12-17) who somewhat disapprove or strongly disapprove of substance use (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	82.8%	Aug 31, 2011
2009	82.8%	76.4% (Target Not Met but Improved)
2008	81%	72.9% (Target Not Met but Improved)
2007	Set Baseline	70.3% (Baseline)

Table 224: Measure 2.3.48: Number of evidence-based policies, practices, and strategies implemented by HIV program grantees[115] (Output)

FY	Target	Result
2011	Discontinued[116]	N/A
2010	270	Aug 31, 2011
2009	160	132 (Target Not Met)[117]
2008	160	509 (Target Exceeded)
2007	Set Baseline	162 (Baseline)

Table 225: Measure 2.3.70: Cost per participant improved on one or more measures between pre-test and post-test (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	$20,167	Aug 31, 2011
2009	$20,167	$5,599 (Target Exceeded)[118]
2008	$20,167	$10,890 (Target Exceeded)
2007	Set Baseline	$22,189 (Baseline)[119]

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. For the MAI Program, measures were reduced by consolidating several of the youth and adult measures into a single measure. As a result, the perceived risks from substance abuse youth and adult measures (2.3.35 and 2.3.38) have been merged into one new measure: 2.3.82; the alcohol non-user stability youth and adult measures (2.3.41 and 2.3.42) have been merged into one new measure: 2.3.83; and the illicit drug non-user stability youth and adult measures (2.3.45 and 2.3.46) have been merged into one new measure: 2.3.84. Baselines and targets for the new consolidated measures are based on FY 2009 performance data.

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

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

[117] Data revised from previously reported.

[118] Calculations have been adjusted from earlier years. Beginning in FY 2009, costs per participant improved were calculated only from programs lasting 30 days or more. Please see data validation table for more information.

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

Table 226: Measure 2.3.72: Percentage of TA recipients who reported that they are very satisfied with the TA received[120] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	69.1%	Aug 31, 2011
2009	69.1%	84.3% (Target Exceeded)
2008	Set Baseline	69.6% (Baseline)[121]

Table 227: Measure 2.3.73: Percentage of TA recipients who reported that their ability to provide effective services improved a great deal[122] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	53.4%	Aug 31, 2011
2009	53.4%	44.4% (Target Not Met)
2008	Set Baseline	65.4% (Baseline)[123]

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. For the Science and Service Activities program, two measures were discontinued — leaving three measures in place. Specifically, measure 2.3.72 (Percentage of TA recipients who reported that there are very satisfied with the TA they received) was discontinued because it is not useful in assessing the impact of TA efforts. Also, measure 2.3.73 (Percentage of TA recipients who reported their ability to provide effective services improved a great deal) was also discontinued because self-assessment of effectiveness is not useful in capturing the impact of TA efforts. One measure has also been added which captures training efforts across SAMHSA Science and Service programs. Currently, the Science to Service Activities program is under administrative review at SAMHSA's CSAP. Starting in FY 2012, measures may be changed and/or revised to reflect significant changes in this program.

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

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

[122] Includes CAPTs and Prevention Fellowships.

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

MACRO PROGRAM INNOVATION AND EMERGING ISSUES - CSAT

PROGRAM CO-OCCURRING STATE INCENTIVE GRANTS

Table 228: Measure 1.2.17: Increase the number of persons with co-occurring disorders served (Output)

FY	Target	Result
2010	Discontinued	N/A
2009	103,679	94,034 (Target Not Met)
2008	Set Baseline	103,679 (Baseline)

Table 229: Measure 1.2.18: Increase the percentage of treatment programs that **screen** for co-occurring disorders (Outcome)

FY	Target	Result
2010	Discontinued	N/A
2009	68%	29% (Target Not Met)
2008	Set Baseline	96.1% (Baseline)[124]

Table 230: Measure 1.2.19: Increase the percentage of treatment programs that **assess** for co-occurring disorders (Outcome)

FY	Target	Result
2010	Discontinued	N/A
2009	32%	17% (Target Not Met)
2008	Set Baseline	76.4% (Baseline)[125]

Table 231: Measure 1.2.20: Increase the percentage of treatment programs that **treat** co-occurring disorders through collaborative, consultative, and integrated models of care (Outcome)

FY	Target	Result
2010	Discontinued	N/A
2009	53%	6% (Target Not Met)
2008	Set Baseline	50.4% (Baseline)[126]

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

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

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

PROGRAM ACCESS TO RECOVERY

Table 232: Measure 1.2.34: Increase the percentage of adults receiving services who had improved family and living conditions (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	53%	47% (Target Not Met)
2009	52%	47% (Target Not Met)
2008	52%	52.9% (Target Exceeded)
2007	52%	59.9% (Target Exceeded)

Table 233: Measure 1.2.37: Increase the percentage of adults receiving services who were currently employed or engaged in productive activities (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	54%	51% (Target Not Met but Improved)
2009	53%	49% (Target Not Met)
2008	53%	59.1% (Target Exceeded)
2007	50%	61.7% (Target Exceeded)

Table 234: Measure 1.2.39: Cost per client served[127] (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	$1,572	$1,374 (Target Exceeded)
2009	$1,588	$1,071 (Target Exceeded)
2008	$1,605	$1,888 (Target Not Met)
2007	N/A	$1,605 (Historical Actual)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and

[127] Successful result is below target.

consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA continued to report number of clients served, abstinence from use, criminal justice involvement and social support. These measures provide a comprehensive view of the program. The housing, employment, and cost per client measures will no longer be reported.

PROGRAM CRIMINAL JUSTICE - JUVENILE AND ADULT PROBLEM SOLVING DRUG COURTS

Table 235: Measure 1.2.68: Juvenile: Percent of drug court participants who exhibit a reduction in substance use while in the drug court program (Developmental) (Outcome)

FY	Target	Result
2010	Discontinued	N/A

Table 236: Measure 1.2.77: Adult: Percent of drug court participants who exhibit a reduction in substance use while in the drug court program. Measured in conjunction with DOJ. (Outcome)

FY	Target	Result
2010	Discontinued	N/A

Table 237: Measure 1.2.62: Juvenile: Percentage of clients that complete treatment (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2009	75%	N/A[128]
2008	74%	75.1% (Target Exceeded)
2007	69%	73% (Target Exceeded)

Table 238: Measure 1.2.66: Juvenile: Increase percentage of clients receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social consequences (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2009	93%	99% (Target Exceeded)
2008	92%	92% (Target Met)
2007	90%	91.2% (Target Exceeded)

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

Table 239: Measure 1.2.69: Juvenile: Reduce cost-per-client served[129] (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2009	$5,610	$5,215 (Target Exceeded)
2008	$5,905	$6,790 (Target Not Met)
2007	$6,742	$6,463 (Target Exceeded)

Table 240: Measure 1.2.71: Adult: Percentage of clients that complete treatment[130] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	53%	47% (Target Not Met)
2009	67%	51% (Target Not Met)

Table 241: Measure 1.2.75: Adult: Increase percentage of clients receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	93%	97.6% (Target Exceeded)
2009	93%	89% (Target Not Met)

Table 242: Measure 1.2.78: Adult: Reduce cost-per-client served[131] (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	$5,554	$4,179 (Target Exceeded)
2009	$5,610	$4,320 (Target Exceeded)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of

[129] Successful result is below target.

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

[131] Successful result is below target.

GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA has chosen to highlight key measures of the program which clearly illustrate the programs goals and objectives. The following measures have been selected for ongoing reporting: number served, abstinence from use, housing, employment and criminal justice involvement.

PROGRAM TREATMENT SYSTEM FOR HOMELESSNESS (GBHI)

Table 243: Measure: Increase percentage of adults receiving services who had no/reduced involvement with the criminal justice system

FY	Target	Result
2011	Discontinued	Discontinued
2010	96.8%	96.5% (Target Not Met but Improved)
2009	96.2%	95.8% (Target Not Met)
2008	N/A	96.2% (Historical Actual)

Table 244: Measure: Increase percentage of adults receiving services who had improved social support

FY	Target	Result
2011	Discontinued	N/A
2010	89.3%	87% (Target Not Met)
2009	85.9%	88.3% (Target Exceeded)
2008	N/A	85.9% (Historical Actual)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA will continue to report clients served, abstinence from use, housing, and employment. These measures serve to demonstrate the program goals and objectives. The social support and criminal justice involvement measures have been discontinued as they do not reflect key goals of the program.

PROGRAM TREATMENT - OTHER CAPACITY[132]

Table 245: Measure 1.2.30: Increase percentage of adults receiving services who experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	66%	87.6% (Target Exceeded)
2009	65%	86% (Target Exceeded)
2008	67%	68% (Target Exceeded)
2007	67%	65% (Target Not Met)

Table 246: Measure 1.2.31: Increase the percentage of grantees in appropriate cost bands (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	79%	Oct 31, 2011
2009	78%	79% (Target Exceeded)
2008	80%	80% (Target Met)
2007	80%	80% (Target Met)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The social consequences and cost band measures are being discontinued as these measures do not meaningfully reflect the program goals.

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

Table 247: Measure 1.4.03: Increase the percentage of drug treatment professionals trained by the program who would rate the quality of the events as good, very good, or excellent (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	96%	95% (Target Not Met)
2009	96%	95% (Target Not Met)
2008	96%	95% (Target Not Met)
2007	96%	95% (Target Not Met)

Table 248: Measure 1.4.04: Increase the percentage of drug treatment professionals trained by the program who shared any of the information from the events with others (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	92%	86% (Target Not Met but Improved)
2009	92%	85% (Target Not Met)
2008	90%	93.5% (Target Exceeded)
2007	90%	89% (Target Not Met but Improved)

Table 249: Measure 1.4.05: Increase the percentage of grantees in appropriate cost bands (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	100%	Oct 31, 2011
2009	100%	100% (Target Met)
2008	100%	100% (Target Met)
2007	100%	100% (Target Met)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of

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

GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. SAMHSA has elected to retain two key program measures: number of participants trained and application of the information. These measures will clearly indicate the extent to which information gained from trainings has been put to practical use. One measure has also been added which captures training efforts across SAMHSA Science and Service programs.

MACRO PROGRAM CHILDREN'S MENTAL HEALTH SERVICES

Table 250: Measure 3.2.11: Increase the percent of funded sites that will exceed a 30 percent improvement in behavioral and emotional symptoms among children receiving services for 6 months[134] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	60%	62.1% (Target Exceeded)

Table 251: Measure 3.2.12: Increase percentage of children attending school 80% or more of time after 12 months[135] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	86.3%	91.1% (Target Exceeded)
2009	86.3%	89.2% (Target Exceeded)
2008	84%	86.3% (Target Exceeded)
2007	84%	87% (Target Exceeded)

Table 252: Measure 3.2.13: Increase percentage with no law enforcement contacts at 6 months (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	71.7%	76.7% (Target Exceeded)
2009	71.7%	68.9% (Target Not Met)
2008	69%	71.7% (Target Exceeded)
2007	70%	71% (Target Exceeded)

[134] Long-term measure only. No annual targets have been set.

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

Table 253: Measure 3.2.14: Decrease average days of inpatient facilities among children served in systems of care at 6 months[136] (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	-2	-0.06 (Target Not Met)
2009	-2	-0.12 (Target Not Met)
2008	-2	-1.05 (Target Not Met)
2007	-2	-1.78 (Target Not Met but Improved)

Table 254: Measure 3.2.15: Percent of systems of care that are sustained 5 years post Federal funding (Outcome)

FY	Target	Result
2010	Discontinued	N/A
2009	85%	64.1% (Target Not Met)
2008	80%	77.8% (Target Not Met)

Table 255: Measure 3.2.17: Increase total savings for in-hospital patient care costs per 1,000 children served (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	$2,376,000	-$82,857 (Target Not Met)
2009	$2,376,000	$160,000 (Target Not Met)
2008	$2,670,000	$1,401,750 (Target Not Met)
2007	$2,670,000	$2,376,000 (Target Not Met but Improved)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of CMHI measures was reduced to a total of five remaining measures. Of these five measures, four are new measures for the program as all GPRA data collection has been moved from the cross-site evaluation to the SAMHSA TRAC system. The FY 2010 performance data were used to set the baselines for future targets.

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

PROGRAM PROJECTS TO ASSIST IN THE TRANSITION FROM HOMELESSNESS

Table 256: Measure 3.4.18: Average Federal cost of enrolling a homeless person with serious mental illness in services[137] (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	$668	Jul 31, 2011
2009	$668	$552 (Target Exceeded)
2008	$668	$669 (Target Not Met but Improved)
2007	$668	$674 (Target Not Met)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. The number of PATH measures was reduced leaving four measures in place. Measure 3.4.18 was deleted as SAMHSA is reviewing its efficiency measures to determine the best approach to achieve meaningful efficiency outcomes.

MACRO PROGRAM REGULATORY AND OVERSIGHT FUNCTIONS

PROGRAM PROTECTION & ADVOCACY

Table 257: Measure 3.4.08: Increase percentage of complaints of alleged **abuse** not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as result of PAIMI involvement (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	84%	Jul 31, 2011
2009	84%	85% (Target Exceeded)
2008	84%	87% (Target Exceeded)
2007	85%	83% (Target Not Met)

[137] Successful result is below target.

Table 258: Measure 3.4.09: Increase percentage of complaints of alleged **neglect** substantiated not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	88%	Jul 31, 2011
2009	85%	87% (Target Exceeded)
2008	85%	84% (Target Not Met)
2007	84%	88% (Target Exceeded)

Table 259: Measure 3.4.10: Increase percentage of complaints of alleged **rights violations** substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, or elimination of other barriers to personal decision-making, as a result of PAIMI involvement (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	90%	Jul 31, 2011
2009	90%	90% (Target Met)
2008	90%	89% (Target Not Met but Improved)
2007	90%	86% (Target Not Met but Improved)

Table 260: Measure 3.4.11: Percent of interventions on behalf of groups of PAIMI-eligible individuals that were concluded successfully (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	97%	Jul 31, 2011
2009	95%	95% (Target Met)
2008	95%	97% (Target Exceeded)
2007	95%	97% (Target Exceeded)

Table 261: Measure 3.4.13: Ratio of persons served/impacted per activity/intervention (Outcome)

FY	Target	Result
2011	Discontinued	N/A
2010	430	Jul 31, 2011
2009	420	801 (Target Exceeded)
2008	420	1,177 (Target Exceeded)
2007	420	473 (Target Exceeded)

Table 262: Measure 3.4.14: Cost per 1,000 individuals served/impacted[138] (Efficiency)

FY	Target	Result
2011	Discontinued	N/A
2010	$1,950	Jul 31, 2011
2009	$2,000	$1,422 (Target Exceeded)
2008	$2,000	$1,886 (Target Exceeded)
2007	$2,000	$1,989 (Target Exceeded)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. Measures 3.4.08, 3.4.09, and 3.4.10 were combined into one measure (now 3.4.21) as the results of the separate measures were similar. Measure 3.4.11 was deleted as performance was at a high level for the past several fiscal years. Measures 3.4 13 and 3.4.14 were deleted as SAMHSA is reviewing its efficiency measures to determine the best approach to achieve meaningful efficiency outcomes.

[138] Successful result is below target.

MACRO PROGRAM PUBLIC AWARENESS AND SUPPORT

PROGRAM SAMHSA'S HEALTH INFORMATION NETWORK (SHIN)[139]

Table 263: Measure 4.4.04: Total number of SAMHSA knowledge products disseminated (Output)

FY	Target	Result
2011	Discontinued[140]	N/A
2010	13,909,297	19,525,378 (Target Exceeded)
2009	13,909,297	16,360,389 (Target Exceeded)
2008	Set Baseline	13,909,297 (Baseline)

Table 264: Measure 4.4.05: Total number of individuals referred for treatment resources (Output)

FY	Target	Result
2011	Discontinued[141]	N/A
2010	373,916	377,428 (Target Exceeded)
2009	Set Baseline	373,916 (Baseline)

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

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

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

MACRO PROGRAM PERFORMANCE AND QUALITY IMPROVEMENT SYSTEMS

PROGRAM SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT - NATIONAL SURVEYS[142]

Table 265: Measure 4.4.01: Availability and timeliness of data for the National Survey on Drug Use and Health (NSDUH) (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	8 months	8 months (Target Met)
2009	8 months	8 months (Target Met)
2008	8 months	8 months (Target Met)
2007	8 months	8 months (Target Met)

Table 266: Measure 4.4.02: Availability and timeliness of data for the Drug Abuse Warning Network (DAWN) (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	10 months	Oct 31, 2011
2009	10 months	12 months (Target Not Met but Improved)
2008	10 months	13 months (Target Not Met but Improved)[143]
2007	12 months	22 months (Target Not Met)[144]

[142] The National Surveys are completed using contracts instead of grants. As a result, they are awarded earlier in the fiscal year than grants. There is no delay between fiscal year funding and the performance year.

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

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

Table 267: Measure 4.4.03: Availability and timeliness of data for the Drug and Alcohol Services Information System (DASIS) (Output)

FY	Target	Result
2011	Discontinued	N/A
2010	10 months	10 months (Target Met)
2009	10 months	10 months (Target Met)
2008	10 months	10 months (Target Met)
2007	15 months	8 months (Target Exceeded)

During the FY 2012 budget formulation process, SAMHSA underwent a comprehensive review of the 190 measures listed in the FY 2011 President's Budget. This review resulted in the deletion, revision, and consolidation of existing GPRA measures and the inclusion of several new measures. This new group of GPRA measures will more accurately capture key program activities and intended outcomes for SAMHSA programs. CBHSQ eliminated three GPRA measures on timeliness because they did not accurately reflect the mission of the Center.

OVERVIEW OF PERFORMANCE

STATEMENT OF MISSION

FY 2012 Performance Overview

SAMHSA's performance measures include outcomes and outputs which allow SAMHSA to effectively manage grants, contracts and data collection activities, and to report performance results to the President, Congress, and other stakeholders.

The FY 2012 Budget includes substantial revisions to SAMHSA's performance measures reported in the Annual GPRA Plan and Annual GPRA Report. The resulting set of measures seeks to capture the following key items for each program: the number of services delivered or people served, a specific measure or two for each individual program area, and a measure that captures client recovery. Further, SAMHSA spent a good deal of time reviewing existing measures to ensure that they were meaningful and met the needs of both program management and policy-makers. This effort resulted in a reduction of measures from almost 200 (as published in the 2011 President's Budget) to around 100 measures in the FY 2012 President's Budget. Although this reduction changes the display of measures in the Annual GPRA Report/Plan, the majority of the measures that have been removed (including NOMS) will continue to be collected and used for program management purposes.

Work on SAMHSA's GPRA measures and other data collection activities is ongoing. SAMHSA is working with internal and external stakeholders on developing appropriate measures of recovery for those with mental or substance use disorders. As these efforts become more defined, the GPRA measures reported in the budget as well as those used for program management may be altered to bring them in line with other cross-cutting efforts.

Support for the HHS Strategic Plan and Other Federal Priorities

SAMHSA data efforts, including GPRA, support many of the priorities of the Secretary and the President. SAMHSA has ongoing activities that relate to each of the Secretarial priorities:

- Transforming Health Care - Through its National Survey on Drug Use and Health, SAMHSA is monitoring the percentage of persons with a mental health or substance use disorder service needs and who have health insurance.

- Advance Scientific Knowledge and Innovation – SAMHSA has established a new Office of Policy, Planning and Innovation to lead cutting edge efforts across SAMHSA and across government.

- Advance the Health, Safety, and Well-Being of the American People - SAMHSA is monitoring trends in mental health and substance abuse disorders. One example is the percentage of youth age 12-20 who report drinking in the past month and taking steps to reduce that percentage to 23.8 percent by 2015 from 27.2 percent in 2009.

- Increase Efficiency, Transparency, and Accountability of HHS programs – SAMHSA is working directly with the HHS Chief Technology Officer to make more SAMHSA data publicly available.

- Strengthen the Nation's Health and Human Services Infrastructure and Workforce – SAMHSA is working with HRSA to examine ongoing technical assistance and training activities and incentives to see if there are more effective and efficient ways of expanding, supporting and reaching the behavioral health workforce.

- SAMHSA is also preparing for implementation of the GPRA Modernization Act of 2010 which endorses improved accountability through quarterly performance data reporting, priority setting and regular senior leadership meetings. SAMHSA is awaiting guidance from OMB and HHS on how this law will be operationalized and has already begun thinking about how to take these new mandates and utilize them internally to improve transparency, accountability and leadership involvement.

SAMHSA is also preparing for implementation of the GPRA Modernization Act of 2010 which endorses improved accountability through quarterly performance data reporting, priority setting and regular senior leadership meetings.

Significant Accomplishments

Over the last several years, SAMHSA has maintained between 58-70 percent target achievement among its GPRA measures published in the budget. The most significant challenge to success was among the FY 2009 and 2010 data. Considering that many of these measures are outcomes (e.g., substance use, housing, and employment) which have been greatly impacted by the economic downturn, SAMHSA has been remarkably successful.

SAMHSA's Strategic Initiatives and a New Vision for Data, Outcomes, and Quality

SAMHSA has spent much of CY 2010 developing and refining a Strategic Plan focusing on eight priorities, which will take SAMHSA and its programs into the future. (See earlier section describing the eight initiatives.) The intent of the Data, Outcomes, and Quality initiative is to realize an integrated data strategy that informs policy, measures program impact, and results in improved quality of services and outcomes for individuals, families, and communities. SAMHSA is:

- Implementing an integrated approach for SAMHSA's collection, analysis, and use of data;

- Creating common standards for measurement and data collection to better meet stakeholder needs;

- Improving the quality of SAMHSA's program evaluations and services research; and

- Improving quality and accessibility of surveillance, outcome/performance, and evaluation information for staff, stakeholders, funders, and policymakers.

This revised approach to data, outcomes, and quality is clearly a work in progress and will require continued discussions into CY 2011 and beyond as SAMHSA's work on this initiative unfolds and as SAMHSA engages in discussions with other HHS agencies and stakeholder groups interested in quality and outcome measurement.

STRATEGIC PLAN

SAMHSA has spent much of CY 2010 developing and refining a Strategic Plan focusing on eight priorities, to guide programmatic, policy, and management decisions and take SAMHSA and its programs into the future. The eight priorities relate to three aims that align with the HHS Strategic Plan, as follows:

Aim: Transforming Health Care in America
Strategic Initiatives (4) Health Care Reform; and (6) Health Information Technology.

Aim: Improving the Nation's Behavioral Health
Strategic Initiatives (1) Prevention of Substance Abuse and Mental Illness; (2) Trauma and Justice; (3) Military Families; and (5) Recover Support.

Aim: Achieving Excellence in Operations
Strategic Initiatives (7) Data, Outcomes and Quality; and (8) Public Awareness and Support.

SAMHSA programmatic activities are guided by these eight priorities and the HHS Strategic Plan. SAMHSA activities support at least one HHS strategic objective; many support more than one.

Many of SAMHSA's activities and its budget for FY 2012 are focused on the first of its eight priorities: the Prevention of Substance Abuse and Mental Illness. Prevention ties closely to the HHS Strategic Plan Objective 3.D, Promote Prevention and Wellness as well as several other objectives including 1.E, 3.A, 3.B, 3.C. The SA and CMHS Block Grants and the majority of the CSAP Innovation and Emerging Issues, including Prevention Prepared Communities, focus on these objectives.

SAMHSA's programs (Safe Schools/Healthy Students, National Traumatic Stress network, Project LAUNCH now included in the Mental Health State Prevention Grant, and Children and Families Programs) focus on Objective 3.A Ensuring the safety, well-being and healthy development of children and youth and are simultaneously being guided by SAMHSA's Trauma and Violence and Prevention initiatives.

SAMHSA recognizes the challenge of serving homeless individuals and understands the incredible need among this population for substance abuse and mental health services. As such, SAMHSA's Recovery Support initiative and ongoing SAMHSA programs addressing services for persons who are or are at risk of being homeless (including Services in Supportive Housing, Grants for the Benefit of Homeless Individuals, an ongoing collaboration with HUD, and the PATH formula grant) support Objectives 1.E, 3.B, and 3.C. SAMHSA further recognizes the changing face of health care service provision and increasing need to modify established programs to meet Health Reform and the development of Health Information Technology. As such, SAMHSA has established initiatives around both of these areas. Programs linked to the Health Reform Initiative are the CMHS and SA Block Grants, the Behavioral Health Community Initiative. Programs impacted by Health IT include an ongoing demonstration project as well as the Block Grants.

Lastly, SAMHSA is working to both improve the outcomes of the people its programs serve through increasing quality of care and more effectively communicating its prevention message through refined Public awareness efforts. The ongoing activities around these two initiatives include health

surveillance, other data collection efforts, information dissemination, and expanding the use of evidence-based practices through technical assistance and training. These programs are closely linked with HHS objectives 2.D, 3.D, 4.C, 5.C.

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

SAMHSA LINKAGES TO HHS STRATEGIC PLAN

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

Table 268: SAMHSA linkages with Goal 1: Transform Health Care

	SAMHSA Strategic Initiatives							
HHS Strategic Objectives	**Prevention of SA/MI**	**Trauma and Justice**	**Military Families**	**Health Care Reform**	**Recovery Support**	**Health IT**	**Data, Outcomes, and Quality**	**Public Awareness and Support**
1.A Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured			X					
1.B Improve health care quality and patient safety	X	X						
1.C Emphasize primary and preventive care linked with community prevention services	X	X		X				
1.D Reduce the growth of health care costs while promoting high-value, effective care					X			
1.E Ensure access to quality, culturally competent care for vulnerable populations	X	X	X	X	X			X
1.F Promote the adoption of health information technology						X		

Table 269: SAMHSA linkages with Goal 2: Advance Scientific Knowledge and Innovation

HHS Strategic Objectives	SAMHSA Strategic Initiatives: Prevention of SA/MI	Trauma and Justice	Military Families	Health Care Reform	Recovery Support	Health IT	Data, Outcomes, and Quality	Public Awareness and Support
2.A Accelerate the process of scientific discovery to improve patient care								
2.B Foster innovation at HHS to create shared solutions								
2.C Invest in the regulatory sciences to improve food and medical product safety								
2.D Increase our understanding of what works in public health and human service practice	X	X		X	X		X	X

Table 270: SAMHSA linkages with Goal 3: Advance the Health, Safety and Well-Being of the American People

HHS Strategic Objectives	SAMHSA Strategic Initiatives: Prevention of SA/MI	Trauma and Justice	Military Families	Health Care Reform	Recovery Support	Health IT	Data, Outcomes, and Quality	Public Awareness and Support
3.A Ensure the safety, well-being, and healthy development of children and youth	X	X			X			X
3.B Promote economic and social well-being for individuals, families and communities	X			X	X			X
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults	X	X		X	X			
3.D Promote prevention and wellness	X		X	X				X
3.E Reduce the occurrence of infectious diseases								
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies	X	X			X			

Table 271: SAMHSA linkages with Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs

	SAMHSA Strategic Initiatives							
HHS Strategic Objectives	**Prevention of SA/MI**	**Trauma and Justice**	**Military Families**	**Health Care Reform**	**Recovery Support**	**Health IT**	**Data, Outcomes, and Quality**	**Public Awareness and Support**
4.A Ensure program integrity and responsible stewardship of resources								
4.B Fight fraud and work to eliminate improper payments								
4.C Use HHS data to improve the health and well-being of the American people							X	
4.D Improve HHS environmental, energy, and economic performance to promote sustainability								

Table 272: SAMHSA linkages with Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce

	SAMHSA Strategic Initiatives							
HHS Strategic Objectives	**Prevention of SA/MI**	**Trauma and Justice**	**Military Families**	**Health Care Reform**	**Recovery Support**	**Health IT**	**Data, Outcomes, and Quality**	**Public Awareness and Support**
5.A Invest in the HHS workforce to meet America's health and human services needs today and tomorrow								
5.B Ensure that the Nation's health care workforce can meet increased demands	X	X		X				X
5.C Enhance the ability of the public health workforce to improve public health at home and abroad	X			X				X
5.D Strengthen the Nation's human services workforce								
5.E Improve national, state, and local surveillance and epidemiology capacity				X				

ADDITIONAL ITEMS

FULL COST TABLE

Methodology: Reporting full cost involves two types of information. First, the full cost for each program is calculated. Second, SAMHSA sums those estimates by each Program's alignment with the HHS Strategic Plan goals and objectives.

Each Program is reporting full cost information using the HHS standard methodology. SAMHSA's application of the methodology involves assigning Program Management dollars across budget lines based upon the number of FTEs directly assigned to the program.

Table 273: SAMHSA program full cost associated with HHS Strategic Goal 1: Transform Health Care (Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2010 Actual	FY 2011 CR	FY 2012 Pres. Budget
1.A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured	0.000	0.000	0.000
1.B: Improve health care quality and patient safety	53.837	53.699	55.468
1.C: Emphasize primary and preventive care linked with community prevention services	65.613	110.102	89.963
1.D: Reduce the growth of health care costs while promoting high-value, effective care	109.768	108.698	106.926
1.E: Ensure access to quality, culturally competent care for vulnerable populations	530.114	530.027	546.094
1.F: Promote the adoption and meaningful use of health information technology	0.000	9.929	4.509
Agency Subtotal for Strategic Goal 1	**759.332**	**812.456**	**802.960**
Agency Total	**3,582.701**	**3,636.959**	**3,649.248**

Table 274: SAMHSA program full cost associated with HHS Goal 2: Advance Scientific Knowledge and Innovation (Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2010 Actual	FY 2011 CR	FY 2012 Pres. Budget
2.A: Accelerate the process of scientific discovery to improve patient care	0.000	0.000	0.000
2.B: Foster innovation at HHS to create shared solutions	0.000	0.000	0.000
2.C: Invest in the regulatory sciences to improve food and medical product safety	0.000	0.000	0.000
2.D: Increase our understanding of what works in public health and human service practice	47.869	47.792	31.494
Agency Subtotal for Strategic Goal 2	**47.869**	**47.792**	**31.494**
Agency Total	**3,582.701**	**3,636.959**	**3,649.248**

Table 275: SAMHSA program full cost associated with HHS Strategic Goal 3: Advance the Health, Safety and Well-being of the American People (Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2010 Actual	FY 2011 CR	FY 2012 Pres. Budget
3.A: Ensure the safety, well-being, and healthy development of children and youth	239.786	240.011	210.635
3.B: Promote economic and social well-being for individuals, families, and communities	19.911	19.917	19.279
3.C: Improve the accessibility and quality of supportive services for people with disabilities and older adults	0.000	0.000	0.000
3.D: Promote prevention and wellness	2,453.719	2,454.018	2,547.174
3.E: Reduce the occurrence of infectious diseases	0.000	0.000	0.000
3.F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies	1.213	1.213	1.259
Agency Subtotal for Strategic Goal 3	**2,714.629**	**2,715.159**	**2,778.346**
Agency Total	**3,582.701**	**3,636.959**	**3,649.248**

Table 276: SAMHSA program full cost associated with HHS Strategic Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs (Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2010 Actual	FY 2011 CR	FY 2012 Pres. Budget
4.A: Ensure program integrity and responsible stewardship of resources	0.000	0.000	0.000
4.B Fight fraud and work to eliminate improper payments	0.000	0.000	0.000
4.C: Use HHS data to improve the health and well-being of the American people	40.242	40.857	13.442
4.D: Improve HHS environmental, energy, and economic performance to promote sustainability	0.000	0.000	0.000
Agency Subtotal for Strategic Goal 4	**40.242**	**40.857**	**13.442**
Agency Total	**3,582.701**	**3,636.959**	**3,649.248**

Table 277: SAMHSA program full cost associated with HHS Strategic Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce (Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2010 Actual	FY 2011 CR	FY 2012 Pres. Budget
5.A: Invest in the HHS workforce to help meet America's health and human service needs today	0.000	0.000	0.000
5.B: Ensure that the Nation's health care workforce can meet increased demands	20.629	20.694	23.007
5.C: Enhance the ability of the public health workforce to improve public health at home and abroad			
5.D: Strengthen the Nation's human service workforce	0.000	0.000	0.000
5.E: Improve national, state, local, and tribal surveillance and epidemiology capacity	0.000	0.000	0.000
Agency Subtotal for Strategic Goal 5	**20.629**	**20.694**	**23.007**
Agency Total	**3,582.701**	**3,636.959**	**3,649.248**

EVALUATIONS INCLUDED IN HHS EVALUATIONS DATABASE FOR FY 2010

Further details on SAMHSA's completed evaluations completed furing any fiscal year can be found at the HHS Policy Information Center website (http://aspe.hhs.gov/pic/performance).

Report Title: Evaluation of the Garrett Lee Smith Youth Suicide Prevention State, Tribal, and Campus Grants

Coordinating Center: SAMHSA's Center for Mental Health Services

Background and Evaluation Questions:
Since being passed into law in 2004, the Garrett Lee Smith Memorial Act has authorized more than $120million to fund community-based suicide prevention initiatives in 65 different States, Tribes, and Territories, and on 78 different college and university campuses. Eighty-six (86) three-year grants have been awarded to States and Tribes, and 93 to campuses. The Cross-site evaluation questions focus on 5 elements of the grant programs: program development and implementation, suicide prevention training, early identification, referral, and follow-up, outreach and awareness, and collaboration and management information systems (MIS) development.

Key Findings:
Program Development and Implementation:

- 98% of grantees engage in outreach and awareness activities.
- Policy and protocol development is being implemented in 88% of State sites, 68% of tribal sites, and nearly 55% of campus sites.
- 46% implement screening activities or tools to identify youths at risk of suicide.
- 17% report a variety of products, services, and activities related to post-intervention.

Suicide Prevention Training:

- As of the end of FY10, 335,653 individuals have received training or participated in an educational seminar sponsored by GLS Campus and State/Tribal grantees.
- The majority of individuals trained through Campus training programs were students (65.8% trainings, 67.7% seminars). Staff members were second (22.1%), followed by family members (9.8%). 32.8% of State/Tribal grantees were teachers and other secondary school staff, and 17.5% were mental health service providers.
- Most State/Tribal trainings occurred in schools (42.7% in primary/secondary schools, and 31.4% in higher education settings).
- Analyses of interviews conducted with 450 participants of GLS training indicate that following training:
    - More than 50% of trainees reported assessing and/or responding to suicide risk.
    - Approximately half of trainees reported that their awareness of the warning signs of suicide had been heightened.
    - Approximately half of trainees reported sharing information with others in order to increase general awareness about suicide and suicide prevention.
    - By 12 months, all respondents reported that they had intervened, directly or indirectly, with an at-risk or suicidal youth.
    - By 12 months, 100% of respondents reported high levels of self-efficacy with regard to their ability to identify and respond to at-risk youths.

Early Identification, Referral, and Follow-up:

- 36 State/Tribal grantees used their funds to support mental health screenings.
- 46 of Campus grantees used in-person or Web-based screening tools.
- As of July, 2010, State/Tribal grantees have tracked data on almost 8,900 at-risk youth.
    - The majority of youths were identified as at risk for suicide through screenings (84.7%) and gatekeepers (55.6%) were identified in school settings.
    - 77.1% of youths identified by gatekeepers and 81.8% through screening received mental health referrals.
    - 47.2% of those youths who did not receive referrals were already receiving mental health services.
    - 65.4% of youths identified as at risk for suicide received mental health referrals.

Outreach and Awareness:

- 89% of grantees created or acquired print and other awareness materials.
- 73% of grantees supported awareness activities, such as Out of the Darkness walks, booths/exhibits, and guest speakers.
- Tribal sites often integrated awareness about suicide prevention into cultural activities.
- 65% of grantees developed or enhanced Web-sites with information about suicide prevention.
- Grantees also used new media such as Twitter, Facebook, MySpace, and YouTube.
- 60% implemented visual or audio media products, including radio ads and PSAs.
- The use of visual or audio media was more common among Tribal grantees (68%) than States (61%) and Campus (58%).
- 97% implemented outreach and awareness products and activities for the entire community.
- 58% developed outreach and awareness products and activities exclusively for youths (including 69% of Campus grantees).
- 88% of grantees reported outreach and awareness efforts directed toward increasing awareness about resources for help and 81% reported efforts for increasing knowledge about warning signs, risk factors, and how to help.
- Nearly 70% of grantees described outreach and awareness efforts aimed at promoting health behaviors (77% among Tribes, 78% among Campuses, 58% among States).

Collaboration and Management Information Systems (MIS) Development:

- 78.5% of State/Tribe grantees reported making referrals to other organizations for youths in need of service.
- 81.8% of State/Tribe grantees reporting having a procedure in place to refer youths who have been identified at risk for suicide. 45.8% have a formal procedure, 36% have an informal procedure and 8.1% have no procedure.
- Campuses have developed their ability to report unduplicated counts of students receiving mental health services from campus counseling centers and other on-campus locations.
- 28 currently funded State/Tribal grantees reported access to epidemiologic data and provided specific examples.

Report Title: Evaluation of the National Suicide Prevention Lifeline and the Crisis Center Follow-Up Grant Program

Coordinating Center: SAMHSA's Center for Mental Health Services

Background and Evaluation Questions:
The National Suicide Prevention Lifeline (Lifeline) is a system of toll-free telephone numbers that routes calls from people in suicidal crisis or emotional distress to a network of 147 local crisis centers. Each month, over 50,000 calls are answered through the Lifeline. Evaluation of the Lifeline is crucial and has resulted in improvements in risk assessment, follow-up on suicidal callers, and is currently starting to assess crisis center follow-up with emergency department discharges. Specifically, the four major aims of the evaluation are to use findings to help crisis centers (1) improve risk assessments by counselors, (2) enhance follow-up services to callers, (3) optimize emergency interventions, and (4) expand linkages and outreach. This has been an iterative process between evaluation findings and practice.

Initial evaluations of the Lifeline found that callers experienced a reduction in hopelessness and suicidal intent during their call. They also showed, however, that **43% of suicidal callers experienced some recurrence of suicidal ideation within the next several weeks**, underscoring the importance of receiving follow-up behavioral healthcare or other appropriate services or interventions. However, the evaluations found that only a minority of suicidal callers had set up an appointment. Upon follow up, only **22.5% of the suicidal callers had been seen by the behavioral healthcare system to which they had been referred** and an **additional 12.6% had an appointment scheduled but had not yet been seen**.

Since FY 2008, two cohorts of six grants each have been funded to promote systematic follow-up of suicidal persons who call the Lifeline. An evaluation of the first cohort is currently being conducted. As of September 30, 2010, 1,626 individuals received Crisis Center Follow-Up grant services. Suicide callers who receive clinical follow-up from a crisis center and who give permission for re-contact by evaluation staff are interviewed by evaluation staff between six weeks and three months after their initial crisis call.

Key Findings:

- Preliminary findings from 423 of the interviews conducted with participants in the Crisis Center Follow-Up evaluation suggest that at the time of their crisis call, many of the callers were at high risk for a suicide attempt.
    - 45.8% of the callers had a current suicide plan;
    - 10% were exhibiting preparatory behavior or an attempt was in progress at the time of the call; and
    - 55.6% reported previous attempts.
- Preliminary findings suggest that the clinical follow-up with callers is providing an invaluable service to these high-risk individuals.
    -
    - When asked to what extent the counselor's call stopped them from killing themselves, ***53.7%*** indicated a lot**,** and ***25.1%***indicated a little;
    - When asked to what extent the counselor call has kept them safe, ***60.8%*** indicated a lot, and ***29.3%***indicated a little; and
    - ***59.8%***reported that just getting or anticipating the call(s)/knowing someone cared was helpful to them.
- Some comments from respondents who reported that call(s) stopped them from killing themselves/kept them safe include the following:

"Yeah it was actually kind of strangely reassuring. I mean, this sounds ridiculous, but I felt really, really alone in the world, and it just felt that someone was out there for me, and they noticed that I needed help. It felt like they cared."

"Just that there was follow-through—when you're suicidal, you don't really feel like anyone cares about you. So when somebody follows through like that, it makes an impression."

"Yeah it made me feel like somebody really did care. It was just a positive thing, it made me feel not just like somebody cared but that someone would continue to look after you, even after the initial crisis is over with. It's a lot more than the caring, it's the stability that it helps you to feel."

"I'm usually the one calling and I feel stupid, whereas she called and I felt cared about."

Report Title: Evaluation of Native Aspirations

Coordinating Center: SAMHSA's Center for Mental Health Services

Background and Evaluation Questions:
The Native Aspirations Project provides mental health assistance to children, youth and their families living on tribal reservations and in Alaska Native villages to (1) decrease the risk factors that contribute to suicide and school violence and (2) increase the protective factors that are linked to the healthy and safe development of children and their families. There are three major objectives for this evaluation: (1) to describe how the communities develop their plans, implement activities, and achieve outcomes; (2) to describe (and as appropriate) determine the key factors that influence program outcomes, and (3) to identify key factors in promoting the sustainability of efforts and outcomes.

Key Findings:

Program Development Activities and Outcomes

- NA Cohort 1 (2005) served 58,980 Tribal members in 6 communities and 2,029 AN in 3 villages.
- NA Cohorts 2 and 3 (2006-7) served approximately 140,408 Tribal members in 14 communities and 733 AN in 2 villages.
- For NA Cohort 1 communities, community readiness scores rose 36%, enabling successful suicide prevention programming. The three communities least ready to implement programs before NA increased readiness to 50–80% during their NA participation.
- Over 750 community members were trained in prevention and mental health promotion in communities serving over 200,000 American Indians and 3,000 Alaska Natives.
- As of May, 2010, 45 communities have joined NA, with 65 anticipated by 2013.
- By the end of the process, each community will have developed a prevention plan using cultural-, evidence-, or practice-based interventions as well as a sustainability plan to continue the efforts beyond their time as a NA Project site.

Factors that Influence Program Outcomes

- The Gathering of Native Americans (GONA) is considered a key activity in addressing issues related to historical trauma, and enabling communities to reach a point where they are able to work together to address current issues of suicide, violence, and bullying prevention. While

GONAs have been conducted in Native communities for over 10 years, this activity has never been evaluated in terms of either process or outcomes. As part of the cross-site evaluation, ICF Macro developed a participant-observation tool that has been used to conduct on-site evaluation of the GONA process, including adherence to the GONA curriculum and a qualitative assessment of the process in general. ICF Macro has conducted participant observation of **3 community GONAs**. Key findings from this include the following:

  - GONA facilitators predominantly adhered to the GONA curriculum, thus ensuring the communication of consistent messages across communities.
  - Key facets to ensuring participation and enthusiasm included utilization of humor, ice-breakers, and interactive activities.
  - The importance of community participation in ensuring a cohesive approach to developing a prevention plan and the ability to work together, successful strategies to maximize attendance included significant advertising of the event, frequent planning meetings, and targeting specific invitations to key community members.

- The Community Researcher/Evaluation Liaison model is critical to building local capacity for evaluation. In this approach, ICF Macro assigns an evaluation staff person to work directly with the community as an evaluation liaison (EL). The EL works with the community to identify a community researcher (CR) – an individual living in the community who is responsible for working with the EL to assist with data collection and obtain training in all evaluation activities and techniques. The EL/CR team work together to collect data through focus groups, surveys, and individual in-depth interviews. The CR receives training in the conduct of qualitative data collection including focus groups and one-on-one in-depth interviews, sampling techniques, and survey implementation. The EL works closely with the CR to identify local data sources that map onto the outcomes developed through the concept mapping process. This approach is key to developing local capacity and ensuring that all evaluation activities are conducted with scientific rigor.

Factors that Promote Sustainability

This program is in its early stages and factors related to sustainability are inappropriate to assess at this stage of the evaluation.

Report Title: Evaluation of the National Child Traumatic Stress Network (NCTSN)

Coordinating Center: SAMHSA's Center for Mental Health Services

Background and Evaluation Questions:

The National Child Traumatic Stress Network (NCTSN) is comprised of over 60 currently and previously funded grantees, who are involved in improving access to care and raising the standard of care for children and families exposed to traumatic events and violence. The cross-site evaluation questions focus on the following elements of the grant program: (1) characteristics of the children and families served by NCTSN centers; (2) impact of the NCTSN-developed interventions on children and their families; (3) characteristics of interventions developed by NCTSN centers; (4) characteristics and impact of training provided by NCTSN centers; (5) level of collaboration among NCTSN centers.

Key Findings:

Characteristics of children served by NCTSN

- Data has been collected from a total of 14,888 children over the course of this evaluation through the descriptive and clinical outcomes study.
- Children served by NCTSN centers have experienced a variety of traumatic events.

- Three trauma types have been reported by the caregivers for greater than 40% of children: domestic violence (48.2%), traumatic loss or bereavement (47.1%), and impaired caregiver (41.4%).
- Emotional abuse or psychological maltreatment (37.3%), physical abuse (27.7%), neglect (26.2%), and sexual abuse (22.1%) were also represented in the trauma history for more than 20% of the children.
- 30% of children were exposed to four or more traumas.

Clinical Outcomes for children receiving services

- Statistically significant decreases have been found overtime in the clinical problems and disorders of children served by NCTSN services.
- Six-month follow-up results include the following.
    - There was a significant decrease in the percentage of children exhibiting PTSD symptoms between the baseline evaluation (67.0%), and the 6-moth follow up (50.4%).
    - Significant declines were also noted in percentages of children with symptoms of depression (from 51.3% at baseline to 38.5% at 6-month follow-up).
    - Similar significant decreases were also observed in the percentages of children with generalized anxiety symptoms (from 46.2% to 38.1%), as well as children with attachment problems (from 40.3% to 33.6%).
- Twelve-month follow-up results include the following.
    - 50.7% of children were within clinical range at baseline based on their CBCL score. This percentage decreased to 29.0% at the 12 month follow-up.
    - The percentage of children with PTSD symptoms within clinical range decreased from 23.0% to 8.5% over the 12-month timeframe.
    - There was a 21.7% decline of behavioral problems at the 12-month timeframe.
    - The percentage of children scoring within the clinical range on the TSCC-A anxiety, depression, anger, and dissociation subscales decreased from 11.6-15.6% to 4.0-6.2% by the 12-month follow-up.

Most commonly used NCTSN-developed interventions

As of the 3-month follow, the children participating in the longitudinal clinical outcomes study were receiving the following evidence-based treatments:

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)-63.8%
- Attachment, Self Regulation, and Competence (ARC)-8.3%
- Child Parent Psychotherapy (CPP)-4.5%
- Parent-Child Interaction Therapy (PCIT)-3.5%
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)-2.5%

Characteristics and Impact of NCTSN Training

- In FY 2009, more than 1,600 individuals have been trained through 60 trainings.
- Psycho-education and clinical interventions were the two most common topics for trainings.
- Since its inception in 2008, over 250 trainings have been implemented and more than 7,500 people have been trained.
- NCTSN provides training to providers in a variety of fields.
    - Mental health providers – 61.7%

    - Child Welfare workers- 13.6%
    - Teachers – 12.4%
    - Childcare Providers – 3.9%
    - Disaster/crisis responders – 2.7%
    - Primary care – 2.5%
    - Faith-based – 2.3%
    - Probation officers – 2.1%
    - Police force – 0.7%
- The results indicate that training participants gained knowledge on new treatments and practices in specialized areas as a result of the trainings. The top five areas in which knowledge was enhanced across training content were as follows:
    - Evidence-based interventions for trauma-exposed children.
    - Overall knowledge about child trauma and its impact.
    - Delivery of clinical interventions to trauma exposed children.
    - Screening for traumatic exposure.
    - Assessment of child traumatic stress.

Collaboration among NCTSN centers

NCTSN centers are involved in many collaborative activities that address the quality of care for traumatized children. Collaborative activities may involve centers partnering to develop and implement new products and interventions or joining interest groups that develop resources such as toolkits, manuals, and informational materials for specific trauma topics or populations. Activities may also include participating in workgroups to develop products or in Learning Collaboratives to increase clinical expertise in particular evidence-based interventions and products.

- Of the key Network activities assessed, the collaboration on product development is the strongest
- Shared interests between NCTSN centers, the willingness of the Network centers to learn and share expertise, and the willingness to participate on workgroup committees and collaborative groups were reported to have greatly enhanced the potential for successful collaboration.
- Major challenges to collaboration included time and resource constraints, long-distance communication between centers, and limited opportunities for face-to-face meetings with staff members from other centers.
- Child welfare, juvenile, justice, education, and health care agencies also collaborate with NCTSN centers for information and referral activities, training, and service coordination.

Report Title: Evaluation of the Safe Schools/Healthy Students Program

Coordinating Center: SAMHSA's Center of Mental Health Services

Background and Evaluation Questions:
The Safe Schools/Healthy Students (SS/HS) Initiative is a unique multiagency response to the goal of using research-based programs and policies to promote safe and effective learning environments for children and youth. Established by Congress in 1999 as a joint program of the U.S. Departments of Education, Health and Human Services, and Justice, SS/HS has helped more than 350 school districts to develop and implement comprehensive plans in collaboration with local mental health, law enforcement, and juvenile justice agencies. The Safe Schools/Healthy Students (SS/HS) national evaluation seeks to quantify the results of the SS/HS Initiative and explore the factors that contributed to the grantees' success. The current 5-year cross-site national evaluation of the SS/HS Initiative encompasses 175 grantees in five successive cohorts that received grants beginning in 2005. The cross-site evaluation questions focus on three elements of the grant program: (1) impact of the program on students and schools; (2) characteristics of SS/HS programs and activities; and (3) level of coordination and service integration among SS/HS partners.

Key Findings:
Program Impact on Students and Schools

- Violent incidents decreased 11 percent.
- Fewer students reported that they had experienced violence (7 percent decrease) or witnessed violence (4 percent decrease).
- Ninety-six percent of school staff said SS/HS had improved school safety.
- More than 90 percent of school staff said SS/HS had reduced violence on campus.
- Almost 80 percent of school staff said SS/HS had reduced violence in the community.
- The number of students receiving school-based mental health services increased 263 percent.
- The number of students receiving community-based mental health services increased 519 percent.
- Almost 90 percent of school staff reported improved detection of mental health problems.
- More than 80 percent of school staff said they saw reductions in alcohol and other drug use.

Characteristics of SS/HS Programs and Activities
Safe Schools/Healthy Students provides communities with the following types of successful programs and services.

- **SafeSchoolEnvironments and Policies**
  - Preparedness plan to address crises in schools (95% of grantees)
  - Security measures for school grounds and facilities (93% of grantees)
  - Reporting on school safety and security incidents (92%)
  - Parental involvement (86%)
  - Student disciplinary policy (98%)
  - School resource officers (
  - Plans to improve school climate
- **Substance use, violence prevention, and early intervention**
  - Social and recreational student activities (88% of grantees)
  - Mentoring (80%)
  - School-wide substance use prevention curricula (99%)

- **Schools and Community Mental Health Services**
  - Screening and assessment (100% of grantees)
  - School-based mental health services (100%)
  - Child and family support services (100%)
  - Referral and follow-up in and outside school (98%)
- **Early Childhood Social and Emotional Development**
  - Screening for developmental milestones and school readiness (96% of grantees)
  - Training of early childhood service providers (86%)
  - Parent and caregiver training and support (100%)
  - Pre- and post-natal home visits by nurses (64%)
- **Supporting and Connecting Schools and Communities**
  - Parental and community involvement 96% of grantees)
  - Staff bullying prevention, discipline, and drug and/or violence prevention training (86%)
  - Family and community involvement in schools
  - Mentoring (80%)
  - Afterschool programs (86%)

Coordination and Systems Integration

- 61% of grantees established processes for identifying and linking students to services
- 66% established processes for sharing data to evaluate activities
- 71% fielded service delivery teams that include members from various systems
- 71% established process for monitoring quality of screening and assessment
- 76% established system for tracking student outcomes
- 97% established system where treatment plans are coordinated/shared across agencies
- 98% established treatment monitoring information system that is shared across agencies

Report Title: Evaluation of the 2008 National Survey of Substance Abuse Treatment Services

Coordinating Center: SAMHSA's Center for Behavioral Health Statistics and Quality

Background:
This report presents results from the 2008 National Survey of Substance Abuse Treatment Services (N-SSATS), an annual census of facilities providing substance abuse treatment. Conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), N-SSATS is designed to collect data on the location, characteristics, and use of alcohol and drug abuse treatment facilities and services throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.

- A total of 14,423 facilities completed the survey. The 13,688 facilities eligible for this report had a one-day census of 1,192,490 clients enrolled in substance abuse treatment on March 31, 2008.
- In the United States, there were 474 clients in treatment per 100,000 population aged 18 and older on March 31, 2008. The rate was highest for persons with both alcohol and drug problems (214 per 100,000 population aged 18 and older), followed by drug problems only (171 per 100,000), and alcohol problems only (89 per 100,000).
- The *total number* of substance abuse treatment facilities remained relatively constant between 2004 and 2008, while the number of clients in treatment increased slightly. The number of facilities increased by 2 percent, from 13,454 facilities in 2004 to 13,688 facilities in 2008. The

number of clients in treatment on the survey reference date increased by 11 percent, from 1,072,251 in 2004 to 1,192,490 in 2008.

- Clients in treatment for both alcohol and drug abuse made up 46 percent of all clients. Clients in treatment for drug abuse only made up 35 percent of all clients. Clients in treatment for abuse of alcohol only made up 19 percent of all clients.
- Thirty-nine percent of all clients in treatment had diagnosed co-occurring substance abuse and mental health disorders.
- Private non-profit organizations operated 58 percent of all facilities and were treating 53 percent of all clients. Private for-profit organizations operated 29 percent of all facilities and were treating 30 percent of all clients. Local governments operated 6 percent of all facilities and were treating 7 percent of all clients. State governments operated 3 percent of all facilities and were treating 4 percent of all clients. The Federal government operated 2 percent of all facilities and was treating 5 percent of all clients. Tribal governments operated 1 percent of all facilities and were treating 1 percent of all clients.
- Outpatient treatment was offered by 80 percent of all facilities, and accounted for 90 percent of all clients in treatment. Residential (non-hospital) treatment was offered by 27 percent of all facilities, and accounted for 9 percent of all clients in treatment. Hospital inpatient treatment was offered by 6 percent of all facilities and accounted for 1 percent of all clients in treatment.

Report Title: Independent Evaluation of the Community Mental Health Services Block Grant

Coordinating Center: SAMHSA's Center for Mental Health Services

Background:
This report presents the findings of an independent evaluation of the Community Mental Health Services Block Grant program (Block Grant). The evaluation used qualitative and quantitative data gathered from FY 2006 State applications and implementation reports, the Uniform Reporting System (URS), and interviews and surveys with State and Federal representatives.

The Block Grant is the principal Federal discretionary program supporting community-based mental health services for adults with serious mental illnesses and children with serious emotional disturbances. To receive a Block Grant award, States must submit an application prepared in accordance with the law for the fiscal year for which the State is seeking funds. The funds awarded are to be used to carry out the State Plan contained in the application; to evaluate programs and services set in place under the Plan; and to conduct planning, administration, and educational activities related to the provision of services under the Plan.

The purpose of the evaluation was to determine whether the Block Grant is effective in encouraging and facilitating development of effective community-based mental health service systems that promote Federal priorities and support recovery and resiliency for adults with serious mental illnesses and children with serious emotional disturbances.

By design, the Block Grant is a flexible source of funding that States can use to meet the unique needs of their community-based mental health systems. In most cases, Block Grant funds are blended with other Federal or State funds or are allocated directly to community-based provider agencies (termed "subrecipients"), where they are combined with other resources. As a result, it is often difficult to draw a direct line from Block Grant funding to a specific outcome. The evaluators sought to capture a combination of quantitative data on outcomes likely affected by Block Grant funding, plus qualitative input from those on the front lines of mental health services in the States who can speak to the impact of the Block Grant from firsthand experience.

This report presents considerable information on the Block Grant, the role it plays in driving change, and the way it fits into the larger context of mental health transformation. The broad lessons, stakeholder recommendations, activities, and specific examples herein may prove useful not only for policymakers and program administrators, but also for the mental health system's other key stakeholders (e.g., service providers, consumers, family members, advocates, etc.).

State and Federal representatives interviewed in the course of the evaluation offered a number of suggestions for improving the Block Grant. Across all recommendations, State and Federal interviewees stressed the importance of involving States and subrecipients to support implementation and ensure that any adjustments are shaped in part by contributions from these important stakeholders.

Following is an overview of the highlights of this independent evaluation of the Block Grant. Taken together, these findings demonstrate that the Block Grant is meeting the requirements of its congressional mandate and has proven effective in helping develop a stronger mental health system both in individual States and nationwide.

Key Findings:

QUESTION 1 – Is the Block Grant being implemented according to congressional intent?

The evaluation indicates that the Block Grant is being implemented according to congressional intent. State and Federal stakeholders reported a high level of collaboration and information exchange that result in the development of effective State Plans serving adults and children with the most serious disorders.

Selected Outcomes
• Nearly 6 million adults and children accessed mental health services through state mental health agencies (SMHAs) in FY 2006. An average of 73 percent of adults and 76 percent of children met the criteria for serious mental illnesses and serious emotional disturbances, respectively. Twenty-three percent of adults and 6 percent of children receiving services had co-occurring mental and substance use disorders.
• All States have State Mental Health Planning and Advisory Councils (Planning Councils). Many Planning Councils played significant roles in statewide planning, advocacy, and outreach efforts that exceed what is required in the Block Grant's authorizing legislation.
• The Block Grant application and guidance encourage States to create comprehensive State Plans that cover the full range of system needs and services for adults and children.
• The regional review process offers an opportunity for States to exchange information, hear about innovative programs or strategies, and learn from the experiences of other States.
• Monitoring site visits allow Federal staff to see Block Grant–funded programs in context and identify opportunities to provide targeted training and technical assistance (TA).
• Training and TA provided to States through the Block Grant expose SMHA staff to promising practices and efficient implementation methods.
• URS data collection and reporting activities have increased the extent to which States are able to comprehensively describe program outcomes and client services, and to identify service gaps.

QUESTION 2 – Is the Block Grant achieving the results it was created to achieve?

The Block Grant, through both its funding design and the application of its legislative requirements, empowers SMHAs to better address the needs of adults and children with serious mental illnesses and serious emotional disturbances. Stakeholders believe that increased funding would provide valuable support for implementation of evidence-based mental health practices, data infrastructure, and TA.

Selected Outcomes
• From 2004 to 2006, the vast majority of consumers of public mental health services said that they were satisfied with adult (84-86 percent) and child (76-79 percent) services.
• Representatives from more than two-thirds of States interviewed credited the Block Grant with contributing to an increase in consumer involvement and use of community- based treatment services, including evidence-based practices; they also credited the Block Grant with decreasing unmet need.
• Eighty-two percent of States reported implementing at least one evidence-based practice in FY 2006. Supported Housing, Supported Employment, and Assertive Community Treatment were the practices most commonly received by adults; Therapeutic Foster Care was the practice most commonly received by children.
• Representatives from more than 50 percent of States interviewed reported leveraging the Block Grant funds to achieve an impact greater than the size of individual State grants would suggest. States also used the Block Grant's Maintenance of Effort (MOE) requirement to protect critical mental health funding from other sources.

QUESTION 3 – Does the Block Grant promotes innovation?

By using Block Grant funds as seed or startup monies, States can demonstrate effectiveness of new or expanded programs, which in turn makes them more effective in seeking additional financial resources such as Medicaid reimbursement or other government funds.

Selected Outcomes
• States have used Block Grant funds to initiate or supplement such promising practices as peer support, jail diversion, suicide prevention, information technology (including telemedicine), self-directed care, and disaster response.
• States have also used Block Grant funds to help build programs around outreach and education, reduction in bias and discrimination, and evaluation and consumer satisfaction, as well as to support programs directed toward rural, transitional, and veteran populations.