DEPARTMENT of HEALTH and HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

FY 2008 Annual Performance Report

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Introduction

This FY 2008 Annual Performance Report provides information on Substance Abuse and Mental Health Services Administration's actual performance and progress in achieving the goals established in the FY 2008 Annual Performance Plan which was published in February 2007.

The goals and objectives contained within this document support the Department of Health and Human Services' Strategic Plan (available at http://aspe.hhs.gov/hhsplan/2007/).

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Message from the Acting Administrator

I am pleased to present the FY 2008 Annual Performance Report for the Substance Abuse and Mental Health Services Administration (SAMHSA). The report represents the monitoring and management of SAMHSA grants in the area of substance abuse prevention, substance abuse treatment, and mental health services programs.

SAMHSA has established a clear vision for its work -- a life in the community for everyone. To realize this vision, the Agency has sharply focused its mission on building resilience and facilitating recovery for people with or at risk for mental or substance use disorders. SAMHSA is gearing all of its resources -- programs, policies and grants -- toward that outcome. Through the use of performance data, SAMHSA can monitor these programs, policies and grants and ensure a life in the community for everyone.

To the best of my knowledge, the performance data reported by SAMHSA for inclusion in the FY 2008 Annual Performance Report is accurate, complete, and reliable.

/Eric Broderick/

Eric B. Broderick, D.D.S., M.P.H.
Acting Administrator
Assistant Surgeon General

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Table of Contents

List of Tables

OAS: Performance Table

Agency Support for the Strategic Plan

Data Source and Validation Tables

Additional Summary Tables

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Summary of Performance Targets and Results

Table 1: Summary of SAMHSA's Performance Targets and Results

Fiscal Year	Total targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2005	55	55	100%	32	58%
2006	73	73	100%	39	53%
2007	91	90	99%	46	51%
2008	118	67	57%	38	57%
2009	140	0			

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Center for Mental Health Services (CMHS)

Mental Health Programs of Regional and National Significance (PRNS)

Suicide Prevention

Table 2: Key Performance Outcomes for CMHS's Suicide Prevention Programs

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.57	Reduce the number of suicide deaths	32,637	April 2009	31,084	April 2010	30,984	April 2011	30,984

[Go to Data Source and Validation for Performance Measures from CMHS's Suicide Prevention Programs]

Table 3: Key Performance Outputs for CMHS's Suicide Prevention Programs

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.58	Increase the number of students exposed to mental health and suicide awareness campaigns on college campuses			Baseline	662,774	662,774	April 2009	662,774
2.3.59	Increase the total number individuals trained in youth suicide prevention: cumulative			Baseline	75,186	97,742	April 2009	127,065

[Go to Data Source and Validation for Performance Measures from CMHS's Suicide Prevention Programs]

SAMHSA's Suicide Prevention portfolio includes campus, state, and tribal activities related to the FY 2004 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.

Baseline data have been reported for both outcome and output measures. The number of suicide deaths (2.3.57) represents national data. The number of individuals trained (2.3.59) includes mental health professionals as well as teachers, police officers, social service providers, advocates, coaches, and other individuals who frequently interact with youth. Data for measure 2.3.57 will not be available until 2011.

Measure 2.3.57 (suicide deaths) was developed as an indicator for the HHS strategic plan based on the long-term goals of SAMHSA.

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

Table 4: Key Performance Outcomes for CMHS's SS/HS Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
3.2.04	Increase the number of children served		1,062,963	1,062,963	1,845,110[1]	1,062,963	2,328,500	2,328,500
3.2.05	Improve student outcomes and systems outcomes: a) Decrease the number of violent incidents at schools 1) Middle schools[2]		30.8%	30%	36.6%	36%	34.4%	34.4%
3.2.06	a) Decrease the number of violent incidents at schools 2) High schools[2]		24.2%	24%	29.8%	29%	23.7%	23.7%
3.2.07	b) Decrease students' substance use 1) Middle schools[2]		16.9%	16%	16%	16%	13.7%	13.7%
3.2.08	b) Decrease students' substance use 2) High schools[2]		35.3%	35%	35%	35%	33%	33%
3.2.09	c) Improve students' school attendance		92.6%	93%	95.1%	93%	93%	93%
3.2.10	Increase mental health services to students and families (Average percentage of students receiving services following a mental health referral)		45.5%	46%	46%	46%	66%	66%

[Go to Data Source and Validation for Performance Measures from CMHS's SS/HS Program]

Table 5: Key Performance Outputs for CMHS's SS/HS Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
3.2.21	Percentage of grantees that provided screening and/or assessments that is coordinated among two or more agencies or shared across agencies			Baseline	66.1%	67.1%	62.4%	68.1%
3.2.22	Percentage of grantees that provide training of school personnel on mental health topics			Baseline	64.4%	65.4%	64.0%	66.4%

[Go to Data Source and Validation for Performance Measures from CMHS's SS/HS Program]

[1] The result for 2007 reported in the FY 2009 Congressional Justification was preliminary. Additional data has been reported by grantees and the final result is reported here.
[2] Successful result is *below* target.

Number of children served (3.2.04): The performance target for this measure was set at an approximate target level. Subsequently, more grants were awarded than anticipated and the number of children served was significantly higher than the target. However, there was no effect on overall program or activity performance. All targets for student outcomes were met in FY 2008. Data is not yet available for the two output measures 3.2.21 and 3.2.22.

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

Table 6: Key Performance Outcomes for CMHS's NCTSI Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
3.2.01	Increase the estimated number of children and adolescents receiving trauma-informed services	50,660	33,910	33,910	31,446	33,910	28,878	16,955
3.2.02	Improve children's outcomes (percent showing clinically significant improvement)	37%	35%	37%	56%	37%	69%	69%
3.2.03	Dollars spent per person served[3]	$497	$741	$480	$774	$774	$948	$718
3.2.23	Increase the unduplicated count of the number of children and adolescents receiving trauma-informed services					Baseline	975	2,925

[Go to Data Source and Validation for Performance Measures from CMHS's Trauma-Informed Services Program]

In FY 2008, the reported estimated number of children receiving services (measure 3.2.01) was 28,878, 15% lower than the projected target of 33,910. This number is down approximately 8% from last year primarily due to the relatively large number of established NCTSN centers that provided direct services that are no longer funded from the FY 2003 Cohort (14 Category 3 centers). Although there have been several new centers added during FY07 (15 sites total, 10 Category 3 sites and 5 Category 2 sites), this decrease in number of children served also reflects: 1) start-up time needed to establish direct services at these new sites, 2) a change in focus of previously funded sites, and 3) the actual number of new centers providing direct clinical services. It should also be noted that this number does not include the more than four thousand children and families served by formerly funded centers that mobilized to respond to natural disasters including Gustav and Ike. Currently this measure is an estimate of clients served based on quarterly reports from grantees. As this does not allow for a true unduplicated count, SAMHSA will be retiring this measure in

[3] Successful result is *below* target.

FY 2011. In FY 2007, CMHS implemented a web-based GPRA data collection system called Transformation Accountability (TRAC) System. The NCTSI began using the TRAC in FY 2008 which ensures the capture of an unduplicated count of children served and a new measure has been added, 3.2.23. In FY 2008, the baseline for this new measure was 975. This result is significantly lower than the estimated number served in measure 3.2.01 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 target for 2009 anticipates significant improvement in compliance with the use of the TRAC system and SAMHSA expects the compliance to continue to improve over time.

The target for improving children's outcomes was exceeded considerably again in FY 2008. The program examined this result, and it appears to be a result of the maturation of the grant program. Targets have been kept at stable levels until additional years of data are obtained to determine whether this outcome will be influenced by a large cohort of new grantees.

Measure 3.2.03 is dollars spent per person served. The efficiency measure simply divides the total dollar amount awarded to grantees by the number who received direct services from those grantees. As discussed above, the number of children served decreased in FY 2008 due to fluctuations in the grant cycle, and that direct service provision may not be a grantee's primary strategy for increasing access of children and their families to trauma-informed interventions. Future targets are based on anticipated fluctuations in the grant cycle. Since this measure utilizes the current estimated client count, SAMHSA intends to retire it in FY 2011 and replace it with a new cost per client measure which would include an unduplicated count of number served in the denominator.

Remaining Capacity Programs[4]

Table 7: Key Performance Outcomes for CMHS's Remaining Programs of Regional and National Significance: Capacity Programs

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.01	Rate of consumers reporting positively about outcomes (State mental health system)	71%	71%[5]	74%	71%	72%	Sept 2009[6]	Retiring
1.2.02	Rate of family members reporting positively about outcomes (State mental health system)	73%[5]	73%[5]	71.5%	65%	73%	Sept 2009[6]	Retiring
1.2.03	Rate of consumers reporting positively about perception of			Baseline	98%[8]	98%	94.8%	98%

[4] Includes Jail Diversion, Older Adults, HIV/AIDS, and Services in Supportive Housing programs.
[5] Corrected from previously reported result
[6] This measure will be discontinued after 2008 reporting. It is no longer a PART measure.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
	care (program participants)[7]							
1.2.05	Increase the percentage of clients receiving services who report improved functioning			Baseline	93%[9]	93%	50.5%	54%
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 (FY 2015 target 50%)	44%						

[Go to Data Source and Validation for Performance Measures from CMHS's Remaining Capacity Programs]

Table 8: Key Performance Outputs for CMHS's Remaining Capacity Programs

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.06	Number of a) evidence based practices (EBPs) implemented	3.9 per state[10]	3.9	3.8	4.0	4.0	Dec 2009	4.0
1.2.08	b) Adults: percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice)	9.7%[10]	9.5%	10.8%	9.4%	10.8%	Dec 2009	10.8%
1.2.09	c) Children: percentage of population coverage for each (reported as percentage of service population receiving any evidence based practice)	3.4%[10]	2.2%	2.6%	3.2%	2.6%	Dec 2009	2.6%

[Go to Data Source and Validation for Performance Measures from CMHS's Remaining Capacity Programs]

[7] Measure has been changed with OMB approval from Rate of consumers/family members reporting positively about outcomes (program participants). CMHS dropped measure 1.2.04 and change measure 1.2.03 to "Rate of consumers reporting positively about perception of care."
[8] Due to the implementation of the TRAC reporting system midyear FY 2007, data reported for FY 2007 will only contain a partial year.
[9] 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.
[10] National average of evidence-based practices per state, based on 35 states reporting. Excludes Medication Management and Illness Self-Management which, continue to undergo definitional clarification.

Measures 1.2.01 and 1.2.02 represent the results for the *nationwide public mental health system*, as reflected in data from the Uniform Reporting System, and includes people receiving services in state psychiatric hospitals as well as those receiving services through community mental health programs. The performance target for consumers and family members reporting positively about outcomes were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance These measures will be retired in 2010 as they were included in the 2005 PART review as temporary measures until the PRNS was able to produce data from TRAC.

Measures 1.2.03, although worded identically to the long-term measure, reflects results for *participants in CMHS PRNS service programs*. Baseline data for consumers has been reported. The target for FY 2008 was missed slightly.

Measure 1.2.05 is to increase the percentage of clients receiving services who report improved functioning. In December 2007, the TRAC reporting capability was incomplete. Once the system was completed, SAMHSA noted that the earlier manual calculation was done incorrectly which accounts for the missing the target by 42.5%. The correct formula is now programmed into the reporting system, which should minimize future reporting errors. A new target will be set accordingly.

Measure 1.2.08 is the percentage of adult service population receiving any evidence-based practice. The evidence-based practices measures reflect the program's efforts to improve the efficiency and effectiveness of mental health services. The efficiency measure was exceeded. For FY 2007, the target for the number of evidence-based practices was exceeded. The evidence based practice percentage of coverage for adults was missed by just 1.0 percent and for children; the target was missed by just two-tenths of one percent. These targets were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Co-Occurring State Incentive Grants(COSIG)

Table 9: Key Performance Outcomes for CMHS's COSIG Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.18	Increase the percentage of treatment programs that a) Screen for co-occurring disorders					Baseline	68%	68%
1.2.19	b) Assess for co-occurring disorders					Baseline	32%	32%
1.2.20	c) Treat co-occurring disorders through collaborative, consultative,					Baseline	53%	53%

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
	and integrated models of care.							

[Go to Data Source and Validation for Performance Measures from CMHS's Co-Occurring State Incentive Grant Program]

Table 10: Key Performance Outputs for CMHS's COSIG Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.17	Increase the number of persons with co-occurring disorders served.					Baseline	103,679	103,679

[Go to Data Source and Validation for Performance Measures from CMHS's Co-Occurring State Incentive Grant Program]

This program is jointly administered by CMHS and CSAT.

The first three years of these grants focus on infrastructure development and enhancements. After this period, grantees may implement service pilot programs, which will generate data for the above outcome measures. Approval for the performance measures for this program were obtained January 2007. In July, COSIG States were required to begin collecting the necessary data, with the first reports due in October 2008. FY 2008 is the first year the data is available and baselines have been established. Data is being collected from grantees through CSAT's SAIS system.

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

Table 11: Key Performance Outcomes for CMHS's CMHI Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
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[11] (FY 2010 target 60%)							
3.2.12	Improve children's outcomes	80.2%	89.7%	84%	87%	84%	86.3%	86.3%

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

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
	and systems outcomes: a) Increase percentage attending school 80% or more of time after 12 months[12]							
3.2.13	b) Increase percentage with no law enforcement contacts at 6 months	68.3%	69.3%	70%	71%	69%	71.7%	71.7%
3.2.14	c) Decrease average days of inpatient facilities among children served in systems of care at 6 months[13]	-1.75	-1.00	-2.00	-1.78	-2.00	-1.05	-2.00
3.2.15	Percent of systems of care that are sustained 5 years post Federal Funding (FY 2013 target 90%)					80%	77.8%	85%
3.2.17	Increase total savings for in-hospital patient care costs per 1,000 children served[14]		$1,335,000	$2,670,000	$2,376,000	$2,670,000	$1,401,750	$2,376,0 00

[Go to Data Source and Validation for Performance Measures from CMHS's Comprehensive Community Mental Health Services for Children and Their families]

Table 12: Key Performance Outputs for CMHS's CMHI Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
3.2.16	Increase number of children receiving services	9,200	10,339	9,120	10,871	10,000	13,051	13,051

[Go to Data Source and Validation for Performance Measures from CMHS's Comprehensive Community Mental Health Services for Children and Their families]

The FY 2008 target for school attendance, measure 3.2.12, was set at an approximate level, and the deviation from that level is slight. The target was exceeded by 2.3 percent. Targets have been maintained level for a number of reasons: Grantees vary in the populations they serve, and those grantees that serve high-risk and/or older children may be less able to achieve these high levels of school attendance. Performance for this measure will vary somewhat depending on the mix of grantees and individuals served in any given year. Performance on this measure has fluctuated over the last four years with no clear trend.

[12] 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.
[13] 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).
[14] Wording for this measure has changed slightly to make the measure more clear.

The FY 2008 target for no law enforcement contact (3.2.13) was set at an approximate level, and the deviation from that level is slight. The FY 2008 target was exceeded by 2.7%. However, grantees vary in the populations they target, and those grantees that serve youth in the juvenile justice system may be less able to achieve reductions in law enforcement contacts. Performance for this measure will vary somewhat depending on the mix of grantees and individuals served in any given year. The FY 2008 and 2009 targets are set at approximately the average performance level of the last four years.

The performance target for reduction in days of inpatient care (3.2.14) was set at an approximate target level. The FY 2008 target was not achieved. This can be partially explained by the variation in level of utilization of inpatient services prior to program intake across fiscal years. If the average utilization prior to program intake is relatively low, then the decreases in average number of days per child that can be achieved by the program will be low as well. When *percentage* change in use is examined, the percentage decrease in FY 2008 (66%) is greater than the percentage decrease achieved in FY 2007 (62%), demonstrating a positive change in the grantees' ability to reduce the utilization of inpatient care.

Grantees funded in FY 2005 serve proportionately larger numbers of very young children who generally have shorter and less frequent hospitalizations. Given this change in populations served, and the sensitivity of the measure to the length of hospitalization *prior to service intake*, the targets for this measure remain stable through 2009.

The efficiency measure reflects per-unit savings in costs. The wording of the measure was changed to better reflect the intent of this measure (total in-hospital cost savings). The FY 2008 target for reduction in costs of inpatient care was not met. Although one of the main goals of the program is to provide least restrictive services to children and youth served by the grantees, more restrictive services, like inpatient hospitalization, which are also among the most expensive to provide, are sometimes required. This measure is also reflective of the variability of each cohort of grantees' utilization of in-hospital care services. Although alternatives to in-hospital care are used by CMHI systems of care whenever possible, this level of care may be necessary for some children. The 2008 result is tied to the reduction in in-hospital days as reported in measure 3.2.14; both of the 2008 targets were not met but did exceed the percentage decrease baseline set in FY 2007.

The long-term sustainability indicator (3.4.15) was estimated using data from the nine communities funded in 1997. The target of 80% was nearly achieved, with 78% of communities funded in 1997 (7 out of 9) achieving sustainability 5 years past the cessation of federal grant funding. The two communities whose systems of care were not sustained were both Tribal communities which, historically, have had limited access to Federal funding alternatives which promote the sustainability of programs.

The data on whether communities were sustained were collected through a Web-based survey administered to four key stakeholders in each grant community (e.g., the current or former site project director, a key person responsible for children's mental health in the community, a family member, and a representative from another child-serving agency). A community was defined as sustained if the community retained flexible funds and sustained at least 50% of non-restrictive services, 50% of system-of-care features and mechanisms, and 50% of system of care goals. The definition accounts for changes in both the (a) system of care relative to the grant period and (b) the absolute level at which the system of care operates 5 years post-funding.

The FY 2008 target for the number of children served (3.2.16) was exceeded by over 30%, reflecting a level of effort by grantee communities and a greater need for services. The 2008 target for the program was ambitious given that the program was funded at roughly the same level in FY 2008 as in the prior two years and costs for services are increasing annually. In 2008, 16 grantees completed their grant funding cycle and CMHS awarded 18 new grants. The first year of the grant is a planning year, and grantees do not enroll children in services, Numbers served are expected to decline through 2009 and rise beginning in 2010.

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

Table 13: Key Performance Outcomes for CMHS's PAIMI Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
3.4.08	Increase percentage of complaints of alleged **abuse** and not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement (FY 2013 target 88%)	78%	84%	85%	83%	84%	July 2009	84%
3.4.09	Increase percentage of complaints of alleged **neglect** substantiated and not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement (FY 2013 target 94%)	83%	88%	84%	88%	85%	July 2009	85%
3.4.10	Increase percentage of complaints of alleged **rights violations** substantiated and	87%	85%	90%	86%	90%	July 2009	90%

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
	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 (FY 2013 target 95%)							
3.4.11	Percent of interventions on behalf of groups of PAIMI-eligible individuals that were concluded successfully (FY 2013 target 95%)		95%	95%	97%	95%	July 2009	95%
3.4.12	Increase in the number of people served by the PAIMI program	21,371	18,998	23,500	18,694	22,325	July 2009	22,325
3.4.13	Ratio of persons served/impacted per activity/intervention	411	407	420	473	420	July 2009	420
3.4.14	Cost per 1,000 individuals served/impacted[15]	$2,072	$2,316	$2,000	$1,989	$2,000	July 2009	$2,000

[Go to Data Source and Validation for Performance Measures from CMHS's Protection and Advocacy for Individuals with Mental Illness Program]

Table 14: Key Performance Outputs for CMHS's PAIMI Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
3.4.19	The number attending public education/ constituency training and public awareness activities			Baseline	119,423	120,000	Oct 2009	120,000

[Go to Data Source and Validation for Performance Measures from CMHS's Protection and Advocacy for Individuals with Mental Illness Program]

Measure 3.4.08 is to increase percentage of complaints of alleged abuse and not withdrawn by the client that resulted in positive change for the client in her/his environment, community, or facility, as a result of PAIMI involvement (same as long-term measure). The FY 2007 target was missed by 2%. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

[15] Succesful result is *below* target

Measure 3.4.09 is the percentage of cases of alleged neglect resolved in client's favor. The FY 2007 target was exceeded.

Measure 3.4.10 is the percentage of cases of alleged rights violations resolved in client's favor. The FY 2007 target was not met. Using what appears to have been an atypical outcome for FY 2004, the targets set for this measure were overly ambitious for FY 2005 (95%) and FY 2006 (95%) as demonstrated by the actuals for FY 2005 (87%) and FY 2006 (85%) and FY 2007 (86%). Targets for FY 2008 – 2009 are still ambitious at 90% compared to the 4-year average of 86%.

Measure 3.4.11, the percentage of interventions on behalf of groups of PAIMI-eligible individuals that were concluded successfully, was exceeded.

Measure 3.4.12, is to increase in the number of people served by the PAIMI program. The FY 2007 target was not met. This measure is the most volatile because of the number of factors that can influence the outcome. Part of this volatility is inherent in the nature of the PAIMI Program which includes both an individual case and systemic focus. This balance shifts over time from a more individual case emphasis to a more systemic emphasis not only within individual programs but nationally across all programs as well. Also, the case-mix can impact this outcome, as individuals with more complex and extensive needs will require more time and resources which will reduce the total number of persons that can be served. Finally, although the program does education and outreach, the number of persons served is ultimately determined by the number of persons who seek services which may vary over time. Because of all of these factors, the targets for FY 2008 – 2009 have been maintained at 22,325, which is still well above the 4-year average of 21,059.

Both efficiency measures exceeded their targets for FY 2007 (3.4.13 ratio of persons served/impacted per activity/intervention and 3.4.14, Cost per 1,000 individuals served/impacted).

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

A baseline was set for measure 3.4.19, the number attending public education/ constituency training and public awareness activities, in FY 2007. An FY 2009 target has been established at 120,000.

Projects for Assistance in Transition from Homelessness (PATH)

Table 15: Key Performance Outcomes for CMHS's PATH Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
3.4.15	Increase the percentage of enrolled homeless persons who receive community mental health services (FY 2013 target 50%)	41%	38%	45%	37%	45%	July 2009	46%
3.4.16	Increase number of homeless persons contacted	148,679	148,655	157,500	142,352	150,000	July 2009	151,000
3.4.17	Increase percentage of contacted homeless persons with serious mental illness who become enrolled in services (FY 2010 target 45%)	48%[16]	52%[16]	45%	55%[16]	55%	July 2009	55%
3.4.18	Average Federal cost of enrolling a homeless person with serious mental illness in services[17]	$668[18]	$623	$668	$674	$668	July 2009	$668

[Go to Data Source and Validation for Performance Measures from CMHS's Projects for Assistance in Transition from Homelessness]

Table 16: Key Performance Outputs for CMHS's PATH Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
3.4.20	Number of PATH providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits.					Baseline	4,927	4,927

[16] 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

[17] Successful result is *below* target.

[18] Actuals for FY 2005 are different from those reported in previous Congressional justifications. The previous figure, $950 for FY 2005, were calculated incorrectly

[Go to Data Source and Validation for Performance Measures from CMHS's Projects for Assistance in Transition from Homelessness]

Measure 3.4.15 reflects the PATH program's legislative intent that it will provide a link to, and depend upon, community-based services, particularly mental health services, funded primarily by States. An analysis of data for this measure indicated that some States were performing poorly on this measure. As a result, the FY 2007 target was not met. In response, the PATH TA Center determined that many States do not accurately collect information about the number of persons who receive community mental health services. The PATH TA Center has begun providing on-site and online assistance to help programs better understand how to report on this measure. A new long-term target for FY 2013 has been set at 50%.

In addition, SAMHSA awarded a contract in FY 2008 to begin working with states to utilize the Department of Housing and Urban Development Homeless Management Information System (HMIS) to assist in obtaining individual level outcome data from PATH-funded efforts. In FY 2009 the program will redesign the PATH Annual Report. This process will enable the program to transition the report to a more outcome-based reporting system that is responsive to the needs of SAMHSA as well as the PATH providers, reflect real consumer outcomes, and will complete the program's alignment with HMIS data elements.

The target for Measure 3.4.16 was not met for FY 2007. The number of individuals served is a key measure for SAMHSA programs that fund services. At this time, the PATH program only collects information on the percentage of persons served with PATH funds. The PATH program is planning to request permission to collect data on all persons served using both Federal and match funds. As part of its data collection package renewal of the PATH data collection tool in 2009, the program will redesign it to collect data on all services provided with PATH Federal and matching funds. Currently the report requires providers to report on only the proportion of services provided with PATH Federal funds. Our analysis of the data indicates that there are inconsistencies in how this is applied and that we are missing critical information on services delivered. We believe that the provision of a full instead of a partial report will improve the quality of the data and improve the measures for the program. Using the Federal-only calculation is an incomplete indicator for performance as the States serve more PATH-eligible consumers than is currently being reported.

The target for the PATH efficiency measure (3.4.18) was not met for FY 2007. This measure will also be affected by the proposed change to collect information on all persons served and not just persons served by Federal PATH funds. The current calculation uses the Federal appropriation divided by the number of persons served by Federal PATH funds only. Because the current data only includes the number of persons served with Federal funds, this measure is currently reported as the total cost, Federal and match, of enrolling a person in services. If programs begin to report information on all persons served, PATH

will be able to accurately capture the Federal cost per person served in addition to the total cost per person served.

Community Mental Health Services Block Grant (MHBG)

Table 17: Key Performance Outcomes for CMHS's MHBG Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.07	Reduce rate of readmissions to State psychiatric hospitals adults and children within 30 days; and, within 180 days: 1) Adults: a) 30 days[19]	9%	9.4%	8.7%	9.8%	8.5%	Sept 2009	8.5%
2.3.08	1) Adults: b) 180 days[19]	19.6%	19.6%	19.1%	20.3%	19.0%	Sept 2009	19.0%
2.3.09	2) Children/adolescents: a) 30 days[19]	6.6%	6.4%	5.9%	6.7%	5.8%	Sept 2009	5.8%
2.3.10	2) Children/adolescents: b) 180 days[19]	14.5%	14.2%	14.0%	15.3%	13.9%	Sept 2009	13.9%
2.3.15	Increase rate of consumers/family members reporting positively about outcomes (a) Adults	71%	71%	73%	71%	72%	Sept 2009	73%
2.3.16	(b) Children/ adolescents	73%	73%	68%	65%	73%	Sept 2009	73%
2.3.17	Number of persons receiving evidence-based practices per $10,000 of mental health block grant dollars spent	3.95	5.7	4.03	6.5	4.03	Sept 2009	6.5

[Go to Data Source and Validation for Performance Measures from CMHS's Community Mental Health Services Block Grant Program]

Table 18: Key Performance Outputs for CMHS's MHBG Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.11	Number of a) evidence based practices (EBPs) implemented[20]	3.9 per state	3.9	3.9	4.0	4.0	Sept 2009	4.0
2.3.12	b) Adults - percentage of population coverage for each (reported as percentage of	9.7%	9.5%	10.4%	9.4%	10.5%	Sept 2009	10.5%

[19] Successful result is performance *below* target.
[20] 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

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
	service population receiving any evidence based practice)[21]							
2.3.13	c) Children - percentage of population coverage for each (reported as percentage of service population receiving any evidence-based practice)[21]	3.4%	2.2%	3.4%	3.2%	3.5%	Sept 2009	3.5%
2.3.14	Increase number of people served by the public mental health system	5,878,035	5,979,379	5,753,633	6,121,641	6,200,000	Sept 2009	6,250,000

[Go to Data Source and Validation for Performance Measures from CMHS's Community Mental Health Services Block Grant Program]

Measure 2.3.07 is to reduce the rate of readmissions to State psychiatric hospitals for adults within 30 days. The FY 2007 target was not met. Readmission rates were slightly above target levels. It appears that the initial targets for FY 2003 – FY 2005, which were set from the FY 2002 baseline, may have been too ambitious since the targets have not been met in any of the previous fiscal years. In response to the unexpected level of difficulty experienced by the States in reducing these rates, the target for FY 2006 was increased to 8.3%, but this also proved to be too ambitious. FY 2009 targets have been increased to allow time for states to make adjustments to service planning in response to the existing rates.

Measure 2.3.08 is the readmission rate for adults within 180 days. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

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

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

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

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

The evidence-based practices measures reflect the program's efforts to improve the efficiency and effectiveness of mental health services. The efficiency measure was exceeded (2.3.17). For FY 2007, the target for the number of evidence based practices was exceeded (2.3.11). The evidence based practice percentage of coverage for adults (2.3.12) was missed by just one percent and for children (2.3.13) the target was missed by just two-tenths of one percent. These targets were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance

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

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Center for Substance Abuse Prevention (CSAP)

Prevention Programs of Regional and National Significance (PRNS) – Capacity

Strategic Prevention Framework-State Incentive Grants (SPF-SIG)

Table 19: Key Performance Outcomes for CSAP's SPF-SIG Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.19	30-day use of alcohol among youth age 12-17 (FY 2013 target 15%)	18.6%						
2.3.20	30-day use of other illicit drugs age 12 and up (FY 2013 target 5%)	8.6%						
2.3.21	Percent of SPF-SIG States showing a decrease in state level estimate of percent of survey respondents who report 30-day use of alcohol a) age 12-20			Baseline	47.1%	51.8%	47.1%	51.8%
2.3.22	b) age 21 and up			Baseline	29.4%	32.3%	41.2%[22]	32.3%
2.3.23	Percent of SPF-SIG states showing a decrease in state level estimates of survey respondents who report 30-day use of other illicit drugs a) age 12-17			Baseline	55.9%	61.5%	55.9%	61.5%
2.3.24	b) age 18 and up			Baseline	44.1%	48.5%	29.4%[22]	48.5%
2.3.25	Percent of SPF-SIG states showing an increase in state level estimates of survey respondents who rate the risk of substance abuse as moderate or great a) age 12-17			Baseline	73.5%	80.9%	50.0%	80.9%
2.3.26	b) age 18 and up			Baseline	47.1%	51.8%	29.4%	51.8%
2.3.27	Percent of SPF-SIG states showing an increase in state level estimates of survey respondents (age 12-17) who somewhat disapprove or strongly disapprove of substance use			Baseline	79.4%	87.3%	67.6%	87%

[22] Data revised from previously reported.

[Go to Data Source and Validation for Performance Measures from CSAP's Strategic Prevention Framework State Incentive Grant Program]

Table 20: Key Performance Outputs for CSAP's SPF-SIG Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.28	Number of evidence-based policies, practices, and strategies implemented: cumulative			Baseline	396	470	781	1166
2.3.29	Percent of grantee States that have performed needs assessments	100%	92.3%	100%	100%	100%	100%	100%
2.3.30	Percent of grantee States that have submitted State plans	28%	92.3%	85%	96.2%	100%	95.2%[23]	95.2%
2.3.31	Percent of grantee States with approved plans	9%	69.2%	85%	88.5%	100%	85.7%[23]	85.7%

[Go to Data Source and Validation for Performance Measures from CSAP's Strategic Prevention Framework State Incentive Grant Program]

The SPF-SIG grantees met or exceeded their FY 2008 outcome/output targets on three measures. These included Measure 2.3.22, the percent of SPF-SIG states showing a decrease in state level estimate of percent of survey respondents who report 30-day use of alcohol for ages 21 and up and Measure 2.3.28 on number of evidence-based programs implemented. They also met their target on Measure 2.3.29 on percent of States that performed their needs assessments. However they failed to meet their targets for the other measures. These failures resulted from a variety of methodological and statistical issues. SPF-SIG grantees are required to go through multiple stages of the SPF process before they begin implementing services. These initial steps lead to a lag between the time the grants are awarded and community change is observable. Also, there is a time lag time in the availability of NSDUH data used to populate these measures. The data used to determine the percent of States improving on each measure are from 2004/2005 and 2005/2006. Since the initial Cohort 1 grantees were funded in 2005, these data cannot reflect actual SPF-SIG impacts. Lastly, State-level percentages of use and non-use are affected by numerous factors external to prevention programs, such as state-level demographic and socioeconomic changes.

Targets for some of the outcome measures are lower for 2009 because they include both earlier and later cohorts of SPF-SIG states. The earlier cohorts will have completed these steps, but the later cohorts are just beginning the Strategic Prevention Framework implementation process. Cohort 1 (21 States) was funded at the end of FY 2004 while Cohort 2 (5 States) was funded in FY 2005.

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

All States in Cohorts 1 and 2 have now funded sub-recipient communities. Cohort 3 (16 total, including 5 tribes and one jurisdiction) was funded in September 2006.

The impact of this program is already being felt throughout the States. For example, 51 States now use SPF or the equivalent for conducting needs assessments, 53 for building State capacity; 53 for planning; 43 for program implementation and 29 States use SPF or the equivalent for evaluation efforts.

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

Table 21: Key Performance Outcomes for CSAP's HIV Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.35	Percent of program participants that rate the risk of substance abuse as moderate or great a) age 12-17		88.6%	89.0%	87.6%[24]	75.8%	Aug 2009	76.6%
2.3.38	Percent of program participants that rate the risk of substance abuse as moderate or great b) age 18 and up			Baseline	94.4%[24]	84.2%	Aug 2009	85.1%
2.3.39	Percent of participants who used alcohol at pre-test who report a decrease in use of alcohol at post-test (user decrease): a) age 12-20			Baseline	74.4%	75.1%	Aug 2009	76.6%
2.3.40	b) age 21 and up			Baseline	59.0%	59.6%	Aug 2009	60.8%
2.3.41	Percent of participants who report no alcohol use at pre-test who remain non-users at post-test (non-user stability): a) age 12-20			Baseline	92.5%	93.4%	Aug 2009	95.3%
2.3.42	b) age 21 and up			Baseline	89.3%	90.2%	Aug 2009	92.0%
2.3.43	Percent of participants who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (user decrease): a) age 12-17			Baseline	89.6%	90.5%	Aug 2009	92.3%
2.3.44	b) age 18 and up			Baseline	68.5%	69.2%	Aug 2009	70.6%

[24] Final FY 2007 result. Data in the 09CJ was preliminary.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.45	Percent of participants who report no illicit drug use at pre-test who remain non-users at post-test (non-user stability): a) age 12-17			Baseline	92.1%	93.0%	Aug 2009	94.9%
2.3.46	b) age 18 and up			Baseline	91.8%	92.7%	Aug 2009	94.6%
2.3.47	Percent of program participants (age 12-17) who somewhat disapprove or strongly disapprove of substance use			Baseline	70.3%[25]	81.0%	Aug 2009	82.8%
2.3.56	Number of individuals exposed to substance abuse/hepatitis education services			Baseline	2,260	2,283	Aug 2009	2,305

[Go to Data Source and Validation for Performance Measures from CSAP's Programs of Regional and National Significance: Other Capacity Activities: Minority AIDS Initiative]

Table 22: Key Performance Outputs for CSAP's HIV Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.48	Number of evidence-based policies, practices, and strategies implemented by HIV program grantees: cumulative			Baseline	162	243	Aug 2009	394
2.3.70	Cost per participant improved on one or more measures between pre-test and post-test					Baseline	$22,189	$20,167

[Go to Data Source and Validation for Performance Measures from CSAP's Programs of Regional and National Significance: Other Capacity Activities: Minority AIDS Initiative]

The goal of the HIV cohort 6 program is to increase the capacity of communities serving the target populations to deliver evidence-based substance abuse prevention, HIV and Hepatitis prevention services. This program was redesigned to incorporate the Strategic Prevention Framework model.

The program is implementing SAMHSA's National Outcome Measures, including an approved efficiency measure (2.3.70) and a new measure on the number of individuals exposed to substance abuse/hepatitis education services, to illustrate the performance of outreach and numbers served. Cohort 6 began serving participants during FY 2007. Other measures reflect use for both those who had used drugs before entering the program and those who had not. These measures require person-level matched data to assess person-level program

[25] Final FY 2007 result. Data in the 09CJ was preliminary.

outcomes on non-user stability and user decrease to assess "improvement." These matched data apply to clients who have participated in prevention interventions lasting at least 30 days. Change is assessed by following each client from program entry to program exit and to 3 to 6 months follow-up. These matched data will be reported in August 2009.

SAMHSA received approval for a new cost efficiency measure in FY 2008 based on "improvement" at the participant level. This measure is defined as the total cost of the HIV program divided by the number of participants who improved. A program participant is considered "improved" if baseline-to-exit comparisons indicate improvement on at least one NOM or non-user stability on at least one 30-day substance use measure and no worse on any other NOM. This measure replaces the previous measure which was based on the assumption that the cost of 50% of the services fell within specified dollar values for each program type. For the HIV cohort 6 program, cost per improved participant was $22,189. Since estimating the number of persons served by environmental strategies is extremely difficult, the cost per client calculation includes only those directly served by the program resulting in a significant overestimation in the cost per person served. SAMHSA is working on ways to better estimate the number served by environmental strategies and hopes to include these persons in the cost per client measure in the future.

Given these substantial program changes, we have had to establish new baseline measures for FY 2008. However, we will not be able to assess progress on them until FY 2009 in August, when we will be able to report actual HIV cohort 6 data. The time lag allows for complete online submission of grantee data and time for required cleaning and analysis.

Prevention Programs of Regional and National Significance (PRNS) – Science and Service

Centers for Application of Prevention Technologies (CAPT)

Table 23: Key Performance Outcomes for CSAP's CAPT Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.33	Increase the percent of clients reporting that CAPT services substantively enhanced their ability to carry out their prevention work		70%	75%	92%	88%	94%	Retiring

[Go to Data Source and Validation for Performance Measures from CSAP's Programs of Regional and National Significance: Science and Service Activities]

Table 24: Key Performance Outputs for CSAP's CAPT Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.32	Increase the number of persons provided TA services	28,160	28,123	32,000	24,121	22,800	19,362	Retiring

[Go to Data Source and Validation for Performance Measures from CSAP's Programs of Regional and National Significance: Science and Service Activities]

Ninety-two percent of CAPT program recipients reported that their ability to carry out their prevention work was enhanced by the training, exceeding the target of 88% by 6 percentage points. The FY 2008 target was ambitious given that it was considerably higher than the previous year's data of 75%. The CAPT's service delivery approach shifted in 2007 in accordance with CSAP's mission to focus more on providing substantive technical assistance services designed to enhance the systemic capacity of prevention systems to implement the Strategic Prevention Framework. The positive result reflects the success of this approach.

The FY 2008 figure for the number of persons served is 19,362, which is lower than the target of 22,800 person-contacts by 3,438. The CAPT approach shifted from providing general training services to a more customized training-of-trainers (TOT) approach designed to enhance the systemic capacity of state training systems. These TOT events generally have fewer participants participating in longer, more intensive events. The intent is that these participants will eventually extend the reach of CAPT services by providing additional training on the Strategic Prevention Framework within their States. The number of individuals receiving Technical Assistance within their States from these CAPT-trained trainers is not captured in these figures.

Substance Abuse Prevention and Treatment Block Grant – 20% Prevention Set-Aside

Synar Amendment Implementation Activities

Table 25: Key Performance Outcomes for CSAP's Synar Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.49	Increase number of States whose retail sales violations is at or below 20%	50	52	52	52	52	52	52
2.3.62	Number of States reporting retail tobacco sales violation rates below 10%			Baseline	25[26]	28	26	29

[Go to Data Source and Validation for Performance Measures from CSAP's SAPTBG: Synar Amendment Implementation Activities]

[26] FY 2007 Actual was inadvertently reported as 27 (the FY 2006 Actual)

Performance has steadily improved, and for the last two years, all States met or exceeded the 20 percent goal. The mean violation rate across all States/Territories was 10.5 percent in FY 2007 and it has declined to 9.9% in FY 2008.

Because of such significant improvement, CSAP has set a new program goal to encourage all States to reduce the sales rate to less than 10% which is in keeping with the initial intent of the legislation, to reduce minors' access to tobacco products. It is also consistent with research suggesting that effectively reducing youth access requires rates lower than the 20% target. This in no way changes the legally required target rate of 20%, but provides CSAP and States with a program goal that fits the legislative intent. In FY 2007, 25 states reported rates below 10% and in FY 2008, 26 reported rates below 10%.

Other Set-Aside Activities

Table 26: Key Performance Outcomes for CSAP's SAPTBG Prevention Set-aside Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.50	Increase perception of harm of drug use[27]	72.3%	73.2%	75%	73%	Retiring	Retiring	Retiring
2.3.51	Improvements in non-use (percent ages 12 and older who report that they have never used illicit substances)[27]	54.2%	53.9%	56%	53.9%	Retiring	Retiring	Retiring
2.3.52	Improvements in use (30-day use)[27]	7.9%	8.1%	6.9%	8.3%	Retiring	Retiring	Retiring
2.3.54	Number of participants served in prevention programs			Baseline	6,322,551	17,482,060	25,258,287	17,482,060
2.3.63	Percent of States showing an increase in State level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17)					Baseline	45.1%	45.1%
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+)					Baseline	27.4%	27.5%
2.3.65	Percent of States showing a decrease in State level					Baseline	51%	51%

[27] FY 2006 NSDUH does not report composite results. CSAP's Data Coordination and Consolidation Center therefore recalculated the baseline and FY 2006 results as the mean of the separate NSDUH results for each drug of the percent of respondents reporting perceived moderate to great risk of any of the drugs.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
	estimates of percent of survey respondents who report 30 day use of alcohol (age 12-20)							
2.3.66	Percent of States showing a decrease in State level estimates of percent of survey respondents who report 30 day use of alcohol (age 21+)					Baseline	37.3%	37.3%
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)					Baseline	52.9%	52.9%
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+)					Baseline	33.3%	33.3%
2.3.69	Percent of program costs spent on evidence-based practices (EBP)					Baseline	69%	70%

[Go to Data Source and Validation for Performance Measures from CSAP's SAPTBG 20% Set-aside Activities]

Table 27: Key Performance Outputs for CSAP's SAPTBG Prevention Set-aside Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
2.3.53	Number of evidence-based policies, practices, and strategies implemented: cumulative			Baseline	10,090	11,000	17,056	24,022

[Go to Data Source and Validation for Performance Measures from CSAP's SAPTBG 20% Set-aside Activities]

Measures 2.3.50, 2.3.51, and 2.3.52 have been used in recent years as proxy measures for the 20% set-aside. Since they are population based measures taken from the National Survey on Drug Use and Health (NSDUH), they do not reflect change at a grantee level and thus have been retired. They are replaced with separate measures reflecting the percentage of States improving on State-level estimates from the NSDUH. The table includes FY 2008 actual data for these measures.

We are replacing the cost band measure with a new efficiency measure (2.3.69), the percent of block grant dollars spent on evidence-based practices (EBPs). In FY 2008, this was 69%.

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

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Center for Substance Abuse Treatment (CSAT)

Treatment Programs of Regional and National Significance (PRNS) - Capacity

Access to Recovery (ATR)

Table 28: Key Performance Outcomes for CSAT's ATR Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.33	Increase the percentage of adults receiving services who: a) had no past month substance use	78%	81.4%	81%	84.7%	80%	82.3%	81%
1.2.34	b) had improved family and living conditions	62%	51%	52%	59.9%	52%	52.9%	52%
1.2.35	c) had no involvement with the criminal justice system	95%	96.8%	97%	97.6%	96%	96%	96%
1.2.36	d) had improved social support	89%	90%	90%	75.1%	90%	91.7%	90%
1.2.37	e) were currently employed or engaged in productive activities	56%	50%	50%	61.7%	53%	59.1%	53%
1.2.39	Cost per client served[28]				$1,605	$1,605	$1,888	$1,588

[Go to Data Source and Validation for Performance Measures from CSAT's Access to Recovery Program]

Table 29: Key Performance Outputs for CSAT's ATR Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.32	Increase the number of clients gaining access to treatment[29]	23,138	96,959	50,000	79,150	30,000	50,845	65,000

[Go to Data Source and Validation for Performance Measures from CSAT's Access to Recovery Program]

All FY 2008 outcome targets for this program were met or exceeded. Based on data, targets were set at appropriate levels and were neither missed nor substantially exceeded.

[28] Successful result is *below* target.

[29] 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.

The target for number of clients served was substantially exceeded. Grantees performed exceptionally well once infrastructure and program processes were full 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 3 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 PART review in CY2007.

In conjunction with the ATR PART review, an efficiency measure has been established. This measure, cost-per-client served, has been implemented with the second cohort of ATR grantees that were awarded in September 2007. SAMHSA is developing further refinements in this efficiency measure. The FY 2008 target for this measure was not met.

Screening, Brief Intervention, Referral and Treatment (SBIRT)

Table 30: Key Performance Outcomes for CSAT's SBIRT Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.41	Increase the percentage of clients receiving services who had no past month substance use	39.8%	47.5%	48%	45.7%	48%	46.5%	50%

[Go to Data Source and Validation for Performance Measures from CSAT's Screening, Brief Intervention, Referral and Treatment Program]

Table 31: Key Performance Outputs for CSAT's SBIRT Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.40	Increase the number of clients served	155,267	182,770	184,597	138,267	139,650	192,840	192,840

[Go to Data Source and Validation for Performance Measures from CSAT's Screening, Brief Intervention, Referral and Treatment Program]

The target for numbers served in FY 2008 was substantially exceeded. As seen in the data above, the target for FY 2007 was missed due to a grantee/contractual issue. SAMHSA worked with the grantee to address and resolve the issue. As

evidenced in the data for FY 2008, the issue has been resolved and grantees exceeded the target for number of clients to be served.

The target for number of clients receiving services who had no past month substance use 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.

Substance Abuse Drug Courts

Table 32: Key Performance Outcomes for CSAT's Drug Court Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.62	**Juvenile**: Percentage of clients that complete treatment		68%	69%	73%	74%	75.1%	75%
1.2.63	**Juvenile**: Increase percentage of clients receiving services who: a) Were currently employed or engaged in productive activities		86%	87%	86%	87%	86%	88%
1.2.64	**Juvenile**: Increase percentage of clients receiving services who: b) Had a permanent place to live in the community		77%	78%	80%	81%	81%	82%
1.2.65	**Juvenile**: Increase percentage of clients receiving services who: c) Had no involvement with the criminal justice system		90.3%	91%	91%	92%	94.3%	93%
1.2.66	**Juvenile**: Increase percentage of clients receiving services who: d) Experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences		89%	90%	91.2%	92%	92%	93%
1.2.67	**Juvenile**: Increase percentage of clients receiving services who: e) Had no past month substance use		68%	69%	71%	72%	69%	73%
1.2.68	**Juvenile**: Percent of drug court participants who exhibit a reduction in substance use while in the drug court program. (Developmental)						TBD	TBD

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.69	**Juvenile**: Reduce cost-per-client served[30]		$8,742	$6,742	$6,463	$5,905	$6,790	$5,610
1.2.71	**Adult**: Percentage of clients that complete treatment	61%	66%	N/A	N/A	N/A	N/A	67%
1.2.72	**Adult**: Increase percentage of clients receiving services who: a) Were currently employed or engaged in productive activities	70%	86%	N/A	N/A	N/A	N/A	88%
1.2.73	**Adult**: Increase percentage of clients receiving services who: b) Had a permanent place to live in the community	69.9%	77%	N/A	N/A	N/A	N/A	82%
1.2.74	**Adult**: Increase percentage of clients receiving services who: c) Had no involvement with the criminal justice system	89%	90.3%	N/A	N/A	N/A	N/A	93%
1.2.75	**Adult**: Increase percentage of clients receiving services who: d) Experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences	86.6%	89%	N/A	N/A	N/A	N/A	93%
1.2.76	**Adult**: Increase percentage of clients receiving services who: e) Had no past month substance use	67%	68%	N/A	N/A	N/A	N/A	73%
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.						TBD	TBD
1.2.78	**Adult**: Reduce cost-per-client served[30]			N/A	N/A	N/A	N/A	$5,610

[Go to Data Source and Validation for Performance Measures from CSAT's Substance Abuse Treatment Drug Courts Program]

Table 33: Key Performance Outputs for CSAT's Drug Court Program

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.70	**Juvenile**: Increase number of clients served		477	821	856	929	783	449
1.2.79	**Adult**: Increase number of	796	357	N/A	N/A	N/A	N/A	965

[30] Successful result is *below* target.

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
	clients served							

[Go to Data Source and Validation for Performance Measures from CSAT's Substance Abuse Treatment Drug Courts Program]

The Treatment Drug Court Program met or exceeded its housing, criminal justice, social consequences, and treatment completion targets. Employment and abstinence targets were slightly missed. The targets were missed by a small amount and program performance was not affected.

The targets for number served and cost per client served were missed. This was due to the fact that the juvenile grants in this program were in their last year and were phasing out their projects during FY 2008. As adult programs were not funded for 2008, data are not available for this group. Data for adult programs will be reported in FY 2009.

All Other Capacity[31]

Table 34: Key Performance Outcomes for CSAT's PRNS Other Capacity Activities

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.25	Increase percentage of adults receiving services who: Had no past month substance use	64.1%	63%	63%	59%	63%	62%	61%
1.2.27	Increase percentage of adults receiving services who: a) Were currently employed or engaged in productive activities	48.9%	52%	52%	57%	52%	54.3%	54.3%
1.2.28	b) Had a permanent place to live in the community		49.3%	53%	46%	51%	47%	51%
1.2.29	c) Had no involvement with the criminal justice system		96%	96%	96%	96%	96%	96%
1.2.30	d) Experienced no/reduced alcohol or illegal drug related health, behavioral or social, consequences		67%	67%	65%	67%	68%	67%
1.2.31	Increase the percentage of grantees in appropriate cost bands		81%	80%	80%	80%	Oct 2009	78%

[31] 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.

[Go to Data Source and Validation for Performance Measures from CSAT's Programs of Regional and National Significance: Other Capacity Activities]

Table 35: Key Performance Outputs for CSAT's PRNS Other Capacity Activities

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.26	Increase the number of clients served	34,014	35,334	35,334	35,516	35,334	33,446	33,446

[Go to Data Source and Validation for Performance Measures from CSAT's Programs of Regional and National Significance: Other Capacity Activities]

The targets for employment, criminal justice, health consequences and social connectedness were either met or exceeded. The targets for abstinence, housing and number served were missed; however, the deviation is slight and does not affect overall program performance. Targets for FY 2009 are lower than FY 2008 target due to anticipated funding decreases.

Treatment Programs of Regional and National Significance (PRNS) – Science and Service[32]

Table 36: Key Performance Outcomes for CSAT's PRNS Science and Service Activities

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.4.01	Report implementing improvements in treatment methods on the basis of information and training provided by the program	87%	93%	93%	90%	90%	92%	92%
1.4.03	Increase the percentage of drug treatment professionals trained by the program who a) Would rate the quality of the events as good, very good, or excellent	95%	96%	96%	95%	96%	95%	96%
1.4.04	b) Shared any of the information from the events with others	86%	87%	90%	89%	90%	93.5%	92%
1.4.05	Increase the percentage of grantees in appropriate cost bands	100%	100%	100%	100%	100%	Oct 2009	100%

[Go to Data Source and Validation for Performance Measures from CSAT's Programs of Regional and National Significance: Science and Service Activities]

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

Table 37: Key Performance Outputs for CSAT's PRNS Science and Service Activities

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.4.02	Increase the number of individuals trained per year	28,630	23,141	23,141	20,516	20,516	21,490	21,490

[Go to Data Source and Validation for Performance Measures from CSAT's Programs of Regional and National Significance: Science and Service Activities]

All but one target, including output and outcome were either met or exceeded, which includes implementing improvements in treatment methods; and share information from events with others; increasing the percentage of grantees in appropriate cost bands; and increasing the number of clients served. The target for 1.4.03 (increasing percentage of treatment professionals who rate the quality of events highly) was missed, however, the deviation is slight and does not affect overall program performance.

Substance Abuse Prevention and Treatment Block Grant (SAPTBG) – Treatment Activities

Table 38: Key Performance Outcomes for CSAT's SAPTBG Treatment activities

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.42	Percentage of clients reporting change in abstinence at discharge	43%				46%	Nov 2009	Retiring
1.2.48	Percentage of clients reporting abstinence from drug use at discharge		68.3%	68.3%	73.7%	69.3%	Nov 2009	69.3%
1.2.49	Percentage of clients reporting abstinence from alcohol at discharge		73.7%	73.7%	80.9%	74.7%	Nov 2009	74.7%
1.2.47	Increase the percentage of States in appropriate cost bands	100%	65%	67%	65%	67%	Oct 2009	68%
1.2.50	Percentage of clients reporting being employed/in school at discharge		40.9%		42.9%	42.9%	Oct 2009	42.9%
1.2.51	Percentage of clients reporting no involvement with the Criminal Justice System		88.9%		88.9%	88.9%	Oct 2009	88.9%

[Go to Data Source and Validation for Performance Measures from CSAT's SAPTBG – Treatment Activities]

Table 39: Key Performance Outputs for CSAT's SAPTBG Treatment activities

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
1.2.43	Number of admissions to substance abuse treatment programs receiving public funding[33]	1,849,528	1,849,891	2,003,324	2,372,302	1,881,515	Oct 2010	1,881,515
1.2.44	Increase the number of States and Territories voluntarily reporting performance measures in their SAPT Block Grant application.	37	53	55	57	Retiring	Retiring	Retiring
1.2.45	Increase the percentage of States and Territories that express satisfaction with Technical Assistance (TA) provided	91%	83%	97%	92%	97%	Oct 2009	97%

[Go to Data Source and Validation for Performance Measures from CSAT's SAPTBG – Treatment Activities]

The long-term measure of change in abstinence at discharge is being retired and being replaced with two annual measures; one reflects abstinence from drug use at discharge and the other one reflects abstinence from alcohol at discharge. Baseline data have been reported and both measures exceeded their FY 2007 targets. New measures have also been added for employment and criminal justice involvement.

The performance target for admissions for FY 2006 was set at an approximate appropriate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance. The target of number of admissions served was exceeded with a total of 2.3 million admissions reported. All outcome targets (abstinence from drugs and alcohol use) were either met or exceeded. The measure related to percentage of grantees in cost bands was missed by a slight deviation which did not affect overall program performance.

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.

[33] Prior to FY 2007, the data for this measure 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.

Office of Applied Studies (OAS)

Substance Abuse Prevention and Treatment Block Grant (SAPTBG) - National Surveys

Table 40: Key Performance Outcomes for OAS's National Surveys

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
4.4.01	Availability and timeliness of data for the: a) National Survey on Drug Use and Health (NSDUH)	8 months	8 months	8 months	8 months	8 months	8 months	8 months
4.4.02	b) Drug Abuse Warning Network (DAWN)	12 months	16 months	12 months	14 months	10 months	22 months	10 months
4.4.03	c) Drug and Alcohol Services Information System (DASIS)	13 months	9 months	15 months	8 months	10 months	10 months	10 months

[Go to Data Source and Validation for Performance Measures from OAS's National Surveys]

The target for the National Survey on Drug Use and Health was met. The performance target for the Drug Abuse Warning System was set at an approximate target level, and the deviation from that level was 12 months. There was an effect on overall program or activity performance. The delay in publication occurred because the national estimates were calculated incorrectly by the contractor. This required a detailed examination of their process for weighting and estimation. New weights had to be produced. These required extensive quality assurance. The publication had to be rewritten. The target for the Drug and Alcohol Services Information System was met.

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Agency Support for the Strategic Plan

Table 41: Substance Abuse and Mental Health Services Administration: Link to HHS Strategic Goals

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

HHS Strategic Goals	**Accountability:** Measure and report program performance	**Capacity:** Increase service availability	**Effectiveness:** Improve service quality
4.2 Increase basic scientific knowledge to improve human health and human development			
4.3 Conduct and oversee applied research to improve health and well-being			
4.4 Communicate and transfer research results into clinical, public health, and human service practice	X		

Summary of Findings and Recommendations from Completed Program Evaluations

Further details on SAMHSA's completed evaluations completed during any fiscal year can be found at the HHS Policy Information Center website (http://aspe.hhs.gov/pic/performance)

Title: Evaluation of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program: Phase III Evaluation Report
Coordinating Office: SAMHSA's Center for Mental Health Services

The independent evaluation of the PAIMI Program found that individual PAIMI programs provide those individuals with psychiatric disability a voice in the exercise of their rights and are highly successful in achieving client and system goals and objectives. Findings show that PAIMI clients are very satisfied with the individual advocate or attorney who provided their services. Of the PAIMI clients surveyed: 82% believe the advocate/attorney listened to their story and truly understood their circumstance; 92% believe their advocate/attorney did everything they could do to obtain the outcome s/he wanted; 70% felt the quality of their representation was "excellent," and 24% felt it was "good." Twenty percent of grantees sampled report that they met or partially met all projected goals and objectives, and overall, grantees reported having met 93% of targeted goals and objectives. The evaluation also found that P&A Executive Directors felt that insufficient resources have diminished PAIMI's capability for work in vital areas such as jail advocacy, outreach, hospital monitoring, and housing.

Title: HIV Cohort 4 and 5 APR Evaluation
Coordinating Office: SAMHSA's Center for Substance Abuse Prevention

These two programs were designed to address the following three goals:

1. Increase provision of effective integrated substance abuse and HIV prevention services to minority youth and adults at-risk for substance abuse and HIV infection.
2. Increase number of community-based organizations that provide effective integrated substance abuse and HIV prevention services to minority youth and adults at-risk for substance abuse and HIV infection.
3. Increase the capacity of community-based organizations to successfully sustain their integrated prevention services. –

There were 22 cohort 4 and 45 cohort 5 grantees totaling 67. Nineteen or 86% of the cohort 4 and 33 or 73% of the cohort 5 grantees submitted data abstract forms totaling 52 or 78%. About 50% of them were community-based organizations located primarily in urban areas. More than half implemented evidence-based programs with the two most popular ones being "Be Proud, Be

Responsible," and "Street Smart." For the most part, social learning and cognitive theory served as their theoretical framework. Most program participants were in the 12-17 and 18-25 year-old age groups. The majority were Black and Hispanic and there were slightly more females than males. The most commonly used recruitment strategies were word-of-mouth, telephone, radio and community outreach. Both individual and group interventions were used. The individual interventions included risk reduction counseling, education, health education, peer education and mentoring. The most commonly employed group interventions were skill building, health education, and cultural enhancement activities. Thirteen of the grantees conducted HIV testing and 27 provided other health care services.

Sixteen or (73%) of the 22 cohort 4 and 40 or 89% of the 45 cohort 5 grantees submitted participant level data equaling 56 or 84% of the total 67 grantees. From this pool of data, 48% could be used to assess program outcomes. This equals 3,207 participants of whom 61.9% were from cohort 4 and 38.1% from cohort 5. At baseline, these participants exhibited lower perception of risk attitudes towards smoking and binge drinking as well as disapproval of substance use by peers than did National Survey of Drug Use and Health (NSDUH), respondents. On the other hand the participants reported higher past 30 day substance use rates than did the NSDUH respondents.

In order to determine how effective the program was only data from matched participant pairs could be used. The number of matched pairs of program entry and exit for youth ranged from 3,400 to 2,620, and for adults they ranged from 300 to 350. For perception of harm, the program demonstrated positive change for all measures except for adults and drinking to 4-5 drink/day. Likewise for disapproval of substance use, the program demonstrated positive increases for all measures except for adults in regard to smoking 1-2 packs/day and smoking marijuana once per twice/day. The numbers of matched pairs for non-user stability and user decrease declined substantially. For non-user stability the number of youth matched pairs ranged from 1,065 to 2,080, however the rates of non-user stability remained high ranging from 90-99%. For adults the number of matched pairs declined to 70-380, but here too the non-user percentages remained high ranging from 83-100% For past 30 day user decrease, the number of youth matched pairs declined further, but the results were impressive ranging 60% for alcohol to 100% for heroin. For adults the declines were also impressive ranging from 31% for cigarettes to 59% for cocaine.

Title: National Survey of Substance Abuse Treatment Services (N-SSATS): 2006. Data on Substance Abuse Treatment Facilities
Coordinating Office: SAMHSA's Office of Applied Studies

This report presents results from the 2006 National Survey of Substance Abuse Treatment Services (N-SSATS), and annual census of facilities providing

substance abuse treatment. The N-SSATS is designed to collect data on the location, characteristics, and use of alcoholism and drug abuse treatment services throughout the 50 States, the District of Columbia and other U.S. jurisdictions. In 2006, 13,771 facilities reported a one-day census of 1,130,881 clients enrolled in substance abuse treatment on March 31, 2006. Facilities operated by private non-profit organizations made up the bulk of treatment facilities (58%). Private for-profit facilities made up 29% of all facilities in 2007, with the remaining facilities operated by local governments (7%), state governments (3%), the Federal government (2%) and tribal governments (1%). Ninety percent of clients in treatment were in outpatient treatment programs, nine percent were in non-hospital residential treatment programs and one percent were in hospital inpatient treatment settings. Eight percent of clients were under the age of 18. Opioid Treatment Programs (OTPs) that provide medication-assisted therapy (methadone or buprenorphine) for the treatment of opioid addiction were available at 9 percent of substance abuse treatment facilities. Clients receiving methadone accounted for twenty-three percent of all clients in treatment on March 31, 2006.

Title: Results from the 2007 National Survey on Drug Use and Health: National Findings
Coordinating Office: SAMHSA's Office of Applied Studies

The 2007 National Survey on Drug Use and Health was administered to a sample of 67,870 persons representative of the U.S. civilian, noninstitutional population aged 12 or older. This initial report on the 2007 data provided national estimates of rates of use, numbers of users, persons meeting criteria for substance use disorders, substance use treatment, and other measures related to illicit drugs, alcohol, and tobacco products. Results also were presented for measures of mental health problems, including major depressive episode and serious psychological distress, as well as data on the co-occurrence of substance use disorders and mental health problems. In 2007, an estimated 19.9 million Americans aged 12 and older (8.0%) were current (past month) illicit drug users, a rate similar to that in 2006 (8.3% or 20.4 million users) and in 2002-2005. Among youths aged 12 to 17, 9.5% were current illicit drug users, down from 11.6% in 2002. Current marijuana use among youths aged 12-17 declined from 8.2% in 2002 to 6.7% in 2007. In 2007, 127 million persons aged 12 or older (51.1%) were current alcohol users; 57.8 million (23.0%) engaged in binge drinking at least once in the past month. Underage drinking (ages 12-20) has remained unchanged since 2002, and was 27.9% in 2007. The rate of current use of any tobacco product among persons aged 12 or older decreased from 29.6% in 2006 to 28.6% in 2007; current cigarette smoking declined from 26.0% in 2002 to 24.2% in 2007. Among youths aged 12-17, the rate changed little from 2006 (10.4%) to 2007 (9.8%) but is lower than the rate in 2002 (13.0%). In 2007, an estimated 23.2 million persons aged 12 or older (9.4%) needed treatment for an alcohol or illicit drug problem. Of those persons, 2.4 million (10.4%) received treatment at a specialty facility; 20.8 million in need of treatment did not receive

care. In 2007, an estimated 16.5 million adults aged 18 or older (7.5%) and 2.0 million youths aged 12 to 17 (8.2%) had a major depressive episode (MDE) in the past year. Around 24.3 million adults aged 18 or older (10.9%) had serious psychological distress (SPD) in the past year.

Title: State Estimates of Substance Use from the 2005–2006 National Surveys on Drug Use and Health
Coordinating Office: SAMHSA's Office of Applied Studies

Researchers prepared State estimates for 23 measures of substance use or mental health problems based on the 2006 and 2007 National Surveys on Drug Use and Health. The surveys are ongoing and cover the civilian, non-institutionalized population of the United States aged 12 years or older. These estimates are based on combined data collected from 136,110 respondents surveyed in 2005 and 2006. Past month use of illicit drugs for all persons aged 12 or older ranged from a low of 5.7% in North Dakota to a high of 11.2% in Rhode Island. The percentage of persons aged 12 or older who used an illicit drug in the past month increased in the period between the 2004-2005 and 2005-2006 NSDUH surveys in Washington State from 8.5 to 10%. The level decreased in Kentucky during this period from 8.4 to 7.0%. Utah had the lowest level of past month marijuana use among persons age 12 or older (4.3%). Vermont had the highest level of past month marijuana use among the same age group (9.7%). Georgia had the lowest level of past month underage binge drinking of alcohol (15.2%), and North Dakota had the highest level (28.5%). Increases in underage drinking levels between the 2004-2005 and 2005-2006 NSDUH surveys occurred in Arkansas (from 25.2 to 28.7%), Nevada (from 25.1 to 27.9%), and Vermont (from 34.0 to 38.3%). Arkansas and Vermont also experienced increases in underage binge alcohol use during this same period (Arkansas from 17.0 to 19.4%, and Vermont from 24.5 to 28.0%). The percentage of persons with a substance use disorder, including either drug or alcohol dependence or abuse, ranged from a low of 7.5% in New Jersey to a high of 12.3% in the District of Columbia. Hawaii had the lowest level of people age 18 or over reporting at least one major depressive episode in the past year (5.0%) while Nevada had the highest rate (9.4%).

Title: Substate estimates from the 2004-2006 National Surveys on Drug Use and Health
Coordinating Office: SAMHSA's Office of Applied Studies

This report presents estimates for 23 substance abuse and mental health-related behavior levels in 345 substate regions representing all 50 states and the District of Columbia. The results were based on the combined data from SAMHSA's 2004 to 2006 National Surveys on Drug Use and Health (NSDUH) and involved responses from 203,870 people aged 12 or older throughout the United States. The report offers highly detailed analyses of the substance abuse and mental health problems occurring within these smaller geographical areas. For example,

one of the smaller geographical areas in the survey --Utah's Salt Lake and Weber-Morgan Counties – have among the nation's highest levels of persons aged 12 or older using pain relievers for non-medical reasons. In these two counties, levels were as high as 7.92%. In contrast, areas of the District of Columbia had some of the nation's lowest levels of this type of substance abuse, as low as 2.48% in parts of the city. Yet the exact same communities in Utah had the among the nation's lowest levels of underage binge alcohol use in the past month (as low as 8.72% of those age 12 to 20). The District of Columbia had equally low levels in some parts of the city, but other parts had some of the nation's highest levels (as high as 39.01% among this age group). For cigarettes, the highest rate of past month use was in West Virginia's South Central II region (35.4%), and the lowest rate was in Utah County, Utah (15.9%). The majority of the 15 substate regions with the highest rates of past month cigarette use were in Kentucky (3 regions) and West Virginia (6 regions). Of the 15 substate regions with the lowest rates of past month cigarette use, 9 were in California and 4 were in Utah.

Title: Treatment Episode Data Set (TEDS) 2005. Discharges from Substance Abuse Treatment Services
Coordinating Office: SAMHSA's Office of Applied Studies

This report presents results from the Treatment Episode Data Set (TEDS) for clients discharged from substance abuse treatment in 2005. The report provides information on treatment completion, length of stay in treatment, and demographic and substance abuse characteristics of approximately 1.5 million discharges from alcohol or drug treatment in facilities that report to individual State administrative data systems. The report includes data on 1,454,768 discharges submitted by 34 States. In 2005, treatment was completed by 41 percent of the reported discharges. Thirteen percent were transferred to further treatment, 24% dropped out of treatment, 8% had treatment terminated by the facility, 2% had treatment terminated because of incarceration, less than 1% died, and 13% failed to complete treatment for other reasons or the reason for discharge was unknown. Among discharges not receiving medication-assisted therapy for opioid addiction, the median length of stay (LOS) in treatment was greatest for discharges from outpatient treatment (76 days), followed by long-term residential treatment (53 days) and intensive outpatient treatment (46 days). The median LOS for short-term residential treatment was 21 days; for hospital residential treatment, 16 days, and for detoxification, 3 days. The strongest predictor of treatment completion or transfer to further treatment was the use of alcohol rather than other drugs. Clients whose primary substance of abuse was alcohol were 82% more likely to complete treatment or transfer to further treatment than clients whose primary substance was another drug.

Title: Treatment Episode Data Set (TEDS) Highlights - 2006. National Admissions to Substance Abuse Treatment Services
Coordinating Office: SAMHSA's Office of Applied Studies

This report presents summary results from the Treatment Episode Data Set (TEDS) for 2006. The report provides information on the demographic and substance abuse characteristics of the 1.8 million annual admissions to treatment for abuse of alcohol and drugs in facilities that report to individual State administrative systems. This summary report is issued in advance of the full TEDS report for 1996-2006. It includes all items from the TEDS Minimum Data Set. The full report will include data from the Supplemental Data Set, State data, and State rates. Five substances accounted for 96% of all TEDS admissions in 2006: alcohol (40%); opiates (18%, primarily heroin); marijuana/hashish (16%); cocaine (14%); and stimulants (9%, primarily methamphetamine). Among all racial/ethnic groups except Hispanics of Puerto Rican origin, primary alcohol use (alone or in combination with other drugs) was the most frequently reported substance at treatment admission. Among persons of Puerto Rican origin, opiates were the most frequently reported substance at admission.

Title: Underage Alcohol Use: Findings from the 2002-2006 National Surveys on Drug Use and Health
Coordinating Office: SAMHSA's Office of Applied Studies

Using data from a sample of 158,000 people aged 12 to 20 from the combined 2002 to 2006 National Surveys on Drug Use and Health (NSDUH), this report found that more than 40% of the nation's estimated 10.8 million underage current drinkers (persons aged 12 to 20 who drank in the past 30 days) were provided free alcohol by adults 21 or older. One in 16 underage drinkers (6.4% or 650,000) was given alcoholic beverages by their parents in the past month. More than half (53.9%) of all people aged 12 to 20 engaged in underage drinking in their lifetime, ranging from 11.0% of 12 year olds to 85.5% of 20 year olds. About one in five people in this age group (7.2 million people) have engaged in binge drinking – consuming five or more drinks on at least one occasion in the past month. An average of 3.5 million people aged 12 to 20 each year (9.4%) meet the diagnostic criteria for having an alcohol use disorder (dependence or abuse). The vast majority of current underage drinkers (80.9%) reported being with two or more people the last time they drank. Those who were with two or more people consumed an average of 4.9 drinks on that occasion, compared with 3.1 drinks for those who were with one other person and 2.9 drinks for those who were alone. Among youths aged 12 to 14 the rate of current drinking was higher for females (7.7%) than males (6.3%), about equal for females and males among those aged 15 to 17 (27.6 and 27.3%, respectively), and lower for females than males among those aged 18 to 20 (47.9 vs. 54.4%). Over half (53.4%) of underage current alcohol users were at someone else's home when they had their last drink, and 30.3% were in their own home; 9.4% were at a restaurant, bar or club. Rates of binge drinking are significantly higher among young people living with a parent who engaged in binge drinking within the past year.

Data Source & Validation

Table 42: Data Source and Validation for Performance Measures from CMHS's Suicide Prevention Programs

#	Data Source	Data Validation
2.3.57	National Vital Statistics Report, Centers for Disease Control and Prevention	See Technical Notes in National Vital Statistics Reports http://www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_19.pdf : Data reporting for this survey has a 3 year lag time. The 2005 data is expected out in April 2008. Due to the lag in "number of suicide deaths" data reporting, measuring performance of the programs in real time or setting targets for out years is difficult
2.3.58	Suicide Prevention Exposure, Awareness and Knowledge Survey (SPEAKS). This survey is part of the Garrett Lee Smith program cross-site evaluation, and is conducted annually.	Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
2.3.59	Training Exit Survey (TES) and a Training Activity Report (TAR) as part of the GLS cross-site evaluation	Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
2.3.60	Data for the number of youth screen are reported in the Early Identification Referral and Follow-up (EIRF) Aggregate and Individual Forms from 14 Cohort 1 & 2 sites	Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the cross-site evaluation to establish the accuracy and reliability of data used to measure the outcome measures. These techniques include double entry of data; range checks coded into the data entry program; and assessing concurrent validity with other measures of the same indicator.
2.3.61	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.

[Go to Data Table - Suicide Prevention]

Table 43: Data Source and Validation for Performance Measures from CMHS's SS/HS Program

#	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.
3.2.05	Data on children's outcomes	Grantees implement various forms of data validation as part of their local

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

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

[Go to Data Table - Safe Schools/Healthy Students – SS/HS]

Table 44: Data Source and Validation for Performance Measures from CMHS's Trauma-Informed Services Program

#	Data Source	Data Validation
3.2.01	Data for number of children served are reported quarterly by grantees utilizing a program-wide electronic Service Utilization Form (eSUF).	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. ("Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected.) Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.
3.2.02	Baseline and follow-up data are collected through the Core Data Set (CDS), a secure web-based system, and three standardized behavioral/symptomology measures (CBCL, TSCC, and PTSD-RI) are used to assess improvement in children's outcomes. Data for training are based on General Adoption Assessment Survey (GAAS) results from the Adoption of Methods/Practices component of the NCTSI National Cross-Site Evaluation.	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. ("Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected.) Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.
3.2.03	The Efficiency Measure is calculated by dividing the budget devoted to clinical services by the number of children and adolescents receiving trauma-informed services. Data for number of children served are reported quarterly by grantees utilizing a program-wide electronic Service Utilization Form (eSUF).	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. ("Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected.) Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.
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 professional trained is reported quarterly by grantees	Duke Clinical Research Institute (DCRI) performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. ("Validation" includes, but is not limited to,

#	Data Source	Data Validation
	utilizing a program-wide electronic Service Utilization Form (eSUF).	data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected.) Evaluation coordinators at ORC Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.

[Go to Data Table - Trauma-Informed Services]

Table 45: Data Source and Validation for Performance Measures from CMHS's Remaining Capacity Programs

#	Data Source	Data Validation
1.2.01	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
1.2.02	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
1.2.03	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.05	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.06	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
1.2.07	For the long term measure, the numerator is the number of people receiving services through the state public mental health system, as reported by the Uniform Reporting System (http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics) The denominator is derived from the National Co-morbidity Study Replication (http://archpsych.ama-assn.org/cgi/content/full/62/6/593), census data, and the 1997 CMHS Client-Patient Sample Survey, as reported in Mental Health 2000 and Mental Health 2002 (see	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp.Data validation for the Co-Morbidity Study is available at http://archpsych.ama-assn.org/cgi/content/full/62/6/593

#	Data Source	Data Validation
	http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/)	
1.2.08	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
1.2.09	Uniform Reporting System	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp

[Go to Data Table - Remaining Capacity Programs]

Table 46: Data Source and Validation for Performance Measures from CMHS's Co-Occurring State Incentive Grant Program

#	Data Source	Data Validation
1.2.18	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.19	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.20	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.17	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.

[Go to Data Table - Co-Occurring State Incentive Grants]

Table 47: Data Source and Validation for Performance Measures from CMHS's Comprehensive Community Mental Health Services for Children and Their families

#	Data Source	Data Validation
3.2.11	Data on children's outcomes are collected from a multi-site outcome study. Data on clinical outcomes were derived from Reliable Change Index scores (Jacobson & Truax, 1991), calculated from entry into services to six months for the Total Problem scores of the Child Behavior Checklist (CBCL, Achenbach,	The Reliable Change Index is a standardized method developed by Jacobson and his colleagues to measure change between two data points. The Reliable Change Index has a clear-cut criterion for improvement that has been psychometrically tested and found to be sound (Jacobson & Truax, 1991).

#	Data Source	Data Validation
	1991).	
3.2.12	Data on children's outcomes are collected from a multi-site outcome study.	Validity analyses were conducted for school attendance and law enforcement contacts. School attendance was found to have a positive relationship with school performance. Children who attended school frequently also had some tendency to receive good grades. The correlation between the two was .313 (p = .000
3.2.13	Delinquency is reported using a self-report survey	Validity analyses were conducted for school attendance and law enforcement contacts
3.2.14	The decrease in days of inpatient facilities utilization per child is calculated for a sample of children with complete data on inpatient hospitalization use at both intake and 6 months assessment points. Decrease in inpatient hospitalization days = total number of inpatient days at 6 months – total number of inpatient days at intake. The scale used to assess inpatient-residential treatment is the Living Situations Questionnaire, was adapted from the Restrictiveness of Living Environments Scale and Placement Stability Scale (ROLES) developed by Hawkins and colleagues (1992)	The Reliable Change Index is a standardized method developed by Jacobson and his colleagues to measure change between two data points. The Reliable Change Index has a clear-cut criterion for improvement that has been psychometrically tested and found to be sound (Jacobson & Truax, 1991).
3.2.15	Former grantee communities are surveyed 5 years after funding ends	Data are validated by evaluation contractor and subject to project officer review
3.2.16	Grantee reports	Data are validated by evaluation contractor and subject to project officer review
3.2.17	The efficiency measure is computed by calculating the average decrease in days of inpatient facilities utilization per child at six months and multiplying the decrease by the average daily hospitalization charges. The cost savings figure is then converted to a rate per 1,000 children served by the program across all sites. The average daily hospitalization charges = $1,335. National	Data are validated b y evaluation contractor and subject to project officer review

#	Data Source	Data Validation
	estimates of average daily hospitalization charges were obtained from Health Care Utilization Project Nationwide Inpatient Sample (NIS) 2001	

[Go to Data Table - Comprehensive Community Mental Health Services for Children and Their Families]

Table 48: Data Source and Validation for Performance Measures from CMHS's Protection and Advocacy for Individuals with Mental Illness Program

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

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

#	Data Source	Data Validation
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

[Go to Data Table - Protection and Advocacy for Individuals with Mental Illness]

Table 49: Data Source and Validation for Performance Measures from CMHS's Projects for Assistance in Transition from Homelessness

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

[Go to Data Table - Projects for Assistance in Transition from Homelessness]

Table 50: Data Source and Validation for Performance Measures from CMHS's Community Mental Health Services Block Grant Program

#	Data Source	Data Validation
2.3.07	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.08	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.09	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.10	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.11	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.12	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.13	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.14	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.15	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.16	Uniform Reporting System.	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp
2.3.17	Uniform Reporting System. This measure is calculated by dividing the number of adults with SMI and children/adolescents with SED who received evidence based practices during the FY by the MHBG allocation for the FY in question, multiplied by 10,000	See http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/about_urs2002.asp

[Go to Data Table - Community Mental Health Services Block Grant]

Table 51: Data Source and Validation for Performance Measures from CSAP's Strategic Prevention Framework State Incentive Grant Program

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

#	Data Source	Data Validation
	calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	activities are submitted by states to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.
2.3.25	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.
2.3.26	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.
2.3.27	Baselines and annual targets for each state will be calculated using 2 years of pooled data from the National Survey on Drug Use and Health. Pooled NSDUH data from 2003/2004 and 2004/2005 were used to calculate the 2007 figures. 2006 state estimates were received too late to use in calculations.	Information on methodology and data verification for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Data related to state activities are submitted by states to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate.
2.3.28	Output measures are obtained from grantee administrative reports	Data related to state activities are submitted by states to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance

#	Data Source	Data Validation
		monitoring.
2.3.29	Output measures are obtained from grantee administrative reports	Data related to state activities are submitted by states to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance monitoring.
2.3.30	Output measures are obtained from grantee administrative reports	Data related to state activities are submitted by states to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance monitoring.
2.3.31	Output measures are obtained from grantee administrative reports	Data related to state activities are submitted by states to the SPF-SIG Cross-Site Evaluation contractor. The Cross-site Evaluation team works directly with grantees to insure that data are complete and accurate. State Project Officers also review the data to assure accuracy. An online data entry system is being developed to increase access and ease of use for data entry and compliance monitoring.

[Go to Data Table - Strategic Prevention Framework-State Incentive Grants]

Table 52: Data Source and Validation for Performance Measures from CSAP's Programs of Regional and National Significance: Other Capacity Activities: Minority AIDS Initiative

#	Data Source	Data Validation
2.3.35	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center (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 to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DACCC Data Analysis Team for analysis and reporting.
2.3.38	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center (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 to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DACCC Data Analysis Team for analysis and reporting.
2.3.39	Data will be provided by grantees. A web-based data collection and reporting mechanism has been implemented and all grantees have received training in using the system.	Data are carefully collected, cleaned, analyzed, and reported by CSAP's integrated Data Analytic Coordination and Consolidation Center (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 to the Government Project officer who works with the Program project Officers to identify a resolution. The Data Management Team then makes any required edits to the files. The edited files are then available to CSAP staff and the DACCC Data Analysis Team for analysis and reporting.

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

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

[Go to Data Table - Minority AIDS Initiative]

Table 53: Data Source and Validation for Performance Measures from CSAP's Programs of Regional and National Significance: Science and Service Activities

#	Data Source	Data Validation
2.3.32	CAPT Annual Reports. The reports reflect data from the national CAPT data collection system.	Each CAPT follows a quality control protocol prior to collecting and submitting data, and CSAP has established an external quality control system through a support contractor overseen by CSAP staff.
2.3.33	CAPT Annual Reports. The reports reflect data from the national CAPT data collection system.	Each CAPT follows a quality control protocol prior to collecting and submitting data, and CSAP has established an external quality control system through a support contractor overseen by CSAP staff.

[Go to Data Table - Centers for Application of Prevention Technologies (CAPT)]

Table 54: Data Source and Validation for Performance Measures from CSAP's SAPTBG: Synar Amendment Implementation Activities

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

[Go to Data Table - Synar Amendment Implementation Activities]

Table 55: Data Source and Validation for Performance Measures from CSAP's SAPTBG 20% Set-aside Activities

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

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

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

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

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

#	Data Source	Data Validation
		by regularly submitted program data inventories, preliminary reports and variable by variable cleaning sheets. The Data Management team then makes any required edits to the files. The edited files are then available to the DACCC Data Analysis Team for analysis and reporting. Grantees are instructed in the use of data collection protocols through grantee meetings and questionnaire administrative guides. The Block Grant Technical Assistance providers have also received training and have begun providing TA to the states..

[Go to Data Table - Other Set-Aside Activities
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Table 56: Data Source and Validation for Performance Measures from CSAT's Access to Recovery Program

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

[Go to Data Table - Access to Recovery]

Table 57: Data Source and Validation for Performance Measures from CSAT's Screening, Brief Intervention, Referral and Treatment Program

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

[Go to Data Table - Screening, Brief Intervention, Referral and Treatment]

Table 58: Data Source and Validation for Performance Measures from CSAT's Substance Abuse Treatment Drug Courts Program

#	Data Source	Data Validation
1.2.62	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.63	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.64	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.65	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.66	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.67	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.68	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.69	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.

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

[Go to Data Table - Substance Abuse Drug Courts]

Table 59: Data Source and Validation for Performance Measures from CSAT's Programs of Regional and National Significance: Other Capacity Activities

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

[Go to Data Table - All Other Capacity]

Table 60: Data Source and Validation for Performance Measures from CSAT's Programs of Regional and National Significance: Science and Service Activities

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

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

[Go to Data Table - Treatment Programs of Regional and National Significance (PRNS) – Science and Service]

Table 61: Data Source and Validation for Performance Measures from CSAT's SAPTBG – Treatment Activities

#	Data Source	Data Validation
1.2.42	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.43	Data are collected through standard instruments and submitted through the Treatment Episode Set. Data are then uploaded to CSAT'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.
1.2.44	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database
1.2.45	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA	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

#	Data Source	Data Validation
	data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities	into the database
1.2.47	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.48	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.49	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.50	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.2.51	Data are collected through standard instruments and submitted through the Treatment Episode Set. TA data are collected through an annual customer satisfaction survey with the States/territories on the Block Grant activities.	All data are automatically checked as they are submitted through the internal control processes in the Treatment Episode Data Set. Validation and verification checks run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

[Go to Data Table - Substance Abuse Prevention and Treatment Block Grant (SAPTBG)]

Table 62: Data Source and Validation for Performance Measures from OAS's National Surveys

#	Data Source	Data Validation
4.4.01	Publication date of NSDUH report	Project officer review
4.4.02	Publication date of DAWN report	Project officer review
4.4.03	Publication date of DASIS report	Project officer review

[Go to Data Table - Substance Abuse Prevention and Treatment Block Grant (SAPTBG) - National Surveys

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Slight Deviations between Target and Actual Result

The following table includes a list of performance measures for which the performance target was set at an approximate appropriate target level, and the deviation from that level is slight (<5% of the target). There was no effect on overall program or activity performance for any of these programs.

Table 63: Slight Deviations between Target and Result

Program	Measure Unique Identifier	Deviation as percent of target
MH PRNS: Remaining Capacity	1.2.03	-3.3%
CMHI	3.2.12	2.7%
CMHI	3.2.13	3.9%
PAIMI	3.4.08	-2.4%
PAIMI	3.4.09	4.7%
PAIMI	3.4.10	-4.4%
PAIMI	3.4.11	2.1%
PATH	3.4.18	<1%
MHBG	2.3.15	-2.7%
MHBG	2.3.16	-4.4%
MHBG	2.3.11	2.6%
SPF-SIG	2.3.30	-4.8%
CSAP HIV	2.3.35	-1.6%
ATR	1.2.33	2.9%
ATR	1.2.34	1.7%
ATR	1.2.36	1.9%
SBIRT	1.2.41	-3.1%
Substance Abuse Drug Courts	1.2.63	-1.2%
Substance Abuse Drug Courts	1.2.65	2.5%
Substance Abuse Drug Courts	1.2.67	-4.2%
CSAT PRNS Other capacity	1.2.25	-1.6%
CSAT PRNS Other capacity	1.2.27	4.4%
CSAT PRNS Other capacity	1.2.30	1.5%
CSAT PRNS Science and Service	1.4.01	2.2%
CSAT PRNS Science and Service	1.4.03	-1.0%
CSAT PRNS Science and Service	1.4.04	3.9%
CSAT PRNS Science and Service	1.4.02	4.7%
SAPTBG: Treatment Activities	1.2.47	3.1%

Discontinued Performance Measures

The following table includes a list of performance measures which have been discontinued since being reported in the Online Performance Appendix of the FY 2009 Congressional Justification available on the SAMHSA website at http://www.samhsa.gov/Budget/FY2009/SAMHSA_Online_appendix.pdf. Measures which are planned for retirement, but which still have data to report have been included in the program performance data tables on preceding pages.

Table 64: Discontinued Performance measures

Program	Measure Unique Identifier
MH PRNS: Remaining Capacity	1.2.04
COSIG	1.2.21
CSAP PRNS: Capacity	2.3.18
CSAP HIV	2.3.34
SAPTBG – 20% Prevention Set-Aside	2.3.55
ATR	1.2.38
Substance Abuse Drug Courts	1.2.56-1.2.61
SAPTBG – Treatment Activities	1.2.46

New Performance Measures

The following table includes a list of performance measures which have been added since the Online Performance Appendix of the FY 2009 Congressional Justification (available on the SAMHSA website at http://www.samhsa.gov/Budget/FY2009/SAMHSA_Online_appendix.pdf).

Table 65: New Performance Measures

Program	Measure Unique Identifier	Link
Trauma-Informed Services	3.2.23	See data for this measure: Trauma-Informed Services
CSAP HIV	2.3.70	See data for this measure: Minority AIDS Initiative
SAPTBG – 20% Prevention Set-Aside	2.3.69	See data for this measure: Other Set-Aside Activities
Substance Abuse Drug Courts	1.2.62-1.2.79	See data for these measures: Substance Abuse Drug Courts

Disclosure of Assistance by Non-Federal Parties

No non-Federal entities were involved in any significant role in the preparation of SAMHSA's 2008 Annual Performance Report.